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

Serving a population of around 365,000, the trust operates from three main hospital sites: Furness General Hospital in Barrow, Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal.

Furness General Hospital and the Royal Lancaster Infirmary have a range of acute services, with full accident & emergency departments, critical/coronary care units and consultant led beds.

Westmorland General Hospital provides a range of acute services, together with a primary care assessment service (PCAS).

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

(Source: Trust Website)

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 any specialist services provided at the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furness General Hospital</td>
<td>Dalton Lane, Barrow-in-Furness, LA14 4LF</td>
<td>All CQC acute core services</td>
</tr>
</tbody>
</table>


The trust also provides a number of community services, which are provided across a number of community locations.  
(Source: Routine Provider Information Return- Sites tab)

**Is this organisation well-led?**

**Leadership**

University Hospitals of Morecambe Bay Service NHS Foundation Trust was governed by a board of directors. Records we reviewed confirmed that the board met formally ten times a year at trust headquarters. Trust board meetings were held in public six times per year.

The senior leadership team at the trust consisted of the chief executive, chairman, five executive directors and six non-executive directors:

- Chief executive
- Chairman
- Medical director
- Chief nurse
- Director of governance
- Director of finance
- Chief operating officer
- Director of people & organisational development
- Seven non-executive directors

The chief executive officer and the chairman had commenced in post in April 2018. However, the chief executive officer had been in post at the trust since 2014 as the deputy chief executive officer and the director of finance. The chairman had extension experience to undertake his role, including a recent term as a chairman at a neighbouring trust.
There was an experienced and committed executive team who engender a positive "can do" attitude to addressing the operational and strategic challenges faced by the trust. All the executive directors were substantive and of good tenure except for the director of finance who came into post in April 2018. Executive directors held responsibility for the day to day running of the trust whilst the non-executive directors brought external expertise to the organisation and provided advice and guidance to the senior management team.

The trust has been held as an exemplar of governance by NHSI and in the last year and had provided peer support to the two other hospital trusts. The trust supported NHS England with a national review of complaints and the new system architecture.

The governance framework was designed to support the ward to board escalation of risks and challenge performance. The trust had leadership structures and processes (WESEE) and the care group level. Executive oversight and challenge were through operational meetings including monthly performance reviews.

Non-executive director challenge and oversight was through the board and the assurance committees. The structure enabled governors to observe non-executive directors in their roles as chair of the board assurance committees as well as receive regular reports at the council of governors.

There was an extensive nurse management structure with the chief nurse being in post since December 2013. There were also two directors of nursing, one for acute and one for community, each having a deputy director of nursing. Each of the clinical care groups had a triumvirate management arrangement which included an associate director of nursing, clinical director, and an associate director of operations. There were five clinical care groups across the trust which included:

- Core clinical services care group
- Medicine care group
- Surgery and critical care group
- Women’s and children’s care group
- Integrated community care group

During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of healthcare providers are fit and proper to carry out this important role. We reviewed six director’s files in total, of which two related to non-executive directors, two related to the newest appointments, including the chair and chief executive officer and one included the longest servicing director. We also reviewed the trust’s Fit and Proper Person Procedure (June 2016). We found that there was an error with the disclosure and barring service (DBS) check within one file where the person had commenced in post in April 2018, but the DBS check was only valid from October 2018. This had been due to an error within human resources (HR). The trust was working on two systems for their FPPR files, one being electronic and one being paper. We found some discrepancies within the files because of the two systems, including incorrect documentation of things such as number of references obtained and recruitment processes.

The trust had developed an OD strategy, named ‘shaping the future’ which outlined the trust approach to systems leadership, compassionate inclusive leadership skills and talent
management. The trust reported their approach sat within a wider context of development within local, regional and national leadership development programmes – supporting broad scale strategic development taking a cohesive approach across a number of strands to support development within the trust. This included year on year participation in National Leadership Academy trainings, Graduate Management Training Scheme, and leadership training at various levels.

The trust informed us leadership development work focused on the executive team, board and integrated care partnership development programmes, developing system leadership (across the Integrated Care Partnership), inclusive leadership, innovative use of the apprentice levy to fund leadership development activity and Aspirant Clinical Leadership programmes.

The approach sat within a wider context of development within local, regional and national leadership development programmes.

The trust was utilising opportunities created through the Sustainability and Transformation Plan and Accountable Care System to ensure cross-organisational learning and true systems leadership. A ‘Transforming the Bay Together’ programme was launched in 2017/18 with 20 system leaders having participated at the time of our inspection.

A leadership academy programme was launched in partnership with a local college in June 2018. To the time of our inspection, 13 members of staff had commenced level five apprenticeship in leadership with a further eight commencing a level three apprenticeship in leadership.

The trust worked closely with the local university management school and local college and had in place leadership programmes at levels three, five and seven, as well as internal programmes bespoke to specific requirements. The trust was also due to launch an aspirant clinical leadership development programme ahead of the clinical leadership refresh scheduled to take place in April 2019. There had been good take-up of national programmes such as the Nye Bevan programme and seven of the 14 individuals to have completed the programme had secured promotion to senior posts both within the trust and across the wider health landscape.

There was a succession plan in place for the executive team which was based upon the NHS north west leadership academy talent management framework and there were plans in place to develop this further and extend it formally to care group leadership teams in Autumn 2018. Development programmes were in place for the executive team and a board development programme was being commissioned following the appointment of a new chairman, chief executive officer, director of finance and non-executive directors.

**Board Members**

Of the executive board members at the trust, 14.0% were Black Minority Ethnic (BME) and 43.0% were female.

Of the non-executive board members 12.5% were BME and 37.5% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>14.0%</td>
<td>43.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>12.5%</td>
<td>37.5%</td>
</tr>
<tr>
<td>All board members</td>
<td>13.3%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
The board had a strong set of clinical, commercial and financial skills across the non-executive directors. The chair had previous experience as a trust chair. There had been some changes in the non-executive directors in the previous year due to terms expiring and the skill set requirements had been well considered prior to their recruitment.

There was regular protected time for board development and the new chair had instigated an externally facilitated board development programme, given the recent changes in board members.

The UHMB council of governors was made up of 17 public governors, six staff governors and eight partner governors, however of these eight, there were three vacant positions. Although information received from the trust in the provider information return (PIR) identified that all of the staff governor positions were filled, senior managers informed us they had experienced difficulty filling three of these posts. There had been a recent recruitment drive and the trust had received some applications into these posts and were reviewing these at the time of our inspection.

The governors held responsibility for overseeing and scrutinising business and performance. However, the governors were invited to attend any of the meetings within the trust, including the board meetings and each of the committees and were very active in attending. This arrangement was established following the trust going into special measures in June 2014 where governors wanted to gain more assurance. However, there was little evidence of where governors had held non-executive directors to account and more of a focus on attendance at other meetings which were not specifically relevant to their role other than for a learning experience. The trust had an opportunity to develop the governor framework to ensure sufficient scrutiny was evident from the governors to the non-executive directors.

Succession planning at board level was in place. A talent management programme was being implemented alongside a more structured approach to appraisal. The trust reported their approach sat within a wider context of development within local, regional and national leadership development programmes – supporting broad scale strategic development taking a cohesive approach across a number of strands to support development within the trust. This included year on year participation in National Leadership Academy trainings, Graduate Management Training Scheme, and leadership training at various levels.

The chief executive officer had carried out formal appraisals and mid-year reviews with executive directors and these were linked to the trust objectives. We saw evidence of this in the personnel files that we reviewed.

Although there was no formal programme of executive walkabouts, there were regular board safety visits and good visibility of the chief executive officer and wider board members across the trust. Board members were ‘buddied’ with clinical services and board meetings were rotated through the trust sites. All senior leaders and non-executives that we spoke with identified they did undertake site visits, predominantly based on purpose and we were provided with a ‘visibility log’ for executive and non-executive directors. An example of this was members of both the executive and non-executive team went out with clinical staff when they were delivering the flu vaccination programme to support the campaign. The chief executive officer also undertook monthly ‘tea and talk’ sessions which he alternated at different times, days and locations each month.

However, in the staff survey 2017, only 31% of staff reported good communication between senior management and staff, which was lower than the national average of 33%. The results of the 2018 NHS Staff Survey for communication between senior managers and staff has shown an increase from 2017 to 2018, rising from 36.2% to 41% and in line with the average. Over the course of the last five years it has risen from 30.4% (well below average) to 41% (average).
Vision and strategy

There were long standing vision and values established within the trust which had been produced with staff engagement and were very much embedded within the organisation. At the time of our inspection, the board identified they were going through a refreshment stage for the vision and values. The vision and values were very visible around the trust.

The trust vision was ‘we will constantly provide the highest possible standards of compassionate care and the very best patient and staff experience. We will listen to and involve our patients, staff and partners’.

The trust values were:

- Patients: Our patients will be treated with compassion, dignity and respect. Their experience is our most important measure of achievement.
- People: Our staff and volunteers are the ones who make a difference. They understand and share our values and this is reflected in their work.
- Partnerships: Our partnerships make us strong. By investing in them, we will deliver the best possible care to our communities.
- Performance: Our performance drives our organisation. Providing consistently safe high-quality care is how we define ourselves and our success.
- Progress: Our progress will be improved through innovation, education, research and technology to meet the challenges of the future.

The recruitment process was based on the trust’s values and were discussed at all corporate inductions for new starters by the chief executive officer. They were also built into the appraisal process and within the cover sheet of policies and procedures.

The organisational clinical strategy was ‘Better Care Together (BCT)’, a strategy designed across a number of partners which was published in February 2015. It received national Vanguard funding until March 2018 but has continued since then.

The strategy aimed to deliver a better future for health and wellbeing across Morecambe Bay by:

- Enabling communities to be as healthy as possible.
- Making sure that health and care services provided across North Lancashire and South Cumbria are the best possible.
- Meeting the needs of the local population, now and well into the future.
- Making sure women’s, men’s, mental health, children’s, and older people’s services receiving equal priority with all other areas of care.

We plan to do this by:

- Health professionals working in local sites sharing their expertise with GPs and community teams.
- They will also work in partnership with people to keep people fit and well.
- They will help people manage their own condition—this could be at home or in their local community.
- Developing system-wide processes – to ensure the public begin to see one NHS.
To support the delivery of ‘Better Care Together’ and staff engagement overall, the trust introduced the ‘listening into action’ approach in September 2014. It was established as part of the trust’s overall improvement approach, alongside quality service improvement redesign. The listening into action programme was delivered over a series of workshops which supported them to clarify their aim and to define improvement measures and outcomes. Each scheme was given an executive sponsor and a coach.

The better care together strategy was published and shared with the public in 2015 following consultation and ongoing engagement with key stakeholders. The development of the strategy was clinically led. It involved 11 local organisations being involved: UHMBT along with three other local NHS foundation trusts, two clinical commissioning groups, two county councils, two GP federations and an ambulance trust.

The trust was very proud of the work they were doing regarding integration and were working hard sharing data across electronic systems, transforming the systems of services new to the trust. The trust took over the community services from neighbouring trust which were working non-compatible systems.

In addition to this, the trust has been working with an external company to create a bespoke electronic prescribing program in an aim to improve electronic prescribing of medications and blood transfusions. This system would be integrated across the trust and community services once operational.

Work was underway in the trust to create an integrated care partnership to take responsibility for the whole health and care needs of the Morecambe Bay population. The Better Care Together was the clinical strategy for healthcare in the Bay. Clinical and operational partners were working with key partners across the Better Care Together workstreams to ensure there was safe and sustainable planning across the entire pathways of care with the whole system solutions to the challenges faced by the system.

The trust had a clear strategic direction focused on the integrated care system across Bay Health and Care Partners (BHCP). In March 2016, organisations across the Bay area agreed to develop a ‘shadow’ integrated care partnership. This decision was supported by an agreement to develop shared governance, leadership and service change. Under this agreement a BHCP leadership structure (programme board, leadership team and delivery board) was formed and this shadow ICP structure reported to the organisational statutory boards. Further development of the accountability and decision-making structures was completed in July 2018 with a revised BHCP governance structure implemented. However, given the magnitude of the financial sustainability challenge facing the economy, there was more work to do in terms of delivery milestones and supporting governance arrangements are established and implemented at pace.

The trust’s leadership development strategy was approved by the board in 2015 and was refreshed and incorporated into the wider learning and development strategy in May 2017 as part of the organisational response to the national Developing People Improving Care framework. A plan for 2018/19 had been produced to set the direction for work and focused on the introduction of new leadership development pathways enabled through the apprenticeship levy.

**Culture**

The trust’s strategy, vision and values underpinned a patient centred culture. Staff felt positive and proud about working for the trust and their team. There was a clear message around balancing quality with financial performance.
The vision and values of the trust were displayed throughout the hospitals and there was a focus on delivering safe care for patients. Most staff reported an improved, open and transparent culture on the wards. We found effective multidisciplinary working and teamwork across the services we inspected with staff feeling motivated and proud to work for the trust and within their teams.

There was a relatively stable workforce and a drive to improve the health and care of patients within the local area. The large and dispersed geography of the trust was a particular challenge but despite this there was good visibility of the chief executive officer and wider board members across the trust.

A variety of communications were used from weekly news updates, monthly team brief and team talk events. The trust reported their staff recognition and award events were highly valued by staff and were well supported.

The trust had appointed a guardian for safe working in 2016. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. Exception reporting is the formal mechanism that junior doctors on the new national contract should use to register variations from their agreed work schedule. In line with requirements, a quarterly report was produced which was submitted to the trust board.

Between 1 April and 31 July 2018, 28 exception reports were made across the trust. The quarterly report for this period identified there was still a reluctance by trainees to submit exception reports but the trust anticipated this would change as the doctors became more familiar with the new contract. The exception report for this time period was noted to be light on information in order to provide the trust with assurance.

The trust appointed a freedom to speak up (FTSU) guardian in July 2015 and was one of the first trusts to do so after a national review of whistleblowing in the NHS (the Freedom to Speak Up Review, February 2015) recommended that all trusts should introduce this role. Initially this was a part time role of two days per week, but this had increased to four days per week due to the demand of the role. Freedom to speak up guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team. The FTSU guardian was supported by both a non-executive director and an executive director at this trust. They also worked in conjunction with the Workforce Team, supporting staff to access the most appropriate channel to resolve concerns.

The role was supported by an up to date policy and 12 respect champions who covered each hospital site and community locations. The champions were from different staff groups and there was a good mix in terms of diversity. Training was offered to these staff. The freedom to speak up guardian had a ‘buddy’ at another trust and attended regional meetings three times per year.

The trust reported 95 incidents of whistleblowing between July 2017 and July 2018. Predominantly the concerns raised fell under the categories of unacceptable behaviours and patient safety issues. Out of the 95 concerns raised, 31 related to health and safety concerns, including patient safety and quality of care, 56 related to unacceptable behaviours, which also included dysfunctional team working. The remaining eight concerns were raised under the ‘other’ category and covers grievance, and other individual concerns not covered by freedom to speak up and were subsequently redirected. Seven of these concerns were raised anonymously, six of which were raised under the trust’s FTSU app. The trust was the first in the country to introduce an app to support staff in raising concerns.

The FTSU guardian did not take part in investigations but did contact the staff member three months after it had been closed to ensure they had not suffered any detriment as a result of raising their concerns and to make sure they felt listened to.
The trust had implemented a behavioural standards framework (BSF), which was described by the trust as 'the heartbeat' of the organisation. The framework was a set of expected behaviours and was very well known to staff across the trust. However, we received mixed feedback from staff during our inspection as to their view of the effectiveness of the behavioural standard framework. Based on a wide range of feedback, the trust had taken the BSF to a further level of implementation and approach where the discussion had widened to describe both the positive and negative behaviours and how to respond to them (commending and challenging as appropriate).

Appraisal rates were reported and monitored at the workforce assurance committee and each care group had responsibility for addressing gaps in their appraisal rates with action plans being discussed monthly at performance review meetings and senior operational meetings. The people information report, July 2018, presented to the trust board, identified that only 76% of staff were up to date with their annual appraisal, which was much lower than the trust target of 95%. This equated to 1261 staff being non-compliant with their annual appraisal. The workforce assurance committee had prioritised improving appraisal completion rates for managers of staff at band 8a and above as well as staff who had never received an appraisal. This had resulted in no staff employed at the trust who had never had an appraisal and a 91% of management appraisal rate, which remained under the trust target.

Bullying and harassment was identified as a key concern following the 2017 staff survey. This was identified to the inspection team as a key concern at the time of our inspection. However, progress in this area had been slow. The first working group was not scheduled to meet until January 2019. We were informed this was due to initial work being undertaken to feed into this working group, including intelligence gathered from staff networks and from the tea and talk sessions run by the chief executive officer.

Given the remedial work successfully implemented to address a range of historic patient safety concerns the trust is now a reference point of good practice for other organisations, for example as an early implementer for ‘freedom to speak up guardian’.

Staff Diversity

As at March 2018, University Hospitals of Morecambe Bay NHS Foundation Trust employed 5,625 people, of which:

- 80% were women.
- Across the trust 5.9% of staff were from black, minority and ethnic (BME) communities, 89.9% were white and 4.2% did not state their ethnic background.
- 2.2% of staff have disclosed that they consider themselves to have a disability, 58.2% of staff have told us they don’t consider themselves to have a disability with the remainder either unknown or have chosen not to disclose
- 58.3% of staff have disclosed as heterosexual and 1.2% as lesbian, gay or bisexual with the remainder unknown or chose not to disclose.
- The most common religion or belief overall was Christianity which accounted for 40.5% of the workforce. The next largest single group was Atheism at 8.6%. 4.6% described their religion or belief as ‘Other’ whilst 44.0% preferred not to disclose their religion or belief.

(Source: UHMB Workforce Monitoring Information 2017/18)
The trust had undertaken a range of equality and diversity development events in the 12 months prior to our inspection. This included:

- Staff completed the NHS core skills e-learning package level one bespoke workshops/events.
- Transgender awareness workshops organised by the lesbian, gay, bisexual and transgender (LGBT) network.
- Learning disabilities awareness events.
- Annual inclusion conferences.
- Black, Asian, minority ethnic (BME) and internal staff conference organised by the BME network.
- ‘Lived experience of recovery from alcohol addiction’ workshops organised by the health early action team.
- A new cohort of staff undertook a development programme to take on the role of respect champion.
- Articles included on the ‘Weekly News’ newsletter and staff networks had organised displays and promotions around different aspects of equality, diversity and inclusion.
- Work had been undertaken with a local university to develop two workshops including an inclusive behaviour workshop (exploring the meaning of diversity and the value of inclusion, unconscious biases and the impact on others and linked in to UHMB case studies) and inclusive leadership workshop (exploring further development of knowledge and understanding of inclusive leadership competences, raising self-awareness of own style, practices and unconscious bias and the implication for leadership).

Equality, diversity and inclusion (core skills) e-learning was part of the trust’s mandatory training programme. Trust wide compliance was 95.8%, which met the trust target of 95%.

The trust had a five-year inclusion and diversity strategy in place since September 2016, which had been developed in partnership with the trust’s inclusion networks. As part of our inspection, we reviewed the ‘towards inclusion’ annual report, July 2018 which was presented to the board and included achievements to date and actions for 2018/19. In January 2015, a new leadership structure for inclusion and diversity was introduced to commence a programme of work to support the trust on to its goal of becoming ‘effortlessly inclusive’. The trust had received two awards in the 2017, these were: Inclusive Top 50 UK Employers List, including the most inclusive NHS organisation nationally, which they achieved annually for the last three years, and eighth most inclusive employer overall in the UK.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>41.9%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.9%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Asian</td>
<td>25.9%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
When looking at medical and dental staff, the largest ethnic group was white (41.9%), followed by Asian (25.9%). The trust also reported that 20.1% of medical and dental staff did not state their ethnicity or their ethnicity was unknown. When looking at nursing and midwifery staff, the trust reported that 92.8% of staff stated that ethnicity as white.

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

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

The trust had 18 key findings that exceeded 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><strong>Equality &amp; diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF20. % experiencing discrimination at work in last 12 months</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>86</td>
<td>85</td>
</tr>
<tr>
<td><strong>Errors &amp; incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>91</td>
<td>90</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.80</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.71</td>
<td>3.65</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>35</td>
<td>36</td>
</tr>
<tr>
<td>*KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.74</td>
<td>3.62</td>
</tr>
<tr>
<td><strong>Working patterns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>56</td>
<td>51</td>
</tr>
<tr>
<td>*KF16. % working extra hours</td>
<td>69</td>
<td>72</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Patient care &amp; experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.94</td>
<td>3.91</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.75</td>
<td>3.71</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>73</td>
<td>66</td>
</tr>
<tr>
<td>*KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>50</td>
<td>45</td>
</tr>
</tbody>
</table>

*indicates a key finding where a low score is better.

Note: For key finding 23, results for the trust appear to be the same as the national average due to rounding.

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

The trust has seven 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><strong>Appraisals &amp; support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.07</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.01</td>
<td>4.05</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>69</td>
<td>70</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.71</td>
<td>3.72</td>
</tr>
<tr>
<td><strong>Managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td><strong>Patient care &amp; experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*KF26. % experiencing harassment, bullying or abuse from staff in last 12 months

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 24%</td>
<td>27%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>BME 25%</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 27%</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>BME 38%</td>
<td>27%</td>
<td>35%</td>
</tr>
<tr>
<td>KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 87%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>BME 77%</td>
<td>75%</td>
<td>77%</td>
</tr>
<tr>
<td>Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 7%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>BME 19%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

*indicates a key finding where a low score is better.

Note: For key finding 3, results for the trust appear to be the same as the national average due to rounding.

(Source: NHS Staff Survey 2017- Link)

All of the executive team identified the staff survey result for bullying and harassment as a key risk for the organisation. A working group had been set up with the first meeting schedules for January 2019 and we were told the reason for this delay was so a full understanding could be obtained first to target the work in the correct direction. The chief executive officer had discussed this at his monthly ‘tea and talk’ sessions to ascertain staff’s thought on this. However, this was limited evidence of any work being done in this area or subsequent positive impact.

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 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. Key Finding and question numbers have changed since 2014.

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.

Of the four questions above, the following questions showed a statistically significant difference in score between white and BME staff:

- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- Q17b. In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?
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 about the same as the England average for recommending the trust as a place to receive care from September 2017 to August 2018.

The trust did not submit Friends and Family test data for November 2017.

(Source: NHS Staff Survey 2017 - Link)

Sickness absence rates

The trust’s sickness absence levels from July 2017 to June 2018 were higher than the England average.

(Source: Friends and Family Test)
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed as expected for all 18 indicators in the survey.

(Source: General Medical Council National Training Scheme Survey)

Governance

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 committee
- Finance committee
- Clinical management group
- Audit committee
- Remuneration committee
- Workforce committee
- Auditor appointment committee

There were several committees and meetings that reported into the quality committee including:

- Nutritional strategy committee
- Infection prevention and control committee
• Emergency preparedness committee
• Health and safety committee
• Joint medicines management and therapeutics sub committee
• Listening to improve steering group
• Joint medicines management, drugs and therapeutics sub committee
• Safeguarding operational performance group
• Enact: senior nursing, midwifery and allied health professionals group
• Clinical audit and effectiveness steering group
• Perinatal mortality and morbidity group
• Hospital transfusion group
• Critical care delivery group
• Cross care clinical records forum
There were robust arrangements for board committees with good cross fertilisation of membership across the committees. Each of the committees were chaired by a non-executive director and had terms of reference. There was an annual process for the committees to review their effectiveness and to revise terms of reference accordingly. However, the terms of reference for the remuneration committee were incorrect as they stated the chief executive officer had voting rights and was the lead director for the committee, when we were told this was not the case.

The arrangements for quality governance were extensive and there were a significant number of committees, sub-committees and meetings which fed into the main committees. This presented a risk of duplication of work and areas being missed. It was acknowledged these arrangements were put in place to address the trust’s historic quality and patient safety concerns. However, they consumed a large management resource. There was scope for the trust to review streamlining these arrangements going forward and potentially enable greater self-sufficiency within the care groups.

We reviewed the finance committee structure and terms of reference. There were a number of groups listed to report to, send minutes, assurance reports and an annual report to the committee, for example the sustainability programme board and strategic groups, but these were not listed within the governance structure.

Within the annual reports for the board of directors’ sub committees it was identified that there was only a 50% attendance requirement.

The trust had a care groups clinical structure which included:

- Core clinical services
- Medicine
- Critical care and surgery
- Women’s and children’s
- Integrated community care

Each care group had several meetings within their individual care group, which all fed into either the quality, finance or workforce committees. Each care group had a management team, which consisted of a clinical director, an associate director of operations and an associate director of nursing.

Each committee had terms of reference written, which were updated annually. As part of the inspection, the terms of reference were reviewed and were up to date, however the terms of reference for the remuneration committee did have an error where it was identified that the chief executive officer had voting rights, which was not the case. We reviewed meetings of a remuneration committee where we noted that the chief executive was there as an observer not as a voting member. We raised this issue with senior leaders at the time of our inspection who identified they would review and change this accordingly.

We reviewed minutes from the board and the quality committee and saw limited evidence of challenge and documenting actions agreed to address adverse performance from the non-executive team. Senior leaders and the chair of the quality committee informed us there was good challenge evident at the committee meetings, but this was not reflected in the minutes.
As part of our ongoing monitoring we attended monthly engagement meetings with the senior team, attending a directorate governance assurance group meeting for each core service, and observed a patient experience forum. In addition to this, we attend the trust patient safety summit, serious incidents requiring investigation (SIRI) panel, board meeting and mortality meetings on an annual basis. Our observations from these meetings provided assurance that they were regularly well attended, embedded in practice and were subject to healthy challenge from member attendees.

As part of our engagement process when met with individuals to discuss their roles, remit, process and procedures within the organisation. This included individual discussion with the CEO, trust chief pharmacist, safeguarding leads and the lead for learning disability. These meetings enabled focused discussions relating to day to day practice, new practices and any areas of concern.

We reviewed the trust management board minutes for October, November and December 2018. We noted that in the October meeting, 34 people were present, and five apologies had been received. We found there was a tendency to review presentations rather than reports at these meetings. Actions from the agenda items were not clear.

A vast amount of information was presented by the many different care groups and committees/sub committees at the monthly quality committee meeting. It was not always clear that the pertinent risks and issues were presented in a way that all staff could understand the key risks from the volume of information provided.

There were policies and processes and documentation in place in relation to safeguarding in the trust. However, this was heavily weighted towards child safeguarding. The adult safeguarding had more of an emphasis on mental capacity act rather than safeguarding. There were gaps noted in the mental capacity act procedures for children between 16 and 18.

The trust’s safeguarding annual report, July 2018, identified that there was an ongoing challenge with the Deprivation of Liberty Safeguards (DoLS) applications due to the high numbers of applications being made to the local authority. A mental capacity act DoLS re-audit was completed in July 2018, which highlighted that the patient safety incidents were not always complete when a DoLS application was made (identified as only 75% at the time of the audit). It also identified that capacity assessments were not always completed prior to a DoLS application.

A learning from deaths policy was in place for and complied with the ‘Learning from Deaths’ national guidance, 2017. The internal process for reviewing an unexpected death was led by the site based mortality review team who met on a weekly basis. These meetings were led by mortality leads and included senior medical and nursing staff. A monthly mortality report was produced and distributed to the care groups. The patient safety unit lead and the deputy medical director compiled a quarterly report for the quality committee along with learning from deaths. We inspected eight learning from deaths review files which we found were compliant with the trust policy.

**Board Assurance Framework**

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its strategic objectives.

The trust provided their Board Assurance Framework, which details five strategic objectives and seven strategic risks to these objectives. A summary of these is below.
Strategic Objectives

1. Continuously improve the patient experience - becoming the provider of choice for excellence with safe and effective patient care

2. Support and develop all staff to take responsibility for what they do and help them to do their best. Getting staff truly engaged in how the Trust works

3. Encourage staff to be innovative when delivering and planning high quality and sustainable services. Achieving long term financial sustainability

4. Work with our partners to provide an integrated health service that meets the needs of the local population. Providing local access, including to specialist services wherever that is feasible

5. Positively contribute to the well-being of the local community

Strategic risks

<table>
<thead>
<tr>
<th>Date Added</th>
<th>Last Review Date</th>
<th>Description</th>
<th>Relevant Strategic Objectives</th>
<th>Inherent Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2018</td>
<td>05/07/2018</td>
<td>People Risk - Ensure the Trust has a motivated and engaged workforce, in sufficient numbers and appropriately trained, to deliver the Trust’s vision, values and objectives to be a “great place to be cared for, great place to work”</td>
<td>2 and 3</td>
<td>20</td>
</tr>
<tr>
<td>01/04/2018</td>
<td>16/07/2018</td>
<td>Finance Risk: Deliver the 2018/19 financial plan and continued development of the Sustainability and Transformation Plans to 2020/21.</td>
<td>3, 4, and 5</td>
<td>20</td>
</tr>
<tr>
<td>01/04/2016</td>
<td>09/07/2018</td>
<td>Urgent Care Performance Risk - Ensuring the Trust achieves its trajectories on the NHS Constitution Access Standards for Urgent and Emergency Care, Elective Care and Cancer Care.</td>
<td>All</td>
<td>20</td>
</tr>
<tr>
<td>01/04/2018</td>
<td>-</td>
<td>Change and Transition Risk - Ensure the Trust leads the system change and retains delivery of safe services.</td>
<td>All</td>
<td>16</td>
</tr>
<tr>
<td>01/04/2016</td>
<td>10/07/2018</td>
<td>Capital and Estates</td>
<td>1 and 3</td>
<td>20</td>
</tr>
<tr>
<td>01/04/2016</td>
<td>10/07/2018</td>
<td>Information Technology</td>
<td>All</td>
<td>15</td>
</tr>
<tr>
<td>01/04/2016</td>
<td>10/07/2018</td>
<td>Achieving Care Quality Commission Essential Standards of Quality: Building on our Quality Improvement ambitions to maintain a CQC rating of Good and work towards achieving a CQC rating of ‘Outstanding’</td>
<td>1, 2, 3, and 4</td>
<td>16</td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework 2018/19 Quarter 1 - July 2018)
The board assurance framework (BAF) was maintained under the portfolio of the director of governance. The framework met the needs of the board. There was a formal annual review process to reset the trust’s strategic risks and good linkage between these and the coverage of the board’s agenda. The board reviewed the BAF quarterly in tandem with the corporate risk register.

The BAF was structured around the risk themes of people, money, urgent care, change and transition. It did not naturally support the examining of risks to the delivery of the trust’s strategy. For each risk it identified; key controls, forms of assurance, examples of actual assurance, gaps in control, gaps in assurance and agreed actions for identified gaps. Each strategic objective had a risk rating score, identified executive leads and the committee through which the risks would be managed.

The BAF for quarter one was considered at the board meeting in July 2018. However, it was not evident from the minutes whether it generated any discussion or challenge. The paper was simply noted within the minutes.

UHMB used the ‘WESEE’ (workforce, efficiency, safety, effectiveness and experience) reporting mechanism and reported monthly through the governance assurance structure.

The issue around bullying and harassment, identified as a worsening trend at the 2017 staff survey was not on the BAF, despite this being identified by senior leaders as a priority risk area.

The trust was reviewing the options for an integrated governance framework across the local health system working towards a standardised approach.

Management of risk, issues and performance

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£324m</td>
<td>£291m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£17m)</td>
<td>(£65m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£341m</td>
<td>£356m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£17m)</td>
<td>(£58m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

University Hospitals of Morecombe Bay NHS Foundation Trust (UHMB) had a planned turnover of £317m in 2018/19. The trust had a very challenging financial position with an underlying deficit of circa £70m. The trust had a deficit of £17m in 2016/17, £64.7m in 2017/18 and was planning a deficit of £69.4m in 2018/19. The trust had declined to agree a financial control total with NHS Improvement (NHSI) for 2018/19 and was therefore ineligible for provider sustainability funding.

The trust’s financial position was reviewed in detail at the finance committee, which included more granular information on care group performance and on the cost improvement programme. The
care groups attended the finance committee on a quarterly basis or more frequently if required.

There remained some £2m of risk to the delivery of the trust’s financial plan for 2018/19 which was a planned deficit of £69m and at the time of our inspection, with limited evidence of any contingency plan to address the shortfall.

Due to the magnitude of the financial deficit, the trust was under NHSI Enforcement Undertakings for financial sustainability. It had been required to submit a five-year sustainability and financial recovery in tandem with partners in the local health economy. This plan provides for a significant reduction in the deficit over the five-year planning horizon although it does not deliver overall financial balance. The sustainability plan was under discussion with NHSI at the time of the inspection.

The trust had recently refreshed its five-year strategy to strengthen the focus on integration and partnership working across Bay Health and Care Partners. The strategy was supported by a sustainability and financial recovery plan to achieve a more sustainable financial position for the trust and the local economy over a five-year period. The latter was subject to further discussion with NHS Improvement. A key enabler was the need for circa £80m of capital investment substantially to address a significant backlog maintenance problem.

Governance arrangements for progressing the implementation of the strategy across the economy had yet to be fully embedded and the delivery milestones for tracking progress are not well developed. Whilst the board recognised these matters required further work, it was felt that the intention to mobilise the strategy in 2019/20 from the current position was ambitious.

Although newly appointed to the trust the finance director, was an experienced NHS trust director. There was an experienced deputy director of finance who had longstanding tenure with the trust. The calibre of the finance team was robust and all senior finance staff were qualified with good retention of key staff. There was a business partner model in place providing the care group teams with dedicated financial expertise, with four out of the five posts filled substantively.

The chair of the audit committee was a qualified accountant. Whilst a relatively new non-executive director with the trust she had previous NHS audit committee experience. All board members were well sighted on the financial challenges face by the trust. The view was expressed that the capability of the care teams in delivering on their operational and financial plans was much improved from a low base. The board recognised the importance of delivering a more sustainable financial position and the need to sharpen delivery on the trust’s five-year strategic plan. The trust recognised a productivity challenge of circa £40m which was aligned to the “model hospital” diagnostic and a structural deficit of circa £30m related to multiple hospital sites in a dispersed geographical patch which was operationally challenging. There was an opportunity for the trust to progress at pace on delivery plans to address the productivity opportunity.

Transactional financial processes were strong and the director of finance intended to sharpen the focus on forecasting, horizon scanning and making better use of patient level costing to inform the resource requirements of out of hospital care models integral to the delivery of the trust’s strategy. The trust was using some benchmarking tools such as ‘model hospital’ and ‘getting it right first time’ to develop the cost improvement programme. It was acknowledged on inspection that there was a need for the programme management team to strengthen its analytical skill set in this regard.

The trust used a risk based approach in setting the annual internal audit programme and the audit committee had effective oversight on tracking the implementation of internal audit recommendations.
The trust had a reasonable track record of planning and delivery on cost improvement programmes although there was reliance on non-recurrent schemes and income generation (best practice tariff related). The trust was cognisant it needed to increase the level of recurrent cost improvement going forward which was being linked with four care pathway accelerator programmes integral to the strategy.

There was a well-resourced programme management office which had recently been consolidated with the commissioner function to provide coverage across the health economy aligned to the objectives of the strategic plan. The function covered both quality and productivity improvement and reported to the trust director of governance.

However, the trust considered there was a need to strengthen the financial skill set within the programme management office with a more proactive approach to benchmarking and predictive analysis as against its current strength in programme management. This work was in progress at the time of the inspection.

**Trust corporate risk register**

The trust provided a document detailing their 58 highest profile risks. Each of these have a current risk score of between 15 and 20. The table below includes details of the 17 highest profile risks. Each of these have a current risk score of 20.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>Risk id</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/04/2016</td>
<td>2100</td>
<td>Inability to meet agreed safe staffing levels may lead to poor standards of care, increased complaints, demotivated and fatigued staff and loss of organisational reputation as well as the inability to deliver the Trust's visions, values and objectives to be a &quot;great place to be cared for, great place to work&quot;</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>17/01/2012</td>
<td>546</td>
<td>Lack of pathway for some interventional procedures, specifically embolization of GI haemorrhage. In September 2016, cover has been agreed regionally for most other emergency IR procedures. The lack of IR for GI bleeds means there will infrequently be patients who come to serious harm or whose death is preventable.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>01/04/2015</td>
<td>1944</td>
<td>Ongoing problems in recruiting specialist gynaecology, haematology and urology radiologists, means that the care group faces a significant challenge in delivering a rota that is sufficient to provide the required level of MDT operational support, this has adverse impacts on patient outcomes and experience, and service delivery. There is a regional issue with radiologist’s availability. As a consequence, patients who have a new diagnosis of myeloma, CLL and other lymphoproliferative disorders will be logged but not discussed.</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td></td>
<td></td>
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<tr>
<td>------------</td>
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<td></td>
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</tr>
<tr>
<td>29/01/2016</td>
<td>2062</td>
<td>Current staffing levels are not sufficient to provide a robust diagnostic imaging and reporting service based upon the current levels of demand, this could impact upon patient outcomes and the achievement of national performance standards and delivery of Keogh Standards and Better Care Together strategies. Risk in 2017 that three radiologists have requested sabbaticals which could further impact upon capacity and specialist cover.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22/10/2015</td>
<td>2011</td>
<td>Due to the commissioned CAMHS provision from MH Trusts (CPFT and LCFT) not being sufficient to meet current demand there is often significant delays in obtaining MH assessments and then subsequent transfer to a MH provider, this has adverse effects on the patient’s safety and well-being and may also put staff and other patients at risk.</td>
<td></td>
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</tr>
<tr>
<td>27/10/2011</td>
<td>305</td>
<td>Due to increased occupancy levels resulting in the delay and/or cancellation of elective operation lists, the care group is at risk of not achieving its RTT target and follow up Indicative Review, this could result in further delays and cancellations of elective operations, reduced patient outcome and experience, inefficient service delivery and an increase in RTT fines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07/02/2017</td>
<td>2236</td>
<td>Due to an on-going local and national shortage of suitably qualified and experienced physiotherapy staff and local issues of maternity leave and sickness, the physiotherapy service is not currently achieving or maintaining its target levels of WTE across the Trust, this means that the provision of physiotherapy services is reduced in most areas and in some services may not be provided, this will have adverse impacts on patient's treatment, clinical outcomes and care experience, and will also have a negative impact upon the health and well-being of the physiotherapy staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/05/2017</td>
<td>2272</td>
<td>Due to sustained high levels of demand, patient acuity and social care capacity, the medicine care group often experiences problems with patient admission, flow and discharge rates with some patients not being admitted from ED within the four-hour target or being outlined on to surgical or WACS wards, and delayed discharge of patients this has adverse impacts on patient’s treatment, safety and experience and on the operational efficiency of the care group.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Text</td>
<td></td>
<td></td>
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<td>------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>01/07/2017</td>
<td>2297</td>
<td>On-going national and local problems in recruiting medical staff (consultant and junior grades), means that the surgery care group faces a significant challenge in meeting its target WTE levels for medical staff and providing sufficiently skilled rota cover, this has an adverse impact on patient outcomes and safety, service delivery and meeting staffing level standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/07/2017</td>
<td>2298</td>
<td>On-going national and local problems in recruiting anaesthetics staff (consultant and junior grades), means that the surgery care group faces a significant challenge in meeting its target WTE levels for anaesthetics staff and providing sufficiently skilled rota cover for theatres, ITU, obstetrics and other emergency calls, this has an adverse impact on patient outcomes and safety, service deliver, national staffing level standards and compliance with national service specification for deanery training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/07/2017</td>
<td>2300</td>
<td>On-going national and local problems in recruiting ward nurses, associated healthcare professionals and healthcare scientists, means that the surgery care group faces a significant challenge in meeting its target WTE levels for ward nurses, associated healthcare professionals and healthcare scientists and providing sufficiently skilled rota cover this has an adverse impact on patient outcomes and safety, service delivery, national staffing level standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23/11/2011</td>
<td>303</td>
<td>Ongoing national and local problems in recruiting nursing and medical staff, means that the care group faces a significant challenge in meeting its target WTE levels for nursing and medical staff, combined with challenges in delivery of training and development and the high level of demand and patient acuity this has adverse impacts on patient outcomes and safety, service delivery and meeting national staffing level standards and the development and training of clinical staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/08/2015</td>
<td>2005</td>
<td>Due to ongoing high levels of demand and bed pressures outlier patients from medicine and surgery care groups are regularly placed on gynaecology Wards (FGH Ward 1, RLI Ward 16). gynaecology ward staff may not appropriately trained and experienced to provide full and safe care to all outlied speciality patients. Lack of speciality knowledge and expertise may lead to deviations from standardised patient pathways and therefore there is the potential to have an adverse impact upon outcomes, safety and experience of the outlier.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Reference</td>
<td>Description</td>
<td></td>
<td></td>
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<tr>
<td>------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30/10/2017</td>
<td>2319</td>
<td>The current counters are in a dilapidated condition with inadequate electrical systems, this could lead to an inability to maintain correct serving temperatures for hot and cold food and difficulty maintaining required cleaning/hygiene standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/10/2016</td>
<td>2183</td>
<td>The current WTE for the breast surgery does meet prevailing national standards for a unit of this size, at present the establishment staffing is below WTE, this means that the unit may be unable to deliver the screening standard, two-week wait and 62-day cancer standard for breast cancer patients and cannot always achieve RTT targets. Additionally, there is insufficient capacity for post cancer and benign treatment patients, for effective patient follow up and to provide an agreed on-call service. This results in delays in patient assessment, treatment and follow up and may have adverse impact on patient clinical outcomes and care experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>08/02/2016</td>
<td>2068</td>
<td>Due to increased occupancy levels, estate requiring restorative works, the impact of the NHSI mandate cancelling elective procedures and vacancies across nursing, medical and allied health professionals resulting in the delay and/or cancellation of elective operation lists; the care group is at risk of not achieving its planned income and expenditure in accordance with the prevailing annual financial plan and the care group may not be able to deliver all of its services within the allocated budget. This could result in further delays and cancellations of elective operations, reduced patient outcome and experience, inefficient service delivery, failure to maintain the NHSI target for waiting list size not to grow and an increase in RTT fines and long waiting patients i.e. 52-week breaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/04/2016</td>
<td>2101</td>
<td>Inability to maintain flow through the hospital may result in poor patient experience through delays in the emergency departments and delays in discharge and transfer of care, increased complaints, fatigued staff and poor compliance against the agreed trajectories for the NHS constitution access standards, particularly in urgent and emergency care and elective care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register - July 2018)
Risks were calculated using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Any risks entered on to a risk register were assigned a risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. From reviewing care group and corporate risk registers there was evidence that the controls in place were reviewed and updated and that the mitigating actions facilitated a risk rating review. However, we noted some concerns around the residual risk ratings but being an accurate rating. Examples of this were the trust’s financial position had a residual rating of 12 and the risk rating assigned to the bullying and harassment concerns was 16 despite it being identified as one of the trust’s main risks.

The trust had reappointed the same external auditor for the sixth year. Evidence supplied by the trust showed that a procurement process had taken place where it was agreed the trust would continue with the same auditor. However, the trust identified that, although the same company was being used, a different individual was undertaking the audit.

We saw good cross-referencing between the corporate risk register and the BAF and a summary of the changes was reported to the board.

The board were sighted on the level of risk in delivering the financial plan for 2018/19. However, at the time of the inspection there was no formal contingency to address the current adverse performance. There was an opportunity for a more granular outturn forecast based on risk assessed scenarios to establish parameters and help to support stakeholder engagement.

The non-executive directors reported that the care groups had a much better understanding of their operational and financial performance risks than previously. However, they expressed some frustration at the pace of change in formulating and implementing solutions.

The trust had monthly performance review meetings with each of the care groups, co-chaired between the director of finance and the chief operating office. On a quarterly basis, the full executive team attended these review meetings. These meetings were reported as supportive but challenging and were focused on solutions to adverse performance.

**Information management**

The trust had a current data quality strategy and managed data quality improvement through the monthly information governance and data quality committee, which reported into the trust’s finance committee and subsequently to the board.

A web-based inhouse data quality analysis and reporting toolkit, called ‘Patient Safety Net’ had been developed. This allowed for metrics to be defined and monitored with the ability to generate automated escalation emails to users who repeatedly made mistakes to data entry within the trust’s electronic patient record (EPR).

The trust had good data warehouse capability and intended to build up the analytical skill set within the care group teams to enable greater self-sufficiency in the use of the business intelligence tools available to them.

The digital status of the trust was very positive. They had successfully completed the implementation of an electronic patient record in the last year and had achieved good connectivity across clinical systems. The trust’s next project was to build on this success and achieve better IT integration across the health economy.

There were no reported challenges with data quality although other than the information governance toolkit assessment it was not evident how the board received assurance on this.
The trust was at an early stage of developing its systems of patient level costing which it considered would benefit modelling and understanding of the cost implications of alternative out of hospital care models.

The trust was in the process of going 'live' on the week of our well led inspection with a virtual control room based at the Royal Lancaster Infirmary but spanning across the trust. This would enable the trust to how live data for bed management meetings on the bed state.

Through the EPR electronic optimisation programme, data quality was a key part of the optimisation and implementation process and had been considered as part of the new functionality rollout for outpatients, inpatients, requesting, prescribing, theatres and maternity. The trust had adopted a full EPR and was developing it further to capture structured clinical data in real-time, which had been the catalyst for improving real-time data quality. This had been developed very much in partnership with clinicians.

In addition, local administration of the trust’s EPR allowed for tight control of what users can, and cannot enter into the system front-end, and this is supported by a comprehensive training suite available to all staff that includes both face-to-face classroom training, training on wards, e-learning and remote support. The trust had also deployed local systems that were integrated into the front-end of the EPR to provide further functionality for clinical support.

**Engagement**

Monthly engagement meetings were held between the trust senior team, CQC, CCG and with minutes shared with NHSI. Meetings were open and transparent with information corroborated by appropriate evidence. There was a set agenda in place which covered a monthly monitoring report, an overview of CQC intelligence, safeguarding concerns, complaints, provider updates, the trust risk register, integrated care system updates and a review of the trust improvement plan. Minutes from the engagement meetings were detailed and comprehensive.

The national NHS staff survey (2017) findings showed the trust scored 3.79 for staff engagement. Staff survey engagement scores have shown improvement yearly. The trust won the Personnel Today national award for staff engagement in 2018.

Feedback from CQC focus groups and interviews with staff during the inspection showed mixed responses from all staff groups. Some staff spoke positively about the level of engagement and support they received, whilst others felt there was still further work to be done.

There were a number of initiatives in place to recognise and celebrate staff achievements. This included ‘MY star awards’, a recognition scheme for teams or individuals. The trust also had an annual ‘celebrating excellence’ event and awards night dinner. We were provided with examples of simple things which had a big impact, such as staff being provided with ice lollies during the hot weather.

The trust had received a total of 21 applications for the 2017/18 clinical excellence awards (CEA). The awards panel had recommended a single CEA point should be awarded to the highest scoring 27 individuals. The gender and balance of applicants with a protected category of the proposed awards were:

- 62% of applicants were of BME origin
- 32% of applicants were female
- 60% of successful individuals were of BME origin
• 25% of successful individuals were female

Three local pulse surveys were completed in 2017, in quarters one, two and four with the national survey being held in quarter three. The focus was on nine domains of staff engagement within the national staff survey under the headings of advocacy, motivation and involvement. Response rates for the pulse surveys were lower than the national survey, however 1000 responses were received each quarter with the exception of February 2018. Generally, the pulse surveys demonstrated that engagement remained high across the care groups but continued work was required to help staff feel they were able to make improvements happen in their area of work. Areas of concern were around culture, motivation and feeling involved in improvements, which were similar findings to the national staff survey.

The improvement and Listening in to Action team hosted ‘Brilliant Bay Days’ twice yearly which give staff an opportunity to share improvements they have made within their areas. Approximately 100 staff, governors, healthcare partners and volunteers join in the celebrations and they were also linked with other organisations.

In terms of external engagement, the trust worked closely with partner organisations within the Sustainability and Transformation Partnership (STP) and more especially within the local health system embracing a single clinical commissioning group, two local authorities and primary care. Considerable work had been undertaken with stakeholders in the health economy to develop the Bay Health and Care Partners Sustainability and Financial Recovery Plan with a commitment to health system integration. Trust governors had also been engaged in this approach to integration.

The chief executive and chair had strong visibility in the integration planning and this was being extended to include other board members in the development of delivery plans and supporting governance arrangements. However, progress for these arrangements was slow in order to achieve a more sustainable health economy by 2023.

The director of finance reported that he has a positive and constructive working relationship with his counterpart in the clinical commissioning group and there was an intelligent approach to contracting.

A patient and public involvement strategy was launched in February 2018 alongside a ten-point action plan to involve patients and the public in their local hospitals. The strategy was a public facing document and provided a supportive and developmental direction of intent for putting patients and the public at the heart of the trust’s quality improvement work.

The trust engaged in new approaches to community engagement and patient experience during 2017/18 using a comprehensive range of opportunities and methods for the public to get involved. This included information sharing, focus groups and public events to partnership and co-production techniques. An example of this was maternity and young people matters community conversion café events, which gave the trust the opportunity to hear directly from women and families about their experiences of maternity services.

The trust was in the process of creating three Macmillan information and support centres situated near the main entrances of Furness General Hospital, Westmorland General Hospital and Royal Lancaster Infirmary. The centres aim to offer practical and emotional support to anyone affected by cancer. A specialist qualified staff member had been recruited and there was a recruiting programme in place to secure a number of volunteers to help welcome patients and citizens to the service. The aim of the service was to assist people by providing time to talk and offering high quality information.
Based on patient and staff feedback from their first 2018 Always Event, the trust had developed a booklet on ‘we will always provide an information booklet when a patient is listed for surgery’. The aim of the booklet was to guide and prepare patients for their admission and give advice throughout their journey. It was hoped that by giving clear and concise information at the point of being placed on a waiting list, patients would be less anxious about the process, know who to contact at each stage and have the booklet to refer to each step of the way.

The trust held at inclusion conference on 14 May 2018, where the theme was ‘beyond boundaries’. This was the third inclusion conference held by the trust, which, explored how the trust worked with other organisations to achieve the best possible care the local communities with a focus on homelessness, dementia and intersectionality.

During our monitoring of the trust we observed the patient experience forum. The meeting enabled the public to have a voice. The meeting was used as a platform to review the quality of patient leaflets and complaints. Random anonymised complaint responses were reviewed by the group to establish whether the quality and ease of reading was appropriate and the group were instrumental in changing the approach and content of complaint responses.

**Learning, continuous improvement and innovation**

The trust used a range of continuous improvement tools and had trained over 200 staff in accredited improvement methodologies. The trust reported strong engagement with the “listening into action” initiative.

The trust promoted leadership development programmes through the NHS leadership academy and local programmes facilitated through a local University. The trust recognised there was more to do in developing the skill set of middle management to maximise the benefits of system integration and new models of care.

There were plans to make better use of benchmarking tools such as “Model Hospital” and this was a key plank of the trust’s five-year sustainability plan.

The finance director was well networked professionally and encouraged engagement of the finance function with wider finance development activities.

The finance team was accredited at level one under the NHS finance development programme and was working towards level two. The procurement function was accredited under the chartered institute of procurement and supply procurement excellence programme.

**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 (July 2017 to June 2018).

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 days</td>
<td>100.0%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>35 days</td>
<td>98.6%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Any extensions are on a case by case basis and agreed with the complainant. However, all complex</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Number of complaints made to the trust

The trust received 441 complaints from July 2017 to June 2018. Surgery received the most complaints with 120 (27.2% of all complaints).

<table>
<thead>
<tr>
<th>Core service</th>
<th>Complaints received</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>120</td>
<td>27.2%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>81</td>
<td>18.4%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>71</td>
<td>16.1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>52</td>
<td>11.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>26</td>
<td>5.9%</td>
</tr>
<tr>
<td>Maternity</td>
<td>25</td>
<td>5.7%</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>5.2%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>17</td>
<td>3.9%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>17</td>
<td>3.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>0.9%</td>
</tr>
<tr>
<td>CHS - Urgent Care</td>
<td>3</td>
<td>0.7%</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>441</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

There was a total of 10.5 whole time equivalent staff dedicated to responding and investigating complaints. 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 advising people how to raise a concern or complaint with the patient advice and liaison service (PALS).

We reviewed six complaints as part of our well led review and found concerns were investigated confidentially, in a timely way and lessons were shared. However, we found the trust were not fully compliant with the complaints policy which stated that all complaints should be signed off by the chief executive officer. However, all the six complaints we reviewed were all signed off by the director of governance rather than the chief executive officer.

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.
Complaints performance was reported on in the bi-monthly integrated performance board report and in the quarterly and annual director of governance report. Data was also provided to the board via the web based data dashboard. In addition, the quality committee received a quarterly and annual complaints report, which included an overview of complaints, concerns, compliments, comments, PALS issues, themes and lessons learned.

**Compliments**

From July 2017 to June 2018, the trust received a total of 1,510 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Compliments received</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>487</td>
<td>32.3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>300</td>
<td>19.9%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>199</td>
<td>13.2%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>126</td>
<td>8.3%</td>
</tr>
<tr>
<td>Other</td>
<td>116</td>
<td>7.7%</td>
</tr>
<tr>
<td>Maternity</td>
<td>98</td>
<td>6.5%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>89</td>
<td>5.9%</td>
</tr>
<tr>
<td>Community</td>
<td>46</td>
<td>3.0%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>23</td>
<td>1.5%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>19</td>
<td>1.3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>7</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,510</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The trust has commented that “A previous analysis of complaints and compliments showed that we were receiving poor feedback from ED and Maternity. These were shared during Care group and corporate governance meetings and fed into the capital planning group to add evidence for major refurbishment programmes within our organisation.”

“As a result of additional significant investment our top performing areas in terms of compliments for the 17/18 period are Maternity FGH and our ED departments. The themes from compliments are fed into their respective committees in order to facilitate necessary change. The main compliment themes are fed back to staff within their own area, and circulated to other areas to share in their success and good ideas where necessary.”

*(Source: Routine Provider Information Request (RPIR) – Compliments)*
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>Accredited Scheme Name</th>
<th>Services accredited</th>
<th>CQC Core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy unit at RLI - JAG accreditation achieved March 2015. JAG accreditation at WGH - achieved June 2014</td>
<td>Medicine (including older people's care)</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>RLI: ward 23, ward 37 FGH: ward 9, AMU</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Histopathology, Microbiology and Blood sciences have all achieved accreditation to ISO 15189 pending clearance of actions to address findings from assessments. The transition from CPA to ISO 15189 is a four-year process that commenced in Autumn 2016 with regular assessments. The UKAS assessments are comprehensive sampling exercises at all operational sites (FGH, WGH, RLI) and, where departments are multi-site, assessment to TPS51 for multisite accreditation is also conducted to ensure consistency across the organisation.</td>
<td>Core clinical services</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>The Echo service and department now hold accreditation awarded by the British society of echocardiography. Which is part of a QA accreditation The Trust’s ultrasound systems have full service cover by Imagex medical and also have annual QA testing by Christies medical All echo cardiographers hold BSE accreditation to scan and report independently</td>
<td>Core clinical services</td>
</tr>
<tr>
<td>The Medical Engineering Team in UHMBT have achieved ISO 9001 accreditation.</td>
<td>The medical engineering team held accreditation for servicing and maintaining of medical devices and electronic equipment.</td>
<td>Core Clinical services</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

There are Emergency Departments at both the Royal Lancaster Infirmary and at Furness General Hospital, with supporting medical and surgical assessment units and ambulatory care facilities. These are consultant led. There is an urgent treatment centre at Westmorland Hospital. This is staffed by GPs, doctors, emergency nurse practitioners and nurses.

The urgent treatment centre is designed to treat patients with minor illnesses and injuries. Patients with more serious conditions such as chest pains, strokes or serious injuries should go to the nearest Accident and Emergency department in Lancaster. Whilst patients with more serious conditions should go to the nearest emergency department (ED), some patients self-presented with more serious conditions at the UTC. In such cases, UTC staff arranged for transfer to the nearest ED, whilst managing the patients’ care and safety within the unit’s capabilities.

(Source: Routine Provider Information Request (RPIR) – Sites tab)
Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of Morecambe Bay NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018

From August 2017 to July 2018, there were 93,223 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

Staff told us the UTC saw approximately 25,000 patients each year. This figure was additional to the 93,223 quoted above.

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,360</td>
</tr>
<tr>
<td>Discharged*</td>
<td>60,210</td>
</tr>
<tr>
<td>Referred^</td>
<td>6,976</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,985</td>
</tr>
<tr>
<td>Died in department</td>
<td>163</td>
</tr>
<tr>
<td>Left department#</td>
<td>1,517</td>
</tr>
<tr>
<td>Other</td>
<td>550</td>
</tr>
<tr>
<td>Not known</td>
<td>69</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 of 95% for completion of mandatory training.

Trust level
A breakdown of compliance for mandatory training courses as at November 2018 for Westmorland General Hospital (WGH) inclusive of medical and nursing staff is detailed below.
This information was provided to us on inspection because the trust had already told us they were unable to provide us with training information solely for the emergency departments.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>88.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>88.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>84.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>73.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>76.9%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care, the 95% target was not met for any of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the health and safety core skills for which zero staff had completed the training at November 2018.

We spoke with staff about training and they told us it was difficult to access training due to low staffing numbers and remoteness of the hospital. Additionally, the department had transitioned from one provider to another within the previous 12 months and changed from a minor injuries unit to an urgent treatment centre where training requirements were different.

When we spoke with managers, they were aware of the training figures and were encouraging staff to attend when they could.

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### 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 as at September 2018 at trust level for all staff in urgent and emergency care inclusive of staff working in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding (Level 3) Supervision</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children (NHS Core Skills) - Level 3</td>
<td>23.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 95% target was met for the one safeguarding training module for which staff were eligible.

We asked the trust for further information about safeguarding training and they provided us with the information below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Total staff</th>
<th>Total trained</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>Safeguarding (Level 3) Supervision</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (NHS Core Skills) - Level 3</td>
<td>17</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>24</td>
<td>20</td>
<td>83.3%</td>
</tr>
</tbody>
</table>
Staff we spoke with about safeguarding were aware of the processes in place within the trust to refer patients they had concerns about to safeguarding.

We saw evidence of incidents raised as a result of safeguarding concerns about both adults and children.

What we found less clear was whether there were any reviews of children’s’ records after discharge to ensure nothing had been missed. Staff we spoke with were not aware of any such checks taking place. Therefore, we had concerns about the robustness of safeguarding because there was no safety net checking mechanism.

Staff told us they saw a significant number of looked after children. When a looked after child attended the department, their social worker was informed and any existing care and support plan was followed. Looked after children were identifiable because of alerts in the records system.

Cleanliness, infection control and hygiene

When we visited the department, we found it to be visibly clean. Cubicles were cleaned between patients and waiting area floors and seating were in acceptable order. Patient toilets were clean. We did however find the sink in the ophthalmology room was very dirty.

Staff could call cleaners to the department if required however, cleaners worked across the site and were not dedicated to the department at all times.

We found the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces.

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 gloves, aprons and masks available to staff. We routinely saw staff using this. Latex gloves and other equipment were disposed of correctly during our inspection.

We noted all staff were bare below the elbow in line with infection prevention and control policies.

In the paediatric waiting area, toys were infection control compliant because they were made from washable and wipe clean materials and when we looked at them, they were clean.

Staff in department were not meeting the trust’s training target of 95% for infection prevention and control.

The department had curtained cubicles for patients although some treatment areas were rooms with solid walls and doors. Curtains were clean and easily replaced as and when required. They were dated to show when they had been hung up.

We looked at the areas where equipment was cleaned and these were visibly clean. Equipment in this area was clean to the eye.

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

The department was located in an older building. It was easy to find as there were clear signs to direct patients. The internal design of the department had a complicated layout although there were signs to direct patients.

The décor was tired and needed to be refreshed. There were wall coverings with joints and cracks which were not IPC compliant.

The children’s waiting area was behind a wall, tucked away in the corner of the waiting room, out of the line of sight of reception staff. There was no access gate or door to keep children contained. We were concerned that children could not be seen by reception staff.

The department had no resuscitation department because it was an urgent treatment centre however, one of the treatment rooms had two trolleys and a resuscitation trolley in case of an emergency. Staff called this the resuscitation room however it was not fit for purpose as a resuscitation room.

Treatment cubicles were an appropriate size and contained the necessary patient equipment. Most cubicles had curtain walls. Because of the curtains, it was difficult to maintain privacy. There were three rooms which could be used to isolate patients, for example if they had diarrhoea and vomiting.

Cubicles had emergency buzzers we noted buzzers were placed in reach of patients during our inspection.

We found equipment in the department had been safety checked. All 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 checked some of the stock held in the store rooms. We found stock was all in date and rotated appropriately.

We looked at the resuscitation trolley. It was appropriately sealed. This meant that staff in the department did not have to carry out resuscitation trolley checks. However, there was no paediatric resuscitation trolley available.

The department had an area it called the resuscitation room. It had two trolleys however was not appropriate to be a resuscitation area. We spoke with senior staff in the department who confirmed to us there was no resuscitation room, only a room which housed the resuscitation trolley.

The waiting area used by patients was spacious with sufficient seating for patients and relatives. The area had natural light making it a more pleasant environment for patients.

The department had no specific room suitable for adult and paediatric patients with mental health conditions. The department currently used a cubicle. These were not suitable rooms because they were not ligature point free, had standard furniture that could be used as a weapon, did not have two exits and did not meet PLAN (psychiatric liaison accreditation network) standards.

When we asked staff, they told us that patients living with a mental health condition did occasionally present to the department. Staff had access to the crisis team to come and see them however until the crisis team arrived, mental health patients were not supported in an appropriate environment.
The trust had carried out training for staff about ligature point management, had a policy in place and the department kept ligature cutters so if a patient tried to self-harm, the ligature could be cut. We still had concerns that patients were at risk of harm using ligatures.

**Assessing and responding to patient risk**

The department did not take part in the 2016 Emergency Department Survey as part of this trust because it joined UHMB in January 2018.

The department had a system in place for assessing patients who attended. Reception staff had received training about how to identify a poorly patient and used a flow chart to assist them. If they had concerns about the wellbeing of a patient they escalated this to the triage nurse if the patient had not yet been assessed, or to other staff if a patient deteriorated whilst waiting to see a doctor.

Patients were triaged on attendance by a qualified nurse who assessed each patient, gave pain relief if it was required and carried out basic observations. They could also request x-rays and perform tests such as electrocardiograms (ECGs). The triage nurse then categorised the patient depending how urgently they needed to be seen.

When a patient attended the department inappropriately (with a condition too serious for the type of service the department provided) nursing staff attempted to make the patient comfortable and stable before calling for an urgent ambulance to transfer the patient to the most appropriate service at a different site.

We looked at the records of nine patients who had attended inappropriately. Some patients were transferred within an hour however some patients waited in the department nearly six hours before being transferred. When we asked staff why, they told us there were often delays in ambulances arriving to transport patients due to ambulance workload. We had concerns about this because these delays meant delays to treatment for some patients.

Managers told us they were working with local media to educate the local population about what type of patients should attend the UTC. They told us sometimes people with serious burns, chest pains, possible stroke, and serious asthma attacks attended. They were stabilised and assessed but had to be transferred to other services for treatment.

The management team told us staff could only triage patients after they had been in post for more than 12 months. They were then supervised rather than having formal triage training. The management team acknowledged this presented a risk.

Nursing staff who carried out triage were experienced and deemed competent to fulfil this important role.

Patients with allergies were identified at triage and given a red wrist band to highlight the allergy.

The department used the National Early Warning Score (NEWS) to monitor patients. Dependent upon their NEWS score (a combination of observations used to calculate how unwell they are) we saw patients having observations carried out in a timely manner to make sure they were not deteriorating. However, of the nine sets of records we looked at four did not have a NEWS recorded.

The department had processes in place to manage deteriorating patients. In the UTC this was predominantly to call the ambulance trust to request a more urgent ambulance to transfer the patient whilst stabilising them.
We asked the trust to send us a copy of their escalation policy. It was written in 2014 and was due for review on 1 December 2018, just after our inspection. When we read the policy, there was no mention of escalation for the WGH site, or specifically for the UTC.

We spoke with staff about escalation procedures. They told us they reported operational concerns to the shift leader or the matron. Staff also told us how they could escalate concerns about patients to the doctor on site and also call the local ambulance trust to request an ambulance be sent more urgently. Some staff did however tell us the process for requesting an ambulance was different for this site than the other two sites and had led to some confusion in both organisations. Staff said there were times when they felt the department was unsafe because of the acuity (level of sickness) of patients present.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median in all twelve months from August 2017 to July 2018. In July 2018, the median time to initial assessment at the trust was 10 minutes compared to the England average of eight minutes.

**Ambulance – Time to initial assessment from August 2017 to July 2018 at University Hospitals of Morecambe Bay NHS Foundation Trust**

![Graph showing median time from arrival to initial assessment from August 2017 to July 2018 at University Hospitals of Morecambe Bay NHS Foundation Trust.](Source: NHS Digital - A&E quality indicators)

Staff told us most patients did not arrive by ambulance to the UTC. Patients requiring an ambulance were generally too unwell to receive treatment at WGH. Therefore, when an ambulance patient did attend, they were handed over and received an initial assessment quickly.

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

There was no information available about turnaround times for ambulances attending WGH. This was because ambulance attendances were infrequent.

**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. There were no black breaches reported for the WGH site.

**Nurse staffing**

The trust reported their staffing numbers for the period October 2017 to September 2018 for urgent and emergency care. As at September 2018, 81.5% of qualified nursing positions were filled across the whole trust.

Nursing fill rates were good at WGH with staffing numbers matching the planned establishment figures. However, staff and managers told us they felt the planned staffing numbers were too low.
The department had carried out a formal assessment of staffing using the BEST assessment tool designed by the Royal College of Emergency Medicine. This had concluded nursing staff numbers in the department was inadequate. Additionally, the trust supplied two staff each night to the overnight service provided by a different organisation. This placed additional pressure on staff because of the low number of nursing staff employed by the department.

The department had one advanced nurse practitioner (ANP) in post when we inspected, with one about to start and another trainee due to start work in the department. From July 2019 the department planned to have three ANPs in post.

Staff worked a number of different shift patterns however there were generally two qualified and one unqualified staff on an early shift, Three qualified and one unqualified on a late shift and two qualified staff overnight. Staff told us this was not always enough to manage the patients attending the department.

Staff in the department had the skills and knowledge to deliver care to patients appropriate to the department however we were concerned that nursing staff were supporting very unwell patients who had attended the department inappropriately for significant periods of time whilst waiting for patients to be transferred by ambulance to the most appropriate services for their conditions. Staff also told us they had concerns about safety when this happened.

The department did not employ any registered sick children’s nurses and adult trained staff had not undergone any additional training to manage sick children. There was a risk because of the anatomical, psychological and physiological differences of children and how they react to certain medicines.

There was no critical care outreach team on site and staff told us the band six held the bleep and was expected to present themselves supporting the resuscitation team at Peri arrest whilst remaining responsibility for the UTC. They also told us they were responsible for the site manager bleep. However, when we spoke with another senior nurse, they told us staff in the department should never hold more than one bleep at any one time.

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 13.5% for qualified nursing staff working in urgent and emergency care.

We asked the nurse in charge to tell us about the staffing levels during our inspection. They told us the department was funded for six band six nurses and had six in post, nine band 5 nurses and had seven in post, 0.8 WTE (whole time equivalent) band four staff and had 0.8 in post and 3.2 band two health care assistants and had 3.2 in post; however, one was on long term sick.

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in urgent and emergency care. This was better than the trust performance measure of 8.5%.

The trust was unable to provide us with site specific information.
Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in urgent and emergency care. The trust was unable to provide us with site specific information.

The trust measured attendance and had a target of 95.6%.

Bank and agency staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 1,016 shifts for qualified nursing in urgent and emergency care were filled by bank staff and 1,255 shifts were filled by agency staff. In addition, 787 shifts remained unfilled by bank and agency staff. This information was not available solely for the UTC.

For nursing assistants, 1,538 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 413 shifts were not filled by either bank or agency staff. As above, this information was not available solely for the UTC.

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

We spoke with senior staff in the UTC about use of agency staff. They told us that because of the complexity of the role and the training required, agency staff were not a safe feasible option. Staff told us in desperate situations they would use bank staff however preferred to use departmental staff working extra shifts where possible.

Medical staffing

In November 2018 the department changed from being a minor injury and illness centre to an urgent treatment centre. This meant the department was overseen by General Practitioners (GPs) with support from advanced nurse practitioners (ANPs). Some of the GPs may have a background in Accident and Emergency however not necessarily.

The department had a clinical lead who was a GP with an A&E background.

All medical staff were trained to advanced life support level (ALS).

Vacancy rates

The UTC was funded for five GPs and at the time of inspection had four in post with a further GP due to join the department two weeks after our inspection. Any gaps in the rota were covered by locum GPs with staff telling us there was always at least one locum GP on each shift.

Turnover rates

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.
From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in urgent and emergency care. This was worse than the trust performance measure of 8.5%.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for the medicine core service at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in urgent and emergency care.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

**Bank and locum staff usage**

Please note the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in urgent and emergency care from April 2017 to March 2018 can be found below. This information was not available solely for the UTC at WGH.

Staff in the department told us there was always at least one locum GP on duty for each shift.

**Trust Wide**

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50</td>
<td>95</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>239</td>
<td>668</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>158</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>921</td>
<td>0</td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**

At June 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower than.
Staffing skill mix for the 29 whole time equivalent staff working in urgent and emergency care at University Hospitals of Morecambe Bay NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>56%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>3%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</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

We looked at the records of nine patients. They were electronic, selected randomly and provided to us after the inspection at our request.

We saw evidence of triage times being recorded and observations being carried out. Of the nine patients, seven had observations recorded.

Five of the patient records had a NEWS (national early warning score) recorded.

Patient records provided evidence of treatments such as blood tests and ECGs being taken.

Whilst we were in the department we saw records were stored securely.

There were no terminals displaying patient information visible to the public.

All members of staff were required to attend information governance training. We found 73% of staff had completed this training against a trust target of 85%.

When patients were transferred to other departments or sites, they took a copy of their clinical records with them.

Medicines

Fridge temperatures minimum/maximum and current temperatures were recorded daily. The record sheet from November 2018 showed only one day had been missed.

Fridge temperatures were within range.

There was information about what action to take if a fridge went out of temperature range.
The medicines fridge was lockable however, the key had been left in the door.

We checked the contents of the fridge and medicine cabinets and found all medications were in date including eye drops and glucagon.

We checked PGDs (patient group directions) and found these were in date. Staff used PGDs to give patients pain relief without the need for a prescription from a doctor.

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 September 2017 to August 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 six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2017 to August 2018.

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

- Treatment delay meeting SI criteria: five incidents (83.3%).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident (16.7%).

Site specific information can be found below:

- Furness General Hospital: two incidents
- Royal Lancaster Infirmary: four incidents

None of these related to WGH.

We looked at incidents recorded about the department since it joined UHMB. There had been 33 incidents recorded. Of these, one was graded as moderate harm, 15 as low harm and 17 as no harm. The most common categories were safeguarding (adults or children) 10, clinical assessment and treatment 10 and medicines 5.

We spoke with staff about reporting incidents. They told us they could access the incident reporting system and knew how to report a patient safety incident. Staff told us although they reported most incidents, sometimes they did not have time to complete the online process because they were busy with patients. They did however recognise the importance of reporting incidents.

(Source: NHS Improvement - 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 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The department had a laminated copy of paediatric emergency drugs and their doses on the side of the resuscitation trolley to ensure staff administered the correct doses of medication for children depending upon their weight.

Resuscitation trolley had a file with adult and paediatric algorithms for life support/choking/anaphylaxis.

The department used evidence based pathways to support patients and had processes in place to ensure patients unsuitable for the department were transferred to the most appropriate service.

Nutrition and hydration

Emergency Department Survey 2016

The UTC was not part of UHMB at the time of the Emergency Department survey in 2016 and therefore results of this survey are not included in the report.

Patients could access water in the department and there were shops on site where patients and relatives could purchase drinks and snacks.

Staff told us they could access light snacks for patients who needed to eat for medical reasons.

Pain relief

Emergency Department Survey 2016

The UTC was not part of UHMB at the time of the Emergency Department survey in 2016 and therefore results of this survey are not included in the report.

We spoke with three patients who told us they were offered pain relief at triage.

Staff told us they could access pain relief for patients and checked a patient’s pain score each time they interacted with the patient.
Patient outcomes

The matron of the department told us they had undertaken a number of audits since taking up their post. They told us, prior to them starting, clinical audit had not been a priority and had not taken place.

Audits included of nursing records looking at the quality, triage and if NEWS scores had been recorded. This was done as the IT system couldn’t provide a clear picture in terms of patient outcomes and they wanted assurance.

The work from audit was ongoing with staff with the trust using ‘my assure’ as an audit tool. The department was asked to lead on this within the trust.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

WGH did not take part in this audit because it does not meet the inclusion criteria.

**RCEM Audit: Consultant sign-off 2016/17**

WGH did not take part in this audit because it does not meet the inclusion criteria.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

WGH did not take part in this audit because it does not meet the inclusion criteria.

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

From September 2017 and August 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally better than the England average. However, since April 2018 there has been an increase in the unplanned re-attendance rate at the trust.

In the most recent month of available data, August 2018, the unplanned re-attendance rate within seven days at the trust was 8.0%, which was similar to the England average of 8.1%. This information was not broken down by site and therefore we have no specific data about the WTC site.

**Unplanned re-attendance rate within seven days - University Hospitals of Morecambe Bay NHS Foundation Trust**

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

#### Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for urgent and emergency care (including the UTC) also includes data for medicine.

As at September 2018, 73.3% of staff within urgent and emergency care services at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,063</td>
<td>776</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>25</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

*(Source: Data request- P43 Appraisal Compliance 2017 to date)*

Whilst we inspected the department, we requested the most up to date information about staff appraisals for the UTC. At the time of the inspection, the appraisal rate was 38.9%. This was because staff found it difficult to allocate time for an appraisal. There were plans in place to address this. The urgent treatment centre transferred to the trust on 01 April 2018, the training and appraisal rates were at 0%. By November 2018, significant progress had been made in the training and appraisal of staff. However, the trust target was not achievable in the nine month period, prior to inspection.

Appraisal rates achieved 100% in December 2018.

Historically, appraisal compliance had not met trust standards. The management team told us this was a work in progress. They told us the process had been improved.

Staff told us they could ask for support from colleagues if they needed it however they said a formal appraisal was not a priority.

The management team in the department told us 92% of staff were basic life support trained, 85% of staff were advanced life support trained and 93% of staff were paediatric immediate life support trained. None of the staff were advanced trauma life support trained despite the possibility of inappropriate patients being brought to the department and none of the senior nurses were advance paediatric life support trained.

The trust had secured funding for advanced paediatric life support (APLS) training and advanced trauma life support training (ATLS).

They assured us that by December 2018 14 of 16 staff would have attended training to manage sick children and manage trauma until patients could be transferred to the most appropriate service.
The trust told us approximately 18% of patients who came to the department were under the age of 18. The department employed no registered sick children’s nurses (RSCNs). Staff had not received any additional training to support them providing care and treatment to people under the age of 18. We had some concerns about this because caring for a sick child can be different to caring for an unwell adult. We were also concerned because there was no on site paediatric cover to support staff.

Staff also told us that they sometimes felt the department was unsafe because they did not always have the skills and knowledge to support the acutely unwell patients who self-presented to the department. This was because there was little onsite support from specialist departments.

We discussed with staff in the department about the skills and knowledge of medical staff working in the department. Staff told us the background and experience of staff varied. Not all of the GPs who worked in the UTC had a background in emergency medicine. However, the NHS England guidance for UTC principles and standards states that UTCs should be GP led, staffed by GPs, nurses and other clinicians. This reflects the staffing model in the UTC.

In October the clinical leader was given additional training with a view to them being an educator, this included areas such as Acute Kidney Injury and National Early Warning Scores.

**Multidisciplinary working**

Patients who attended the department inappropriately, such as those with chest pain or major injuries were transferred to the closest appropriate A&E department by ambulance. The department had a working relationship with the ambulance trust.

The department worked closely with wards and departments on the WGH site to support patients who had additional health and social care needs.

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 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 and there was information about these services advertised around the department.

The trust worked closely with local care providers such as community health teams to provide a team who could support patients in their own homes and prevent admission and reattendance at the department.

**Seven-day services**

The WGH urgent treatment centre was open from 8am until 11pm, staffed by GPs, ANPs and nurses provided by University Hospitals of Morecambe Bay Trust (UHMB). After 11pm the department was staffed by GPs employed by a different organisation although nursing staff were employed by UHMB. After 11pm staff told us there was not always a doctor on site to treat patients.
The department could access diagnostic imaging services from 8am until 4.30pm however after this time, an on call radiographer attended to any urgent x-ray needs. The clinical lead told us they had negotiated with the radiology department to have diagnostic imaging until 11pm.

There was limited point of care testing at WGH; however more detailed blood analysis requests were couriered to a different trust site for analysis. Staff told us patients had long waits for blood test results.

**Health promotion**

Staff 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 and leaflets advising patients about support services like drug and alcohol services around the department.

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

Staff could refer patients to the frailty team if they were frail or elderly and needed extra support. 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**

Staff understood the importance of consent when delivering care to their patients and displayed an 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 most cases this was implied consent and not documented however when an intervention was required, formal written consent was sought. It was uncommon for written consent to be needed at WGH as patients with major illnesses and injuries were not treated on this site.

Staff told us they explained procedures to patients and made sure they understood what they were giving consent for.

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, could describe the tests for assessing competence to consent to treatment for patients aged under 16 years. This was particularly important as staff told us there was a local population of looked after children who attended the department.

The Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people aged 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. The organisation had a robust process in place to monitor the DoLS process, follow up any urgent requests and ensure patients remained protected. However, DoLS were not used in the UTC.
When we spoke with staff, they told us they would look to the senior clinicians on duty or the psychiatric liaison team for guidance about patients living with a mental health condition.

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 or the same as the England average in all months from August 2017 to July 2018. In July 2018, performance at the trust was 88.9%, which is better than the England average of 86.7%.

A&E Friends and Family Test performance - University Hospitals of Morecambe Bay NHS Foundation Trust

(Source: NHS England Friends and Family Test)

During our inspection, we spoke with three 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 friendly and reassured them.

Patients and relatives we spoke with told us they were comfortable and offered drinks while waiting for treatment in the department.

We saw a vulnerable patient left alone in the waiting area after being admitted by ambulance. We raised this with staff on duty who moved the patient to a suitable clinical bay to be observed.

Emotional support

We saw examples of staff supporting patients and showing empathy to them.

Patients we spoke with said the department was friendly and they felt they were in safe hands. Patients told us staff were calm and offered reassurance to both concerned patients and their family members.

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

This department was not part of UHMB at the time the Emergency Department survey was carried out and therefore it is inappropriate to include UHMB results in this report.

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

Is the service responsive?

Service delivery to meet the needs of local people

The trust involved patients and families when developing leaflets and investigating some complaints to help reflect the views of local people who have used the service. Staff gave an example of identifying a theme of incidents and involving relatives to support shaping the service going forwards.

The care group (which included urgent & emergency care and medicine core services) had appointed a matron for service user and public engagement. Staff told us this job role will set up a group of patients and families who were involved in the development of services. The trust was planning to create a new mental health facility and had plans ready to be signed off to address this. The trust had received compliments from patients waiting in the department for more than one day about how staff had supported their privacy and dignity.

The urgent and emergency care service at Westmorland General Hospital transferred from another local trust in December 2017. Staff we spoke with told us they were trying to publicise what kind of illnesses and injuries were appropriate for the unit but because of the local geography and distance to other services, found patients walked in with inappropriate conditions.

Local ambulance staff told us there was no clear criteria for what patients could be accepted in the department but that it was based on clinical judgement of the severity of the patient’s acuity. This was corroborated by staff who told us there was no current criteria or standard operating procedure for what kinds of conditions were seen in the department.

The service did not have a designated mental health room. A ligature risk assessment had been done and training provided for staff. Staff told us if they had a patient with mental health needs they would use a room nearest the clinical hub room. We asked the trust for their ligature risk assessment of the unit. It identified changes that had been made to the unit to make it less risky and identified that all rooms with high risks should be locked when not in use. Some rooms were identified as being safe if patients were observed, however staff told us they felt staffing levels were already unsafe at times and this would mean less staff available to run the service. From our observations, none of the rooms identified were suitable, there were clear ligature risks and visibility of the rooms was poor.

There was a main waiting area with a paediatric section and a toilet for patients to use. The paediatric waiting area was around the corner from the main waiting area and there was no line of sight from clinicians or staff to monitor any deterioration of children in this area.
Meeting people’s individual needs

Emergency Department Survey 2016

The UTC was not part of this trust at the time of the 2016 survey and therefore we are unable to detail the results.

Staff we spoke with told us there was no paediatric cover on the unit which meant staff did not always have the knowledge and skills needed to treat paediatric patients.

The trust had access to interpreting services for people whose first language was not English.

The trust had a chaplaincy service available on the Westmoreland General Hospital site. The service was recently reviewed to assess the local belief needs and provision of the service to meet them. There were volunteer representatives from a variety of faith and belief groups on the volunteer visiting team who could support people whatever their belief or non-belief. The chapel at Westmorland General Hospital had been updated to include posters and prayers from different religions, and an alternative space had been identified as a neutral quiet space. There were nine different parish groups rostered to provide Sunday worship at this site.

Access and flow

Staff we spoke with told us the most common reason for ambulances waiting was mental health patients and this affecting access and flow in the department. The other main reason for delays in patient care was waiting for blood test results. Staff told us blood samples were currently sent to the Royal Lancaster Infirmary site to be tested and this took time to process. However, staff told us the service had just secured point of care testing, so patients would be able to get results much quicker; this was not in place at the time of our inspection.

Staff told us that the band 6 nursing staff held the advanced life support (ALS) bleep for the hospital. This meant at any time, they could be called from the department to other areas of the hospital leaving only two other nursing staff in the unit. This meant that flow through the department could be affected by reduced staffing levels and skill mix.

We observed vulnerable patients left in the waiting room on their own without suitable observation. This was concerning as the layout of the department meant that patients could not always be seen easily by reception staff or clinicians.

The layout of the waiting area meant that any paediatric patients were likely to be behind a wall in the children’s waiting area. This meant there was no oversight of this patient group and clinicians might not be aware if they were deteriorating.

We saw estimated waiting times displayed in the reception area to inform patients of how long they would wait to see a clinician.

We saw information displayed in the reception area which told patients that nursing staff could stream patients and provide analgesia.

Staff told us the service did not have specific criteria or a standard operating procedure to follow for what kinds of ailments and injuries should be seen in the unit. This meant that staff could start assessing and treating a patient who was not suitable for the scope of the department. The unit had conducting a staffing audit tool in the previous year which showed the staffing levels were
inadequate. We saw examples of patients who were assessed and treated inappropriately in the department. This was of concern when considering there was an issue with staff skill mix and staff told us it was difficult to release staff to do training because of staffing pressures.

There were no pathways or decision trees in place for clinicians to follow for common ailments or injuries to ensure best practice and appropriate treatment plans were followed. Staff told us some patients were sent to the department from the Royal Lancaster Infirmary ambulatory care unit for tests and there was no pathway in place for these patients.

Staff told us there were three rooms that could be used to isolate patients for infection prevention and control purposes.

Staff told us the resuscitation room was not in a convenient area. It was situated away from the main clinical hub and close to reception. This meant that patients moved past the room regularly to access other areas of the department and staff were not close to systems and additional resources if they were required.

The trust displayed information about the “Think! Why A&E” campaign on their website with a hyperlink to Westmoreland Urgent Treatment Centre webpage in the walk-in centre section. It contained information on the kinds of ailments that could be seen at this site. This meant members of the public could access up to date and useful information and treatment options online.

**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 five months over the 12-month period from September 2017 to August 2018. The standard has not been met since January 2018. At the trust, the median time from arrival to treatment has also been greater than the England average since February 2018.

In the most recent month of available data, August 2018, the median time to treatment at the trust was 64 minutes compared to the England average of 56 minutes.

**Median time from arrival to treatment from September 2017 to August 2018 at University Hospitals of Morecambe Bay NHS Foundation Trust**

[Graph]

(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.

When looking at four-hour target performance, the trust consistently breached the 95% standard from September 2017 to August 2018. Furthermore, the trust’s four-hour target performance was lower than the England average in 10 of the last 12 months. A large improvement in the trust’s performance can be seen between March 2018 and May 2018 where the percentage of patients
seen within 4 hours increased from 76.3% in March 2018 to 90.6% in May 2018, however, performance has been declined since this point.

**Four-hour target performance - University Hospitals of Morecambe Bay NHS Foundation Trust**

We requested information from the trust about the four hour performance target for individual sites. The performance data provided ranges from 92.85% in March 2018 and 97.75% in October 2017. The data shows the Westmoreland Urgent Treatment Centre site met the national four hour performance target of 95% in seven out of 10 months.

**Westmoreland Urgent Treatment Centre**

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendances</th>
<th>Breaches</th>
<th>4 hour performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-17</td>
<td>1811</td>
<td>53</td>
<td>97.07%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1340</td>
<td>40</td>
<td>97.01%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>1360</td>
<td>31</td>
<td>97.72%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>1581</td>
<td>113</td>
<td>92.85%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>2096</td>
<td>86</td>
<td>95.90%</td>
</tr>
<tr>
<td>May-18</td>
<td>1871</td>
<td>91</td>
<td>95.14%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>1920</td>
<td>60</td>
<td>96.88%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>2451</td>
<td>133</td>
<td>94.57%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>1856</td>
<td>98</td>
<td>94.72%</td>
</tr>
<tr>
<td>Total</td>
<td>21279</td>
<td>848</td>
<td>96.01%</td>
</tr>
</tbody>
</table>

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

From September 2017 to August 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally better than the England average.
Over the winter months there was an increase in the percentage of patients waiting more than four hours from the decision to admit until being admitted at the trust, following a similar trend to the England average.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals of Morecambe Bay NHS Foundation Trust**

![Graph showing percentage of patients waiting more than four hours from decision to admit until admitted over time.](source: NHS England - A&E SitReps).

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

Over the 12 months from September 2017 to August 2018, 214 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 March 2018 (78 patients), January 2018 (37 patients) and February 2018 (25 patients).

*(Source: NHS England - A&E Waiting times)*

We requested information from the trust about 12 hour performance target for individual sites. The data shows that the Westmorland General Hospital site had patients breaching the number of hours they should wait from the decision to admit to being admitted in eight out of nine months.

<table>
<thead>
<tr>
<th>Westmoreland Urgent Treatment Centre *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>Dec-17</td>
</tr>
<tr>
<td>Jan-18</td>
</tr>
<tr>
<td>Feb-18</td>
</tr>
<tr>
<td>Mar-18</td>
</tr>
<tr>
<td>Apr-18</td>
</tr>
<tr>
<td>May-18</td>
</tr>
<tr>
<td>Jun-18</td>
</tr>
<tr>
<td>Jul-18</td>
</tr>
</tbody>
</table>
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From September 2017 to August 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment had fluctuated month on month. The percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment had been lower than the England average in all months from April 2018 to August 2018.

In August 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0.0%, compared to the England average which was 2.1%. The trust did not provide us with site specific data.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals of Morecambe Bay NHS Foundation Trust

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

Median total time in A&E per patient (all patients)

From September 2017 to April 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average. Since May 2018, the trust’s monthly median total time in A&E for all patients has been similar to the England average.

Over the last 12 months, median total time in A&E for all patients at the trust was highest in March 2018 (187 minutes compared to the England average of 160 minutes). Since then, there has been a decrease in the trust’s monthly median total time in A&E for all patients to a level that is similar to the England average. In August 2018, the trust’s monthly median total time in A&E for all patients was 149 minutes compared to the England average of 146 minutes. The trust did not provide us with site specific data.
Learning from complaints and concerns

During our inspection we saw there were processes in place to allow patients to give feedback. Medical staff told us they were setting up a monthly meeting to discuss learning from incidents and complaints and to set up a board in the staff room with this information. This was due to commence in December 2018, after the time of our inspection.

There was a comments box in the main waiting area and one in the minor’s unit waiting area which gave patients an opportunity to leave feedback on the day of their visit. Staff we spoke with told us these comments were collated once a week by the trust but they did not give examples of this being fed back to the service.

During our inspection we saw a “you said, we did” information board. It stated there was not enough information on how patients could make a complaint. We saw evidence this was rectified in the main waiting area; there were leaflets and a notice for the Patient Advice and Liaison Service (PALs) which gave patients the location of their office on each trust site, telephone numbers and an email address to make contact.

Staff we spoke with during the inspection told us learning from complaints was cascaded to staff during the monthly staff meeting, on shift handovers and by email. Some staff we spoke with gave us examples of learning implemented in the department from complaints, such as the introduction of a coffee machine in the waiting room. However other staff could not give examples. There was a learning board in the staff room where key issues were displayed. Plan on a page learning was sent to medical staff to communicate learning from complaints and incidents. For example, electrocardiogram (ECG) of the week and case study examples were sent to junior doctors and were used as real examples seen in the department to aide learning.

Summary of complaints

From July 2017 to June 2018, there were 71 complaints about urgent and emergency care services trust wide. The trust took an average of 38 working days to investigate and close
complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days. Of the 71 complaints received during the 12-month period, 27 (38.0%) related to a diagnosis problem and nine (12.7%) related to discharge arrangements. A breakdown of complaints by site can be found below.

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

We reviewed an example of a complaint response from the Westmorland Urgent Treatment Centre as part of the inspection. The response followed the trust’s guidance about how to respond to complaints, however the response time was outside of the trust’s set timescale.

**Number of compliments made to the trust**

From July 2017 to June 2018, there were 126 compliments in urgent and emergency care. The breakdown by site is shown below:

- Furness General Hospital: 36 compliments
- Royal Lancaster Infirmary: 90 compliments

The trust did not provide the complaints data for the Westmoreland Urgent Treatment Centre site. We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

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**Is the service well-led?**

**Leadership**

At the time of our inspection, the department had a relatively new management structure with a clinical lead taking overall responsibility for the department with support from a new in post matron who had responsibilities for services on all three UHMB sites.

Both the clinical lead and the matron were experienced and acknowledged the department was undergoing a period of change to ensure it had appropriate staff and systems in place to ensure patient safety.

They told us they were working to ensure the department worked appropriately in their new position and an urgent treatment centre.

We met with these staff and found them to fully understand the challenges of the department in relation to performance, demand, staffing and risks. They presented a cohesive team committed to the ED and its staff.

Staff we spoke with had no concerns about the leadership team at the UTC. They told us they could approach the management team with any concerns they had and were confident the team would do their best to resolve them.

**Vision and strategy**

The department had recently moved from the responsibility of one trust to become the responsibility of UHMB. As a result, the department was undergoing a period of transition. In
addition, the department had also changed from a minor injuries unit to an Urgent Treatment Centre meaning they could accept a different, less unwell type of patient. As a result, staff and the local population were still adjusting to the type of health conditions the department could treat.

The vision for the department was that patients needing emergency care, such as for chest pain, suspected stroke, burns and suspected sepsis would attend the nearest Accident and Emergency department in Barrow in Furness and that only patients with a minor illness or injury would attend the UTC.

Culture

There was a culture of teamworking in the department. Staff of all disciplines and grades worked together well with the patient as their focus.

The atmosphere in the department showed staff focus was on treating patients in an efficient way however staff also took time to support each other.

The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked together to ensure patients received good coordinated care. Staff were very committed to the care of patients and we were told of examples when staff had worked extra hours or stayed late to be with a patient.

Staff told us they could rely on their colleagues for support.

Governance

The UTC fed in to the trust wide governance processes however this was a work in progress due to changes in responsibility for the department. We were not confident that new governance processes such as sharing lessons learned from incidents or changes in practice were embedded in the department.

Staff told us information from committees such as complaints, learning from deaths and learning from incidents were not regularly discussed with staff and lessons learned were not always shared.

The trust had a process in place to ensure all relevant National Institute for Health and Care Excellence (NICE) guidance, patient safety and drug alerts were assessed and implemented and staff were aware of any changes. This had not been fully embedded at the time of the inspection.

Staff could access up to date information about care and treatment online in the department and there was detailed information about treatment pathways and medicines as well as links to the original guidance source.

Management of risk, issues and performance

A departmental risk register was in place and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department. These risks mostly correlated with the risks we observed during our time in the department.

However, one of the biggest risks we considered the department faced was inappropriate patients attending. Although the risk register detailed work being undertaken to publicise the new function
of the department, there was no mention of the risks caused by the attendance of inappropriate patients.

Additionally, the risk register did not highlight staffing concerns such as overnight cover as discussed with us on inspection.

The staff we spoke with were clear about the risks the department faced.

When we spoke with the management team, they could tell us about most of the risks posed to the department and how these were being addressed.

**Information management**

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department. These were used by the management team.

The department used several IT systems to collect and share information such as test and x-ray results, admission and discharge times and patient records.

Staff were able to access patient information using an electronic system. This included information such as clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant 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.

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

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 terminals unlocked left unattended.

**Engagement**

Staff told us some patients were unsure what an urgent treatment centre did. Staff also felt the use of the phrase ‘urgent treatment’ was misleading to patients who believed they could come with serious conditions and be seen quickly.

The management team told us they were exploring different ways to engage with the local community. At the time of the inspection and as noted on the risk register, this involved work with local groups to widen awareness of the role of the UTC using media, leaflets and posters.

The department participated in the friends and family test but had not carried out any local surveys in relation to the quality of urgent and emergency care services.

It was unclear other than through observation and discussions within the department how managers gauged staff morale, job satisfaction or physical and mental health needs of staff.
**Learning, continuous improvement and innovation**

Staff were encouraged to develop their skills and knowledge through training.

The department was in the early phase of transition to an urgent treatment centre and therefore the stability of the department and implementation of new ways of working were the priority for staff and the management team. This included access to training and development.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment across three sites; Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital.

At Royal Lancaster Infirmary, there are 203 medical beds including the medical assessment unit accommodated in the main Centenary building and on medical unit two. This bed base includes a 15-bed acute frailty unit adjacent to the medical assessment unit.

At Furness General Hospital, there are 120 medical beds including the medical assessment unit.

In addition to general medicine and care of the elderly, medical specialties, which are provided cross bay include respiratory, cardiology, diabetes and endocrinology, gastroenterology, dermatology and rheumatology. Neurology and nephrology services in-reach from the Royal Preston Hospital.

There were no inpatient medical beds at Westmorland General Hospital.

Cardiology has a cardiac catheter lab at the Westmorland site and has strong network links to Blackpool.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 38,562 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 20,025 (51.9%), 463 (1.2%) were elective, and the remaining 18,074 (46.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine with 19,868 admissions
- Gastroenterology with 6,052 admissions
- Medical oncology with 4,070 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Staff were required to complete mandatory training in topic areas such as infection prevention, manual handling and information governance. Dementia awareness training was provided separately, and we saw staff wearing ‘dementia friend’ badges on their lanyards.

The trust did not routinely provide training on mental health as part of mandatory training. There were plans in place for some day long training sessions delivered by the psychiatric liaison team.

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

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. This was delivered either by eLearning or face to face. Staff we spoke to said that they found time to complete their mandatory
training. However, on viewing WESEE (ward level governance) reports, we saw that care group compliance with Basic Life Support (BLS) training was below target and falling (80.6% in June 2018 and 79.9% in October 2018). The governance team were aware of this issue and were using messages in WESEE reports to encourage greater compliance. Practice educators had been asked to provide more sessions to increase training capacity.

**Trust level**

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,251</td>
<td>1,285</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,228</td>
<td>1,282</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,178</td>
<td>1,284</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,168</td>
<td>1,281</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training CRT</td>
<td>1,061</td>
<td>1,179</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,142</td>
<td>1,289</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>882</td>
<td>1,107</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>978</td>
<td>1,273</td>
<td>76.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for two of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the general fire safety awareness module, for which only 76.8% staff had completed the training at September 2018.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency services at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

**Safeguarding**

Staff had a good knowledge and understanding of the trust safeguarding policies and knew their role and responsibilities. Staff were clear on how to contact the safeguarding team for advice. They knew what constituted a safeguarding concern and could give examples of having raised these. Policies and links to multi-agency safeguarding procedures were stored on the trust’s intranet. These were in date. The trust was not meeting a 95% target for completion of Safeguarding Children and Adults Level 1 or 2, however at this site there was a 100% completion rate for Safeguarding Adults Level 2. Where appropriate to their role, staff received level 3 training.
Senior staff told us that staff undertook Level 2 safeguarding for adults and children. They said that this included female genital mutilation, sexual exploitation, counter terrorism (PREVENT) and domestic abuse. This training was in the process of being redesigned by the safeguarding team to fulfil the requirements of the Intercollegiate Document (2014).

The trust set a target of 95% for completion of safeguarding training and were exceeding this.

Compliance rates for Safeguarding Adults Level 2 were as shown in the table below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy</td>
<td>100%</td>
</tr>
<tr>
<td>Morecambe Bay Cardiac Centre</td>
<td>100%</td>
</tr>
</tbody>
</table>

Trust level

A breakdown of compliance for safeguarding training as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,174</td>
<td>1,275</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still fairly high.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

Cleanliness, infection control and hygiene

Staff attended infection prevention training as part of their mandatory training. Trust compliance was 97.4% for the directorate, which included Emergency Care.

We saw that areas were clean and uncluttered in the Morecambe Bay Cardiac Unit. Infection control measures were in place and staff adhered to the uniform policy to restrict cross infection.

The Endoscopy Unit was spacious, clean and uncluttered. Scopes were decontaminated at the Royal Lancaster Infirmary, a JAG accredited site.

The trust conducted a monthly infection control audit and all medical areas had met or exceeded the 96% compliance target for the previous five months.

Environment and equipment

Morecambe Bay Cardiac Unit had a wide range of specialist equipment. There had been an equipment replacement programme in 2017. This project had been led by the senior radiographer,
who had procured a significant amount of new equipment including a total refurbishment of the operating theatre.

The cardiac unit was purpose built and staff were proud that during the move to a mobile unit for refurbishment in 2017, patient service was not interrupted and staff managed to maintain the same levels of activity.

Staff carried out daily checks of emergency equipment on wards. Resuscitation trollies were sealed and part of the daily check was to ensure the seal was intact. We checked the resuscitation trolley in the Endoscopy unit. All equipment had been serviced and was functioning. The trolley was neat, clean and daily checks were signed and dated for the previous month.

We saw that in both the Endoscopy Unit and Morecambe Bay Cardiac Unit, the environment was dementia friendly, with contrasting wall and floor colours and both pictures and word signage.

### Assessing and responding to patient risk

Measures were in place to ensure that staff could assess and respond to patient risk. The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating. NEWS data was recorded on paper and stored at the foot of the patient’s bed in the Morecambe Bay Cardiac Unit and staff we spoke to were confident they could identify and act promptly in the case of a deteriorating patient. The trust’s audit of NEWS 2 scores showed that compliance for all areas was above 90% for the last six months.

Staff told us that they were in the process of implementing a version appropriate to the unit of the World Health Organisation (WHO) 5 Steps to Safer Surgery. Staff had devised and refined their LocSSIPS (Local Safety Standards for Invasive Procedures) to include a safety briefing and debriefing prior to each surgery.

Staff we spoke to had a good awareness of sepsis, the need for screening, and the ‘Sepsis Six’ tool which was in use. The trust had undertaken an audit of the recognition and management of sepsis which showed improvement since the 2017 audit.

Staff at the Morecambe Bay Cardiac Unit told us that patients were given blood tests to aid the early identification of people with a low eGFR result (indicating potential reduced kidney function). The unit had developed a pathway whereby the renal team could be involved in patient care prior to surgery. The team worked closely with nephrology staff to ensure that the patient was not transferred unless necessary, meaning that more patients could have their kidney condition managed within the unit.

### Nurse staffing

Staff in the Morecambe Bay Cardiac Unit told us that they had no nursing vacancies and staff retention was good. They commented that in the past there had been a lack of capacity and when key team members had been sick it had been difficult to cover their posts. However, they felt that this situation had markedly improved in the past year. On the day of our visit, both the Endoscopy Unit and Morecambe Bay Cardiac Unit met their planned staffing levels.

We were told that no bank or agency staff were used in the cardiac unit due to the specialist care required. Staff planned for sickness and annual leave carefully and adjusted rotas accordingly. The unit had strong links with larger regional centres in the event of a catastrophic staffing event.
The trust commissioned a nurse staffing levels review for 2018/19, undertaken by an external provider. The biggest identified risk was that the trust did not have a safe nurse staffing policy in place, nor a staff rostering policy. As a result, it was not clear how or when to escalate risk caused by low nurse staffing levels, however we saw that the trust had action plans in place to rectify this.

The trust has reported their staffing numbers below for the period October 2017 to September 2018 for medicine. As at September 2018, 87.6% of qualified nursing shifts were filled across the whole trust. During this period, there was an over-establishment of qualified nursing staff at Westmorland General Hospital with a fill rate of 111.0%.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>23.7</td>
<td>24.8</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

Vacancy rates

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust. From October 2017 to September 2018, the trust reported a vacancy rate of 13.5% for qualified nursing staff working in medicine.

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

Turnover rates

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust. From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in medicine. This was better than the trust performance measure of 8.5%.

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

Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust. From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in medicine. The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

Bank and agency staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.
From April 2017 to March 2018, the trust reported that 132 shifts for qualified nursing in medicine were filled by bank staff and no shifts were filled by agency staff. In addition, 32 shifts remained unfilled by bank and agency staff.

For nursing assistants, 38 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 22 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>132</td>
<td>0</td>
</tr>
</tbody>
</table>

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

**Medical staffing**

We had no concerns about the levels of senior doctors at this site. We were told there was always one Consultant available seven days a week. There were no inpatient medical beds at the hospital.

The trust has reported their staffing numbers below for the following periods for medicine: From October 2016 to September 2017 and from October 2017 to September 2018. As at September 2018, 92.0% of medical and dental shifts were filled across the whole trust. Westmorland General Hospital had an over-establishment of medical and dental staff, with fill rates of 110.8% respectively. It should also be noted that due its size, Westmorland General Hospital has a much lower planned staffing level when compared to the other two sites.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in medicine.

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

**Turnover rates**
The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in medicine. This was worse than the trust performance measure of 8.5%.

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

Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in medicine.

The trust measured attendance and had a target of 95.6%.

(Source: Data request - P19 Sickness)

Bank and locum staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in medicine from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

Trust wide

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,949</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>11</td>
<td>801</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,464</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>4,214</td>
</tr>
</tbody>
</table>

Westmorland General Hospital

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>27</td>
</tr>
</tbody>
</table>

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

Staffing skill mix
At June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

### Staffing skill mix for the 129 whole time equivalent staff working in medicine at University Hospitals of Morecambe Bay NHS Foundation Trust

![Staffing skill mix chart]

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</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 - Medical (01/06/2018 - 30/06/2018)

### Records

The trust held records both electronically and in paper format. Paper records were stored in moveable trolleys with lockable lids. Trolleys were either locked, or stored with closed lids within sight of nursing stations.

We examined nursing and medical notes across the trust during our visit and found they were of good quality, appropriately completed, clear and timely. The trust’s systems were supportive of comprehensive record keeping, with electronic reminders for staff to complete assessments and applications.

There was a trust clinical records management policy which clearly outlined correct procedures for managing records and their retention period. The policy was available to all via the trust’s document library and had recently been reviewed and approved.

Records processes were monitored by the Cross Care Group Clinical Records Forum, which reported to the quality committee. We saw the results of monthly record keeping audits, which included a monthly review of five sets of notes, looking at the completeness, timeliness and legibility of both paper and electronic records. We noted that the results showed an improving picture over the previous 12 months.

### Medicines

Pharmacy operated their service seven days a week for supply of medicines and clinical advice.

Staff on the cardiac unit told us that obtaining medication was not a problem, and as patients only stayed for a short period of time, very few were kept onsite. We saw that the medicines storage
area was organised and tidy. All drugs were labelled and in date, and fridge temperatures were recorded daily and in range.

Incidents

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 September 2017 to August 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.

No serious incidents were recorded at this site during this timescale.

(Source: Strategic Executive Information System (STEIS))

Staff at the Morecambe Bay Cardiac Unit told us about a serious incident prior to this time that had led to patient harm. A full root cause analysis had been completed, and the staff had also conducted their own further research at the medical library to ensure learning had been maximised. Although the review concluded that the incident was a ‘one off’ and neither preventable nor foreseeable, the team produced a standard operating procedure to manage such patients should this recur which we saw on the trust’s intranet. We were therefore assured that learning from incidents was good quality.

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 took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 13 falls with harm and 11 new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at University Hospitals of Morecambe Bay NHS Foundation Trust

1
Total Pressure ulcers
(22)

2
Total Falls
(13)

3
Total CUTIs
(11)

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the safeguarding children policy, the NEWS policy, sepsis policy, and information governance policy. All but one (information governance, which expired on 1 November 2018) were within their review date.

The care group’s WESEE report for October 2018 showed that the care group had a programme of reviewing practice against current National Institute for Health and Care Excellence (NICE) guidance. Where the trust had rated themselves as partially compliant, a named individual was tasked with moving this to compliance and we saw evidence that this had taken place.

The trust participated in local and national audit and used this to measure and improve effectiveness of care and treatment. We saw that the trust had action plans in place to address poor performance in national and local audit.
Nutrition and hydration

The trust had a nutrition policy in place, supported by a multidisciplinary nutrition strategy group. In the Morecambe Bay Cardiac Unit, patients were all offered a selection of drinks. Cold food was available for people staying in the unit for four hours or less, and a hot meal was provided for those staying all day or overnight.

Hot and cold drinks were available to patients in the Endoscopy suite following their procedure.

Pain relief

Staff told us that pain relief would be prescribed if patients had discomfort following a procedure or had pain from another co-morbidity. We noted a range of pain-relieving drugs were in stock in the medicine’s storage area in the Morecambe Bay Cardiac Unit. These were correctly stored in a lockable area and were appropriately labelled and in date.

Patient outcomes

The trust participated in local and national audit and used their results to drive changes to improve care and treatment. Local audit plans were comprehensive, and audits were completed and stored as part of an electronic audit system. We viewed a sample audit and saw that it had clear targets and deadlines, a named owner and associated action plan.

We examined the local diagnostic reference levels for the Morecambe Bay Cardiac Centre. All were well below the recommended national reference level (RNRL) and in some cases 85% lower. Staff commented that although they do have a standard operating procedure (SOP) for patients receiving a high radiation dose, it was rarely used.

The unit’s arrhythmia service cardioversion audit showed that the new nurse-led service was achieving good outcomes. They reported a 92% on the day success rate, and 61% of patients could be discharged at their six week follow up appointment.

The Endoscopy Unit was JAG (Joint Advisory Group on GI Endoscopy) accredited. The Unit manager provided evidence that they were in the advanced stages of planning for their next accreditation in early 2019.

The team had investigated why patients did not attend their appointment and found that this could often be due to nerves. They had created a video which introduced the patient to the operating theatre, the unit and the staff and the link for this was to be placed on every outpatient letter so that people could see what they were coming to prior to their visit. The outpatient team were also providing a computer in a separate room within their department for patients who wished to view the video but did not have this facility at home. This video was ready for use, pending national guidance on wording around radiation. The team were hopeful that this would have a real impact on their patients’ understanding of their care and that the number of missed appointments would reduce. They had taken advice from learning disability specialists on how they might adapt this video for someone with a learning disability and this was one of their future plans.

The Morecambe Bay Cardiac Unit team had recently received a £1500 exemplar award and were considering using this money to expand their new video scheme.

The cardiac unit’s lead arrhythmia nurse had entered a ‘Dragon’s Den’ competition at the trust to fund a pilot of the use of a mobile phone App for patients experiencing physical symptoms of
arrhythmias. The app allowed patients to record their cardiac rhythm when symptoms began. This would be more effective than 24-hour monitoring where the patient might be symptom free.

Relative risk of readmission

Trust level

From May 2017 to April 2018, patients at the trust had a lower 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 Admissions – Trust Level

There are no medical inpatient beds at Westmorland General Hospital.

Competent staff

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for medicine also includes data for urgent and emergency care.

As at September 2018, 73.3% of staff within medicine at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,063</td>
<td>776</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>25</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

(Source: Data request- P43 Appraisal Compliance 2017 to date)

Endoscopy nurses told us that some nurses are trained to obtain patient consent. Those who are not trained are able to call upon a more senior staff member to assist if required. They described how they would allow extra time for a patient with dementia, a learning disability or autism and would stay as a familiar face with the person throughout the process. The unit uses a specially adapted consent form (consent form 4) for people with cognitive impairment to ensure they have been fully briefed about their procedure and are happy to go ahead.

Multidisciplinary working

All staff we spoke to were very positive about multidisciplinary team (MDT) working. All groups of staff said that relationships were strong.

There was multi-disciplinary working evident in the cardiac unit with embedded working processes within the unit between nursing, radiography and medical staff. In addition, there was good communication into the community with GPs being fully advised on the procedures completed and follow up required. We heard that there was also a close working relationship with other providers across the region.
Seven-day services

The Morecambe Bay Cardiac Centre provided a service Monday to Friday and was also able to provide overnight stays (7pm-7am) for those patients who required it. At weekends patients were admitted to RLI if their condition was not urgent and could wait until the unit reopens, or were transferred to Blackpool (The Lancashire Cardiac Centre) for urgent treatment. A Consultant was available to review patients seven days a week.

The Endoscopy Unit had recently expanded its services and now opened 8am to 7pm six days a week.

Health promotion

In both the Morecambe Bay Cardiac Centre and the Endoscopy Unit we saw that there were bright, tidy displays on appropriate topics and leaflets available for patients. In the cardiac centre there was a separate stand displaying leaflets for people who either have or are going to have a pacemaker fitted.

The trust was smoke free, and information was provided to patients on the benefits of stopping smoking prior to their visit if attending for planned treatment. Signposting to a stop smoking helpline was available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) protects and empowers people who may lack mental capacity to make their own decisions about their care and treatment. People can lack capacity to make some decisions and not others. When someone has been assessed (using a capacity assessment) and found they do not have the capacity to decide, this can be made in their best interests, on their behalf.

The MCA allows the use of restraint and restrictions but only if they are in a person's best interest. Extra safeguards are required if the restrictions and restraint used will deprive a person of their liberty.

At the previous inspection we were not assured that staff were fully aware of the requirements of the MCA and were competent to apply for a Deprivation of Liberty Safeguard (DoLS).

At this inspection, we reviewed eight DoLS records across the trust, including best interest and mental capacity assessments. These were of a good standard; they were fully and appropriately completed. Guidance and support with completing these records was available to staff on the intranet.

Staff received training on MCA and DoLS through their Safeguarding Adults Level 2 training. The DoLS co-ordinator had plans to extend this further. Staff we spoke to understood the principles of MCA and DoLS and knew who to approach for guidance. Additionally, staff in both the Endoscopy Unit and Morecambe Bay Cardiac Unit were particularly knowledgeable about the nuances of informed consent and situations in which this could change.

The Morecambe Bay Cardiac Unit were aware of and working hard to improve their patients’ understanding and informed consent prior to their procedure.

Mental Capacity Act and Deprivation of Liberty training completion
Compliance rates for Safeguarding Adults Level 2 were as shown in the table below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopy</td>
<td>100%</td>
</tr>
<tr>
<td>Morecambe Bay Cardiac Centre</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

Is the service caring?

Compassionate care

Staff were providing compassionate care. We saw staff offering drinks and chatting to patients waiting for procedures in the Morecambe Bay Cardiac Unit. Patients were happy and seemed relaxed. We saw staff greeting patients in the Endoscopy Unit and providing support and reassurance to nervous patients before their procedure.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 30% which was better than the England average of 25% from August 2017 to July 2018. A breakdown by site and ward at the trust can be found below.

Wards with fewer than 100 responses have been excluded. There is therefore no available FFT data for WGH.

(Source: NHS England Friends and Family Test)

Emotional support

We saw that patients were well supported emotionally, and staff were caring and empathetic. Patients in the Endoscopy Unit were encouraged to use dignity shorts if applicable to their procedure to maintain their privacy and dignity. They were offered bright, spacious rooms to wait in and were fully clothed while waiting for their procedure. The procedure room was locked once a patient had entered, eliminating any chance of their dignity being compromised by another member of staff entering the room during the procedure. If there was any need to deliver bad news following a procedure, staff told us they took patients into the admissions room which is small, quiet and had a lockable door.

Understanding and involvement of patients and those close to them

Staff spoke to patients in a caring and respectful way. They took time to listen to their concerns and made sure decisions were fully informed.

The team were discussing their thoughts around further enhancing the patient experience with patients who use the unit, so they could any additional funds were used in the most beneficial way for their patients.
Is the service responsive?

Service delivery to meet the needs of local people

The trust had good oversight of service planning and was responsive to the needs of local people. Leaders were aware of the logistical and recruitment issues posed by the trust’s geography and could give examples of how they had worked hard to mitigate this, for example by ensuring that all senior staff worked across the whole bay and all three sites.

The trust took an active role in the Morecambe Bay Integrated Care Community (ICC) entitled Better Care Together. A five-year plan had been developed, outlining the proposed transformation of patient pathways and moving care closer to home.

The Morecambe Bay Cardiac Unit delivered services to local patients and avoided the need where possible to attend tertiary sites.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, patients with a learning disability were flagged on the trust’s electronic system so that the learning disabilities matron was aware of any admissions and could ensure their care was appropriate.

Meeting people’s individual needs

The service accommodated people’s individual needs. Patients with a learning disability or dementia were well supported in this trust. People with a learning disability used passports so that staff were clear about their likes and dislikes and who needed to be included in discussions about their care. Passports were stored electronically so they were easily accessible even in an emergency.

The trust used dementia friendly signage and walls and floors were of contrasting colour. Signage was easily changeable to meet the shifting needs of local areas.

Staff had access to translation services, both using the telephone and face to face. It was possible to book a British Sign Language interpreter. We did not see any patient information in additional languages. Staff told us that they had not experienced any problems using translation services.

The Morecambe Bay Cardiac Unit took the opportunity to redesign their patient monitoring systems following patient feedback. This means that all patients were now be monitored centrally from the main desk rather than using individual monitoring machines. Patients staying overnight were not disturbed by the constant beeping of machines and reported to staff that they had a more comfortable stay as a result.

Access and flow

There were no medical inpatient beds at this site. Day lists and overnight stays were well managed by individual units and there was good liaison and information sharing with GPs.

At the Morecambe Bay Cardiac Centre, they had recently moved to a new nurse led system of injectable loops. Previously the insertion of a loop meant a consultant led operation. This change allowed the service to maximise their resources, and nurse led loop insertions were scheduled when the theatre was out of action. This gave consultants the opportunity to focus their resources solely on things that only they can do.
The service also carried out nurse-led cardioversions twice a week. This service had been very successful, and staff told us they would have liked to be able to provide more, but were limited by the amount of theatre time available.

Since our last visit, the Morecambe Bay Cardiac Centre had undergone a complete relocation while their premises were refurbished with new equipment. The team described the considerable planning and resource management that took place during this process. They secured a mobile unit so that their day to day work could continue. Impressively, the team told us that not a single patient’s procedures were postponed or cancelled during the move, and they returned to their original accommodation without a hitch.

The Endoscopy Unit was up to date and delivering on time for its two week wait and six week wait patients. There was a small backlog with surveillance patients, but an action plan was in place to address this. The unit had had no breaches in the previous month.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was generally better than the England average, with the trust performing better than the England average in all months other than January 2018. For the period

In the most recent month (July 2018), the trust’s referral to treatment performance was at 100% (17 admitted pathways), in comparison to the England average of 89.2%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Three specialties 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>Rheumatology</td>
<td>100.0%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.1%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Patient moving wards per admission

There was no data available for ward moves at WGH. This is because there are no inpatient beds for medical patients at this site.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

There was no data available for ward moves at WGH. This is because there are no inpatient beds for medical patients at this site.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

Summary of complaints

Complaints were valued by the trust and information relating to these was disseminated at ward/unit level using the WESEE governance tool. Units displayed their Friends and Family Results and how many complaints and compliments they had received in the previous month. Posters and leaflets advising how to make a complaint were visible on wards.

Ward leaders were clear what the main theme of their complaints were, and that they received few. They told us they received more compliments than complaints.

From July 2017 to June 2018 there were 81 complaints about medical care trust wide. The trust took an average of 32.7 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 35.0 days.

Of the 81 complaints received during the 12-month period, 17 (21.0%) related to treatment given, 15 related to nursing care (18.5%), 10 related to diagnosis problems (12.3%) and nine (11.1%) related to discharge arrangements. A breakdown of complaints by site can be found below.

Westmorland General Hospital

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Given</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1</td>
</tr>
</tbody>
</table>

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

We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Medical care was provided within the medicine care group. This care group included responsibility for the provision of emergency care. Monthly and quarterly care group review meetings provided oversight and assurance to the group leaders.

Ward leaders were effective and had good oversight of their areas. Ward leaders told us that their matrons were very visible and visited them every day. Without exception, they told us they were well supported to do their job and felt comfortable sharing any concerns with their immediate manager. We saw clear and extremely good leadership at all levels within the Morecambe Bay Cardiac Centre. Leaders were visible, and staff reported they did not feel isolated from the bigger sites.

The trust offered leadership courses in partnership with Kendal College and Lancaster University at levels three, five and seven, as well as bespoke internal programmes for those with specific requirements. One of the team at the Morecambe Bay Cardiac Unit was undertaking the Level 5 diploma. They were released one day a month to undertake this. The course was delivered over two and a half years and the staff member reported that as part of the process they had undertaken some interesting shadowing of other areas such as finance and mentoring and coaching.

Vision and strategy

The medicine care group followed the trust 2016-2019 strategy which was aligned to the wider Better Care Together health economy transformation programme. The group had a separate two-year operational delivery plan to support strategic work. As part of the elective care clinical workstream of the Better Care Together plans, the group had worked with partners to explore and implement telehealth solutions to enable more postoperative care and assessment to be done outside the hospital environment.

The care group’s strategic plan contained appropriate planning including assessment and planning for risk, finance, estates and communications.

There was clear vision and strategy which sought to enhance the health and well-being of the community.

Staff in both areas we visited told us about the visibility and accessibility of their matron and said they saw them every day. We were told that matrons were supportive and service managers were working with staff to continually improve delivery. We saw that staff in the cardiac unit worked with a passion to achieve continuous service development and worked hard to overcome obstacles to do so.

Culture

Staff spoke very positively about the trust and morale was high. We found staff to be highly motivated and focussed on patient care and development of the service. In addition, we saw that staff spoke with each other and patients in a respectful way. Staff we spoke with told us that the culture had improved ‘beyond recognition’ over the last five years.

It was evident in the cardiac unit that there was no hierarchy between disciplines or levels of staff development. There was very much a ‘whole team’ ethos.
We saw a handwritten thank you note from the chief executive to the Cardiac Centre team. This was written specifically to the service and was clearly valued by the staff who had displayed it prominently near the main nursing station.

**Governance**

Accountability structures were clear within the Medicine Care Group and staff were confident about their role within the structure. Staff were using their WESEE reports, containing information about training, appraisal rates, incidents, complaints etc to disseminate learning within teams. Staff at both areas we visited told us that they found these useful and we saw minutes prominently displayed in staff rooms.

We reviewed the care group WESEE meeting notes. Attendance at the care group meeting was recorded in the WESEE notes and while this was good in September 2018, with representatives including the associate director of nursing, clinical leads, matrons and service managers, in previous months attendance had been very low, with less than half of those invited attending the four meetings prior. Points of actions were noted, and it was clear where issues should be escalated.

**Management of risk, issues and performance**

The care group WESEE monthly report monitored workforce issues such as mandatory training, incidents, lone working, efficiency, medication errors, document control, medicine audit exceptions, NICE alerts, claims and patient experience. This document did not clearly state what the targets were in all areas and there was no direction of travel visibly displayed.

There was a care group risk register and each risk had a named lead. Risks were stored on the electronic recording system risk module and could be reviewed online. Risks we identified on inspection were evident on the risk register and all risks had a review date. Risks were appropriately and fully recorded including current and planned mitigations. Senior staff on Morecambe Bay Cardiac Unit were clear about the risks in their department and could explain what was on their risk register. This included security, and the risk of patient haemorrhage.

**Information management**

The trust was using information management systems effectively and auditing this well. A recent move to an electronic audit proposal, registration, tracking and reporting system has meant that leaders could track progress easily.

Staff told us they were provided with the right systems to do their job. The intranet was easy to navigate and find information, and the patient records system was clear and prompted staff to renew or refresh elements of patient care as appropriate. Access was also available where needed to wider systems such as those used by adult social care teams and GPs. Managers had access to their staff’s electronic staff records so they could view appraisal rates, sickness and training.

A new electronic ‘review workspace’ was introduced for procedural documents enabling staff to view, review and comment electronically, saving time and reducing duplication of effort.
The trust’s information governance and data quality committee monitored the implementation of the data quality strategy. Information governance training rates were monitored at care group leadership level and was 89.8% in September 2018.

**Engagement**

The trust launched its new Patient and Public Involvement Strategy in 2018 including a ten-point action plan for involvement. There was a recognition that different groups of stakeholders would want to be listened to in a variety of different ways and there was evidence of some innovative thinking around this. Staff we spoke with told us they felt involved in development of services and this promoted good team working.

The Morecambe Bay Cardiac Unit worked hard with its patients to capture their experience and use this to improve services. They provided examples of when a patient had told them something, and they had adapted their services or practices as a result. The unit was very patient focussed and due to their ongoing excellent engagement, was delivering what patients wanted.

**Learning, continuous improvement and innovation**

The newly introduced nurse led injection loop procedure was less invasive and involved a small incision. Staff had received specific out of area training to deliver the service. Patients could take home a box which meant they could be monitored at home, reducing their time in hospital. This meant better outcomes for patients. Cardiac resynchronisation devices were also supported by remote monitoring.

The nurse led cardioversion service freed up consultant time and was having an impact on waiting lists. Staff auditing the service were aware of where further improvements could be made that would bring the service closer to the gold standard for this type of care.

The cardiac unit’s lead arrhythmia nurse had entered a ‘Dragon’s Den’ competition at the trust to fund a pilot of the use of a mobile phone App for patients experiencing physical symptoms of arrhythmias. The app allowed patients to record their cardiac rhythm when symptoms began. This would be more effective than 24-hour monitoring where the patient might be symptom free.

Morecambe Bay Cardiac Unit had created a video introducing patients to the staff and environment so that people could feel more prepared and comfortable when attending their appointment. This was due to be implemented imminently and it was hoped this would reduce the number of patients not keeping their appointments.
Facts and data about this service

The trust delivers its surgical services across three sites; Royal Lancaster Infirmary, Furness General Hospital, and Westmorland General Hospital.

At Royal Lancaster Infirmary, there are 136 inpatient surgical beds including the surgical assessment unit accommodated in the Centenary building and two day surgery wards within medical unit one. At Furness General Hospital, there are 92 inpatient beds, including the surgical assessment unit and a mixed day surgery unit.

At Westmorland General Hospital, there are 43 inpatient surgical beds across three surgical wards. The site provides elective day case surgery for breast surgery, general surgery, ophthalmology, orthopaedics and urology.

Surgery at the trust includes all main surgical specialties with the exception of cardiothoracic, neurosurgery, plastics and vascular which are provided by other local NHS foundation trusts.

(Sources: Routine Provider Information Request AC1 - Acute context, Routine Provider Information Request- Sites tab)

The trust had 35,117 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,630 (27.4%), 21,086 (60.0%) were day case, and the remaining 4,401 (12.5%) were elective.

(Source: Hospital Episode Statistics)

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

- ensure care pathways are reviewed in accordance with the trust policy;
- ensure hand hygiene audits take place monthly and that improvements are made;
- nursing documentation should include whether a patient has had food or drinks whilst in the emergency department;
- continue to improve referral to treatment times (RTT);
- increase orthogeriatrician input on surgical wards;
- ensure all transfers between locations are performed in line with best practice guidance and policy;
- continue to engage staff and encourage team working, to develop and improve the culture within the wards and theatre department;
- continue with staff recruitment and retention;
- ensure medicines reconciliation is completed in a timely way; and
- ensure medication fridge temperatures are checked within trust policy timescales.

During this inspection we visited main theatres, the day surgery unit, and wards 2, 6 and 7.

We observed care being given and surgical procedures being undertaken in theatres and recovery areas. We spoke with 10 patients and relatives and 12 members of staff. We observed care and treatment and looked at eight care records.
Is the service safe?

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 September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,269</td>
<td>1,280</td>
<td>99.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,225</td>
<td>1,278</td>
<td>95.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,220</td>
<td>1,277</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,191</td>
<td>1,277</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,105</td>
<td>1,189</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>1,172</td>
<td>1,275</td>
<td>91.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,173</td>
<td>1,281</td>
<td>91.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>932</td>
<td>1,097</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for three of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for Resus - Basic life support, for which only 85.0% staff had completed the training at September 2018.

The training data submitted by the trust was split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported included staffing figures for critical care at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

There was a focus on improving compliance with mandatory training throughout the wards we visited. Staff we spoke with said that training completion was discussed at annual appraisals and throughout the year. Ward managers liaised with the practice education facilitator to provide opportunities for staff to complete training on the ward during their shifts. Staff we spoke with told us that they felt access to mandatory training was easier now that this was in place.

The care group senior management team provided us with updated compliance figures as of December 2018, shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The figures showed an improvement in compliance across all mandatory training modules.

### Safeguarding

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

#### Trust level

A breakdown of compliance for safeguarding training as at September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,173</td>
<td>1,260</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was not met for the one safeguarding training modules for which staff were eligible, although completion rate for this module was still high.

The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

There were systems and processes in place to protect patients from abuse. The trust had appointed a head of safeguarding and professional lead since the previous inspection. The safeguarding subgroup reported to the safety and quality committee which reported to the board.

Ward managers told us that the head of safeguarding was easy to contact if they needed advice. There was a daily safeguarding teleconference where individual cases were discussed and allocated to an appropriate practitioner to handle.

There were up-to-date policies, including ‘Adults at Risk’ and ‘Safeguarding Children’, and links to multi-agency safeguarding procedures on the intranet. Staff could describe where to find these documents, as well as the process they would follow to make referrals. Staff gave examples of safeguarding referrals which were handled and escalated appropriately, and they received feedback about investigations.

All frontline staff were required to complete Safeguarding Adults Level 2 training, and all staff who worked with children and their carers were required to complete Safeguarding Children level 2 training. We requested compliance figures for safeguarding adults and children training. We were told that 91% of eligible staff had completed level 2 training and 79% of eligible staff had
completed level 3 training. Delivery of level 3 training had changed from an external provider to a recently appointed practice education facilitator who provided face-to-face level 3 training on wards.

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean and tidy. The trust environmental cleaning policy outlined the trust’s commitment to maintain a ‘high standard of cleanliness within all clinical and public areas. Environmental audits showed that all areas within the hospital met the trust cleaning standard of 95% in high risk areas (surgical inpatient wards, day case surgery and ward 2 rehabilitation) in the three months prior to inspection. The trust cleaning standard for very high risk areas (theatres and Westmorland Surgical Centre) was 98%. One theatre scored 96% in September 2018, however the matron and theatre manager took action and audit results improved for this theatre, reaching 99% in November 2018.

Patient led assessments of the care environment (PLACE) showed the hospital scored 95.5% for cleanliness against the national average of 98%. Actions resulting from these assessments were taken forward by matrons, infection control nurses, staff and patient environment services managers. A cleanliness and infection prevention group reviewed patient and service user information, cleanliness and cleaning audits and records. The group reported any significant risks to the infection prevention and control committee and the health and safety committee.

We observed staff washing their hands and using hand gel between patients. Staff were bare below the elbows. There were alcohol hand gels available on entry to each ward and highly visible signage directed staff and patients to hand washing sinks. Sluice and linen rooms on the wards were clean and tidy. Waste was segregated and removed from trust premises in line with the policy for waste management and health technical memorandum (HTM) 07-01 ‘safe management of healthcare waste’.

There were rooms available on each ward to care for patients who required isolation. There were clear instructions outside isolation rooms for staff around infection control principles. There were signs requesting visitors to report to staff for further instruction before entering the room. We observed staff wearing appropriate personal protective equipment when caring for patients in isolation.

Elective surgical patients were cared for away from non-elective surgical patients to reduce the risk of infection. However, we saw that one patient who was too unwell to go home was transferred from the day surgery unit to the elective orthopaedic ward without screening for methicillin-resistant *Staphylococcus aureus* (MRSA).

**Environment and equipment**

Surgical wards were clearly signposted along the corridors of the hospital and the environment was spacious and bright.

The domestic and linen rooms were clean and tidy. Designated storage space was limited, however staff made effective use of any available space in their areas. For example, ward 6 was not currently being used for patient care, so staff used one of the bays as a second office and to store equipment.

One patient we spoke with told us that the ‘airy, spacious’ environment had been a factor in his decision to come to Westmorland General Hospital rather than another hospital site.
There was a day room on each of the wards with books and board games for patients to use. Staff told us there were plans to modernise the day rooms.

Electrical equipment was labelled with up-to-date testing stickers. Resuscitation trolleys were well stocked and routinely checked, and equipment was securely stored. However, we saw that on one trolley, laryngoscopes, blades and forceps had been removed from sterile packaging. We raised this with ward staff who removed these items from the trolley.

During our inspection, one theatre was being refurbished. Some of the improvements included an upgraded air handling unit, rewiring for an uninterrupted power supply, and new flooring and walls. The refurbishment was part of a wider programme across the trust to upgrade theatres.

Although we saw that wards were well maintained, on ward 7, the flooring required maintenance and was patched in several places.

**Assessing and responding to patient risk**

The care group had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. Staff completed patient risk assessments on admission, including falls, nutrition and hydration and pressure damage risk.

Staff recorded patient observations using the updated version of the National Early Warning Score (NEWS2) system, to assess each patient’s condition and determine when a patient may need a higher level of care. Staff were able to describe how they would treat and escalate a patient whose score increased. The NEWS2 charts we reviewed were completed correctly and the trust’s own audit of NEWS2 for the inpatient surgery unit and day surgery unit over the three months prior to our inspection showed that compliance was consistently above the trust target of 90%.

The trust provided figures showing that since NEWS2 was rolled out in October 2018, 76% of staff had completed NEWS2 training against the trust target of 95%. However, at the time of inspection, we were told this figure had increased, but ward managers were awaiting sight of training certificates from staff before they could mark training as complete.

At the time of inspection, further training was taking place for matrons and ward managers to monitor and challenge the application of NEWS2 and improve training compliance.

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. Staff used a sepsis screening tool and placed patients who met the criteria on the sepsis pathway. This pathway included ‘Sepsis 6’, designed by ‘The UK Sepsis Trust’, which consists of diagnostic and therapeutic steps to be taken within one hour of diagnosis to improve patient outcomes, including up to a 50% reduction in mortality. There were two Sepsis/Acute Kidney Injury (AKI) practice educators who supported and trained staff. Sepsis screening and management was audited and had improved since the previous year’s audit. Any delays in treatment for sepsis or missed opportunities to put patients on the sepsis pathway were investigated and learning was shared with staff.

In theatres, we observed staff using the ‘Five Steps to Safer Surgery’ checklist appropriately, including briefing, sign-in, timeout, sign-out and debriefing. Audits from August to October 2018 showed an average of 99% overall compliance at Westmorland General Hospital.

Risks associated with falls, pressure ulcers, catheter-acquired urinary infections, *Clostridium difficile* (C. diff) and MRSA were monitored monthly using the NHS Safety Thermometer.
There was a quality assurance accreditation scheme so that best practice could be shared across wards and theatres, with a focus on reducing patient harms such as pressure ulcers and falls. One of the wards we visited had been awarded ‘exemplar status’ due to its success.

**Nurse staffing**

The trust reported their staffing numbers below for the period October 2017 to September 2018 for surgery. As at September 2018, 83.8% of qualified nursing positions were filled across the whole trust. Nursing fill rates were below establishment at all three locations offering surgical services at the trust. Fill rates of 86.6%, 79.2%, and 90.3% were reported for Furness General Hospital, Royal Lancaster Infirmary, and Westmorland General Hospital respectively.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 to September 2017</th>
<th>October 2017 to September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>154.4</td>
<td>173.7</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>192.8</td>
<td>235.4</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>77.8</td>
<td>88.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>425.0</strong></td>
<td><strong>497.7</strong></td>
</tr>
</tbody>
</table>

*Source: Data request - P16 Total Staffing*

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 11% for qualified nursing staff working in surgery.

The data reported included staffing figures for critical care at the trust.

*Source: Data request – SDR4 Vacancy*

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 7% for qualified nursing staff working in surgery. This was better than the trust performance measure of 8.5%.

The data reported included staffing figures for critical care at the trust.

*Source: Data request – SDR5 Turnover*

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 6% for qualified nursing staff working in surgery. The trust did not report a target rate.

The data reported included staffing figures for critical care at the trust.

The trust measured attendance and had a target of 95.6%.

*Source: Data request - SDR6 Sickness*
Bank and agency staff usage

The trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we were unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 3,944 shifts for qualified nursing in surgery were filled by bank staff and 4,627 shifts were filled by agency staff. In addition, 5,478 shifts remained unfilled by bank and agency staff.

For nursing assistants, 13,466 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 3,786 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>4,365</td>
<td>0</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>8,446</td>
<td>0</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>655</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,466</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

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

Ward managers regularly reviewed nurse staffing. They used the Safer Nursing Care acuity tool (SNCT), along with the number of admissions and professional judgement, to plan and flexibly adjust staffing levels accordingly. Staff were moved between wards if necessary to ensure safe staffing levels. Decisions to move staff were informed by the use of Situation, Background, Assessment, Recommendation (SBAR) handovers. Matrons and ward managers worked on the wards when necessary to increase cover.

Theatre staffing levels were planned according to theatre lists a week in advance using the SNCT. The previous inspection (2016) showed that actual qualified and non-qualified staffing levels were less than planned qualified and non-qualified staff levels and fill rates were lower (86%) than during this inspection. Matrons and staff explained that safe staffing levels were maintained through constant review and assessment of surgical activity and patient acuity and through daily bed and cross-site meetings to meet demands in ward activity.

The senior management team told us that staffing was on the care group risk register. They were taking action to recruit more nursing staff. As well as advertising vacancies, they were making efforts to recruit internationally, and had introduced internal nursing degree apprenticeships.
Medical staffing

The trust reported their staffing numbers below for the period October 2017 to September 2018 for surgery. As at September 2018, 90.5% of medical and dental positions were filled across the whole trust.

Medical fill rates were below establishment at all three locations offering surgical services at the trust. Fill rates of 86.7%, 92.7%, and 74.0% were reported for Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital respectively.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>64.7</td>
<td>75.3</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>143.1</td>
<td>149.2</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>3.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>215.0</strong></td>
<td><strong>233.0</strong></td>
</tr>
</tbody>
</table>

(Source: Data request - P16 Total Staffing)

Vacancy rates

From November 2017 – October 2018, the trust reported a vacancy rate of 9% for medical and dental staff working in surgery.

The data reported included staffing figures for critical care at the trust.

(Source: Data request – SDR7 Vacancy)

Turnover rates

From November 2017 to October 2018, the trust reported a turnover rate of 13% for medical and dental staff working in surgery. This was worse than the trust performance measure of 8.5%.

The data reported included staffing figures for critical care at the trust.

(Source: Data request – SDR8 Turnover)

Sickness rates

From November 2017 to October 2018, the trust reported a sickness rate of 5.76% for medical and dental staff working in surgery. The trust did not provide a target rate. The data reported included staffing figures for critical care at the trust.

The trust measured attendance and had a target of 95.6%.

(Source: Data request – SDR9 Sickness)

Bank and locum staff usage

The number of shifts at the trust covered by bank and medical locum staff in surgery from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

Trust Wide
<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,083</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>21</td>
<td>1,301</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,140</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>3,524</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Westmorland General Hospital**

The trust reported that no shifts were covered by bank and agency staff at Westmorland General Hospital from April 2017 to March 2018.

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

**Staffing skill mix**

At June 2018, the proportion of consultant staff reported to be working at the trust was similar to 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 University Hospitals of Morecambe Bay NHS Foundation 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>26%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>10%</td>
<td>28%</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)

Consultant surgeons were based primarily at Royal Lancaster Infirmary. Consultants visited Westmorland General Hospital weekly. If patients required consultant review outside of the consultant visit, staff called them for advice, and patients could then be transferred to Royal Lancaster Infirmary if necessary.

A consultant orthogeriatrician was available and there was a resident medical officer (RMO) on site at all times who also provided out of hours medical cover. The RMO was trained in advanced life support (ALS), and would lead emergency response. There were no junior doctors (foundation years 1 and 2) at Westmorland General Hospital.
We spoke with consultants in theatres who had no concerns about medical staffing in theatres.

Records

Staff used an electronic patient record supported by paper records for each patient. Electronic patient records were secure and could only be accessed by inserting an identification card into the computer. Paper records were stored securely and were only accessible to staff.

We reviewed a sample of nursing and medical records across wards and checked care plans and risk assessments. We found they were completed accurately, updated regularly and included sepsis checks, nutrition and hydration records, appropriate frequency of observations and NEWS2, pressure care, falls assessments and do not attempt cardiopulmonary resuscitation (DNACPR) forms where appropriate.

Staff told us the quality of record keeping was a priority. Matrons and ward managers carried out documentation audits on records throughout the care group. Although we did not find any issues with record keeping at the time of inspection, audit results showed there were deficiencies in record keeping in May and June 2018 in Theatre 1. These audits had not been repeated for Theatre 1, therefore, we were not provided with evidence that the trust assured itself that these issues had been addressed.

Medicines

The trust had an up-to-date medicines policy which described how medicines should be stored and managed, including controlled drugs. We observed that all medicines and intravenous fluids were stored behind keypad locked doors. Drugs cupboards were locked, and staff ensured cupboards were not left unlocked while unattended.

We checked a sample of drugs on each ward and found them to be in date. The controlled drugs register showed the correct balance for each drug, it was fully completed, and each entry had been signed by two staff members.

Pharmacists and pharmacy technicians completed medicines reconciliation daily from Monday to Friday, to ensure that patients were taking the correct medicines. Wards were compliant with the trust policy regarding monitoring medications that required refrigeration.

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 both mechanically (anti embolism stockings) and chemically (prescribed medication).

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 September 2017 to August 2018, Westmorland General Hospital reported one incident classified as a never event for surgery.
The never event had been investigated and a root cause analysis was completed. The never event was attributed to inconsistencies in following local safety standards for invasive procedures (LocSSIPs) in theatre. Immediate action was taken to disseminate the LocSSIP to all staff in ophthalmology. All staff were asked to sign to confirm they had read and understood the LocSSIP going forward. The theatre matron and theatre manager undertook random spot checks to review how the LocSSIP was being used in the months following the never event.

Breakdown of serious incidents reported to STEIS

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

Of these, the most common types of incident reported were:
- Surgical/invasive procedure incident meeting SI criteria with seven (37% of total incidents).
- Pressure ulcer meeting SI criteria with four (21% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (16% of total incidents).
- Treatment delay meeting SI criteria with two (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (5% of total incidents).
- Operation/treatment given without valid consent with one (5% of total incidents).
- Medication incident meeting SI criteria with one (5% of total incidents).

Site specific information can be found below:
- Westmorland General Hospital: three incidents

The serious incidents reported at Westmorland General Hospital included two surgical/invasive procedure incidents meeting SI criteria and one pressure ulcer meeting SI criteria.

There were systems in place for reporting, monitoring and learning from incidents. Staff reported incidents using an electronic system.

There was a monthly meeting for all care groups to present and share their top three incidents. These were discussed, with focus on capturing of incidents and how to measure improvement, and the information was shared with the Care Quality Committee.

Staff knew how to incident report following the policy on the intranet. They could describe isolated incidents and the feedback they received from their line managers. Incidents were shared with staff at daily huddles and the information was recorded for staff to read through. There were regular newsletters and ward meetings where incidents were discussed.

We observed notices alerting staff to recent incidents around overdoses of gentamycin and paracetamol. The trust informed us that they had identified the cause as being an issue with
electronic prescription charts. They had recently redesigned these charts in the electronic patient record to reduce the risk of recurrence.

**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 26 new pressure ulcers, 20 falls with harm and six new catheter urinary tract infections from August 2017 to August 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at University Hospitals of Morecambe Bay NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>Total Pressure ulcers</th>
<th>Total Falls</th>
<th>Total CUTIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>(26)</td>
<td>(20)</td>
<td>(6)</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital)

Each area we visited displayed Safety Thermometer results for the current month near ward entrances. These included actual staffing levels against recommended staffing levels, incidence of both hospital acquired pressure ulcers and patients admitted with pressure ulcers already, falls
resulting in harm to the patient, catheter acquired urinary tract infections, incidence of \textit{Clostridium difficile (C. diff)} and Methicillin-resistant \textit{Staphylococcus aureus} (MRSA), and audit results for hand hygiene and cleanliness.

### Is the service effective?

#### Evidence-based care and treatment

The care group followed National Institute for Clinical Excellence (NICE) guidelines, and there was a NICE Guideline lead who maintained responsibility for monitoring compliance. Any gaps in practice were identified using the GAP analysis toolkit provided by NICE. Staff accessed policies and other guidance through the trust intranet. Policies we reviewed were in date, with version control and a named author.

Enhanced recovery pathways were in place for patients undergoing surgery. Enhanced recovery is an evidence-based approach focusing on ensuring patients are in the best possible physical condition before surgery and optimising perioperative and postoperative care so that patients recover more quickly.

The trust had introduced the ‘Gold Standards Framework’ to co-ordinate Individual patient needs and communicate these to all staff. Patients identified for the framework usually have one or more illnesses that may affect their life expectancy and result in rapid access to health care.

The framework ensured patients received the highest standard of care, focussed on their needs, wishes and symptoms. Individual plans were developed ensuring patients received the care needed in the place of choice. The electronic patient record prompted staff to ask for more detail about individual preferences, enabling teams to anticipate possible issues, listen better and communicate with others involved in care.

The trust participated in the ‘Getting It Right First Time’ (GIRFT) project, commissioned by the Department of Health. This is a national programme designed to improve the quality of care within the NHS by reduction unwanted variations and/or divergence from the best evidence. The trust had developed GIRFT projects within trauma and orthopaedics, urology, ophthalmology, ENT and maxillofacial surgery.

Schemes such as John’s Campaign and ‘End PJ Paralysis’ were promoted throughout wards. John’s Campaign promotes the right of carers to stay with patients with a dementia, and there is evidence to show that this can reduce falls, the chance of reduced cognitive impairment throughout admission and the average length of stay. ‘End PJ Paralysis’ is focused on evidence showing that patients who stay in bed can become deconditioned, recover more slowly and stay in hospital for longer.

The care group participated in several national audits including the bowel cancer audit and oesophago-gastric cancer audit for example. In addition, the trust conducted several internal audits and we saw evidence of action plans in response.

#### Nutrition and hydration


There was a nutrition policy supported by a multidisciplinary nutrition steering group. We reviewed electronic and paper care plan documentation and risk assessments were fully completed and fluid, food and rounding charts were completed appropriately.

All patients were screened on admission using the Malnutrition Universal Screening Tool (MUST) and a nutritional care plan was created for each patient. Screening was repeated weekly and patients were referred to the dietician if necessary. The trust had introduced an improved fluid balance chart and policy that included reference points for emergency conditions such as acute kidney injury.

There were protected meal times, but these were flexible to the patient’s wishes if they preferred friends or family to stay or assist them during meals.

We saw that patients were offered drinks outside meal times and water jugs and cups were within reach. Modified cutlery and cups were available to patients who needed them.

Patients told us they were happy with the food choices available. Special dietary requirements were catered for and snack boxes were available outside regular meal times on request.

The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE). The results showed that ward food scored 98.21%. The average score nationally for ward food was 90.52%.

Pain relief

Staff used a pain-scoring tool to assess patient’s pain levels and recorded pain scores in patient notes and the electronic patient record. Pain relief was provided as prescribed in a timely manner.

Patients told us that they felt their pain was being controlled and that staff regularly checked how they were feeling. Additional pain relief could be accessed through medical staff if required.

The trust used an appropriate pain scale to assess and minimise pain in patients who may not be able to communicate this to staff, such as patients living with dementia.

The trust had developed a LocSSIP (May 2015) for the management of pain relief procedural blocks and other invasive pain procedures performed. This was based on the ‘four steps to safe patient procedural safety’ process to ensure correct site marking and ensure patient safety during the invasive procedure.

Patient outcomes

Relative risk of readmission

Trust level

From May 2017 to April 2018, patients at the trust had a lower expected risk of readmission for elective admissions and a similar expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions – Trust Level

| England Avg. | _____ |

20190508 RTX University Hospitals of Morecambe Bay NHS Foundation Trust Evidence Appendix
Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

- General surgery patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

Westmorland General Hospital

From May 2017 to April 2018, patients at Westmorland General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Westmorland General Hospital
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 represents the opposite. Top three specialties for specific site based on count of activity

- Trauma and orthopaedics patients at Westmorland General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at Westmorland General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Westmorland General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, 74.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than expected. The 2016 figure was 70.7%.

The risk-adjusted 90-day post-operative mortality rate was 2.6% which was within the expected range. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 19.7% which was within the expected range. The 2016 figure was 21.9%.

The risk-adjusted 30-day unplanned readmission rate was 9.4% which was within the expected range. The 2016 figure was 10.2%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 52.7% which was within the expected range. The 2016 figure was 51.8%.

(Source: National Bowel Cancer Audit)

**Oesophago-Gastric Cancer National Audit**

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0.0%. 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 0.0%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%. This was similar to 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.

(Source: National Oesophago-Gastric Cancer Audit 2016)
The trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:

- further assessment of case ascertainment rates;
- review local protocols and referral processes to ensure patients diagnosed with high grade dysplasia are discussed at a specialist MDT;
- coordinate the patient pathway to avoid patient waits longer than necessary to start treatment; and
- ensure surgical teams regularly monitor markers of quality of surgery and act when any concern arises.

**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 for groin hernias was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

*(Source: NHS Digital)*

In addition to participating in national audits, the trust conducted internal local audits to drive improvements in patient outcomes within the care group. Some examples include an audit of all surgical operations throughout the year to monitor the quality of surgical outcomes, an
intraoperative analgesic audit to measure the effectiveness of pain relief in recovery and a surgical readmissions audit to look for opportunities to reduce readmissions within the care group. Key audit outcomes were fed into meetings throughout the care group and audit action plans were created.

**Competent staff**

**Appraisal rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust provided data split by clinical care group and therefore the appraisal data for surgery also includes data for critical care.

As at September 2018, 75.6% of staff within surgery at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,055</td>
<td>794</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>18</td>
<td>17</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,073</td>
<td>811</td>
<td>75.6%</td>
</tr>
</tbody>
</table>

(Source: Data request- P43 Appraisal Compliance 2017 to date)

The senior management team had advised that appraisers should forward plan and book in appraisals with staff in advance. There had been a continual rise in appraisal rates and as at November 2018, 79% of nursing staff and 93% of medical staff had received an appraisal within the last 12 months. In terms of staff bands, the senior management team told us that at the time of inspection, 80.4% of staff at bands 1 to 7 and 94.4% of staff at bands 8a and above had received an appraisal.

We were informed that appraisals were undertaken on the anniversary of the start date of a member of staff. At the time of inspection, the completion rate was above the expected rate and trajectory (75%) to meet trust targets.

**Multidisciplinary working**

Within the care group, there were multidisciplinary team meetings in various specialties such as breast, urology and general surgery. These groups met regularly either on a weekly or twice-weekly basis with representation from radiology, pathology, specialist nursing and medical teams.

On the wards, there was a multidisciplinary meeting each morning, attended by nursing and medical staff, clinical support workers, pharmacists and pharmacy technicians, physiotherapists and occupational staff.

In addition, there was wider multidisciplinary working with partner organisations with the aim of reducing levels of patients staying in hospital while medically fit for discharge.
Mental health and learning disability specialist nurses had been introduced on inpatient wards to provide a wider skill set.

**Seven-day services**

The trust monitored its working scheme against NHS Services, Seven Days a Week Clinical Standards. The standards highlight how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams.

Surgery at Westmorland General Hospital was predominantly carried out from Monday to Friday. Occasionally this would include Saturdays dependent on patient waiting lists.

Consultant surgeons carried out weekly patient reviews but could be called if they were needed urgently outside of their regular visits. There was an on-call consultant at all times. Patients could be transferred to access emergency care if needed seven days a week.

There was regular availability of physiotherapy and occupational therapy staff from Monday to Friday and limited access to these services at weekends for those patients identified as high priority.

The pharmacy was open from Monday to Friday. At weekends, services were provided from Royal Lancaster Infirmary. There was access to an on-call pharmacist for clinical advice and emergency medicines outside of pharmacy opening hours. A pharmacist or pharmacy technician attended the wards from Monday to Friday to complete medicines reconciliation.

**Health promotion**

There were leaflets available for patients and visitors on all wards providing advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention. We did not see patient information leaflets in languages other than English, but there was guidance on how these could be accessed on the back of each leaflet.

There were displays on entry to wards encouraging patients, their carers and their families to become actively involved in reducing health risks to patients. For example, ‘No Pressure’, which included guidance on what patients and carers could do to prevent pressure ulcers, and ‘Falls Prevention Tips’.

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

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

We were provided with information that showed 91% of eligible staff had completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of Safeguarding Adults and Children (NHS Core Skills) Level 2, and 79% of eligible staff had completed Level 3. Neither of these training completion rates met the trust standard of 95%.

*(Source: Data request – SDR14 & 15 MCA & DoLS)*

Patient led assessments of the care environment (PLACE) showed the hospital scored 68.88% for meeting the dementia needs of patients. This was lower than the national average of 79%. The trust had developed action plans from these assessments which were monitored by matrons.
The trust had Mental Capacity Act (July 2018) and Deprivation of Liberty Safeguards (July 2018) policies in place and staff could access guidance and information if needed. The Mental Capacity Act policy defined staff responsibilities, enabling people to make decisions, capacity assessments, documentation required, consent, best interest decisions and statutory duties. The DoLS policy defined what constitutes a deprivation of liberty, who is covered by DoLS, when a DoLS should be used, applying for standard and urgent authorisations and where to seek support throughout the application process. There was a Mental Capacity Assessment, Mental Health Act and Deprivation of Liberty Safeguards co-ordinator to support the safeguarding team, who scrutinised applications submitted and processed them to the local authority.

We observed inconsistent practice in recording information regarding the MCA and DoLS. For example, we observed a patient living with dementia who was consented for surgery by a locum doctor, without carrying out a mental capacity assessment and subsequently completing the incorrect consent form.

Although a consultant noticed and completed the appropriate consent form the following day, staff were unable to show us an appropriate mental capacity assessment or DoLS had been undertaken.

Is the service caring?

Compassionate care

Friends and Family test performance

A breakdown of FFT performance by ward at Westmorland General Hospital can be found below.

Westmorland General Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Ward 7</td>
<td>871</td>
<td>77%</td>
<td>Apr-17: 100%</td>
</tr>
<tr>
<td>High Day Surgeon Unit</td>
<td>162</td>
<td>139%</td>
<td>Apr-17: 100%</td>
</tr>
<tr>
<td>High Ward 5</td>
<td>120</td>
<td>79%</td>
<td>Apr-17: 100%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Wards with a response rate of less than 100 have been removed.

Key

| 100% | 50% | 0% |

(Source: NHS England Friends and Family Test)

The most recent Family and Friends Test results were displayed on each of the wards we visited. The response rate for FFT completion was 40%. This was higher than the England average of 25%. We saw that 96% of patients who completed the test on ward 6, and 100% of patients who completed the test on ward 2, would be extremely likely or likely to recommend the service to friends and family if they needed similar care or treatment.

All patients we spoke with were happy with their care. We observed staff caring for patients and found that they showed empathy to patients and reassured them. Patients told us they felt staff treated them with dignity and respect. We saw staff closing curtains and doors to protect patients’ privacy. All patients who told us they had used their call bells felt that staff attended quickly.
Patient led assessments of the care environment (PLACE) showed the hospital scored 73% for caring. The national average was 84%. Matrons, staff and patient environment services managers had taken forward actions to improve based on PLACE results.

**Emotional support**

Each of the wards we visited had a room for patients and relatives to go if they needed privacy. Staff we spoke with told us they used this room when necessary to discuss anything sensitive with patients and relatives to maintain their privacy and dignity.

Staff recognised when patients may need support to come to terms with their diagnosis. There was a specialist breast care nurse on ward 6 who provided wellbeing sessions with patients. There were leaflets for patients with a diagnosis of breast cancer, explaining how to access emotional and practical support, and providing advice on how to explain their diagnosis to family members, particularly children.

There was a chapel on site which was open 24 hours a day. There was a chaplaincy team comprised of staff and volunteers providing spiritual and religious support. For individual religious needs, the chaplaincy service could provide prayer and sacraments for Christians and would try to accommodate faiths not represented in the chaplaincy team.

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

Patients we spoke with told us staff had taken time to explain what would happen to them in hospital, and that they had been involved in choices and discussions about their care. They felt staff listened to their preferences or concerns and acted appropriately to support them.

There was open visiting until 20:00 every evening. In addition to open visiting, each of the wards we visited displayed clear information promoting and supporting John’s Campaign.

**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 a five year trust strategic and operational plan which included surgery and a care group business plan was also in place. Senior managers described working with business managers, the clinical director and matrons to plan services.

The senior management team confirmed the care group’s priority was to deliver high quality, safe services that meets the needs and expectations of patients through the ‘Better Care Together’ programme. This is a clinically led, health economy-wide integrated care community that is the main route through which the trust’s long-term future is delivered. A strategy to support ‘Better Care Together’ had been developed to provide staff, local communities and regulators with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

Ward managers told us there had recently been an increase in capacity for elective orthopaedic surgery patients at Westmorland General Hospital due to the introduction of a mobile operating theatre facility. There had also been a reconfiguration of surgical wards to support this facility and increase availability of surgical beds.
The reconfiguration also enabled patients who had surgery at Royal Lancaster Infirmary or Furness General Hospital, but who lived near Kendal, to be transferred to Westmorland General Hospital for rehabilitation. One patient who had been able to choose to come to Westmorland General Hospital told us he really valued being able to stay closer to home.

Scoping work was being done to widen the range of surgical services available at Westmorland General Hospital such as vasectomies and other minor procedures.

**Meeting people’s individual needs**

There were electronic boards on the wards displaying a bed map and flagging any patients with additional needs such as hearing impairments, interpreter requirements and dietary requirements. Staff gathered this information through assessments on admission. We saw one patient with a hearing impairment who was having surgery that day. We observed that a signer was available at all times before, during and after their procedure.

There was a range of patient information leaflets throughout the wards. There were none on display in other languages, however staff knew how to access them if required. A comprehensive and user-friendly booklet to support patients awaiting surgery had been developed. This provided patients with clear information to support their preparation for surgery and improve the patient experience and enable informed choices as well as better theatre use.

Ward managers described how patients attending under different specialties were grouped together on wards. For example, breast patients were cohorted in one bay on ward 7 and had a key specialist breast care nurse. The ward manager told us they had received compliments from patients who found coping with their diagnosis was made easier by building a relationship with their key nurse and patients going through a similar experience.

Wards were flexible in their organisation of patients. Staff told us they would plan for admissions by swapping female-only and male-only bays around to accommodate patients depending on the mix of patients on the ward at the time, rather than simply admitting patients to whichever bed was free.

Staff supported and used the Butterfly Scheme in practice. This scheme aims to improve the experience of patients with a dementia whilst they are in hospital. Patients were identified by a butterfly symbol on ward boards to ensure all staff were aware of these patients. Wards had literature and resources available for people living with and caring for people with a dementia. Ward areas were dementia friendly, for example, brightly coloured signage with pictures, coloured toilet seats and door frames.

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. The department was accessible for patients with limited mobility and people who use a wheelchair. Staff knew how to access specialised bariatric equipment if necessary.

**Access and flow**

**Average length of stay**

**Trust Level**

From June 2017 to May 2018, the average length of stay for elective patients at the trust was 3.3 days, which is lower compared to the England average of 3.9 days. The average length of stay for
all non-elective patients at the trust was 5.6 days, which is higher compared to the England average of 4.9 days.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>4.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Urology</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>General surgery</td>
<td>2.4</td>
<td>3.9</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

- The average length of stay for trauma and orthopaedics elective patients at the trust was 4.4 days, which is higher compared to the England average of 3.8 days.
- The average length of stay for urology elective patients at the trust was 2.0 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for general surgery elective patients at the trust was 2.4 days, which is lower compared to the England average of 3.9 days.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>General surgery</td>
<td>4.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>10.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.9</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is similar compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.0 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at the trust was 2.6 days, which is similar compared to the England average of 2.9 days.

**Westmorland General Hospital**

From June 2017 to May 2018, the average length of stay for elective patients at Westmorland General Hospital was 2.8 days, which is lower compared to the England average of 3.9 days. The average length of stay for non-elective patients at Westmorland General Hospital was 17.6 days, which is higher compared to the England average of 4.9 days.

**Elective Average Length of Stay - Westmorland General Hospital**
Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at Westmorland General Hospital was 3.3 days, which is lower compared to the England average of 3.8 days.
- The average length of stay for breast surgery elective patients at Westmorland General Hospital was 1.1 days, which is lower compared to the England average of 1.6 days.
- The average length of stay for urology elective patients at Westmorland General Hospital was 2.0 days, which is lower compared to the England average of 2.5 days.

**Non-Elective Average Length of Stay - Westmorland General Hospital**

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics non-elective patients at Westmorland General Hospital was 19.5 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at Westmorland General Hospital was 2.0 days, which is lower compared to the England average of 2.9 days.

(Source: Hospital Episode Statistics)

Westmorland General Hospital does not carry out emergency surgery. We asked the care group senior leadership team why there were non-elective admissions. They told us that this was due to patients being transferred to Westmorland General Hospital from the other two hospital sites within the trust. We also asked why the average length of stay for non-elective patients was higher than the England average. They told us the only patients who were transferred were those requiring rehabilitation or repatriation to Kendal, so the longer than average length of stay was expected for these patients.
Staff told us discharges were organised and managed during daily and weekly ward meetings and multidisciplinary team meetings on the wards and staff worked with the ward based discharge co-ordinator to ensure discharges happened as effectively as possible.

The trust had developed a performance dashboard to improve patient flow and which gave a summary of performance for a range of measures, including elective metrics at care group level. The dashboard allowed performance to be reviewed at trust, care group, specialty, site and individual consultant. The dashboard reported metrics, for example, cancer waits (seven days, sixty-two days), referral to treatment time and waiting list size.

A theatre dashboard had also been created and utilised data from the electronic theatre module to plan theatre sessions, scheduling and to challenge inefficiency (e.g. start and finish times, turnaround times between patients, cancellations).

Efforts were made to reduce length of stay for patients who were medically fit for discharge. The trust had introduced ‘Hospital Home Care’ whereby clinical support workers employed by the trust supported patients on their return home, so they could leave hospital sooner.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From August 2017 to July 2018, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which is worse than the England average of 67.0%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Performance for the ENT specialty was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>66.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>73.9%</td>
<td>76.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>65.0%</td>
<td>72.7%</td>
</tr>
<tr>
<td></td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.4%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>45.5%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>39.5%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the care group. From August 2017 to July 2018 the trust’s performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.

At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing, and the loss of a laminar flow theatre due to estate break down had impacted on RTT waiting times.

**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.

From July 2016 to June 2018, the percentage of patients at the trust whose operation was cancelled and were not treated within 28 days was lower than the England average. In Q1 2018/19, the trust cancelled 77 surgeries. Of these, all were treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**
- University Hospitals of Morecambe Bay NHS Foundation 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 showed a similar trend to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. In Q1 2018/19, less than 1.0% of elective operations at the trust were cancelled.
Cancelled Operations as a percentage of elective admissions - University Hospitals of Morecambe Bay NHS Foundation Trust

(source: NHS England)

Learning from complaints and concerns

From July 2017 to June 2018, there were 120 complaints about surgery. The trust took an average of 33 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 35 days.

Of the 120 complaints received during the 12-month period, 27 (22.5%) related to a diagnosis problem, 23 related to adverse outcomes following an operation (19.2%), 11 related to treatment given (9.2%) and 10 (8.3%) related to operation cancellation. A breakdown of complaints by site can be found below.

Westmorland General Hospital

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Time for Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Operation - Adverse Outcome</td>
<td>2</td>
</tr>
<tr>
<td>Diagnosis Problems</td>
<td>1</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>1</td>
</tr>
<tr>
<td>Operation (IP) Cancellation</td>
<td>1</td>
</tr>
<tr>
<td>Appointment Notification</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

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

Staff told us they were made aware of any complaints. Feedback from complaints was shared with staff in team meetings and in shared files in ward offices. Wards displayed ‘You said, we did’ notices near ward entrances, describing any complaints or suggestions and action taken.

Number of compliments made to the trust

From 1 December 2017 to 30 November 2018, there were 342 compliments in the care group across the trust.

Westmorland General Hospital received 205 of these compliments which equates to 59.9%.
The trust stated they carry out their own analysis of compliments, which was shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

(Source: Data request – SDR18 Compliments)

Is the service well-led?

Leadership

The care group had a triumvirate management structure in place with clear lines of responsibility and accountability. The care group was managed by an overall senior leadership team which included a clinical director, associate chief nurse and assistant director of operations. Each ward visited had a ward manager in place, ward sister and a matron with overall management responsibility.

The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care. During our meeting the team were well aware of the main risks affecting service delivery and were able to explain the actions they had taken to mitigate.

Staffing levels were planned so that ward managers were given management time with other senior nurses in their teams. All ward managers and sisters said they were supported well by their matron and the senior management team. They said members of the board, particularly the chief executive, were visible and approachable.

During this inspection we saw matrons regularly on wards and were told some matrons had undertaken clinical duties to cover staff shortages.

Vision and strategy

We discussed the care group vision and strategy with the senior management team. The current strategy was designed to provide services on an elective and acute basis, reconfigured over the three sites, concentrating non-elective services on the two main sites. Emergency pathways were in place and all emergency orthopaedic procedures were carried out at Royal Lancaster Infirmary and Furness General Hospital.

The senior management team acknowledged the difficulties in covering the anaesthetic rota at Furness General Hospital and informed us that recruitment had recently been made ensuring the rota would be covered across the trust through the re-alignment of staff across all three sites.

We asked senior managers about planning the services and were told there was a five-year trust strategic and operational plan which included surgery and a care group business plan was also in place. Senior managers described working with business managers, the clinical director and matrons to plan services.

The senior management team confirmed the care group’s priority was to deliver high quality, safe services that met the needs and expectations of patients through the ‘Better Care Together’ programme. This was a clinically led, health economy-wide integrated care community that was the main route through which the trust’s long-term future was delivered.
A strategy to support ‘Better Care Together’ had been developed to provide staff and local communities with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

**Culture**

All staff we spoke with during the inspection told us there was good teamwork, openness and morale was good. We held focus groups with staff before this inspection. There was an overwhelmingly positive view of how much the trust had improved in terms of clear leadership, motivation, recognition of achievement and teamwork.

Staff told us the care group had strong leadership and senior managers were visible and engaged with staff. We interviewed 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 reiterated that high quality care was a priority. All staff were clear about their roles and responsibilities, patient-focused, worked well together and felt they received appropriate support from management to allow them to perform their roles effectively.

Nursing staff reported a positive culture and good working relationships between staff groups. Ward managers 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 monthly surgery governance and assurance meeting for the care group. Minutes confirmed the meetings were well attended and discussed issues around workforce effectiveness, safety, experience and efficiency (WESEE). Specifics included compliance with training, audits, incidents, root cause analyses, risk registers, IT and updates to national guidance.

There were departmental governance meetings, which provided information to the monthly surgery and governance assurance meeting, which then reported by exception to the surgery management board. In addition, there was also a weekly meeting for service managers, matrons and corporate support teams which was chaired by the associate director of operations.

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 governance meetings and quality and safety meetings. The senior management team were able to describe the risks to services, for example referral to treatment performance.
The care group risk register 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 meeting referral to treatment targets, medical and nursing recruitment, anaesthetist recruitment, meeting screening standards and referral to treatment targets within the breast screening unit and achieving planned income and expenditure. 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.

To support information management the trust had policies in place for information sharing (July 2018), information risk (February 2018) and information security (February 2018).

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**

The trust had developed a patient and public involvement strategy (January 2018). This confirmed the trust commitment to engage effectively with the local community, ensure stakeholders are aware of the trust’s work, successes and challenges. It specifically expresses the trust’s commitment to listen and learn from what local people say about services.

This achievement of the aims of the strategy were supported through national and local satisfaction surveys, patient experience information panels, patient stories and diaries and feedback through comments, concerns, compliments and complaints from individual service users and members of the public. People using the service were encouraged to give their opinion on the quality of service they received. The care group carried out ‘two minutes of your time’ surveys to gather feedback on services from patients.

Leaflets about the friends and family test, and the Patient Advice and Liaison Service (PALS) were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards and letters displayed at the entrances to wards.

We saw staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families. Matrons and ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
Staff engagement

The national NHS staff survey (2017) showed the trust scored 3.79 (out of five) for an overall indicator of staff engagement. This was the same (3.79) when compared with other trusts of a similar type.

We were told the care group had improved leadership and accountability to create a better culture for staff. Specific changes had been made, such as increasing the numbers of clinical leaders within theatres, the introduction of a staff voices forum, ‘back to the floor’ sessions for the senior management team, weekly discussions about good and bad behavioural practice and sessions to promote the trust behavioural standards framework.

The staff voices forum was an open session for staff to drop in and discuss their issues. Concerns raised had been acted upon and feedback given.

Senior managers 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 manager, receive feedback and discuss concerns. Staff we spoke to said they felt appreciated by the ward manager and sisters and senior managers and felt listened to when they raised concerns.

Learning, continuous improvement and innovation

The care group had developed initiatives to improve and enhance care and treatment:

- Commitment to meeting the needs and expectations of patients through the ‘Better Care Together’ programme.

- The transfer of specialist inpatient elective surgery from the two main sites in Lancaster and Barrow in Furness to Westmorland General Hospital. Focusing elective surgery on one site rather than three sites had the aim of increasing the quality of care and outcomes for patients.

- Specialist qualified learning disability and mental health nurses had been recruited to ensure individual patient needs were met.

- Care support workers were providing support to vulnerable patients at risk of harm, supporting them with meals and drinks and engaging them in conversation. This has resulted in reductions in falls and pressure ulcers.

- The hospital had introduced standardised products, designated storage areas and created education packs for pressure relieving products. Pictorial booklets had been created for each ward and visual clocks trialled which indicated when a patient last had pressure relief. These initiatives had resulted in increased periods of days free from acquired pressure ulcers.

- The ophthalmic nursing team had timetabled slots to allow outreach to patients at the hospital. This resulted in a holistic approach to patient care and better supported patients’ needs.

- Wards and departments had areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms.
• A comprehensive and user-friendly booklet to support patients awaiting surgery had been developed. This provided patients with clear information to support their preparation for surgery.

• Reasonable adjustments had been made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients’ care and emotional needs.
Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

There are Emergency Departments at both the Royal Lancaster Infirmary and at Furness General Hospital, with supporting medical and surgical assessment units and ambulatory care facilities. These are consultant led and are not referenced in this document as they sit in other core services.

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

The Royal Lancaster Infirmary provides urgent and emergency care services for the people of Lancaster and the surrounding areas. The department had three main areas, minor injuries, majors for sicker patients and resuscitation bays.
Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of Morecambe Bay NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018.

From August 2017 to July 2018, there were 93,223 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 decreased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)
Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,360</td>
</tr>
<tr>
<td>Discharged*</td>
<td>60,210</td>
</tr>
<tr>
<td>Referred^</td>
<td>6,976</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,985</td>
</tr>
<tr>
<td>Died in department</td>
<td>163</td>
</tr>
<tr>
<td>Left department#</td>
<td>1,517</td>
</tr>
<tr>
<td>Other</td>
<td>550</td>
</tr>
<tr>
<td>Not known</td>
<td>69</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?

Mandatory training

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. We reviewed mandatory training information for nursing staff on site which showed good levels of compliance.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>97%</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>96%</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion</td>
<td>92%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>92%</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>87%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>83%</td>
</tr>
<tr>
<td>Infection Prevention and Control Level 2</td>
<td>79%</td>
</tr>
</tbody>
</table>

Mandatory training comprised of face to face and online learning. Training records were kept on the trusts electronic training management system. There were processes in place which enabled individual staff and the unit manager to see when training was due for renewal.

Medical staff told us there was an annual training day, during which all required training was delivered. This helped with training compliance.
Trust level

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in urgent and emergency care inclusive of staff working in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,251</td>
<td>1,285</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,228</td>
<td>1,282</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,178</td>
<td>1,284</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,168</td>
<td>1,281</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,061</td>
<td>1,179</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,142</td>
<td>1,289</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>882</td>
<td>1,107</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>978</td>
<td>1,273</td>
<td>76.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 95% target was met for two of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the general fire safety awareness module, for which only 76.8% staff had completed the training at September 2018.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

Following the inspection, we were provided with data on sepsis training compliance. For nursing staff at this site, it was 92% and 100% for medical staff.

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 as at September 2018 at trust level for all staff in urgent and emergency care inclusive of staff working in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,174</td>
<td>1,275</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care, the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still fairly high.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

We were shown safeguarding training compliance on site for nursing staff by the unit manager. We were told all staff undertook level two adult safeguarding training. Compliance for nursing staff was 77%. Level three adult safeguarding was undertaken by all staff at band four and above, compliance for this was 51%. Both figures were below the trust target of 95%.

Staff working in an emergency department were expected to hold level three safeguarding for children. Further information provided by the trust (see table below) showed the following regarding training compliance. We were told that level three training was provided externally and there had been difficulty in booking places. The trust had employed someone to provide this level of training but the timeframe for required training to be completed was not known.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Medical staff completion rate</th>
<th>Overall department completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 2</td>
<td>78%</td>
<td>82%</td>
</tr>
<tr>
<td>Safeguarding Children (NHS Core Skills) - Level 3</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Adult Safeguarding level 3</td>
<td>100%</td>
<td>44%</td>
</tr>
<tr>
<td>PREVENT</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

PREVENT training is part of the governments counter terrorism strategy and informs staff about to safeguarding vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

The department had four senior registered sick children’s nurses (RSCN). We observed and staff told us about robust safeguarding processes in place for when children came to the department. This included mandatory fields within the patient records relating to the assessment and care of the child.

If any concerns were identified there was a clear flow chart to follow, and the child would not be discharged until all the questions within this had been answered. This ensured appropriate action was taken where necessary. For younger children (those not yet crawling/pulling to standing) a non-mobile baby safeguarding tool was used for any child with marks or bruises to their body.

In the minor injuries unit, we saw that a safeguarding audit had been undertaken from February 2018 to April 2018. This looked at any children who had attended and identified any information missing from their records. For example, if a child assessment form had not been completed. We were not aware of any action plans in response to this audit.
Trust protocols and guidance on safeguarding were easily accessible and there was a safeguarding team who could be contacted if further advice was needed. Safeguarding alerts were flagged on patient’s records; these would be picked up by reception staff and alerted staff involved in their care. Staff we spoke with could describe what may be seen as a safeguarding concern, including domestic violence and how they would escalate this. Safeguarding training included information about child sex exploitation (CSE), female genital mutilation (FGM) and domestic violence. Senior nurses were confident about staffs understanding of safeguarding.

Staff could describe the processes they would follow if a patient required restraint, and an incident form would be completed if any form of restraint was used. The department also had a new proforma to provide information to staff when patients required sedation.

We saw staff managing a potential safeguarding concern during inspection, the concerns were discussed and escalated appropriately.

During the inspection we attended the cross site daily safeguarding huddle. During this any safeguarding incidents from the previous day were discussed. We saw good multidisciplinary working and information sharing with external staff such as health visitors and GP’s. There was recognition of good practice within this meeting, for example, the non-mobile baby tool being completed.

**Cleanliness, infection control and hygiene**

Trust wide data for the directorate which included urgent and emergency care, showed that infection prevention and control training compliance exceeded the trust target of 95%.

Data see on site showed that 97% of nursing staff had completed level one infection prevention and control training, 79% had completed level two.

Cleanliness and hand hygiene audits took place monthly. The results were displayed in the department. In October the department had achieved 100% in the cleanliness audit, hand hygiene was 90%.

The department was visibly clean, tidy and free from clutter. There was an area of flooring in the resus area which was cracked and uneven. The area had tape on it but this was worn through and appeared to have been in place for some time.

In addition to domestic staff housekeepers were employed who provided seven-day cover from 7.30am to 3.30pm. One aspect of their role was cleaning, this included things such as cleaning monitors, phones and computer keyboards.

We saw weekly cleaning schedule checklists in each cubicle. We reviewed four weeks of checks in three cubicles and found several gaps. We also found that the mattress in one of the cubicles had a blood stain on it, this was raised with staff who immediately attended to this.

There was a system in place for cleaning children’s toys kept in the paediatric waiting room and the cubicle used for children. The cleaning was undertaken by the paediatric staff and we saw evidence of daily checklists for this being completed. The toys we saw were made from washable and wipe clean materials and were visibly clean. We saw a container to put toys in after they had been played with so staff knew they have been used and need cleaning.

Hand wash facilities were available in each area and alcohol gel and personal protective equipment (PPE) was available in each cubicle. We found appropriate waste segregation and disposal systems in place. The department had a biohazard spill kit and we saw information displayed on managing blood spills.
We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene and the use of PPE. All the staff we observed were compliant with arms bare below the elbow.

There were cubicles which could be used if a patient required isolation. We observed this taking place during our inspection. We were concerned that visitors or staff from outside the department may not be aware a patient required isolation, as information alerting people was not put on the door. A trolley was placed outside of the cubicle, however we observed this was between two cubicles, so it wasn’t clear which one it was for. Staff told us that a code ‘U/P’, meaning universal precautions, was put on the patient tracking information board. We were not confident that staff outside of the department would be aware of this information.

**Environment and equipment**

The department pre-dated national guidance for compliance with Health Building Notice 15-01 Accident and Emergency Departments. There was sufficient seating in the waiting area which was secured to the floor. In one corner there was a separate children’s waiting area and toilet/baby change. This area was quite small with no seating for parents.

Closed circuit television was in place; however the waiting area had no direct line of sight from reception staff or staff within the department. Minor injuries was accessed from this area as was the main department. Access to the main department was restricted.

There was a helipad within the grounds of the hospital. There was a separate entrance for ambulance patients with a handover area. There were ten cubicles in the major’s area, and four bays in the resuscitation area, each had an area dedicated for children.

We observed the room which would be used for patients with mental health needs. This cubicle faced the nurse’s station in the department. However, the location of the viewing panel in the door did not allow for full observation of the room if the doors were closed. We also found a number of ligature risk points. We raised these concerns at the time of inspection, immediate action was taken to remove any ligature risks. Further plans were in place to improve the facilities for patients with mental health needs by creating two new rooms.

We found that all consulting and treatment cubicles were of an appropriate size and contained the necessary equipment. Space could become an issue when the department was busy. During our inspection we observed patients on trollies and chairs in a corridor waiting for a cubicle.

Department and ambulance staff told us there was a lack of equipment for when patients were on the corridor. Monitoring equipment would be used from ambulances and moving, and handling equipment would be used from areas such as resus.

We checked the major incident equipment storeroom and found all equipment present and in date. Staff told us they had enough equipment in the department to meet the needs of patients. However, ambulance staff reported during busy times they would have to use their monitoring equipment for patients, particularly if they were waiting for a cubicle or to handover.

We checked 20 pieces of equipment, including blood pressure machines, blood gas machines and infusion pumps and found evidence of up to date electrical safety testing.

There were resuscitation trollies centrally located in majors and minors and in each bay in the resuscitation area. We checked four trollies (one paediatric and three adult) and found contents were sealed and in date. The checking procedure involved daily checks and a full weekly contents check. On these four trollies since April 2018, 12 checks had been missed.
Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored “about the same” as other trusts for all five of the five Emergency Department Survey questions relevant to safety.

<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>7.8</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>6.7</td>
<td>About the same as 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>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</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>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median in all twelve months from August 2017 to July 2018. In July 2018, the median time to initial assessment at the trust was 10 minutes compared to the England average of eight minutes.

During this inspection we tracked the time of arrival to time of initial assessment for six patients who arrived by ambulance and found that only one had been assessed within 15 minutes. The times to initial assessment ranged from six to 45 minutes. We observed an ambulance crew waiting 25 minutes in the corridor with a patient to handover.

In addition to this we looked at triage times on six sets of adults and children’s notes (from patients who arrived by ambulance and those who self-presented to the department) and found that three had been assessed within 15 minutes.

We observed, and staff told us about the challenges with triage particularly when the department became busy. Staff from the department and ambulance crew told us the additional ambulance triage nurse had helped with this. However, this had only been in place for two weeks prior to the inspection.
Ambulance – Time to initial assessment from August 2017 to July 2018 at University Hospitals of Morecambe Bay NHS Foundation Trust

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

Some staff told us that patient assessment did not happen in the corridors, but other staff told us they had assessed and treated patients in the corridor regularly. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The electronic system used by the trust did not allow for a treatment start time to be recorded so the first time the patient was seen after triage was used as a proxy.

We requested further data from the trust on median time to treatment. Data from September 2017 to August 2018 is shown below.

This graph indicates the trust met the standard at this site for 11 months over the 12-month period from September 2017 to August 2018.

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

Royal Lancaster Infirmary

From September 2017 to August 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Lancaster Infirmary, with a performance ranging from 41% to 61%.

In the latest month, August 2018, 51% of ambulance journeys had turnaround times over 30 minutes.
Ambulance: Number of journeys with turnaround times over 30 minutes - Royal Lancaster Infirmary

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Lancaster Infirmary

(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 July 2017 to June 2018, the trust reported 233 “black breaches”, with the highest number of breaches being reported in July 2017 (34), February 2018 (26), November 2017 (25), and December 2017 (25).

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

The reception staff we spoke with described the training they had received for adults and children. We saw there were clear flow charts to support them in alerting the medical staff to any obvious urgent cases.
Registered nurses were trained in triage assessment and used a recognised triage tool. We observed the triage process during our inspection. We were concerned that following triage patients were not then seen in order of clinical priority. This was particularly noted when the department was full and patients were waiting in corridors. We observed patients were seen in the order they were ‘queued’ in the corridor.

As part of the triage process the national early warning score system (NEWS) was used. This is a tool for identifying deteriorating patients. A paediatric version was used for children. We reviewed ten sets of adult records and four paediatric records and found that NEWS was recorded.

We were concerned about the oversight of patients and their potential deterioration within the department, particularly those waiting on the corridor. The patient tracking information board (among other things) contained information on presenting condition and NEWS scores. This board was used to give an overview of activity and acuity within the department. We observed this was not kept up to date and information did not always match what was recorded in patient records. For example, those responsible were not fully aware of what patients were in the resus area and NEWS scores on the board did not always reflect those in patient records.

Sepsis pathways were in place and pre-alert calls were made to the department if a patient coming by ambulance was thought to be septic. The pathway identified a specific bundle of care to be provided which included timely administration of antibiotics. Staff could recall occasions when patients with sepsis had been on the corridor due to a lack of cubicles. We observed a patient arrive by ambulance with suspected sepsis, the patient waited 45 minutes to be triaged. This was a concern as sepsis can be life threatening and timely treatment is crucial.

The incident data we reviewed highlighted ten incidents between 1 September 2017 and 31 August 2018 relating to sepsis management. In these incidents the sepsis tool had either not been implemented or there was a significant delay in antibiotics being administered.

We had concerns over patients who were held in the corridor whilst awaiting a cubicle. We observed a lack of ownership and responsibility of the care for these patients. The nursing staff we spoke with were not clear who was responsible for them, staff in different areas of the department gave different answers when asked this.

We requested incident data from the trust. The data from 1 September 2017 to the 31 August 2018 showed 35 incidents relating to patients in the corridor. During our inspection staff told us they would not be happy with more than six patients being cared for on the corridor.

The incidents we looked at showed examples of when there had been between nine and 12 patients in the corridor. There was also an incident of a patient being left for nine hours without appropriate care and treatment being provided. Another incident form described patients in the corridor who were ‘poorly and should have been in resus’.

One of the patients whose notes we reviewed had come in following a collapse, it was unknown if they had lost consciousness. We were concerned they had been triaged as ‘green’ indicating they had a minor injury and required little medical attention. A blood glucose level had not been recorded and staff did not seem to recognise why this would be required. We raised concerns with the medical staff and the patient was moved in to a cubicle for further assessment.

During our inspection we observed patients with potentially serious injuries on the corridor and we were not confident there was sufficient oversight to monitor any potential deterioration. We were also concerned that in the event of a fire or emergency, there could be delays in evacuating the department due to the congestion in this area.
We escalated these concerns and requested guidance from the trust over the arrangements in place for when patients were in the corridor. The evening we visited was particularly busy with 15 patients in the corridor and holding area, this was described as an extreme situation. The escalation protocol described the escalation scoring calculation, related escalation levels and senior staff’s roles and responsibilities. The protocol did not specifically mention the responsibility and oversight arrangements for patients in holding areas such as corridors. We also requested a risk assessment for when there were patients in the corridor. We were informed a standard operating procedure (SOP) was in development and was due to be completed by the end of December. We were told a risk assessment for the evacuation of the department when there are patients in the corridor and fire safety advice would also be included in the SOP.

The department had a checklist in use to evidence regular checks were being undertaken on all patients in the department. This was a simple checklist and covered areas such as pressure area care, diet and fluids and pain scores. We found these were not always fully completed. During our evening visit none of the patients in the corridor had one of these checklists in their records.

The completion of these documents was audited weekly. Data provided by the trust from June 2018 to October 2018 showed compliance was between 63% and 94%. Further investigation revealed the 64% rate was related to none submission for one of the weeks in that month. The relatively high compliance rates did not reflect what we found during our inspection.

We were told there were clear pathways with paediatrics and the department had a low threshold for referring children. The paediatric consultant for the children’s ward was available during the day with a registrar on site overnight.

Staff did not have access to any specific risk assessment or care plans to support patients with mental health associated risks. There was twenty-four-hour access to a mental health crisis team, who were based in the department. We were told about plans to employ mental health nurses within the department, although no time frame had been set for this.

Several staff told us problems occurred when patients with mental health needs required a bed. The lack of availability meant these patients could remain in the department for long periods of time. This was for both adult and paediatric patients. The trust was working with the local mental health trust to improve engagement and strengthen escalation plans to support this group of patients.

Staff told us at that they would plan to nurse patients at risk of suicide and self-harm with increased levels of observations and locate them near to the nurse station. In some situations, security staff would also be requested to provide additional support.

Nurse staffing

The department ran the Baseline Emergency Staffing Tool (BEST) in January 2018. This is a national tool developed to calculate staffing numbers and skill mix needed, taking into account workload and rostered staffing levels. We were told this showed the department needed an uplift in staffing and the decision had been made to run the tool again in September 2018, although as yet this hadn’t been done.

The trust has reported their staffing numbers below for the period October 2017 to September 2018 for urgent and emergency care. At Royal Lancaster Infirmary, there was a fill rate of 69.0% for qualified nursing with 18.1 FTE less staff than the trust had planned for.
## Location

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>37.0</td>
<td>55.7</td>
</tr>
</tbody>
</table>

*(Source: Data request- P16 Total Staffing)*

### Vacancy rates

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 13.5% for qualified nursing staff working in urgent and emergency care.

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

At the last inspection nurse fill rates were low and there were vacancies within the establishment. The data provided by the trust showed a slight improvement in these figures. However, during the inspection nurse staffing was a significant concern.

We reviewed staffing numbers on site and information showed there were 26 whole time equivalent (WTE) vacancies at band five. This was further impacted with nine WTE staff on maternity leave. Seven WTE new starters were due to commence employment and the band six establishment had been over recruited by two WTE staff.

To further support staffing the band three post had been over recruited to. The establishment was 5.6 WTE however, at the time of inspection 13 WTE were in post.

The department also employed band two health care support workers and housekeeping staff. There were two band seven unit managers who both worked 30 hours per week. Four of the band six staff were RSCN’s.

### Turnover rates

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in urgent and emergency care. This was better than the trust performance measure of 8.5%.

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

### Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in urgent and emergency care. This reflected the figures we were shown during the inspection and was better than the trust target of 5%.
The trust measured attendance and had a target of 95.6%.

(Source: Data request - P19 Sickness)

Bank and agency staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 1,016 shifts for qualified nursing in urgent and emergency care were filled by bank staff and 1,255 shifts were filled by agency staff. In addition, 787 shifts remained unfilled by bank and agency staff.

For nursing assistants, 1,538 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 413 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>937</td>
<td>0</td>
</tr>
</tbody>
</table>

The accident and emergency department at Royal Lancaster Infirmary had the highest bank and agency usage for the period April 2017 to March 2018, with 862 shifts covered by bank staff and 1,255 being filled by agency staff.

The trust has attributed this to vacancies within the department and have highlighted plans to recruit staff to fill these vacancies.

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

The majority of the staff worked long shifts, from 7am to 8pm. Night shifts were from 7.45pm to 7.15am. Some staff worked early and late shifts and there was also a twilight shift from 5pm to 2am to support busy periods.

Planned staffing levels were:

<table>
<thead>
<tr>
<th></th>
<th>Registered</th>
<th>Non-registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Late</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Night</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Twilight</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Staffing was done using an electronic rostering system. The allocation of staff was done on a daily basis and written on a whiteboard. This also identified the co-ordinator for the shift.

One registered nurse was allocated to work in each area, these being: minors triage, ambulance triage, resus and majors (cubicles 1-4). Two nurses were allocated to the other six cubicles in majors and when needed one of these staff would be moved to support in resus. In addition to this...
there would be a co-ordinator. We were concerned that the staffing establishment was light. In addition, as we observed during our inspection, having patients in the corridor added to these concerns. We found it was difficult to establish which staff member was allocated to the corridor area, this was felt to be because of staffing being stretched in the department.

Current establishments for RSCN’s did not support RCEM recommendations as cover was not twenty-four-hours a day. There was seven-day cover until 2am.

Any gaps in staffing would be covered by bank or agency staff. If shifts were still unfilled then managers, matrons or the clinical educator would be asked to support with staffing.

We reviewed four weeks of nursing rotas to compare the planned and actual registered nurse figures. We found six early shifts and 18 late shifts did not meet the planned level for registered nurses. Seven of these shifts were short by two registered nurses and of these shifts only two had additional unregistered staff on duty.

None of the night sifs met the planned levels for registered nurses. The twilight shifts for this period had between one and three nurses on duty to support the gaps in the night staffing. This still meant from 2am until 7am staffing levels were below the planned level by at least one registered nurses for every shift.

Joint handovers with nursing and medical staff took place three times a day. We observed handover which detailed discussions about numbers of patients and any potential flow issues as well as information about individual patients.

There was a matron on site seven days a week with specific remit to support safe staffing.

**Medical staffing**

The trust has reported their staffing numbers below for the period October 2017 to September 2018 for urgent and emergency care. As at September 2018, 83.6% of medical and dental positions were filled across the whole trust. Medical fill rates were below establishment at Royal Lancaster Infirmary with fill rates of 81.3%.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>18.6</td>
<td>26.6</td>
</tr>
</tbody>
</table>

(Source: Data request-P16 Total Staffing)

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in urgent and emergency care.

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

The College of Emergency Medicine (CEM) recommends a department of this size should employ ten WTE consultants and provide onsite consultant cover from 8am to 12am seven days a week.
The number of consultants employed had reduced by one since the last inspection. Seven consultants were in post, they were employed on 12 programmed activities (PA’s) to cover the rota requirements. The consultants covered two shifts, 8am to 4pm and 2pm to 11pm. Outside of these hours there was a consultant available on an on-call basis. They would attend the department for any trauma calls, or at the request of the middle grade doctor or the nurse in charge.

Any gaps in the rota were covered by consultants working extra shifts or by regular locum consultant staff.

The department was funded for 16 WTE middle grade doctors, at the time of inspection there were 14 in post. They worked a variety of shifts to provide twenty-four hour on site cover. Overnight there would be two middle grades present, one of which would always be senior. The crossover of shifts during the days provided cover from two to three doctors. In addition to this the department had a rota of five junior doctors.

Minor injuries was staffed by GP’s and advanced care practitioners. These staff were part of the trusts corporate staffing.

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in urgent and emergency care. This compares to the trust performance measure of 8.5%.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in urgent and emergency care.

The trust measured attendance and had a target of 95.6%.

*(Source: Data request- P19 Sickness)*

**Bank and locum staff usage**

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in urgent and emergency care from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

**Trust Wide**

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50</td>
<td>95</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>239</td>
<td>668</td>
<td>0</td>
</tr>
</tbody>
</table>
Junior  0  158  0  
Total  289  921  0  

Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50</td>
<td>95</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>239</td>
<td>313</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>408</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Staffing skill mix

At June 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower than.

Staffing skill mix for the 29-whole time equivalent staff working in urgent and emergency care at University Hospitals of Morecambe Bay NHS Foundation Trust.

![Staffing Skill Mix Graph](image)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>56%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>3%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</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

Paper and electronic records were used in the department. We noted that paper records were not stored securely. Within the major's area paper records for each patient were stored on work top at a central desk. There was not always a member of staff present so these records could be accessed by anyone in the department. For patients in holding areas such as corridors, loose sheets of patient records were stored in an open file.
We also observed in each of the areas, minors, majors and resus, computer screens were left unlocked with access cards left in situ. The computer screens had confidential patient information displayed. We asked a staff member to assist us in viewing the electronic records of patients and they could not locate their access card. It was found a few minutes later by another member of staff.

Information governance training was mandatory. Trust level compliance for all staff in urgent and emergency care inclusive of staff working in medicine was 91%, this was just below the trust target of 95%. Information seen on site for nursing staff in the department showed compliance was 83%.

With support from staff, we reviewed eight sets of patient records in detail looking at care plans and risk assessments. The electronic records were accurate and in line with trust and professional standards. However, at busy times this was not always done contemporaneously. For example, in two of the records we looked at the patients had been in the department for between two and two and a half hours and risk assessments had not been completed. We were assured by the nurse overseeing their care that they would be completed.

The electronic system had flags in place for example, if there were known safeguarding concerns or if the patient had a learning disability.

**Medicines**

The department stored medicines and intravenous fluids securely. There was an automated storage cabinet in use which was accessed using staff fingerprints. There was a stock of medicines pre-labelled for patient use available for discharge outside of pharmacy opening hours. Prescriptions were prepared, and the medicines were selected electronically to provide an audit trail.

We found emergency drugs boxes to be sealed and labelled with the date of expiry. All were in date and maintained by pharmacy staff.

Controlled drugs stock was checked each day. We checked the cupboards in minor injuries and resus. Records of checks were only kept for the current month. Three checks had been missed during this time.

In resus we observed that the controlled drug stock book and order book were left out on the worktop. This was not in line with trust policy and should have been kept secure. We also observed controlled drugs that had arrived from pharmacy being signed into cupboard. The two staff involved in this were interrupted twice during this procedure and one of the nurses had a conversation with another staff member during this checking process. This was not in line with guidance and best practice for controlled drug management.

Controlled drugs audits were part of the trust annual audit programme. These were undertaken using a specifically designed app. The pharmacy department at this trust were the first hospital pharmacy in the Country to use this for medicines audits. The audit tool included four patient audit checks, these included two signatures being present and entries being dated. This site had high levels of compliance in these areas from the quarter three audit (93% to 100%).

The tool also looked at 13 recommended measures. These included details about the location of the controlled drug keys and the contents of the cupboard. Data from the same audit showed varying levels of compliance from 59% to 100%. Areas for improvement included, daily stock balance checks and ensuring the keys were kept separate to other keys.
We looked at Patient Group Directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We saw a patient had been administered pain relief using a PGD. The department had access to a wide range of PGDs, paper copies were held, these were in date and correctly signed to authorise staff to use them.

The fridge temperatures were checked on most days, however we found the temperature to be out of range for both minimum and maximum temperatures on the day of inspection and for 10 days in November. Medicines can be ineffective or unsafe if they are stored outside of the manufacturer’s instructions.

No action had been taken by staff in the department. This was escalated during inspection, reviewed by the pharmacy team and immediate action was taken. We were also assured by the chief pharmacist that the department had been visited by the pharmacy team and a refresher on the escalation process had been provided to the unit manager. The escalation chart had also been updated with actions to take written in red.

Medicine prescription charts were on an electronic system. With support from staff we reviewed five electronic charts. We found they were completed in line with trust and national guidance. On each prescription the allergy status had been completed. The medicine charts we reviewed had antibiotics prescribed in line with national guidance.

The care group governance minutes from September 2018 noted a ‘spike’ in medication incidents since the launch of electronic prescribing

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

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 September 2017 to August 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 six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2017 to August 2018.

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

- Treatment delay meeting SI criteria: five incidents (83.3%).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident (16.7%).

Site specific information can be found below:

- Furness General Hospital: two incidents
• Royal Lancaster Infirmary: four incidents

(Source: NHS Improvement - STEIS)

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents, however none could recall any feedback or learning from a recent or serious incident. We saw there was a learning board in the staff room and information about incidents was also shared via emails.

The trust advised that in 2018, 100% of the staff who reported incidents in the emergency department received formal acknowledgement of the incident report. Formal feedback was provided on 85.83% of incidents.

We observed the morning safety huddle, incidents were not discussed during this. Senior staff told and we saw from minutes, incidents were a standing agenda item at the care group governance meetings.

We were concerned that a number of staff described potentially unsafe situations or ‘near misses’ which they told us they did not report as incidents. Examples of these were focused around when the department was short staffed or particularly busy and staff could not deliver the level of care they would like.

We were provided with incident data from 1 September 2017 to 31 August 2018 for the department. During this time 899 incidents were reported, the majority (497) were graded as no harm with 302 graded as low harm. The highest reported incidents were categorised as operational issues and clinical assessment and treatment.

The electronic incident reporting system included a prompt on the duty of candour. This 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.

From reviewing care group governance minutes, we saw evidence of safety alerts being monitored and actioned.

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 the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

Polices and guidance were accessed on the trust intranet which was easy to navigate. We reviewed five clinical polices and found them to be in date with an author and version control. They also included links to other documents and related flow charts. For example, the management of massive haemorrhage in adult’s guideline, contained a flow chart specific to each site, based on British Association of Haematology Guidelines.

We saw laminated copies of specific sepsis screening and action tools for adults and children of different ages in the department. There were also copies of flow charts for other conditions such as, cardiac chest pain and the management of meningococcal disease in patients.

The trust had a lead for NICE guidance at both trust level and in individual care groups. In addition to this there was a well-established and robust process for ensuring policies were up to date. Any new guidance was considered as part of this process. We were told about this and saw evidence of it within governance meeting minutes.

There were a range of pathways in use which linked in with the electronic record system. These were based on the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine’s (RCEM) clinical standards for emergency departments. Care pathways had been established for conditions such as acute kidney injury (AKI) and pulmonary embolisms (PE). These aimed to promote early treatment and improve patient outcomes.

We saw pathways completed for patients with suspected sepsis. Following the inspection, we were provided with sepsis screening and treatment audit data. This data was collated and reviewed on each month. The data from May 2018 to October 2018 showed at this site an improvement in sepsis screening. From August to October 100% patients who needed sepsis screening in response to their NEWS score had this done. The audit reflected the incident data, with small numbers where antibiotics were not administered within an hour. An action plan and ongoing data collection was in place in response to this.

Some of the staff we spoke with felt there was a lack of clear clinical guidelines. An example of this was patients admitted following a head injury. We saw in three sets of notes a plan for neurological observations to be undertaken. However, the frequency of this was not recorded. When we asked nursing staff about this we were told they would use their clinical judgement.

The department participated in national RCEM audits to monitor standards of care and improve practice. Action plans were put in place based on audit result recommendations. Junior doctors in the department participated in audit activity.

The department had access to a specialist frailty nurse who provided expert advice and supported the comprehensive assessment of elderly patients physical, mental and social care needs.

Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 7.7 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 (October 2016 to March 2017; published October 2017)
We observed, and patients told us they were provided with fluids and food if they could have them. However, we found that the checklist to evidence food and fluids had been provided to patients were either absent or not fully completed.

Food could be requested if it wasn’t readily available in the department, this included any specific dietary requirements.

In the waiting room there were vending machines which contained cold and hot drinks and a variety of snacks.

**Pain relief**

We found evidence of pain scoring being done and action taken in response to this in the patients records we reviewed. This was documented as patients were triaged.

A pain score tool was used to assess if a patient had pain. There was a paediatric pain assessment tool with pictures and descriptors to help identify the level of pain.

With the exception of one, the patients and relatives we were able to speak with reported pain control being effective and that it was provided in a timely way.

Data from clinical audits showed varying results in relation to the timeliness of pain assessment and re-evaluation following administration of analgesia to children. We saw actions had been taken in response to this.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.6 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.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Patient outcomes**

The RCEM has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes. The emergency department had participated in a number of audits to benchmark their performance against the CEM standards.

There was variable performance in relation to the majority of the standards described below. The least performing was the administration of steroids for children presenting with asthma.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Royal Lancaster Infirmary**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department at Royal Lancaster Infirmary failed to meet any of the national standards.

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

- 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

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

- 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: 0.0%; UK: 19%.

- Standard 5b (fundamental): within 4 hours (moderate). This department: 0.0%; UK: 28%.

The department’s results for the remaining four standards were all within the middle 50% of results.

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. This department: 15.2%; UK: 19%.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 23.9%; 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: 34.8%; UK: 25%.

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 85.7%; UK: 77%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Royal Lancaster Infirmary

Royal Lancaster Infirmary did not participate in the 2016/17 Consultant sign-off audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Royal Lancaster Infirmary

In the 2016/17 Severe sepsis and septic shock audit, the emergency department at Royal Lancaster Infirmary met the national audit standard for one of the eight audit standards (standard two).

The department was in the upper UK quartile for three of the audit standards:

- 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: 100.0%; UK: 64.6%.

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 66.1%; UK: 30.4%.
• Standard 5: Blood cultures obtained within one hour of arrival. This department: 68.8%; UK: 44.9%.

The department’s results for the remaining five standards were in the middle 50% of results:

• Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 68.8%; UK: 69.1%.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 68.8%; UK: 60.0%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 53.1%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 56.3%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 25.0%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

We reviewed RCEM clinical audit data from 2017/2018 for this site in relation to pain relief for children attending the department. This audit looked at five standards, including the timeliness of assessment, administration and re-assessment of pain levels.

The audit included 49 cases and showed varying results. Only 4% of cases had their pain assessed within 15 minutes, however 100% of cases with severe pain had analgesia given within 20 minutes. None of the cases had evidence that pain was re-evaluated 60 minutes after analgesia had been given.

In response to this the department employed two further full time paediatric nurses in June 2018. We also saw in minor injuries there was an ongoing audit of ten records each week, looking at the completion of pain scores. Information showed from 12 October 2018 to 28 October 2018 showed completion rates were between 80-100%.

Following the inspection, we were provided with the departments audit plan and further data relating to the most recent RCEM audits, which were:

• Procedural sedation in adults 2017/2018. This highlighted very poor documentation in relation to this, as 91% of cases had not been recorded. This had affected the data in the audit.

• Fractured neck of femur 2017/2018, the data showed poor performance with only one of the nine standards being achieved:
  o 75% of patients should have an X-ray within 120 minutes of arrival or triage

• In five of the standards the department scored 0%. These all related to the assessment and management of pain.

Each of the RCEM audits mentioned had a related action plan. We reviewed these and found they were very brief. For example, in relation to procedural sedation the action plan was to ‘refurbish and streamline the complete sedation checklist to a single page’.

We were unclear how the action plans would be shared with staff; this was vital as the failure to meet many of the standards related to poor documentation.
We were provided with the departments clinical audit plan for 2018/19. This showed further audits that were ongoing. This included, feverish children, vital signs in adults and risk in lower limb immobilisation. These were due to conclude in January 2019.

In addition to the RCEM audits, there was local audit activity in place. This included areas such as; high impact interventions (these are an evidence based approach that relate to key clinical procedures or care processes, for example, cannula insertion), documentation and triage. We were told audit results were discussed at handover meetings and departmental meetings, however staff did not articulate this, and we saw no evidence of this from the handover we observed.

Unplanned re-attendance rate within seven days

From September 2017 and August 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally better than the England average. However, since April 2018 there has been an increase in the unplanned re-attendance rate at the trust.

In the most recent month of available data, August 2018, the un-planned re-attendance rate within seven days at the trust was 8.0%, which was similar to the England average of 8.1%.

Unplanned re-attendance rate within seven days - University Hospitals of Morecambe Bay NHS Foundation Trust

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

Competent staff

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for urgent and emergency care also includes data for medicine.

As at September 2018, 73.3% of staff within urgent and emergency care services at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.
<table>
<thead>
<tr>
<th></th>
<th>Staff responsibilities</th>
<th>1,063</th>
<th>776</th>
<th>73.0%</th>
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<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>25</td>
<td>22</td>
<td>88.0%</td>
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</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
<td></td>
</tr>
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</table>

(Source: Data request- P43 Appraisal Compliance 2017 to date)

We reviewed appraisal data for nursing staff on site, this showed 89% of staff had undergone a recent appraisal. Whilst this was below the trust target of 95% it was a significant improvement from the last inspection where the figure had been 53%.

There was a practice facilitator in post who covered the emergency departments at the three hospital sites.

Eighty one percent of the band six staff had received training in advanced paediatric life support. All band five staff were trained in paediatric life support. There was always a doctor on site who had skills in advanced life support for adults and children.

Any newly qualified staff to the department would not work in triage independently until they had 12 months experience. Training was also provided which comprised of two parts, methodology and an exam. The use of PGD’s and requesting x-rays was also included in this.

Any newly qualified staff or staff new to the department would have a preceptorship booklet to work through to gain competencies. They would also have an initial meeting with the unit manager and practice facilitator regarding expectations and to look at their training needs. All new staff had a supernumerary period of four to six weeks, and probationary periods were in place to monitor any competency issues.

There was an induction pack in place for any new bank or agency staff. Prior to their first shift they were required to complete training on the electronic patient record system.

Doctors were provided with ‘learning on a page’ documents, these covered different topics, and included case studies. We saw an example of electrocardiogram (ECG) of the week.

There was dedicated time for teaching for junior and middle grade doctors one afternoon each week. The sessions often involved case studies. The sessions were recorded so anyone unable to attend could still access the learning from these sessions.

We were told about a recent ‘away day’ for middle grade doctors. This was externally facilitated, and the training used ‘real life’ scenarios, for example, the absconding patient.

**Multidisciplinary working**

We observed good multidisciplinary team working; this was supported by the staff we spoke with. Handovers took place with nursing and medical staff three times a day to share information about the status of the department and address any issues.

Staff were allocated to different areas of the department but supported each other and moved if one area was particularly busy.

Staff reported good working relationships with other departments in the hospital for example, paediatrics. The referral process for speciality doctors worked well and there was access to clinical nurse specialists.

There were clear internal referral pathways to mental health services, the crisis team were based in the department. Staff were clear on the referral pathways and how the team were accessed.
We spoke with ambulance staff who told us they had good working relationships with staff in the department, and they all worked together to support and assist each other.

We spoke with the frailty nurse who worked in the hospital and in the community. They provided 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.

Seven-day services

The department operated 24 hours a day, seven days a week. Consultants provided 24 hour on call medical cover, 15 hours of these were on site. There was 24 hours access to a paediatric consultant.

There was 24-hour access to services such as X-ray and computerised tomography (CT) scanning with facilities within the department. Pharmacy services were also available, this was via an on-call system out of regular working hours. Seven day pathology services were provided on site.

There was 24-hour access to psychiatric liaison services for adults. There was also access to child and adolescent mental health services (CAMHS).

Health promotion

Staff completed assessments on admission to the unit about patients' individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions. The department provided patients with information leaflets about their condition and aftercare such as from falls or head injuries.

We saw there was information available for patients about smoking cessation services and access to drug and alcohol services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and asking permission prior to performing tests or examinations.

Consent forms were available and completed for some specific procedures within the department, for example, if patients required sedation.

Paediatric staff we spoke with were aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as included in the departments safeguarding training. During inspection, staff we spoke with demonstrated an understanding of this as well as when best interest decision-making was appropriate. We also saw an example of this, a through discussion took place and all the necessary documentation was completed.
We observed a situation where rapid tranquilisation was used. There was immediate recognition and discussion about this as a method of restraint, and other options were considered. Advice was sought, and appropriate assessments and documentation completed.

Is the service caring?

Compassionate care

During our inspection, we spoke with 13 patients and their relatives, 11 of these were happy with the care they received. They provided us with positive feedback about the attitude of staff saying they were kind, friendly. Comments were made such as ‘staff couldn’t have done anything better’, ‘the staff were amazing’ and ‘they have looked after me, more than was needed’.

We saw medical staff show empathy and competent listening skills while taking a history from patients.

When the department was not too busy staff were able to deliver care that was compassionate, and we saw patients being treated with patience and kindness. However, when the department became busy and was in escalation status, we observed a number of situations where patient’s privacy and dignity was not maintained.

We saw an example of a patient being moved from a trolley to a bed in a corridor; although there was a privacy screen available, hospital staff did not provide it to the ambulance staff who were moving the patient. We also observed two patients being assessed by medical staff in the corridor. Patients were next to each other with relatives also stood by them. There was no privacy or confidentiality whilst these assessments took place.

We observed a patient being treated in the resuscitation area in a non-designated cubicle space. Procedures were undertaken without screens being around them. The curtains were also not pulled round other patients, so they could see what was happening.

We spoke with an elderly gentleman who had been in the department for several hours. They commented that as the department had got busier, the frequency of checks on him had reduced. He was also observed mobilising unaided to try and find a bathroom, he was unsteady on his feet and was using the wall as support.

Some staff commented that when the department was busy they did not feel able to provide the level of care that they would like.

During our observations, we saw staff ignore alarms on medical equipment; staff explained why the alarm was going off to the patient when a visiting doctor raised the issue, but it was concerning that staff did not do this straight away.

We were also concerned that on a number of occasions whilst observing care delivery, patients were not asked if they would like a chaperone.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than or the same as the England average in all months from August 2017 to July 2018. In July 2018, performance at the trust was 88.9%, which is better than the England average of 86.7%.
Friends and family test data was publicly displayed in the department. The data for September 2018 showed that 89.9% of patients would recommend the service.

**Emotional support**

Staff told us about how they would provide support to patients who were distressed or anxious. When the department was busy, this was a challenge due to a lack of staff and difficulties talking to patients in corridors.

We spoke with one patient and her mother who felt emotional support had not been provided in a timely way. However, the rest of the patients we spoke with told us they felt safe and supported by staff. We also observed situations where staff spoke with patients and relatives in a calm way and offered reassurance.

We saw a number of activities being used to distract children if they were upset. These included colouring sheets and a range of age appropriate toys. Bravery certificates were also given to children.

Staff gave us an example of a patient with a learning disability being assessed and treated in a room away from the main department because of the anxiety they felt in the busy and noisy unit. This helped to ease their anxiety and meant assessment and treatment was more comfortable for the patient.
During a staff huddle, we observed an example of staff considering the care of a patient and their family; the patient was the main carer for their husband and staff in the department considered their care needs even though they weren’t both patients.

The department had rooms available that could be used by people such as family and friends of patients in the resuscitation room. A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients.

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

The patients who were in designated areas were mostly aware of their plan of care and what was happening with them. The exception to this was when a member of staff attended to a patient to attach a monitoring device. The patient did not seem aware this was going to happen and asked if this meant they were staying in hospital.

Those patients in holding areas were aware they were waiting for either a bed on the ward or a cubicle in the department, however, none were aware of how much longer they would be waiting for and some commented that they had been left for some time without any further update.

During our inspection, we witnessed good interactions with patients when the department was not too busy and staffing enabled discussions to take place. 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. Patients and relatives told us they understood their care and treatment plans. One patient explained how she was hard of hearing but that everyone spoke slowly and clearly and checked that she had understood what had been said.

We saw packs for information and support on drug and alcohol services for under 25’s available and other leaflets for organisations and charities that could help and support patients’ health and social needs.

Staff told us the care of the elderly nurses attended a local dementia hub once a month which collated local services to help and support dementia patients and their families in the community. Patients were referred to this service frequently and leaflets were handed out by the care of the elderly nurses to patients who had been assessed by them.

**Emergency Department Survey 2016**

The trust scored better than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for none of the questions and about the same as other trusts for the remaining 23 questions. The trust performed better than other trusts for the question “Did hospital staff take your family or home situation into account when you were leaving the emergency department?”.

<table>
<thead>
<tr>
<th>Question</th>
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<th>2016 RAG</th>
</tr>
</thead>
<tbody>
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<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>4.0</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>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
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<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>8.2</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining 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>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.8</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>8.3</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>9.0</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>8.2</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>9.3</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>7.5</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>7.2</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>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>8.3</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>9.2</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>9.2</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>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>6.6</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. This included providing 24 hours a day access to the mental health liaison team who were based in the department.

The department had a minor injuries unit co-located in the emergency department which meant that patients could be streamed to the relevant service. This met the Royal College of Emergency Medicine (RCEM) recommendations to achieve safe sustainable care in emergency departments in terms of configuration of services.
There was also direct access to the children’s assessment unit once triage had taken place.

The care group (which included Urgent & Emergency Care and Medicine core services) had appointed a matron for service user and public engagement. Staff told us this job role will set up a group of patients and families to be involved in the development of services, but this had not been completed at the time of our inspection.

The trust involved patients and families when developing leaflets and investigating some complaints to help reflect the views of local people who have used the service. The leadership team gave an example of identifying a theme of incidents of falls in elderly patients and if they were fit for discharge. They worked closely with the relatives involved to support shaping the service going forwards across the trust.

Staff were aware the facilities in the department did not meet the needs of patients living with a mental health condition. The trust planned to create a new mental health facility and had plans ready to be signed off to address this.

The general waiting areas had adequate seating but there was no seating for adults in the paediatric waiting area. When the department became busy we observed a lack of cubicles for patients. Relatives had to stand in corridors next to patients waiting on trollies and chairs.

There was a private relative’s room which had tea and coffee making facilities and a telephone. It was a pleasant environment. There was a dual-purpose viewing room which was also used as an ambulance handover room, and a decontamination room when not needed as a viewing room. This room had clinical equipment and a shower in it and was used for patient assessments throughout our inspection. Both the relatives’ room and the viewing room sat between the resuscitation bays and the ambulance pathway into the emergency department. There was a notice stating this was a quiet area but in peak times we heard it was noisy.

There were information boards in the waiting areas explaining who the different staff were and provided performance information about the department. We saw laminated signs with wait times but it was unclear how often these were updated.

**Meeting people’s individual needs**

The trust computer software had a flagging system that could alert staff to specific needs of patients who had attended before. For example, patients with an existing dementia diagnosis had a butterfly flag on the system which alerted staff to their needs and patients with a known learning disability had a flag which alerted staff to their care plan.

The trust had access to interpreting services for people whose first language was not English. Most staff we spoke with were aware of how to access telephone interpreters however due to the local demographic, rarely needed to do so.

We spoke with staff about patients living with complex needs, dementia, or a learning disability. All staff told us they would treat patients as individuals, would try to involve family and carers in discussions about care needs and would access any passports or flags on the computer system to find out more about the patient.

There were dementia trolleys in the emergency department containing sensory items and the care of the elderly nurses had leaflets to give patients and families. Dementia and frailty training was mandatory for clinical staff and was provided internally three times a month. There was also a dementia champion in the emergency department.
Staff gave us an example when a patient with a learning disability was assessed and treated in a room away from the main department because of the anxiety they felt in the busy and noisy unit.

Generally, patients with learning disabilities who had visited the trust before 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. If a patient had not visited the department before, staff would make sure the patient did not leave without a passport in place.

The trust had developed a care of the elderly nursing service that worked across the site. They had a screening system of all patients who attended the emergency department aged 75 or over and assessed their frailty. Staff told us this system was embedded at this site and medical staff identified patients who were at risk a lot sooner. Staff gave us an example of an elderly patient who had been sent back to their care home with the appropriate community treatment organised within two hours of their arrival at the department. The team assessed the patient with the medical staff and made a decision based on their best interests reducing unnecessary interventions.

Staff we spoke with told us sometimes mental health patients waited for more than one day to be admitted to an appropriate bed in the mental health service. We also saw incident forms to support this. Staff gave examples which included regular observations and comfort checks on patients and they made sure patients accessed shower facilities on the wards, accompanied by staff or security depending on the level of risk. The trust had implemented a number of initiatives to support patients with mental health issues, including: partnership working with mental health trusts, mental health first aid training and development of seven-day child and adolescent mental health services (CAMHS).

The children’s waiting area had toys, books, child sized tables and chairs and appropriate television programmes for children being played. There was a designated toilet/baby change/feeding room attached, however, there was no seat available to comfortably feed a baby.

The trust had a chaplaincy service available the service was recently reviewed to assess the local belief needs and provision of the service to meet them. There were volunteer representatives from a variety of faith and belief groups on the volunteer visiting team who could support people whatever their belief or non-belief.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all 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>7.5</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>7.3</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>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

We spoke with staff about flow through the department. Staff told us the main barriers were patients who waited for mental health beds and beds on the wards when the hospital was busy.
Staff told us, and we observed, patients waiting in the corridor during busy periods on trolleys and chairs. We were told there was a corridor coordinator in peak times to have oversight of the patients waiting, however we observed times when there was no staff monitoring patients in the corridor. Staff told us it was difficult to treat patients when there were no cubicles available which meant the time patients waited to be treated was long and some patients were assessed or treated in inappropriate places.

The department had a flow co-ordinator and nurse in charge who were responsible for flow through the department. The nurse in charge wore a red arm band to identify their role and attended the handover three times per day and the bed meetings. Bed meetings were attended by senior staff across the trust who could influence discharges and free up beds. However, staff told us they didn’t feel the bed meetings were always effective.

Staff spoke with told us tests and monitoring were not always initiated at triage. This meant a potential delay to treatment because patients had to wait to see a doctor before these were ordered. The trust had identified this as an issue and work was underway to develop a protocol for ECG testing at the point of triage.

The emergency department and flow improvement programme was provided. This was an eight-week project identified the need for a clinical decision unit. The model of care and estates plan for this had not yet been agreed and the plan was behind schedule.

Another aspect of this plan related to pathways within ambulatory care. This workstream was also delayed as the pathways had not been agreed and consultant guidance was still required.

Staff from the minor’s unit told us that in peak times clinical support worker staff could be moved to work in the major’s unit. This had an impact on the waiting times in the minor’s unit.

Staff we spoke with in the minor’s unit told us in peak times they had been able to treat some patients who had arrived by ambulance with appropriate injuries for their competency. They told us they would make a clinical assessment of patients waiting to be seen and this helped to alleviate the queue of patients waiting for an ambulance handover to the major unit.

From our observations during the inspection, we saw patients waiting in the corridor on trolleys, in wheelchairs or standing up during a peak of activity. Ambulance staff told us they often had to wait with patients as they could not be handed over. We were not assured there was a robust process to manage these patients and this affected the flow through the department.

During our inspection, ambulance staff told us the emergency department staff were responsive to pre-alert patients arriving by ambulance. They told us there were some pathways in place for specific pre-alerted conditions where patients could be assessed by a doctor and then taken straight to ambulatory care. This was better for the patients because it meant they could commence treatment more quickly.

Staff told us there was a clear pathway for paediatric patients and a paediatric consultant was available during the day and a paediatric registrar during the night. Paediatric patients could be fast tracked to the paediatric department provided triage and observations were completed and it was appropriate to do so.

Referrals from GP practices presented in the emergency department with a referral letter. If the GP was unable to contact the relevant specialist, these patients had to be booked into the emergency department and wait for the appropriate consultant to review them. This meant patients could not always access the relevant department quickly.
We observed conversations between medical staff who considered early discharge planning and continuing treatment planning as appropriate for specific patients.

Medical and nursing staff completed a handover three times a day. Staff told us there was a proforma used for one handover a day only. We observed staff discussing patients’ status, how long they had been in the department and any barriers to them being admitted or discharged.

The department had an electronic board outside of the entrance to the building. Patients could see updated estimated treatment times to be seen in the department and an advice script was shown telling patients where else they could seek medical advice. We saw a large display to aide patient choice in which service was most appropriate for their illness or injury outside of the emergency department.

The trust had an electronic patient records system. The booking in system could be used to monitor patient wait times, however we did not see this utilised in the major's unit. The minor's unit utilised this technology to help patient flow in busy or peak times by assessing the patients waiting on the system to see if they could treat the presenting complaint in the minor’s unit.

The trust used technology to link with the local ambulance trust. There was a system in place to show the presenting complaint of an incoming patient and their estimated time of arrival.

The trust had a live electrocardiogram (ECG) system and we observed a live ECG that was fed directly for review by a cardiologist. This meant that the appropriate medical professional could see the test results in real time and make appropriate decisions and recommendations.

The trust displayed live A&E waiting times on their website that was regularly updated. This was displayed alongside information about the “Think! Why A&E” campaign and information on wellbeing and mental health helplines. This meant members of the public could access up to date and useful information and alternative treatment available without attending the emergency department.

**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 five months over the 12-month period from September 2017 to August 2018. The standard has not been met since January 2018. At the trust, the median time from arrival to treatment has also been greater than the England average since February 2018.

In the most recent month of available data, August 2018, the median time to treatment at the trust was 64 minutes compared to the England average of 56 minutes.
Median time from arrival to treatment from September 2017 to August 2018 at University Hospitals of Morecambe Bay NHS Foundation 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.

When looking at four-hour target performance, the trust consistently breached the 95% standard from September 2017 to August 2018. Furthermore, the trust’s four-hour target performance was lower than the England average in 10 of the last 12 months. A large improvement in the trust’s performance can be seen between March 2018 and May 2018 where the percentage of patients seen within 4 hours increased from 76.3% in March 2018 to 90.6% in May 2018, however, performance has been declined since this point.

Four-hour target performance - University Hospitals of Morecambe Bay NHS Foundation Trust

(Source: NHS England - A&E Waiting times)
We requested information from the trust about the four-hour performance target for individual sites. The data provided by the trust also included attendances to the Ophthalmic CAS clinic which does not fall under the scope of the inspection.

The performance data provided ranges between 69.06% in March 2018 and 87.63% in May 2018. The data shows that the Royal Lancaster Infirmary site did not meet the national four-hour performance target of 95% in any month.

Royal Lancaster Infirmary*

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendances</th>
<th>Breaches</th>
<th>4-hour performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-17</td>
<td>4291</td>
<td>550</td>
<td>81.18%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>4878</td>
<td>640</td>
<td>86.88%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>4552</td>
<td>865</td>
<td>81.00%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>4475</td>
<td>902</td>
<td>79.84%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>4304</td>
<td>1072</td>
<td>75.09%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>4042</td>
<td>989</td>
<td>75.53%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>4696</td>
<td>1453</td>
<td>69.06%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>4606</td>
<td>884</td>
<td>80.81%</td>
</tr>
<tr>
<td>May-18</td>
<td>5182</td>
<td>641</td>
<td>87.63%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>4860</td>
<td>671</td>
<td>86.19%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>4890</td>
<td>778</td>
<td>84.09%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>4624</td>
<td>845</td>
<td>81.73%</td>
</tr>
<tr>
<td>Total</td>
<td>55400</td>
<td>10290</td>
<td>81.43%</td>
</tr>
</tbody>
</table>

* includes Ophthalmic CAS Clinic (type 2)

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

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

Over the winter months there was an increase in the percentage of patients waiting more than four hours from the decision to admit until being admitted at the trust, following a similar trend to the England average.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals of Morecambe Bay NHS Foundation Trust

(Source: NHS England - A&E SitReps).

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

Over the 12 months from September 2017 to August 2018, 214 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 March 2018 (78 patients), January 2018 (37 patients) and February 2018 (25 patients).

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

We requested information from the trust about 12-hour performance target for individual sites.

The data showed that the Royal Lancaster Infirmary site had patients breaching the number of hours they should wait from the decision to admit to being admitted in every month.

### Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Date</th>
<th>Breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-17</td>
<td>12</td>
</tr>
<tr>
<td>Oct-17</td>
<td>23</td>
</tr>
<tr>
<td>Nov-17</td>
<td>55</td>
</tr>
<tr>
<td>Dec-17</td>
<td>64</td>
</tr>
<tr>
<td>Jan-18</td>
<td>114</td>
</tr>
<tr>
<td>Feb-18</td>
<td>79</td>
</tr>
<tr>
<td>Mar-18</td>
<td>209</td>
</tr>
<tr>
<td>Apr-18</td>
<td>69</td>
</tr>
</tbody>
</table>
May-18 26
Jun-18 24
Jul-18 32
Aug-18 41
Total 748

Staff we spoke with gave examples of patients who had waited more than one day in the emergency department for a mental health bed. Staff told us there were often barriers to mental health patients getting a bed in the local mental health trust which affected their patient flow through the department. The trust provided further evidence following the inspection of their plans to develop a mental health unit but did not give timescales for this work to be completed.

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

From September 2017 to August 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment has fluctuated month on month. The percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment has been lower than the England average in all months from April 2018 to August 2018.

In August 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0.0%, compared to the England average which was 2.1%.

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

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

**Median total time in A&E per patient (all patients)**

From September 2017 to April 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average. Since May 2018, the trust’s monthly median total time in A&E for all patients has been similar the England average.

Over the last 12 months, median total time in A&E for all patients at the trust was highest in March 2018 (187 minutes compared to the England average of 160 minutes). Since then, there has been
a decrease in the trust’s monthly median total time in A&E for all patients to a level that is similar
to the England average. In August 2018, the trust’s monthly median total time in A&E for all
patients was 149 minutes compared to the England average of 146 minutes.

**Median total time in A&E per patient - University Hospitals of Morecambe Bay NHS
Foundation Trust**

![Graph showing median total time in A&E per patient](graph.png)

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

**Learning from complaints and concerns**

During our inspection we saw there were mechanisms in place to allow patients to give feedback.
There was a comments box in the main waiting area and one in the minor’s unit waiting area
which gave patients an opportunity to leave feedback on the day of their visit. Staff we spoke with
told us these comments were collated once a week by the trust but they did not give examples of
this being fed back to the service.

During our inspection we saw a “you said, we did” information board. It stated there was not
enough information on how patients could make a complaint. We saw evidence this was rectified
in the main waiting area; there were leaflets and a notice for the Patient Advice and Liaison
Service (PALS) which gave patients the location of their office on each trust site, telephone
numbers and an email address to make contact.

Staff we spoke with during the inspection told us that learning from complaints was cascaded to
staff during the monthly staff meeting, on shift handovers and by email. There was also a learning
board in the staff room where key issues were displayed. Some staff we spoke with gave us
examples of learning implemented in the department from complaints, such as the introduction of
a coffee machine in the waiting room. However other staff could not give examples.

We reviewed an example of a complaint response from the emergency department at Royal
Lancaster Infirmary as part of the inspection. The response followed the trust’s guidance about
how to respond to complaints, however the response time was outside of the trust’s set timescale.

**Summary of complaints**

From July 2017 to June 2018, there were 71 complaints about urgent and emergency care
services. The trust took an average of 38 working days to investigate and close complaints. This is
not in line with their complaints policy, which states complaints should be completed within 35 days. Of the 71 complaints received during the 12-month period, 27 (38.0%) related to a diagnosis problem and nine (12.7%) related to discharge arrangements. A breakdown of complaints by site can be found below.

**Royal Lancaster Infirmary**

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Problems</td>
<td>15</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>6</td>
</tr>
<tr>
<td>Waiting Time for ED Department</td>
<td>4</td>
</tr>
<tr>
<td>Attitude of Staff - Doctor</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of Staff - Admin</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Treatment</td>
<td>3</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of Staff - Nursing</td>
<td>2</td>
</tr>
<tr>
<td>Prescription - Given</td>
<td>2</td>
</tr>
<tr>
<td>Attitude of Staff - Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Operation - Adverse Outcome</td>
<td>1</td>
</tr>
<tr>
<td>Patient's Privacy and Dignity</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From July 2017 to June 2018, there were 126 compliments in urgent and emergency care. The breakdown by site is shown below:

- Furness General Hospital: 36 compliments
- Royal Lancaster Infirmary: 90 compliments

We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

**Is the service well-led?**

**Leadership**

Emergency care was part of the trust’s medicines care group. Monthly care group performance meeting took place which fed into the workforce, quality and finance committee meetings.

The service had a clear management structure. There was a clinical and governance lead as well as a matron and general manager.

There were two unit managers in post. The worked clinically 80% of the time and covered two out of three weekends. They were supported by band six staff.
Staff were allocated areas of responsibility for each shift. Challenges occurred when the department became busy and staff had to support other areas in the department.

We observed the department when it was busy, and we were concerned that there was a lack of local leadership. At times the department felt chaotic and we had concerns about the lack of management and oversight of activity. This was evidenced with a lack of communication and two patients arriving into one available bed space in resus. For a period of 18 minutes this meant there were five patients in an area with space for four patients.

We also observed an ambulance crew arriving to transfer a patient to another hospital, staff were not clear which patient was to be transferred and if they were ready.

We were particularly concerned over the lack of oversight and monitoring of patients in holding areas. We were concerned that there were unknown risks with these patients due to a lack of robust communication and lines of responsibility. These concerns were escalated at the time of inspection. We were provided with the emergency department escalation triggers and action cards protocol and were told a SOP was due to be completed by December 2018. This SOP would relate specifically to the management of patients in holding areas such as corridors.

The staff we spoke with felt supported by their managers and described them as visible and approachable.

From discussions with the leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. However, the actions and learning they described were not reflected in what we found at departmental level.

There was a focus on developing and training for staff to support them in their roles. This was supported by the practice facilitator and unit managers and evidenced in the improved training and appraisal figures.

**Vision and strategy**

The medicine care group followed the trust 2016-2019 strategy which was aligned to the wider Better Care Together health economy transformation programme. The management team had a clear vision for the service and was working with other departments within the hospital as well as local providers and commissioners to ensure services met the needs of the local populations.

The care group’s strategic plan contained appropriate planning and assessment of risk, finance, estates and communications.

The management team were working to ensure that the service was sustainable for the future. This included developing new roles such as nurse practitioners who, in the future would be able to work within the junior doctor rota.

The vision of the trust focused on providing high standards of compassionate care and listening to patients, staff and partners. There were five values; patients, people, partnerships, performance and progress. These were displayed in the department and staff were aware and could talk about these.

**Culture**

Staff we spoke with told us they felt proud of their work and the care they provided to patients and their relatives. Several staff spoke about how staffing challenges impacted the level of care they
would like to provide, but that they worked as a team and supported each other during busy periods.

Staff said they felt able to raise concerns, however would not always record these in the form of an incident. Staff were aware of the importance of being honest and open. They were able to explain the duty of candour and the need to apologise to patients and relatives in line with trust policy if there had been a mistake.

We found the culture of the department open and inclusive. Staff off all levels felt they were valued and respected by their colleagues and managers. We asked staff about the morale of the department and they all said that morale was generally good despite the challenges in the department.

There was a desire from all staff to provide good care and treatment to patients. We observed staff working well together and there were positive working relationships with the multidisciplinary teams.

**Governance**

The department had a patient safety lead who managed incidents, investigations, safety and quality of patient care. The department also had governance leads who attended clinical governance, patient safety and mortality and morbidity meetings where information about complaints and incidents was shared. We reviewed meeting minutes which had these areas a standing agenda items.

From our observations and discussions with staff there were missed opportunities for sharing information and learning with staff. Information was displayed on notice boards; however, discussions and involvement of staff can be a more effective way of sharing information. During handovers and huddles we did not see information being shared about incidents, risks or learning. This was reflected in conversations with staff as most could not talk about any serious incidents or learning that had occurred in response to incidents.

Matrons and senior managers were very visible on both units and had an ‘open door policy’ for staff.

Whilst staff were generally aware of their individual roles and responsibilities. When the department became busy, this became unclear. Particularly in relation to patients in holding areas.

We were also concerned when staff described ‘near misses’ and potential safety incidents that they said they had not reported.

**Management of risk, issues and performance**

There was a care group risk register in place. Each risk was live on an electronic system and allocated to a named lead. Some department level risks were amalgamated into a single risk for the care group so that they could be addressed as a team. For example, staffing, recruitment and finances.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

We reviewed the risk register and it was reflective of the risks we saw and staff identified. From our discussions with the leadership team they were clear about key risks to the service. They talked about nurse staffing, provision for mental health patients and access and flow. We were not
provided with information on, nor did we see evidence of robust plans and mitigating actions to address all of these risks. In particular, staffing and access and flow.

Whilst these risks reflected what we found during our inspection. We identified additional specific risks which had not been identified. There related predominantly to the patients being held in corridor areas, in terms of staff responsibility, oversight of risk in terms of patient condition and risk in relation to corridors being obstructed which may slow evacuation in an emergency.

We requested protocols to support and advise staff. These were not in place at the time of inspection. We were told they were in development and would include a risk assessment and fire safety advice for the evacuation of the department when there are patients in the corridor.

We were provided with information on current mitigation for these risks. This included the use of the emergency department escalation triggers and action cards and the use of a document to evidence hourly checks which was being audited on a weekly basis. However, we observed a situation where the department was in escalation and the offer of additional staff was declined, we also found the checklists were not in place for patients during our inspection. This therefore remained a concern.

The trust had a major incident policy on the trust intranet. Staff understood their roles and responsibilities regarding major incidents. The department had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents. There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.

We saw the performance monitoring report for the care group. This included the daily accident and emergency delivery dashboard, performance reports and information from the afternoon bed meetings. This information enabled the service to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team.

Performance was also measured by the outcomes of RCEM audits. The department contributed to a number of these. Some results showed poor performance. We lacked assurance that the action plans in place were detailed and robust enough to support improvements.

In some areas we found that performance had improved in response to audit activity. This was particularly noted in terms of the recognition and management of sepsis.

We saw evidence of local audit activity however it was unclear how the results were collated and what action was taken as a result. It was also unclear how this information was shared with staff to improve performance.

**Information management**

Staff accessed information relating to policies and guidance electronically. The system was easy to navigate.

Staff received training on information governance. Electronic patient records and medication charts were in use. Some records were still paper, we found these were not stored securely. We also found a number of computers left with screens unlocked.

The department used several 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.
Engagement

Staff from the department had taken part in trust wide engagement exercises such as online surveys. However, there had been no specific engagement work carried out with staff within the department. Discussions with staff showed limited examples of staff engagement.

The department participated in the friends and family test and CQC surveys but had not carried out any local surveys in relation to the quality of urgent and emergency care services.

The chief executive held open forums for staff which called ‘Tea and Talk’, where any issues or concerns could be raised.

The trust held annual Health Hero’s awards, to acknowledge the excellence and dedication of staff across the hospitals and community teams.

There was a patient experience forum held monthly where patient representatives advocate for the public.

There was a sign in the paediatric cubicle for remembrance and thanks for generous funding and support in memory of child who had used the service. This had enabled refurbishment and additional paediatric emergency diagnostic equipment to be purchased.

Learning, continuous improvement and innovation

The department was part of an eight-week improvement plan looking at specific area to improve, including ambulatory care and the development of a clinical decision unit.

The department was committed to improving the facilities and environment for patients admitted with a mental health issue.

The service had posters offering confidential feedback from paramedics about patient care they had been involved in via a post box. This meant ambulance staff could identify concerns anonymously and the trust could use this information to inform improvement and development.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment across three sites; Royal Lancaster Infirmary (RLI), Furness General Hospital (FGH) and Westmorland General Hospital (WGH).

At RLI, there are 203 medical beds including the medical assessment unit accommodated in the main Centenary building and on medical unit two. This bed base includes a 15-bed acute frailty unit adjacent to the medical assessment unit.

Inpatient acute medical care is provided onsite. The Acute Medical Unit (AMU) cares for acutely ill adult patients with varying complex needs. Most patients are from the Emergency Department and GP admissions. Patients are assessed, a plan of care provided and transferred to a relevant pathway / ward or discharged home.

The Ambulatory Care Unit provides same day emergency ambulatory care facilities to optimise the patient journey and utilise appropriate patient pathways.

Integrated medical specialities cover inpatient and outpatient facilities in relation to cardiology, cardiac devices, respiratory, healthcare of the elderly, gastroenterology, diabetes and endocrinology, haematology, oncology, stroke services and dermatology.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 38,562 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 20,025 (51.9%), 463 (1.2%) were elective, and the remaining 18,074 (46.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine with 19,868 admissions
- Gastroenterology with 6,052 admissions
- Medical oncology with 4,070 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Staff were provided with mandatory training in key skills. They were required to complete training in topic areas such as infection prevention, manual handling and information governance. Dementia awareness was not a part of mandatory training but was separately delivered, and we saw staff wearing ‘dementia friend’ badges on their lanyards.

The trust did not provide training on mental health as part of mandatory training. There were plans in place for day long training sessions delivered by the psychiatric liaison team, and some staff we spoke to were booked to attend these. Some wards employed a mental health nurse as part of their core staffing and we heard that these nurses provided ad-hoc learning for their colleagues.
Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. This was delivered either by eLearning or face to face. Staff we spoke to said that they did find time to complete their mandatory training. However, on viewing WESEE reports (ward level bulletins), we saw that care group compliance with Basic Life Support (BLS) training was below target and falling (80.6% in June 2018 and 79.9% in October 2018). The governance team were aware of this issue and were using messages in these reports to encourage greater compliance. Practice educators had been asked to provide more sessions to increase training capacity. We heard on inspection that some nurses and doctors did not maintain their protected learning time due to time pressures.

Trust level

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,251</td>
<td>1,285</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,228</td>
<td>1,282</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,178</td>
<td>1,284</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,168</td>
<td>1,281</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,061</td>
<td>1,179</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,142</td>
<td>1,289</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>882</td>
<td>1,107</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>978</td>
<td>1,273</td>
<td>76.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for two of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the general fire safety awareness module, for which only 76.8% staff had completed the training at September 2018.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency services at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

Safeguarding

Staff had a good knowledge and understanding of the trust safeguarding policies and knew their role and responsibilities. Staff could explain how to contact the safeguarding team for advice. They knew what constituted a safeguarding concern and could give examples of having raised...
Policies and links to multi-agency safeguarding procedures were stored on the trust’s intranet. These were in date. The trust was not meeting a 95% target for completion of Safeguarding Children and Adults Level 1 or 2.

Senior staff told us that staff undertook Level 2 safeguarding for adults and children. They said that this included learning on female genital mutilation, sexual exploitation, counter terrorism (PREVENT) and domestic abuse. This training was in the process of being redesigned by the safeguarding team to fulfil the requirements of the Intercollegiate Document (2014). Safeguarding Level 3 training was offered and completed as appropriate.

Patients and relatives, we spoke with did not highlight any concerns relating to this area. They said people were generally well looked after and they felt safe.

DBS checks were undertaken as part of the pre-employment checks and thereafter on a three-yearly basis.

The trust was due to commence Female Genital Mutilation (FGM) Risk Indication System as soon as the implementation schedule required. However, staff were not able to explain what the process for reporting or identifying FGM was, nor could they demonstrate any real understanding of the practice.

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training and were not meeting this.

Safeguarding Adults Level 2 was completed face to face initially, and then a yearly refresher was offered online. We saw that on some wards, refresher training for Adult Safeguarding Level 2 was as low as 53%.

Compliance rates for Safeguarding Adults Level 2 were as shown in the table below.

<table>
<thead>
<tr>
<th>Ward/Area</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Frailty Unit</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Medical Unit</td>
<td>85.5%</td>
</tr>
<tr>
<td>Huggett Suite (Acute Stroke)</td>
<td>90.9%</td>
</tr>
<tr>
<td>CCU</td>
<td>81.3%</td>
</tr>
<tr>
<td>Clinical Investigations</td>
<td>90%</td>
</tr>
<tr>
<td>Day Treatment Unit</td>
<td>100%</td>
</tr>
<tr>
<td>Dermatology Unit</td>
<td>100%</td>
</tr>
<tr>
<td>Endoscopy Unit</td>
<td>75%</td>
</tr>
<tr>
<td>Lancaster Suite</td>
<td>84.4%</td>
</tr>
<tr>
<td>Oncology Day Unit</td>
<td>56.3%</td>
</tr>
<tr>
<td>Specialist Nurses</td>
<td>85.7%</td>
</tr>
<tr>
<td>Ward 20</td>
<td>81%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>81.8%</td>
</tr>
<tr>
<td>Ward 23</td>
<td>75%</td>
</tr>
<tr>
<td>Ward 37</td>
<td>75.9%</td>
</tr>
</tbody>
</table>
Trust level

A breakdown of compliance for safeguarding training as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,174</td>
<td>1,275</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still high.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

Cleanliness, infection control and hygiene

Staff attended infection prevention training as part of their mandatory training. Trust compliance was 97.4% for the directorate, which included Emergency Care.

We saw two nurses working in CCU using the World Health Organisation (WHO) ‘five steps of hand hygiene’ when washing their hands. Hand sanitisation gel was available in bed spaces and at the entrance to the ward. We saw that in the Huggett Suite staff were using protective equipment to deliver patient care and were sanitising hands between one patient and the next. We observed nursing staff cleaning a trolley prior to preparation for an aspiration procedure.

Patients with an infection were nursed in a side room using appropriate barrier nursing techniques and signage to indicate this. We saw in all areas that this was working well and there were no doors left open.

We saw appropriate separation of clinical waste and disposal of needles. Sharps bins were correctly assembled, dated and signed with a temporary closure in place.

The trust conducted a monthly infection control audit and all wards had met or exceeded the 96% compliance target for the previous five months.

Environment and equipment

All wards we visited were well organised and visibly clean. We saw cleaning in progress and noted that safety signs were used appropriately.

We checked 29 pieces of equipment including blood pressure monitors, scales and hoists. All were in good working order and maintenance checks were in date. All equipment was clean, except on ward 23 where we found eight manual blood pressure monitors, which had undated stickers, so we could not be assured that they were clean.
Staff carried out daily checks of emergency equipment on wards. Resuscitation trollies were sealed, and part of the daily check was to ensure the seal was intact. We checked four resuscitation trollies including breaking the seal on one to check the full contents. We saw that in three areas, daily trolley checks were complete. In a fourth, the resuscitation trolley had not been checked on two dates that month, and three dates the previous month. We saw that all equipment, consumables and supplies on the resuscitation trollies were in date. However, all four trollies were visibly dusty, despite having ‘I am clean’ stickers showing that day’s date.

Sluice rooms were found to be unlocked. Products such as bleach were safely stored away in a locked cupboard marked Control of Substances Hazardous to Health (COSHH) within the sluice. In the Cardiac Care Unit, the COSHH cupboard was left unlocked with the key in the lock. The room was unattended which could pose a risk to vulnerable patients. We brought this to the attention of the ward manager who promptly found the padlock and secured the cupboard.

In medical wards there was a wipe clean log for recording bath and shower temperatures. These had not been completed monthly. In the Huggett Suite, the check was last recorded two months prior to the inspection. On Ward 20 the check sheet was displayed on the wall but had not been used. Audits showed that several of the medical wards had not taken part in the care group’s safe bathing audit, and the care group were 54% compliant. We were not assured that regular checks were being conducted.

The ward environment on ward 23 appeared cluttered. There was no separate day room for patients, so when up and dressed they sat in a horseshoe of chairs around a television in the main area, which was quite noisy.

While therapy staff on ward 23 were provided with separate accommodation and lockable storage, this was not always used. We noted the area was unattended and several computers and mobile phones were on display. The gym was in poor decorative order and cluttered.

Assessing and responding to patient risk

Measures were in place to ensure that staff could assess and respond to patient risk although staff did not always use these appropriately. We saw that nursing staff completed a range of patient risk assessments on admission to the area. These included falls, nutrition and hydration, cognitive assessment and pressure damage risk. We reviewed 10 sets of records consisting of paper records and the corresponding electronic records. We saw that risk assessments had been completed correctly.

National Early Warning Scores (NEWS) were recorded on paper and stored at the foot of the patient’s bed or just outside their door if they were being nursed in a side room. We spoke to staff who told us they knew what to do if a patient showed signs of deterioration, and they could tell us what they would do to escalate this. We checked six sets of patient records and saw NEWS assessments and escalations were appropriate. We found that in all cases, recording was complete, and patients had been escalated and reviewed promptly. The trust’s own audit of NEWS 2 scores for the medical wards showed that compliance was above 90% on all wards.

Staff we spoke to had a good awareness of sepsis and the need for screening, and the ‘Sepsis Six’ tool was in use. The trust conducted an audit of the recognition and management of sepsis which showed improvement since the previous year.

In the Acute Medical Unit (AMU), staff had implemented a new initiative entitled ‘purple for purpose’. Purple non-slip socks were being provided to patients with a cognitive impairment, so that any staff seeing these patients attempting to move around the ward would know instantly that
this was a potential risk and assist the patient. The ward was using social media to promote this to families, patients and share good practice with other areas of the Trust.

There were three medical wards in Medical Unit 2 (wards 20, 22 and 23). These held a total of over sixty patients. We were told that because the unit was some way from the main hospital, a deteriorating patient would have to wait for a private ambulance or onsite patient transport to take them back to the main building. There was no patient transport contract in place between the hours of 8pm and 10am and staff were advised to see if they could self-transfer using the onsite patient transport vehicle and a nurse from the ward. There was no separate crash team for Medical Unit 2. However, information provided by the trust showed only three arrests in the unit in 2018. There were no reported incidents of delay in obtaining assistance from the RLI crash team.

Stroke physicians told us they had raised concerns about the stroke stepdown ward not being in the same building as the Huggett Suite as patients required a transfer by ambulance between the two areas. This was on the care group care group risk register as both a risk to patients due to delays in transfer, and a risk to the stroke service in that they were not meeting Royal College of Physicians (RCP) guidance due to the stroke wards being separated.

Nurse staffing

We had concerns about the levels of registered nurse staffing on medical wards on wards 23 and 37. On all other wards, staffing was either as planned or if it was not, actions had been put in place to offset the impact of this.

In AMU, there were no registered nurse or clinical support worker vacancies. However, four members of staff were on extended leave. The ward used bank and agency staff to cover any shortfall and was appropriately and safely staffed during the inspection.

There were two Registered Nurse vacancies for the Huggett Suite and two registered nurse vacancies and one CSW vacancy for ward 23. The Huggett Suite had the right number of staff for patients requiring more intensive care.

Ward 20 had 24 beds for patients with dementia. Staff told us that matron normally addressed staffing issues but it was rare for a nurse to be found from the main building to help. We were told that the ideal would be to staff the ward with four nurses but it more commonly operates with three.

We had concerns about nurse staffing levels on ward 23. This was a stroke ward with 24 beds, but nine of the beds were occupied by medical (non-stroke) patients with a variety of illnesses. We were told that there were eight patients with dementia on the ward on the day we visited. Planned nursing cover was four nurses, but on the two days we visited the ward, there were only two nurses on duty.

We were advised of long gaps between observations due to staff shortages and it was highlighted that skill mix was also problematic. CSW’s were increased when the ward was short of registered nurses which restricted practices such as medication administration and the issuing of IV fluids. Figures provided by the trust showed that on average actual nurse staffing was three nurses below planned levels over the previous six months.

Where a ward was one nurse short, extra clinical support workers (CSW) were provided. For example, on ward 22 (which had 24 beds) they had planned for four nurses but had three, but had brought in two extra CSWs to offset this. Nurse staffing levels is on the care group risk register and we heard from ward staff that the Trust had been very proactive in its recruitment. We spoke
to a nurse recently recruited from overseas, who explained that staff had been very supportive. 
They had felt welcomed to the Trust and would recommend it to their colleagues as a place to come and work. Other than ward 23, staff on the wards felt they were sufficiently and safely staffed.

Staff on wards 20 and 23 told us that staffing was often a problem, and that they relied heavily on bank staff, although they tried to use the same people. They said that the wards were often stressful and could be difficult to work in.

Ward 37 could host patients on acute non-invasive ventilation (NIV). We were informed there was always one nurse on duty with the correct competencies to care for these patients.

The trust had carried out internal audits against NCEPOD guidelines for patients receiving NIV. This data had been analysed and was awaiting discussion at the appropriate clinical meeting. It did not include all the suggested elements of the NCEPOD self-assessment checklist. British Thoracic Society guidelines state that in all areas providing acute NIV, a minimum staffing ratio of one nurse to two acute NIV patients must be in place. We were not assured that this level could or would be met, nor that all nursing staff had appropriate competencies to care for these patients.

The trust commissioned a nurse staffing levels review for 2018/19, undertaken by an external provider. The biggest identified risk was that the trust did not have a safe nurse staffing policy in place, nor a staff rostering policy. As a result, it was not clear how or when to escalate risk caused by low nurse staffing levels, however we were informed that action had already been taken to address this.

The trust has reported their staffing numbers below for the period October 2017 to September 2018 for medicine. As at September 2018, 87.6% of qualified nursing shifts were filled across the whole trust. Nursing fill rates were low at the Royal Lancaster Infirmary with fill rates of 87.1%. However, we saw evidence that the trust had made significant improvements in their nurse fill rates since our last inspection and although there is further work to be done, good progress had been made in recruiting and retaining nursing staff.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>241.5</td>
<td>277.4</td>
</tr>
</tbody>
</table>

(Source: Data request - P16 Total Staffing)

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 13.5% for qualified nursing staff working in medicine.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

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

**Turnover rates**
The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in medicine. This was better than the trust performance measure of 8.5%.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

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

Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in medicine.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

Bank and agency staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 2,354 shifts for qualified nursing in medicine were filled by bank staff and 520 shifts were filled by agency staff. In addition, 2,740 shifts remained unfilled by bank and agency staff.

For nursing assistants, 8,963 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 2,743 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>8,963</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Medical staffing

We had concerns about the levels of stroke consultants during the week and at weekends.

Consultants reviewed stroke patients on the Huggett Suite every day, Monday to Friday. Stroke nurses provided cover at weekends, and deteriorating patients could be reviewed by the medical consultant on call at weekends or evenings. There was no stroke specific medical cover at
weekends. This did not meet recommendations set out by the Royal College of Physicians, and was on the care group risk register.

On ward 23, we had concerns about the levels of doctor cover as at times there was only one doctor on duty with periods of no overlap with colleagues. We heard that this situation was in part due to long term leave within the team.

We were advised that a junior doctor led ward rounds on a Tuesday. The stroke consultant told us that they were available to contact should the junior doctor need support.

Out of hours medical cover consisted of twilight cover from a registrar and Senior House Officer (SHO), plus a junior doctor, until 12.30am. After this time until 9am there was one night registrar and a SHO based in AMU covering all the hospital’s medical wards. There was a hospital at night team, consisting of two nurses, one based in the main building, and one in Medical Unit 2. There was no critical care outreach team.

We were told that there was junior doctor and consultant cover for AMU seven days a week. However, an average of only 75.9% of patients were reviewed by a consultant within 14 hours of arrival.

The Elderly Assessment Unit (EAU) hosted a junior doctor and a GP on rotation but as the GP was also on call there was often only one doctor present. We heard on inspection that some junior doctors were working long hours. The guardian for safer working’s last report to trust board showed 65 incidents reported from junior doctors over the previous three months, relating to long hours.

On ward 37 patients were reviewed by a consultant daily, and at weekends the consultant on call saw new patients.

Medical staffing was on the risk register and the trust were actively recruiting to vacant posts.

In addition, the trust were in the process of recruiting and training more advanced nurse practitioners and exploring alternative ways of working.

The trust has reported their staffing numbers below for the following periods for medicine: From October 2016 to September 2017 and from October 2017 to September 2018. As at September 2018, 92.0% of medical and dental shifts were filled across the whole trust. The fill rate for medical and dental staff at Royal Lancaster Infirmary was an over-establishment, with fill rates of 106.3%, however, this does not reflect our observations when we inspected.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>118.8</td>
<td>118.7</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

Vacancy rates

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.
From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in medicine.

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

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in medicine. This compares to the trust performance measure of 8.5%.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in medicine.

The trust measured attendance and had a target of 95.6%.

(Source: Data request - P19 Sickness)

**Bank and locum staff usage**

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in medicine from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

**Trust wide**

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,949</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>11</td>
<td>801</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,464</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>4,214</strong></td>
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</table>

Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,292</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>11</td>
<td>133</td>
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<tr>
<td>Junior</td>
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<td>1,055</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>2,480</strong></td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**
At June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 129 whole time equivalent staff working in medicine at University Hospitals of Morecambe Bay NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</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 - Medical (01/06/2018 - 30/06/2018)

**Records**

The trust held records both electronically and in paper format. Paper records were stored in moveable trolleys with lockable lids. Trolleys were either locked or stored with closed lids within sight of nursing stations.

There was a trust Clinical Records Management policy which outlined correct procedures for managing records and their retention period. The policy was available to all via the trust's document library and had recently been reviewed and approved.

Records processes were monitored by the Cross Care Group Clinical Records Forum, which reported to the Quality Committee. We saw the results of monthly record keeping audits, which included a monthly review of five sets of notes, looking at the completeness, timeliness and legibility of both paper and electronic records. We noted that the results showed an improving picture over the previous 12 months.

We looked at a sample of 17 patient records including nursing and medical notes. Notes were thoroughly completed, including; nursing assessment, VTE assessment, pressure ulcer assessment, nutritional risk assessment, falls risk assessment, MDT and family input and NEWS escalation where appropriate. It was clear in all cases who had completed the notes and the person reviewing the patient was clearly documented. In one case a bed rail assessment had been overlooked but this was the only time we saw an error in documentation.

Two records on ward 22 contained 'do not resuscitate' forms. These were appropriately completed, reviewed by a consultant and discussed with the correct person or people. Patients had an alert showing on their electronic record so that staff were aware of it and the red form was stored at the front of the patient’s paper notes. Staff told us that these patients were discussed regularly at handover so that everyone was aware who they were.
**Medicines**

Medicines were not always stored securely on every ward. This was rectified during the inspection when we brought it to the attention of staff. We checked a sample of medicines and found these were not always in date. We found a box of tablets that had expired and two bottles without the opening date on them. Fridge temperatures were being recorded daily, however in some areas the minimum and maximum temperatures were not being recorded in line with trust policy. When we checked these temperatures, they were out of range and this was escalated. In CCU the fridge temperature had not been recorded for five days in November. No previous logs were available to assess if this was a recurring issue. We could not see any method of monitoring the temperature of the room, which felt hot. Staff did not know if the temperature exceeded 25 degrees.

Medicines reconciliation was being completed but not always within 24 hours. There was no clinical pharmacy or medicines reconciliation service at weekends although the trust told us that they were considering the possibility of providing this for wards admitting patients.

We checked the storage of controlled drugs on CCU and saw that record keeping was good and had been checked daily. Three registers were kept, one for patients’ own medication, a second for controlled drugs and a third for enhanced controlled drugs. We could see that balances for controlled drugs were correct, there were two signatures against every entry, and there were no deletions or amendments. We spoke to a pharmacy technician visiting the ward to do medicines reconciliation. They told us that as well as daily visits, they also conducted a monthly pharmacy audit.

We checked nine prescription charts. All had up to date and correct information on patient allergies and antibiotics. There were no missed doses. All five were clear and legible as they were electronic. All staff were trained to use the system.

The trust had completed an omitted doses audit, reported to the Medicines Safety Committee in May 2018. The results showed that there was an issue with missed doses which was not meeting the trust’s target of zero as one of the yearly quality priorities. The issue was escalated to the patient safety group and ward managers received an email making them aware of the audit and reiterating the need to reduce this figure.

**Incidents**

Ward staff were aware of the need to report incidents and were all able to tell us how they would do this. Incidents were recorded on an electronic online system. Ward managers had good oversight of their incidents, which were documented in their monthly WESEE governance report. They could tell us what the most common types of incidents were for their ward or area.

Ward managers told us that all incidents graded moderate and above were discussed at the patient safety summit. Staff would receive automatic feedback on these, and if appropriate, would be asked to complete some reflection work.

In all areas staff could give examples of learning from mistakes and were clear how this information was disseminated. We saw a ‘lessons learnt board’ where learning was shared visually, and staff were required to sign to say they had seen this.

All staff told us that there was an open and honest culture when it came to reporting incidents, and they would not feel worried about doing so. Some felt that in the past there may have been...
something of a blame culture but were clear that this was not the case now and they were encouraged to report both incidents and near misses.

Qualified ward staff could describe the duty of candour process and its requirements. Ward managers could tell us how and when duty of candour would apply and what they would do as a result. We heard that the trust had appointed a new patient and family support officer to support patients and their families who had been involved in incidents, and this had improved the overall experience.

**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 September 2017 to August 2018, the trust reported no incidents classified as never events for medicine.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.

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

- Slips/trips/falls meeting SI criteria with four (27% of total incidents).
- Pressure ulcer meeting SI criteria with four (27% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (20% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (13% of total incidents).
- Medication incident meeting SI criteria with one (7% of total incidents).
- Incident pending review with one (7% of total incidents).

Site specific information can be found below:

- Royal Lancaster Infirmary: nine 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 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 13 falls with harm and 11 new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at University Hospitals of Morecambe Bay NHS Foundation Trust

1. Total Pressure ulcers (22)
2. Total Falls (13)
3. Total CUTIs (11)

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff had access to policies and procedures and other evidence based guidance via the trust intranet. We reviewed a random selection of five policies including the safeguarding children policy, the NEWS policy, sepsis policy, and information governance policy. All but one (information governance, which expired on 1 November 2018) were within their review date.

The care group’s WESEE governance report for October 2018 showed that the care group had a programme of reviewing practice against current National Institute for Health and Care Excellence (NICE) guidance. Where the Trust had rated themselves as partially compliant, a named individual was tasked with taking this forward and we saw evidence that this had taken place. We spoke to a stroke physiotherapist who told us that they provide each patient with at least 45 minutes per day of therapy time in line with NICE guidelines.
The trust participated in local and national audit and used this to measure and improve effectiveness of care and treatment. We saw that the trust had action plans in place to address poor performance in national and local audit.

**Nutrition and hydration**

The trust had a nutrition policy in place, supported by a multidisciplinary nutrition strategy group. Patients were screened using the Malnutrition Universal Screening Tool (MUST). We saw that these were stored in a patient’s electronic record and these had been appropriately completed. Any patient scoring medium and above was automatically referred to a dietitian for further input.

Meal times were protected, but friends and family were encouraged to stay and assist patients with feeding if they wished. We spoke to a total of 14 patients and their families, and all said that they were happy with the food choices available (with one minor exception) and that their portion sizes were good. Patients had a choice of menus and special dietary needs were catered for. Patients were assisted in their choices where required.

We saw that patients always had access to drinks and that water jugs and cups were within reach. Two handled beakers with spouts were available for those who needed them, and colour coded beakers were used to indicate what stage of diet and fluids the patient should receive. Fluids amounts were put on a fluid balance chart to inform care decisions. We saw five of these which had been kept up to date.

We observed a mealtime on ward 23. Patients were being served their food at the same time as having their observations taken. This did not allow them to eat in a timely manner although we also saw a CSW feeding a patient and taking time to do so. We also saw food being taken (as directed by the server) to a patient who was nil by mouth. the CSW realised this and returned the food before it reached the patient.

**Pain relief**

We saw that pain relief was considered in the electronic record and prescribed where required. Patients told us that their pain was well managed and kept under control.

We spoke to a patient living with dementia who told us that they were not in pain, but that if they were, they would ask for paracetamol and this would be provided.

One patient was due a morning dose of pain relief and received this over six hours later as there was insufficient stock on the ward. They told us they had been uncomfortable without their pain relief.

**Patient outcomes**

The trust participated in local and national audit and used their results to drive changes to improve care and treatment. Local audit plans were comprehensive, and audits were completed and stored as part of an electronic audit system. We viewed a sample audit and saw that it had clear targets and deadlines, a named owner and associated action plan.

Ward 37 had achieved the Gold Standard Framework accreditation. Staff spoke of how proud they were about this achievement as there were very few hospital wards in the country achieving this.
The trust was working to NICE Guidelines and every Guideline was assigned a lead who took responsibility for ensuring compliance and regular audit. Compliance was monitored monthly using the care group WESEE report.

Matrons conducted a monthly local audit of all medicine’s wards using a range of standards including environment, communication, harm free care, patient experience and medicines management. This included checking notes, observing practice, checking medicines and environmental scrutiny. Wards were rated according to their compliance. Three wards (The Lancaster Suite, ward 22 and ward 23) were not compliant in October 2018.

The endoscopy unit was Joint Advisory Group on Endoscopy (JAG) accredited.

The Trust’s Quality Committee minutes noted that Sentinel Stroke National Audit Programme (SSNAP) data was poor and this was mainly due to a lack of therapy staff. Patients were not being offered a seven-day therapy service due to low staffing levels. A lack of thrombolysis trained staff in A&E meant that some eligible patients had not received this treatment. The trust’s 2018 SSNAP data was published while the inspection was underway and showed a much-improved picture for therapy services.

We saw that the Royal College of Physicians had visited the Trust and produced a report on stroke services in February 2018. They felt that the SSNAP data should begin to improve as the opening of the Huggett Suite began to have an impact on patient outcomes.

The Trust supplied us with a copy of their gap analysis following the National Audit of Inpatient Falls 2017. Despite outcomes well below the national aspirational standards, the Trust had RAG rated themselves as already recording or meeting 17 of the 21 recommendations, the other four rated amber. Given the current position we did not feel this action plan offered sufficient challenge to improve.

**Relative risk of readmission**

**Trust level**

From May 2017 to April 2018, patients at the trust had a lower 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 Admissions – Trust Level**

![Graph showing relative risk of readmission](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.*

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
• Patients in clinical haematology had a similar to expected risk of readmission for elective admissions

Non-Elective Admissions – Trust Level

![Bar chart showing risk of readmission for non-elective admissions](chart.png)

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.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

Royal Lancaster Infirmary

From May 2017 to April 2018, patients at Royal Lancaster Infirmary had a lower 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 Admissions - Royal Lancaster Infirmary

![Bar chart showing risk of readmission for elective admissions](chart.png)

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.

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions.
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions.
• Patients in clinical haematology had a lower than expected risk of readmission for elective admissions.

Non-Elective Admissions - *Royal Lancaster 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.

• Patients in general medicine had a lower than expected risk of readmission for non-elective admissions.

• Patients in cardiology had a lower than expected risk of readmission for non-elective admissions.

• Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions.

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

**Royal Lancaster Infirmary**

Royal Lancaster Infirmary takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the hospital achieved grade D in latest audit, August 2017 to November 2017. The trust’s 2017 SSNAP data showed the hospital achieved grade D in the latest audit available prior to inspection. The trust’s 2018 SSNAP data was published while the inspection was underway and showed a much-improved picture for therapy services.

The hospital performed particularly badly for its stroke unit, thrombolysis, and speech and language therapy achieving a grade E in team centred and patient centred performance. The hospital performed well for standards by discharge, discharge processes, physiotherapy, and scanning, all achieving a grade B in the most recent audit for team centred and patient centred performance. The hospital achieved a grade C in the most recent audit for occupational therapy, this is after the hospital dropped to a grade E for this domain in the previous audit.
### Patient centred performance

<table>
<thead>
<tr>
<th>Domain</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>C↓↓C</td>
<td>C</td>
<td>A↑↑A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
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<tr>
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<td>E</td>
<td>E↑E</td>
<td>E</td>
<td>E</td>
<td>E</td>
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<tr>
<td>Domain 3: Thrombolysis</td>
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<td>E↑E</td>
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<tr>
<td>Domain 4: Specialist assessments</td>
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<td>D</td>
<td>D</td>
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<tr>
<td>Domain 5: Occupational therapy</td>
<td>B↑C↓C</td>
<td>C</td>
<td>C</td>
<td>E↓↓C↑↑</td>
<td>C↑↑</td>
<td></td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
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<td>D↑</td>
<td>D↑</td>
<td>C↑</td>
<td>B</td>
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<td>E</td>
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<td>E</td>
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<tr>
<td>Domain 8: Multi-disciplinary team working</td>
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<td>D</td>
<td>D</td>
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<tr>
<td>Domain 9: Standards by discharge</td>
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<td>A</td>
<td>B↓</td>
<td>B</td>
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<tr>
<td>Domain 10: Discharge processes</td>
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<td>B↓</td>
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<td>B</td>
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<tr>
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<td>D</td>
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### Team centred performance

<table>
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<tr>
<th>Domain</th>
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<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>
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<td>A</td>
<td>A</td>
<td>B↓</td>
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<tr>
<td>Domain 2: Stroke unit</td>
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<td>E</td>
<td>E↑E</td>
<td>E</td>
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<tr>
<td>Domain 3: Thrombolysis</td>
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<td>E</td>
<td>E↑E</td>
<td>E</td>
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<tr>
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<td>D</td>
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<td>D</td>
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<tr>
<td>Domain 5: Occupational therapy</td>
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<td>C</td>
<td>C</td>
<td>C</td>
<td>E↓↓C↑↑</td>
<td></td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C↑B↑D↓↓D</td>
<td>D↑</td>
<td>D↑</td>
<td>C↑</td>
<td>B</td>
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<td>E</td>
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<tr>
<td>Domain 8: Multi-disciplinary team working</td>
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<td>C</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
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<td>A↑</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
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<td>B↓</td>
<td>B</td>
<td>B</td>
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<td>D</td>
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### Overall Scores

<table>
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<tr>
<th></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>
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</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>D</td>
<td>D</td>
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<tr>
<td>Case ascertainment band</td>
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<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>B</td>
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<tr>
<td>Combined total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
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(Source: Royal College of Physicians London, SSNAP audit)
**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 94.3%, which met the audit minimum standard of 90%. The 2016 figure was 47.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 12.2%. This is worse than expected. The 2016 figure was not significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 63.5%. This is within the expected range. The 2016 figure was not significantly different to national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 83.0%. This is better than expected. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 is 36.7%. This is within the expected range. The 2016 figure was significantly worse than the national level.

*(Source: National Lung Cancer Audit)*

**National Audit of Inpatient Falls 2017 (Royal Lancaster Infirmary)**

The crude proportion of patients who had a vision assessment (if applicable) was 15%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 6%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 5%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 86%. This did not meet the national aspirational standard of 100%.

*(Source: Royal College of Physicians)*

**Competent staff**

**Appraisal rates**

Most staff we spoke to said they had received an appraisal. However, appraisal rates were low and below the 95% target. For example, on ward 37 only 60% of staff had a current appraisal. Appraisal rates were monitored at ward level but were not monitored using the care group WESEE report. Appraisal rates were something we had asked the Trust to improve following our previous inspection.

It was not clear whether bank staff had appraisals and access to a supervision framework. One bank staff member we spoke with could not remember completing an appraisal and felt it would be helpful.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for medicine also includes data for urgent and emergency care.
As at September 2018, 73.3% of staff within medicine at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,063</td>
<td>776</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>25</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

(Source: Data request - P43 Appraisal Compliance 2017 to date)

Staff we spoke to were positive about the opportunities to develop and grow both within their current role and the wider trust.

A ward leader described being supported in their journey from being a CSW to their current role. They had a 1:1 meeting every week with their matron and told us they were also taking part in a development opportunity to help to devise a training package for aspirational ward managers.

We saw that there was a leadership education package in place and staff were encouraged to undertake this. However, staff told us this could be difficult due to staffing numbers.

Junior medical staff had a protected time for training weekly for an afternoon but, we were told by some staff this was not always possible due to staffing numbers.

We spoke to a qualified learning disability (LD) nurse. They undertook a competency framework and it had been agreed that they would undertake registered nurse training so that they would be dual registered. Staff working with them were very positive about the opportunity this presented to learn more about LD and dementia and said it gave them more of a holistic view and possible strategies to use, citing an example where a patient wasn’t eating and in fact had dental problems which hadn’t been identified before.

All staff on both stroke wards undertook STARs (Stroke Training and Awareness Resources) learning. CSWs working on either stroke ward received bespoke training from a stroke nurse and stroke therapists. A member of the therapy team told us that they provided an in-house stroke awareness training day every month which was open to therapists, nurses and CSWs to attend.

We spoke to an occupational therapist (OT) who told us that they had a dual role and 50% of their time was released for research. They were researching evidence based practice and working with a local university to build new programmes. They received OT fellowship funding for this work.

CSWs were offered the opportunity to undertake a four-year course, working 50% in staffing numbers and 50% protected time to move towards becoming a registered nurse. Staff undertaking this course told us they valued the opportunity this presented.

**Multidisciplinary working**

All staff we spoke to were very positive about multidisciplinary team (MDT) working. All groups of staff said that relationships were strong.

The trust’s MDT working functioned on three levels, firstly MDT board rounds as part of the SAFER care bundle, secondly MDTs for medical tumour groups, and lastly, wider MDTs with
partner organisations as part of discharge to assess and reductions in medically fit for discharge levels within the hospital.

We observed the end of a MDT board round led by a consultant. There was good interaction between the members of the MDT team and it was clear that the team worked well together. Everyone’s views were considered and listened to. We were told that these were attended by a range of people including consultants, doctors, therapists, nursing staff, ward managers, discharge co-ordinators and specialist nursing staff.

Patient records showed good evidence of MDT planning of care and treatment.

Staff on wards knew how to refer to specialist care including tissue viability, stroke nurse specialist and stroke physiotherapists. We spoke to a stroke physiotherapist who told us that therapy for patients is good and has improved. They explained that they use the Warrington categories to predict the length of stay for stroke patients and can provide early supported discharge. In the Huggett suite, the MDT room includes a small en suite kitchen so that occupational therapists can assess patients’ abilities in this environment.

The occupational therapy team has two referral pathways; stroke occupational therapy and non-stroke occupational therapy. All patients on ward 23 can access the relevant occupational therapy pathway to meet their specific clinical needs.

While the discharge to assess programme was provided from a specially commissioned group of occupational therapy staff, there was a perception amongst other staff teams that this was having a negative impact on ward based therapy. We found it difficult to speak to AHP’s to obtain their perception of the services.

Two teams from other organisations provided in reach services to AMU. These were the REACT (Rapid Emergency Assessment and Co-ordination Team) Monday to Friday 8am to 8pm and Rapid Response 8am to 8pm seven days a week.

Seven-day services

Inpatients and new patients who had a Non-ST-elevation myocardial infarction (NSTEMI) (a type of heart attack) travelled to Westmoreland General Hospital between Monday and Friday to receive treatment. There was no weekend service. We were told that if a patient required treatment at Westmoreland General Hospital over the weekend, they would be admitted to hospital in Lancaster and monitored pending treatment on Monday. We spoke to a member of nursing staff who reported that there had not been any adverse incidents or deaths because of a lack of weekend service.

Speech and language therapists provided a six day a week service with an on-call service on Sundays. On Saturdays, therapists prioritised new patients and those who could be discharged over the weekend and up to 1 pm on Monday. Patients who were not new, potentially fit for discharge or in the acute stroke unit did not routinely receive therapy visits at weekends. Consultants reviewed stroke patients on the Huggett Suite Monday to Friday. Stroke nurses provided cover at weekends, and deteriorating patients could be reviewed by the medical consultant on call at weekends or evenings. There was no medical stroke service at weekends.

AMU was not meeting the NHS Services, Seven Days a Week Priority Clinical Standard 8 which states that all patients should be seen and reviewed by a consultant twice daily. Over the past eight months, only 75.9% of post take patients were seen by a consultant within 14 hours.
Trust audits showed that 100% of patients who required twice daily medical reviews received these on weekdays, however this fell to 33% on weekends. The same percentage requiring once daily reviews did not receive these at the weekend.

Board rounds on medical wards took place every morning, however at weekends these were not consultant led.

CT and MRI scanning was available seven days a week on all three hospital sites.

Health promotion

On AMU we saw that staff had created a ‘dementia board’ which was displayed just outside the entrance to the ward. This contained information on services including the South Lakes Dementia Hub which provides support for patients, staff and carers.

The Huggett Suite displayed appropriate leaflets such as ‘What is a stroke’ which included the contact details for the stroke nurse specialist team.

On ward 23, two sets of leaflets (Preventing Falls in Hospitals and Hospital Home Care Team) were not up to date and should have been reviewed in 2016 and 2017 respectively. However, the patient advice and liaison service leaflet displayed adjacent to these was current and in date.

The trust was a smoke free trust and information was provided to patients on the benefits of stopping smoking prior to their visit if attending for planned treatment. Signposting to stop smoking helplines was available.

On ward 22, nursing staff were actively promoting International Stop Pressure Ulcers Day and were using costumes and literature to educate patients and staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) protects and empowers people who may lack mental capacity to make their own decisions about their care and treatment. People can lack capacity to make some decisions and not others. When someone has been assessed, using a capacity assessment and it is determined that they lack capacity to make a specific decision relating to their care and/or treatment, this can be made in their best interests, on their behalf.

The MCA allows the use of restraint and restrictions but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty.

At the previous inspection we were not assured that staff were fully aware of the requirements of the MCA and were competent to apply for a Deprivation of Liberty Safeguard (DoLS).

At this inspection, we reviewed eight DoLS records including best interest and mental capacity assessments. These were of a good standard and fully and appropriately completed. Guidance and support with completing these records was available to staff on the intranet. DoLS referrals were stored electronically, generating an automatic reminder should the application need extending seven days later. Staff confirmed that they were prompted to renew applications they had submitted. The safeguarding team held copies of all referrals.

Staff we spoke to had a good understanding of consent and the principles of the Mental Capacity Act. They told us that had training as part of the mandatory Safeguarding Adults Level 2 course. The Trust’s yearly safeguarding report indicated that the intention for the coming year was to
extend this to a ‘standalone’ session to facilitate more in-depth learning. Safeguarding Adults Level 3 was offered to applicable staff.

Staff on wards were using a passport for patients with a learning disability and had access to a matron for learning disability, autism and complex needs for further advice on capacity in these patients.

Staff told us they had good access to the psychological liaison team and would discuss referrals with patients who had capacity to agree. Where they had concerns about capacity they could do a mini mental capacity assessment. Security staff were sometimes used to sit with patients who needed extra monitoring while waiting for a psychological review. Ward staff told us that security staff had recently undertaken training in caring for people with a cognitive impairment, delivered by the dementia lead nurse. Staff told us that they felt that the way security staff spoke with and looked after patients had improved significantly since this training.

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

Staff received training on MCA and DoLS through their Safeguarding Adults Level 2 training.

Compliance rates for Safeguarding Adults Level 2 were as shown in the table below.

<table>
<thead>
<tr>
<th>Ward/Area</th>
<th>Compliance</th>
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<tbody>
<tr>
<td>Acute Frailty Unit</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Medical Unit</td>
<td>85.5%</td>
</tr>
<tr>
<td>Huggett Suite (Acute Stroke)</td>
<td>90.9%</td>
</tr>
<tr>
<td>CCU</td>
<td>81.3%</td>
</tr>
<tr>
<td>Clinical Investigations</td>
<td>90%</td>
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<tr>
<td>Day Treatment Unit</td>
<td>100%</td>
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<tr>
<td>Dermatology Unit</td>
<td>100%</td>
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<tr>
<td>Endoscopy Unit</td>
<td>75%</td>
</tr>
<tr>
<td>Lancaster Suite</td>
<td>84.4%</td>
</tr>
<tr>
<td>Oncology Day Unit</td>
<td>56.3%</td>
</tr>
<tr>
<td>Specialist Nurses</td>
<td>85.7%</td>
</tr>
<tr>
<td>Ward 20</td>
<td>81%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>81.8%</td>
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<tr>
<td>Ward 23</td>
<td>75%</td>
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<tr>
<td>Ward 37</td>
<td>75.9%</td>
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</tbody>
</table>

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

**Is the service caring?**

**Compassionate care**

We saw staff providing compassionate care. We spoke to 12 patients and two relatives throughout the inspection. They told us they had been looked after by kind staff who had been polite and respectful.
We observed staff, a volunteer and patients in the activity room on ward 22. This room had been modified to provide an engaging environment for patients. Staff were seen to maintain patients’ dignity and privacy, and engaged patients in activities.

We were advised that not all wards had a modified or engaging environment and some patients and their families told us that staff were always too busy. They felt this had resulted in lack of engagement and this had contributed to their relatives’ low mood. Staff had allowed the patient to go home on day visits to try and alleviate this. We saw that some staff were not able to respond in a timely way to patients’ requests for information during busy periods.

We saw two patients in a day room in ward 20 who were asleep and were not checked on by staff during our time on the ward. We raised concerns with the ward manager about their hydration and pressure areas. We saw that on ward 23 staff did not always have the time to sit with or speak to patients as they were rushing to complete basic care and observations.

A patient told us that they had been well looked after, however, they had felt their dignity had been compromised on one occasion.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 30% which was better than the England average of 25% from August 2017 to July 2018. A breakdown by site and ward at the trust can be found below.

**Royal Lancaster Infirmary**

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<tbody>
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<td>Daycases</td>
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<tr>
<td>RL Acute Stroke Unit - Huggins Suite</td>
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<td>100%</td>
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<tr>
<td>RL Endoscopy Unit</td>
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</tbody>
</table>

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Wards with fewer than 100 responses have been excluded.

Key: 100% 50% 0%
(Source: NHS England Friends and Family Test)

**Emotional support**

We saw that patients were well supported emotionally, and staff were caring and empathetic.

We spoke to a patient who had recently experienced a loss of mobility and cognitive impairment. They told us that staff made them feel valued, which was important to them, and they were listened to and treated with dignity and respect. They felt that they could ask any questions about their health and be supported to fully understand the answer, and that this understanding would be checked by staff.

The trust applied the butterfly scheme with which to identify patients living with dementia. We observed this in use across the care group. We observed and heard staff speaking to patients in a kind and respectful manner.

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In the acute frailty unit, we heard a patient in extreme distress. Staff were heard to be managing the patient’s challenging behaviour very well, remaining respectful and using a reassuring tone.

Understanding and involvement of patients and those close to them

Patients and their families told us that they were involved in decision making and could tell us what the plan was for their ongoing care.

We heard staff speaking with patients in a respectful and kind manner even though ward areas were busy. Ward staff told us that they were proud they could offer a high standard of care in a challenging environment. Patients spoke very highly of medical staff and confirmed that they did know what the plan was for their care and that doctors took the time to explain things properly.

We spoke to a patient living with dementia who told us that they were well fed and received good care. They felt that staff did explain their medical needs to them, and they felt safe.

We saw a ‘people important to our patient’ section within patient notes where discussions with the patient and their family had been clearly documented.

The trust supported ‘John’s Campaign’, a national initiative to encourage carers to support and stay with people with dementia while they are in hospital. The Trust uses lanyards to identify carers and this enables carers open access to those they are supporting, and they are encouraged to become actively involved in the patient’s care. We saw carers wearing their lanyards and the staff we spoke to knew what this meant.

Is the service responsive?

Service delivery to meet the needs of local people

The trust had good oversight of service planning and was responsive to the needs of local people.

Leaders were aware of the logistical and recruitment issues posed by the trust’s geography and could give examples of how they had worked hard to mitigate this, for example by ensuring that all senior staff worked across the whole bay and all three sites.

The trust took an active role in the Morecambe Bay Integrated Care Community (ICC) entitled Better Care Together. A five-year plan had been developed, outlining the proposed transformation of patient pathways and moving care closer to home.

The Royal College of Physicians’ February 2018 report on stroke services stated that the current stroke service was too small to be viable, given that it had (at the time of writing) 1.5WTE consultants. This meant that if a consultant was sick or on leave there would not even be daytime weekday cover. There was no stroke consultant presence in A&E, meaning that management of acute stroke patients in A&E was done by A&E consultants.

We were told that at weekends, the stroke specialist nurses provide weekend ward rounds. The RCP felt this was concerning and could lead to patients being nursed as having had a stroke when in fact their condition could have other causes.

While a clinical psychology service was not available to support stroke patients, they could access cognitive behavioural therapy and talking therapies. The trust was aware of the frailty of the current stroke service and the impact this had on patients.

There was an ambulatory care unit located next to both the acute medical unit (AMU) and the elderly assessment unit. All accepted patients who could be seen and discharged the same day.
The unit was open Monday to Friday from 7am to 7pm, and 8am to 4pm on Saturdays. Referrals came from GPs, A&E and clinics. The unit also ran hot clinics and Venous Thromboembolism clinics. Staff told us that they audited attendance numbers for new and follow up appointments and that the results were positive.

Liaison services were provided through a service level agreement. Staff told us that this was working well and they did not have any issues either contacting the team or receiving a timely response.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, patients with a learning disability were flagged on the Trust’s electronic system so that the learning disabilities matron was aware of any admissions and could ensure their care was appropriate.

**Average length of stay**

**Trust Level**

From June 2017 to May 2018, the average length of stay for medical elective patients at the trust was 4.8 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.0 days, which is similar to the England average of 6.4 days.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay](image)

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in general medicine is higher than the 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 elective patients in general medicine is similar to the England average.
- Average length of stay for elective patients in gastroenterology is similar to the England average.
- Average length of stay for elective patients in geriatric medicine is lower than the England average.

**Royal Lancaster Infirmary**

From June 2017 to May 2018, the average length of stay for medical elective patients at Royal Lancaster Infirmary was 5.9 days, which is similar to the England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.5 days, which is lower than England average of 6.4 days.

**Elective Average Length of Stay - Royal Lancaster Infirmary**

Note: Top three specialties for specific site based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is similar to the England average.
- Average length of stay for elective patients in cardiology is higher than the England average.
- Average length of stay for elective patients in general medicine is higher than the England average.
Non-elective average length of stay - Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.5</td>
<td>6.4</td>
</tr>
<tr>
<td>General medicine</td>
<td>5.5</td>
<td>5.9</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>10.5</td>
<td>9.6</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific site based on count of activity.

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 cardiology is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service accommodated people’s individual needs. Patients with a learning disability or dementia were well supported and we saw several examples of this on the wards.

The Trust used a butterfly symbol to identify patients with dementia on the wards. This was an opt-in scheme, and required verbal consent from the patient or their relative. The butterfly was placed both above the patient’s bed and on their electronic record. This stayed in place if the patient was transferred to another ward and ensured that staff knew extra support and care was needed.

The care of the elderly team visited all patients over the age of 65 and conducted a mini mental test with patients. Consultants conducted mental capacity assessments on the electronic patient system. Patients with dementia were coded within the assessment. All patients over the age of 75 were screened for dementia on any emergency admission.

We were told that security staff were used to supervise people with dementia. We asked if they had received appropriate training to do this. We were told that the Dementia Lead Matron had worked with security staff to deliver appropriate training and nursing staff told us that since this time they felt the practices and approach of security staff had been much improved.

In AMU, staff were using the butterfly symbol to identify people with dementia and told us that there were two dementia champions on the ward, and that these had received both internal and external training to support their roles. Staff also told us that there is a dementia matron for the Trust who oversees the delivery of the trust’s dementia strategy.

On ward 37, we checked the medical notes and care plans for two people with a learning disability. There were no learning disability nurses on the ward to provide specific input, and staff told us that other than training received at induction, they did not receive any further specific or...
refresher training regarding people with a learning disability. However, contact details for the trust learning disability lead were readily available.

We reviewed the patients’ notes and could see that their individual needs and preferences were clearly documented. We saw a ‘LD passport’ which contained comprehensive detailed information on daily living and communication preferences. Choking risks were noted and feeding plans were in place. A referral to the speech and language team had been made.

One of the people with a learning disability had complex nutrition needs. We observed them at mealtimes being fed a pureed and thickened fluid diet. Staff were supporting the person to feed and had ensured that they were appropriately supported and positioned and were adequately nourished.

The trust used dementia friendly signage and walls and floors were of contrasting colour. Signage was easily changeable to meet the shifting needs of wards.

We saw that on the frailty unit there was a qualified learning disability nurse, who had undertaken some general nursing competencies. Ward staff told us this had been valuable in helping staff to understand the patient in a holistic manner and suggested strategies for helping patients. Staff were positive about this and felt that this model should be rolled out across the trust.

We saw that patients were offered dignity and privacy when taken for intimate cares. A lady sitting in a ward area had to be taken to be changed and this was done kindly and with privacy.

The trust had access to translation services, both using the telephone and face to face. It was possible to book a British Sign Language interpreter. We did not see any patient information in additional languages. Staff told us that they had not experienced any problems using translation services.

There was a policy in place for mixed sex breaches and staff knew how to report these. There were no reported mixed sex breaches for this directorate between July 2017 and June 2018.

On both ward 20 and the Elderly Assessment Unit the nursing team incorporated a learning disability (LD) specialist nurse and a mental health specialist nurse. Staff told us that these team members were broadening the ward’s experience and providing different and valuable perspectives on care, especially around managing challenging patients with delirium.

**Access and flow**

The hospital did not have any additional escalation wards or beds open when we visited.

Medical outlying patients were seen daily by a consultant or specialist registrar. We reviewed the records of three medical outlying patients on ward 16, a gynaecological ward. These patients were seen daily by a doctor and their notes showed us that they were being appropriately cared for.

The elderly assessment unit were working with other wards to ensure patients were discharged in a timely manner. A Discharge Coordinator told us they worked towards discharge from the moment of admission. They felt the main challenges were around barriers in access to social care including working with two local authorities with different processes. Social workers were allocated to a patient, but they still felt that some issues were slow to progress.

We heard about a new ‘discharge to assess’ pathway whereby an OT would travel home with the patient and assess them in their own home rather than at hospital. If this was successful, they would leave the patient at home with planned follow up, and if not, the patient would return to the hospital. Trust audits showed this was working well and allowed patients to be assessed in a
familiar environment with their own aids and equipment. Staff told us that most of these patients had not returned to hospital and remained in their own home.

We were told that the EAU could experience issues when there was no space on wards 20 or 22 to take patients. However, the unit could keep patients there if there was a chance they could be discharged home rather than moving the patient again. The discharge co-ordinator for the unit met weekly with complex case managers. The unit described their biggest challenge as managing the expectations of patients and their relatives in terms of them accepting the type or amount of care on offer.

Staff in AMU told us that there were sometimes issues obtaining porters to take staff to and from AMU and this can cause delays. Non-clinical support staff had transferred patients to AMU to improve flow.

We noted that the trust had recently ordered badges for staff stating, “Ask me about when you will go home.” We felt this was a good prompt for patients and staff to ensure discharge was at the forefront of everyone’s mind.

We heard that the frailty unit were working with a local GP to develop a nurse led decision tool which would be electronically available to GPs. This would enable a GP to conduct a comprehensive geriatric assessment and assess whether a patient really did need to be admitted.

Thrombolysis for stroke patients took place in the emergency department seven days a week. Specialist stroke nurses provided advice and stroke consultants provided a telemedicine service to support this if needed.

We were told that ward 23 was sometimes sent patients from the Huggett suite who were not clinically appropriate as they were too poorly. We saw evidence of an incident where a patient was described on transfer as ‘critically ill’. A communication error during handover led to them not receiving a much-needed potassium infusion and they had a cardiac arrest and passed away despite CPR. While it is not possible to say if the missed infusion contributed to the patient’s death, it is evident that on occasion more poorly patients were being accommodated in ward 23.

There was no catheterisation laboratory onsite. Diagnostic percutaneous interventions were carried out at Westmoreland General Hospital. Patients requiring treatment for ST-Elevation Myocardial Infarction (STEMI) were transferred to a local cardiac centre. There was a dedicated ambulance alerting system to take patients to Blackpool in a timely manner. Both inpatients and new patients who had a NSTEMI would go to Westmorland General Hospital WGH Monday to Friday only as there was no weekend service. A sister on CCU reported that there had not been any adverse incidents or deaths because of a lack of weekend service.

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was generally better than the England average, with the trust performing better than the England average in all months other than January 2018.

In the most recent month (July 2018), the trust’s referral to treatment performance was at 100% (17 admitted pathways), in comparison to the England average of 89.2%.
Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties 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>Rheumatology</td>
<td>100.0%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.1%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

Patient moving wards per admission

From July 2017 to June 2018, 61.3% of individuals did not move wards during their admission, and 38.7% moved once or more. A breakdown by site can be found below.

- Royal Lancaster Infirmary - 62.8% patients did not move wards during their admission, and 37.2% moved once or more.

Patient moving wards at night

From July 2017 to June 2018, there were 3,292 patient moving wards at night within medicine across the trust. A breakdown by site and ward can be found below.

Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Ward moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>RLI Acute Medical Unit</td>
<td>1,344</td>
</tr>
<tr>
<td>RLI Lancaster Suite</td>
<td>124</td>
</tr>
<tr>
<td>RLI Coronary Care Unit</td>
<td>107</td>
</tr>
<tr>
<td>RLI Ward 37 RESP</td>
<td>97</td>
</tr>
<tr>
<td>RLI Acute Frailty Unit</td>
<td>74</td>
</tr>
<tr>
<td>RLI Acute Stroke Unit - Huggett Suite</td>
<td>65</td>
</tr>
<tr>
<td>RLI Ward 23</td>
<td>25</td>
</tr>
<tr>
<td>RLI Ward 20</td>
<td>14</td>
</tr>
</tbody>
</table>
Table: RLI Ward 22

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Care</td>
<td>12</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>10</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>8</td>
</tr>
<tr>
<td>Diagnosis Problems</td>
<td>7</td>
</tr>
<tr>
<td>Inadequate Care/treatment</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of Staff - Nursing</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of Staff - Consultant</td>
<td>3</td>
</tr>
<tr>
<td>Clinical Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Communication/Info to Patients</td>
<td>2</td>
</tr>
<tr>
<td>Operation - Adverse Outcome</td>
<td>2</td>
</tr>
<tr>
<td>Waiting Time for Results</td>
<td>2</td>
</tr>
<tr>
<td>Attitude of Staff - Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Dispensing Error/failure</td>
<td>1</td>
</tr>
</tbody>
</table>

Total: 1,863

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

Summary of complaints

Complaints were valued by the trust and information relating to these was disseminated at ward level using the WESEE governance tool. Wards displayed their Friends and family results and how many complaints and compliments they had received in the previous month. Posters and leaflets advising how to make a complaint were visible on wards.

Ward managers could tell us what the main theme of complaints was for their area. Staff in AMU told us that since implementing the policy of supporting carers to visit whenever they wished, they had noted an improvement in communication and a resulting reduction in complaints. Learning from complaints was shared daily at handovers and noted in the ward communication book on AMU and monthly governance meetings. We saw thank you cards on wards in staff areas.

From July 2017 to June 2018 there were 81 complaints about medical care across the trust. The trust took an average of 32.7 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 35.0 days. We reviewed the content and style of a sample complaints response to a patient and found this to be well written, offered an apology and provided an explanation of care.

Of the 81 complaints received during the 12-month period, 17 (21.0%) related to treatment given, 15 related to nursing care (18.5%), 10 related to diagnosis problems (12.3%) and nine (11.1%) related to discharge arrangements. A breakdown of complaints by site can be found below.

Royal Lancaster Infirmary

Table: Royal Lancaster Infirmary

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
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<tr>
<td>Nursing Care</td>
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<td>Inadequate Care/treatment</td>
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<tr>
<td>Attitude of Staff - Nursing</td>
<td>3</td>
</tr>
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<td>Clinical Treatment</td>
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<tr>
<td>Attitude of Staff - Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Dispensing Error/failure</td>
<td>1</td>
</tr>
<tr>
<td>Enquiry</td>
<td>1</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Medication Error</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Patient's Privacy and Dignity</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>60</td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From July 2017 to June 2018 there were 487 compliments in medicine.

The breakdown by site is shown below:

- Royal Lancaster Infirmary: 248 compliments

We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

**Is the service well-led?**

**Leadership**

Medical care was provided within the medicine care group. This care group included responsibility for the provision of emergency care. Monthly and quarterly care group review meetings provided oversight and assurance to the group leaders.

Ward leaders were effective and had good oversight of their areas. All ward leaders told us that their Matrons were very visible and visited them every day. Without exception, they told us they were well supported to do their job and felt comfortable sharing any concerns with their immediate manager.

Ward staff told us that they felt supported by the ward managers and that they thought senior managers had made themselves visible and accessible. This was evident with pictures and contact details of the chief executive around the hospital.

The trust offered leadership courses in partnership with a local college and University at levels three, five and seven, as well as bespoke internal programmes for those with specific requirements.

Staff knew how to raise whistleblowing concerns and where to find information. The whistleblowing policy was accessible on the trust intranet and internet. The trust had a freedom to speak up guardian who had built on their role since 2015, and a mobile phone app allowed staff to contact them directly and anonymously. In October 2017, the trust won the first ever national Freedom to Speak up Communications award for this dual approach.

**Vision and strategy**

The medicine care group followed the trust 2016-2019 strategy which was aligned to the wider Better Care Together health economy transformation programme. The group had a separate two-
year operational delivery plan to support strategic work. As part of the elective care clinical workstream of the Better Care Together plans, the group had worked with partners to explore and implement telehealth solutions to enable more postoperative care and assessment to be done outside the hospital environment.

The care group’s strategic plan contained appropriate planning including assessment and planning for risk, finance, estates and communications.

Trust values were prominently displayed throughout the hospital including on stairways and high traffic areas. Mirrors prompted staff to stop and take a moment to think about how they reflected these values.

**Culture**

Staff spoke very positively about the trust and morale was high. Teams supported each other very well and staff praised their colleagues for their teamwork and help. Staff told us that there had been a significant change in culture and staff no longer felt afraid to raise concerns and could be open and honest. They explained that years ago they felt there had been a blame culture but that this had now changed.

We heard from staff working at all levels on the medical wards that teamwork was very strong and that staff weren’t afraid to ‘pitch in’ with tasks as needed. Ward leaders talked about their staff as their greatest asset and most valuable resource. Staff told us that they felt there had been a marked improvement in the culture of the organisation and that the behavioural standards had made a positive difference.

We spoke to a nurse in CCU who told us that they were happy working on the ward. They felt supported by a strong team and had no concerns about working there.

We were told of a specific example of positive culture and reward where a nurse had taken a patient’s clothes home and washed them as the patient had little else. The patient was very thankful that the nurse in question had gone ‘above and beyond’ and this was recognised by Trust leaders who thanked the nurse personally.

**Governance**

Accountability structures were clear within the medicine care group and staff were confident about their role within the structure.

Ward leaders told us unanimously that they felt confident raising concerns or reporting incidents. They were all clear how to do this, using the Ulysses system, and explained that learning was fed back using minutes of ward meetings and bulletins printed and placed in staff rooms.

We reviewed the care group WESEE meeting notes. Attendance at the care group meeting was recorded in the WESEE notes and while this was good in September 2018, with representatives including the associate director of nursing, clinical leads, matrons and service managers, in previous months attendance had been very low, with less than half of those invited attending the four meetings prior. Points of actions were noted, and it was clear where issues should be escalated.
Management of risk, issues and performance

The care group WESEE monthly report monitored workforce issues such as mandatory training, incidents, lone working, efficiency, medication errors, document control, medicine audit exceptions, NICE alerts, claims and patient experience. This document did not clearly state what the targets were in all areas and there was no direction of travel visibly displayed.

Individual wards received their own WESEE reports for review at monthly team meetings. Ward leaders told us that they had regular team meetings, and in some areas, these were held at different times of the day, including evenings, to maximise attendance. These were driven by the trust’s WESEE reports.

On examination, wards were not regularly completing WESEE reports monthly. Of the nine wards we looked at, seven had not completed their last three reports and one had not shown evidence of any WESEE reports or minutes this year. This was noted at care group level in the care group-wide WESEE report, but no solution or action plan was in place to address this. The care group team were not assured that the flow of information from ward to board was in place. Attendance was not recorded in six of the 27 local reports we examined, and therefore we could not tell if meetings were always quorate. Care group leaders on ward walkabouts noted that staff did not know what the WESEE acronym was for and some staff were not aware of the incidents in their area.

Minutes of ward WESEE reports varied in quality. Some were excellent, covering lessons learnt, compliments and complaints, local staffing and environment issues, mental health updates and Trust wide and national updates and alerts. Others were very poor, featuring little or no ward specific information and no dissemination of learning from incidents. We were not assured that the ‘ward to board’ governance arrangements were therefore robust.

We were told by staff that the WESEE reports covered risk but having reviewed 27 sets of notes from a variety of wards, we could not see any specific mention of ward level risk.

We saw evidence of monthly ward audits, completed by matrons, covering the majority of CQC Key Lines of Enquiry. These were regularly discussed and there had been an increase in compliance over the last 12 months.

Care group managers outlined their top three risks as staffing levels, the urgent care pathway and mental health in the emergency department. The leadership team was honest and sighted on the physical problems caused by medical unit two being separate to the rest of the medicine wards and told us about the long-term vision of integrating these in the future.

There was a care group risk register and each risk had a named lead. Risks were stored on the Ulysses system Risk Module and could be reviewed online. Risks we identified on inspection were evident on the risk register and all risks had a review date. Risks were appropriately and fully recorded including current and planned mitigations.

We were not assured that wards had good oversight of their own risks. When asked what was on their risk register, leaders usually mentioned something of an estates nature such as decorating or suction not working. Their ‘worry list’ often featured staffing but this was not something they mentioned when discussing risk. Ward leaders told us that they would escalate any risks to their matron who would discuss it with governance who would then grade and add the risk to the register if appropriate. As a result, we were not assured that risks were known and regularly discussed at ward level.
Senior leaders had put in place clear plans for winter pressures and had worked with wider system partners to develop these. Contingency planning was also in place, underpinned by a business continuity plan which.

**Information management**

The trust was using information management systems effectively and auditing this well. A recent move to an electronic audit proposal, registration, tracking and reporting system has meant that leaders can track progress easily.

Staff told us they were provided with the right systems to do their job. The intranet was easy to navigate and find information, and the patient records system was clear and prompted staff to renew or refresh elements of patient care as appropriate. Access was also available where needed to wider systems such as those used by adult social care teams and GPs. Ward managers had access to their staff’s electronic staff records so they could view appraisal rates, sickness and training.

A new electronic ‘review workspace’ was introduced for procedural documents enabling staff to view, review and comment electronically, saving time and reducing duplication of effort.

The trust’s information governance and data quality committee monitored the implementation of the data quality strategy. Information Governance training rates were monitored at care group leadership level and was 89.8% in September 2018.

**Engagement**

The trust launched its new Patient and Public Involvement Strategy in 2018 including a ten-point action plan for involvement. There was a recognition that different groups of stakeholders would want to be listened to in a variety of different ways and there was evidence of some innovative thinking around this including the use of patient diaries.

Patient experience was captured at a variety of levels and tools were provided to encourage ward staff to collect this. Patients were encouraged to share their experience not just through the friends and family test but also drop-ins and stalls. Complaints and compliments were encouraged.

‘You said we did’ boards were used on wards to show patients what had changed because of sharing their experiences.

Staff were recognised and rewarded for long service and for their achievements at an annual awards night.

There was a guardian for safer working within the trust, however some staff even at a senior medical level were not sure what this entailed.

Staff we spoke with told us that generally they felt involved in service development and consultations. Several mentioned that the chief executive held regular ‘tea and talk’ sessions and that they felt this was a good way of being heard.

**Learning, continuous improvement and innovation**

Ward 37 had received Gold Standard Framework accreditation for their work with end of life patients and staff were very proud of this.

The safer patient flow bundle was being piloted on ward 37 and they had received good feedback on this. This had led to a reduction in length of stay from 7.3 to 4.9 days. The project was
supported by NHS Improvement and an external company. There was a project meeting every Tuesday chaired by the assistant chief nurse. Staff visited other trusts to see how it had been used there.

We saw that in the medicine care group that qualified mental health and learning disability nurses were employed on areas where there was a significant number of patients with frailty and dementia. We observed and heard that this was valuable in sharing good practice and strategies. There was a competency framework for nurses to gain knowledge of general nursing with the possibility of taking an additional general nurse qualification. The staff were keen for this to be rolled out as a model of good practice.

Staff felt that the use of Listening in Action had driven service improvements. There was a specific team to support this. Staff had accessed some ‘Dragons Den’ style funding to develop an exercise app for patients to support stroke recovery which was in use on stroke wards.

Senior leaders told us that intensive leadership work at all levels had changed how teams see each other and the quality of conversation was far better. The care group had set up cost improvement ‘mini-companies’ to decide how to split their own budget and investment in a way that is better for patient care whilst making cost improvements. The companies co-designed the investment with the support of clinicians and held regular mini board meetings. As a result, change was clinically rather than financially driven, and the companies had overdelivered on the year’s cost improvements.

Patients with haemochromatosis regularly attended the trust for bloodletting as part of their condition management. Historically it had not been possible to donate this blood. However, as the result of a suggestion from a service user, the trust has worked with the blood donation service to develop systems and protocols which meant this could happen.

The new ‘purple for purpose’ initiative, which provided purple non-slip socks to patients with a cognitive impairment to reduce falls was recently instigated, but staff told us they felt it had already had some impact in falls prevention.

The trust had invested significantly in new systems for scope decontamination. This included replacing some existing scopes. This meant that as the first location in Europe to have the current system, there was good assurance that the latest requirements were being met and patients were safer as a result.

The introduction of ordering meals for patients electronically using a hand-held device allowed patients more time to choose and had reduced waste. Patients transferring to a different ward still received their chosen food as the meal was allocated to them, rather than their bed.
Surgery

Facts and data about this service

The trust delivers its surgical services across three sites; Royal Lancaster Infirmary, Furness General Hospital, and Westmorland General Hospital.

At Royal Lancaster Infirmary, there are 136 inpatient surgical beds including the surgical assessment unit accommodated in the Centenary building and two day surgery wards within medical unit one. At Furness General Hospital, there are 92 inpatient beds, including the surgical assessment unit and a mixed sex day surgery unit, which is open 24 hours a day 4 days a week. At Westmorland General Hospital, there are 43 inpatient surgical beds across three surgical wards. The site provides elective day case surgery for breast surgery, general surgery ophthalmology, orthopaedic and urology. Surgery at the trust includes all main surgical specialties with the exclusion of vascular which is provided at the Royal Preston Hospital.

(Source: Routine Provider Information Request AC1 - Acute context, Routine Provider Information Request- Sites tab)

The trust had 35,117 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,630 (27.4%), 21,086 (60.0%) were day case, and the remaining 4,401 (12.5%) were elective.

(Source: Hospital Episode Statistics)

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

- ensure care pathways are reviewed in accordance with the trust policy;
- ensure hand hygiene audits take place monthly and that improvements are made;
- nursing documentation should include whether a patient has had food or drinks whilst in the emergency department;
- continue to improve referral to treatment times (RTT);
- increase orthogeriatrician’s input on surgical wards;
- ensure all transfers between locations are performed in line with best practice guidance and policy;
- continue to engage staff and encourage team working, to develop and improve the culture within the wards and theatre department;
- continue with staff recruitment and retention;
- ensure medicines reconciliation is completed in a timely way; and
- ensure medication fridge temperatures are checked within trust policy timescales.

During this inspection we visited main theatres, the pre-operative assessment unit, the day case unit, the acute surgical unit, wards 36 (trauma and orthopaedic), ward 33 (urology, ENT, colorectal, ophthalmology), ward 34 (urology, ENT, colorectal, ophthalmology), and ward 35 (elective orthopaedics).
We observed care being given and surgical procedures being undertaken in theatres and recovery areas. We spoke with 29 patients and relatives and 15 members of staff. We observed care and treatment and looked at 12 care records.

Is the service safe?

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 September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,269</td>
<td>1,280</td>
<td>99.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,225</td>
<td>1,278</td>
<td>95.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,220</td>
<td>1,277</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,191</td>
<td>1,277</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,105</td>
<td>1,189</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>1,172</td>
<td>1,275</td>
<td>91.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,173</td>
<td>1,281</td>
<td>91.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>932</td>
<td>1,097</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for three of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for Resuscitation - Basic life support, for which only 85.0% staff had completed the training at September 2018.

The training data submitted by the trust has been split down into the clinical care groups at the trust and we were unable to split the data into CQC core services.

The data reported included staffing figures for critical care at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

At ward level ward managers told us 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 care group senior management team had encouraged staff to increase levels of compliance and provided us with updated compliance figures as follows:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

This showed an improvement in compliance across all mandatory training modules.

**Safeguarding**

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

**Trust level**

A breakdown of compliance for safeguarding training as at September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,173</td>
<td>1,260</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still high.

The training data submitted by the trust has been split down into the clinical care groups at the trust and we were unable to split the data into CQC core services.

The data reported included staffing figures for critical care at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

At the time of inspection, we were given information which confirmed 91% of eligible staff within the care group had completed safeguarding adults and children (NHS core skills) level two.

The care group also confirmed that 79% of eligible staff within the care group had completed safeguarding adults and children level three, including Mental Capacity Act and Deprivation of Liberty Safeguards training.

The care group senior management team confirmed the trust had systems and processes in place to protect patients from abuse. We saw that the trust had current ‘adults at risk’ and ‘safeguarding children’ policies in place that staff accessed on the trust’s intranet. The safeguarding operational group reported to the quality committee which reported to the board.

Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Staff could
describe circumstances when they had made a safeguarding referral with the help of the central team.

**Cleanliness, infection control and hygiene**

The trust environmental cleaning policy outlined the commitment of the trust to maintaining a ‘...high standard of cleanliness within all clinical and public areas, through the setting and monitoring of clear hygiene standards’. To ensure this all cleaning was carried out in line with the NHS National Standards of Cleanliness, a trust wide strategic cleaning plan and audit was in place, training on infection prevention and control was available for relevant staff and cleaning schedules were in use and displayed throughout the hospital.

We saw that a cleanliness and infection prevention group was in place that reviewed patient and service user information, cleanliness and cleaning audits, records shortfalls in audits and reviews and reported significant risks to the infection prevention and control committee and the health and safety committee.

Environmental audits in the three months before inspection confirmed that all very high-risk areas met the trust cleaning standard (98%) and all significant risk areas met the trust cleaning standard (85%).

Some areas (acute surgical unit, wards 33, 35 and 36) designated as high risk did not meet the trust cleaning standard (95%). We saw that action had been identified to address shortfalls, e.g. ‘ward manager supporting actions, hotel services requested to clean under beds, flagged with non-clinical care support workers to ensure areas are cleaned in accordance with cleaning schedule and ward manager enforcing. Matron requested an additional six-month audit’ (ward 36).

Patient led assessments of the care environment (PLACE) showed the hospital scored 94% for cleanliness (national average 98%). Actions resulting from these assessments were taken forward by matrons, infection control nurses, staff and patient environment services managers.

Waste was removed and segregated from trust premises in accordance with the policy for waste management and health technical memorandum (HTM) 07-01 safe management of healthcare waste.

We saw staff washing their hands, using hand gel between patients and staff and complying with ‘bare below the elbows’ policies. Rooms were available on all wards for the isolation of patients and signage was in place to advise anyone before entering an isolation room. We saw that infection prevention and control information was visible on all wards and that staff wore personal protective equipment (PPE) and complied appropriately with the principles of infection control.

Patients were screened for healthcare acquired infections and the assessment of patients who were at risk of developing a healthcare infection were recorded in 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 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.

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

The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. We inspected resuscitation equipment in wards and surgical areas and confirmed daily checks had been undertaken. Sharps bins were properly assembled, stored off the floor, not over full and signed and dated.

Staff we spoke with reported 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.

All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked.

Assessing and responding to patient risk

The surgical care group had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. 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 updated version of the national early warning score (NEWS 2) system. The NEWS 2 electronic system had been introduced in October 2018 along with additional staff training.

The trust had undertaken walkabout sessions across surgical ward areas to identify areas of concern and provide training on NEWS in preparation for the roll out of ‘NEWS 2’ in October 2018. At the time of inspection there was 76% compliance with NEWS 2 e-learning which was in line with the trajectory to meet the trust compliance target of 95%.

Further training was taking place for matrons and ward mangers to monitor and challenge the application of NEWS 2 and improve training compliance. Further weekly audits of NEWS 2 completion and escalation were carried out on wards where initial audit scores were below 90% (ward 34).

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 National Institute for Health and Care Excellence (NICE) guidance (July 2016). We saw wards displayed posters about the risk of sepsis.

Staff we spoke with described what they would do to treat and escalate sepsis. All patients with an elevated NEWS 2 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. During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded.

In theatres, staff used the World Health Organisation (WHO) surgical safety checklist. 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 latest audits (October 2018) for the hospital showed completion of the checklist had achieved
100% compliance in all areas except for ‘did all team attend debrief for learning lessons’ (95%). This reduced the overall compliance with the checklist to 99%.

Local safety standards for invasive procedures had been developed, e.g. counts of swabs, instruments and non-retainable items in operating theatres, and national safety standards for invasive procedures had been incorporated in to the WHO surgical safety checklist.

**Nurse staffing**

The trust reported staffing numbers below for the period October 2017 to September 2018 for surgery.

As at September 2018, 83.8% of qualified nursing positions were filled across the whole trust. Nursing fill rates were below establishment at all three locations. Fill rates of 86.6%, 79.2%, and 90.3% were reported for Furness General Hospital, Royal Lancaster Infirmary, and Westmorland General Hospital respectively.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 to September 2017</th>
<th>October 2017 to September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>154.4</td>
<td>173.7</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>192.8</td>
<td>235.4</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>77.8</td>
<td>88.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>425.0</strong></td>
<td><strong>497.7</strong></td>
</tr>
</tbody>
</table>

*(Source: Data request- P16 Total Staffing)*

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 11% for qualified nursing staff working in surgery. The trust did not provide a target rate.

The data reported included staffing figures for critical care at the trust.

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

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 7% for qualified nursing staff working in surgery. This was better than the trust performance measure of 8.5%.

The data reported included staffing figures for critical care at the trust.

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

**Sickness rates**

From November 2017 to October 2018, the trust reported a sickness rate of 5.76% for medical and dental staff working in surgery.

The data reported included staffing figures for critical care at the trust.

The trust measured attendance and had a target of 95.6%.
Bank and agency staff usage

The trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we were unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 3,944 shifts for qualified nursing in surgery were filled by bank staff and 4,627 shifts were filled by agency staff. In addition, 5,478 shifts remained unfilled by bank and agency staff.

For nursing assistants, 13,466 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 3,786 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>4,365</td>
<td>0</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>8,446</td>
<td>0</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>655</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,466</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

The trust highlighted wards that had the highest bank and agency usage for qualified nursing shifts. Two of these wards were surgical, with high bank and agency usage in theatres at Royal Lancaster Infirmary (Theatres - General) and Royal Lancaster Infirmary (Theatres - Anaesthetics and Recovery). Agency usage for qualified nursing staff was particularly high in theatres at Royal Lancaster Infirmary with 1,723 shifts being filled with agency staff in the period April 2017 to March 2018.

The trust has attributed this to vacancies within the service and has highlighted plans to recruit staff to fill these vacancies.

(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 on this inspection.

Matrons and ward managers held daily meetings to identify wards most at risk of running at less than optimal staff numbers. This occasionally resulted in staff being moved from wards and areas to cover shortages on other surgical wards. We did not identify that this resulted in unsafe numbers or practice. We were told matrons worked clinically during periods of staff pressures.

We spoke with operational matrons who confirmed that staffing levels were reviewed across the trust, based on staffing numbers, the use of an acuity tool safer nursing care tool (SNCT) and professional judgement. Staff were moved between wards to reach an acceptable staffing level. The trust also 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.

Theatre staffing levels were planned according to the lists, on a daily basis.

Actions had been identified to address staffing vacancies, e.g. recruitment plans for current vacancies, sickness monitoring, the use of bank and agency nurses, monitoring of staff rotas. Longer term plans had also been developed, such as advertised vacancies and international recruitment.

The trust had initiated student nurse apprenticeships (a four-year programme that enabled healthcare assistants within the organisation to be seconded and trained).

**Medical staffing**

The trust reported staffing numbers below for the period October 2017 to September 2018 for surgery.

90.5% of medical and dental positions were filled across the whole trust. Medical fill rates were below establishment at all three locations. Fill rates of 86.7%, 92.7%, and 74.0% were reported for Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital respectively.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>64.7</td>
<td>75.3</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>143.1</td>
<td>149.2</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>3.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>215.0</td>
<td>233.0</td>
</tr>
</tbody>
</table>

(Source: Data request - P16 Total Staffing)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 9% for medical and dental staff working in surgery. The trust did not provide a target rate.

The data reported included staffing figures for critical care at the trust.

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

**Turnover rates**

From November 2017 to October 2018, the trust reported a turnover rate of 13% for medical and dental staff working in surgery. The trust did not provide a target rate.

The data reported included staffing figures for critical care at the trust. (Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**
From November 2017 to October 2018, the trust reported a sickness rate of 5.76% for medical and dental staff working in surgery. This was better than the trust performance measure of 8.5%.

The data reported included staffing figures for critical care at the trust.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

Bank and locum staff usage

The trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we were unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in surgical services from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

The trust highlighted wards that had the highest bank and medical locum usage, three of which were surgical. Medical locum usage was high on the trauma and orthopaedics ward at the hospital. The trust has attributed this to vacancies within the service and has highlighted that recruitment in these wards has either been successful or is currently being undertaken.

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,083</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>21</td>
<td>1,301</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,140</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>3,524</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

(Royal Lancaster Infirmary)

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>650</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>21</td>
<td>332</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>725</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
<td><strong>1,707</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

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

Staffing skill mix

The proportion of consultant staff reported to be working at the trust was similar to the England average (June 2018), and the proportion of junior (foundation year 1-2) staff was also similar.
Staffing skill mix for the whole time equivalent staff working at University Hospitals of Morecambe Bay NHS Foundation 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>26%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>10%</td>
<td>28%</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 care group made use of on call rota. Consultants were supported at ward level by foundation year one doctors assigned to each ward. We spoke with consultants in the theatres and there were no concerns raised about medical cover.

Junior doctors were assigned to each ward and trust data showed the trust was in line with 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.

Post-operative ward rounds were completed daily and medical outliers on surgical wards were seen by consultants from medicine.

Staffing was on the care group’s risk register because the senior management team recognised that, while it achieved safe staffing levels, the position was only maintained with close monitoring.

The senior management team confirmed that the risk register identified ongoing national and local problems in recruiting medical staff (consultant and junior grades) as a risk. It was recognised the care group had a significant challenge in meeting target staffing levels for medical staff and providing sufficiently skilled rota cover, this had the potential for adverse impacts on patient outcomes and safety, service delivery and meeting staffing level standards.

The care group had developed initiatives to increase medical staff recruitment, for example, Medical Training Initiative for breast care, trauma and orthopaedics, and ear, nose and throat.
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 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 hospital and matrons and ward managers carried out documentation audits on records in all wards, these were used to identify learning and improvement. Audits provided (November 2018) identified shortfalls in documentation e.g. wards 35 and 36, leading to action plans, learning, sharing of issues and monitoring of improvements.

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 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 always recorded on wards (wards 36 and 33). We saw temperatures had been recorded out of range and this had not been escalated. We did not receive explicit reasons from staff why this had not been done.

Registers were kept for patients’ own medication, controlled drugs and for enhanced controlled drugs. We confirmed balances for controlled drugs were correct and there were no deletions or amendments. However, we did not always see two signatures against every entry; ward managers addressed this with staff immediately.

Pharmacy technicians visited wards daily for medicines reconciliation and monthly for medicines audits.

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 September 2017 to August 2018, the trust reported three incidents classified as never events for surgery. One of the three reported never events occurred at Royal Lancaster Infirmary (the retention of part of a drain within the knee following knee replacement).
(Source: Strategic Executive Information System (STEIS))

We reviewed the root cause analysis (RCA) and comprehensive investigation (160418) carried out on this never event. The RCA detailed the background and summary of the event, the involvement and support of the patient, relatives and carers as well as the involvement and support of staff. Contributory factors including root causes as well as lessons learnt, and findings and conclusions were clearly identified.

The analysis concluded with a robust action plan, responsibilities for progress and timescales in place. This included the sharing of the RCA through the orthopaedic audit meeting (September 2018), shared with all orthopaedic wards and the recommended change to operation notes to mitigate the risk of recurrence.

**Breakdown of serious incidents reported to STEIS**

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

Of these, the most common types of incident reported were: Surgical/invasive procedure incident meeting SI criteria with seven (37% of total incidents).

- Pressure ulcer meeting SI criteria with four (21% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (16% of total incidents).
- Treatment delay meeting SI criteria with two (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (5% of total incidents).
- Operation/treatment given without valid consent with one (5% of total incidents).
- Medication incident meeting SI criteria with one (5% of total incidents)

Site specific information can be found below:

- Furness General Hospital: five incidents
- Royal Lancaster Infirmary: 11 incidents
- Westmorland General 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 example, we saw posters on wards reminding staff of best practice for identifying sepsis and for the correct administration of medication e.g. gentamicin and paracetamol.

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 methods to ensure learning was shared about incidents such as safety huddles, handovers, and during ward meetings. In addition, on the wards there were communication
folders, monthly bulletins for staff to see and read. Staff said they received feedback on incidents they had reported, including 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 associate director of nursing for the surgery care group 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 26 new pressure ulcers, 20 falls with harm and six new catheter urinary tract infections from August 2017 to August 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at University Hospitals of Morecambe Bay NHS Foundation 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
Whilst the moderate pressure ulcer harms remain in single figures, the minor harms continue to fluctuate and were a focus for improvement. From April 2018 to date the trust had developed a robust methodology for reviewing pressure ulcers for both hospital and community acquired pressure ulcers. Any harms which caused moderate harm were subject to scrutiny through the patient safety summit.

Safety thermometer results were on display on each ward. These included staffing levels, occurrence of pressure ulcers, falls and catheter acquired urinary tract infection (CUTI) as well as cleanliness, hand hygiene and cleaning audits. Compliance rates for the assessment of clostridium difficile and methicillin-resistant Staphylococcus aureus (MRSA) 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 trust participated in the ‘Getting It Right First Time’ (GIRFT) project, commissioned by the Department of Health. This covers clinical areas to support the NHS in delivering productivity and efficiency improvements through identifying areas of unwanted variation in clinical practice and divergence from the best evidence. The trust has developed GIRFT projects within ENT, maxillo-facial, ophthalmology, trauma and orthopaedics and urology services.

The care group had care plans and pathways for conditions including stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis. 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 2, 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.

The care group participated in 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 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 with fluid, food and rounding charts completed appropriately. The electronic patient record enabled staff to identify patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes.

The trust had introduced an improved fluid balance chart and policy that includes reference points for emergency conditions such as acute kidney injury.

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. Patients said food was good, menus varied, and their nutrition and hydration needs had been met.

The trust nutrition policy (January 2018) was based on National Institute for Health and Clinical Excellence (NICE) guidelines (2006) that recommended all hospital inpatients on admission and all outpatients at their first clinic appointment should be screened (weighed, measured and have body mass index (BMI) calculated) for the presence of malnutrition using the malnutrition universal screening tool (MUST). The policy instructed screening should be repeated weekly for inpatients and when there is clinical concern for outpatients.

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

From May 2017 to April 2018, patients at the trust had a lower expected risk of readmission for elective admissions and a similar expected risk of readmission for non-elective admissions when compared to the England average.
Elective admissions – trust level

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

- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Non-elective admissions – trust level

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

- General surgery patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

Royal Lancaster Infirmary

From May 2017 to April 2018, patients at Royal Lancaster Infirmary had a higher expected risk of readmission for elective admissions and a higher expected risk of readmission for non-elective admissions when compared to the England average.
Elective admissions - Royal Lancaster 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

- Urology patients at Royal Lancaster Infirmary had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Royal Lancaster Infirmary had a lower expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Royal Lancaster Infirmary had a higher expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - Royal Lancaster 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

- General surgery patients at Royal Lancaster Infirmary had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Royal Lancaster Infirmary had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Royal Lancaster Infirmary had a lower expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Royal Lancaster Infirmary

In the 2017 National Hip Fracture Database (NHFD), the risk-adjusted 30-day mortality rate was 6.9% which was within the expected range. The 2016 figure was 7.3%.
The proportion of patients having surgery on the day of or day after admission was 55.6%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 67.4%.

The perioperative medical assessment rate was 80.8%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 87.7%.

The proportion of patients not developing pressure ulcers was 95.3%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 97.6%.

The length of stay was 27.4 days, which falls within the bottom 25% of trusts. The 2016 figure was 28.1 days.

(Source: National Hip Fracture Database 2017)

The trust had introduced full time orthogeriatricians and the ‘consultant of the week’ working model which had improved co-ordination, review and consistency of care.

The trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:

- Audit number of patient deaths;
- Appoint site trauma lead;
- Record the American Society of Anaesthesiologists (ASA) physical status classification fitness of patients before surgery on the database and monitor on a monthly basis.

The following had been implemented to improve patient outcomes:

- Regular multidisciplinary team (MDT) meeting led by trauma lead and identifying every single breach of best practice tariff (BPT) and lessons learnt;
- An online dashboard had been set up which gave real time information about neck of femur fractures and BPT requirements – actions were taken daily by the trauma co-ordinators to meet BPT requirements;
- The ‘gold standard framework’ for patient scheme had been set up which facilitated hip fracture patients to be identified for next day’s trauma list and reviewed by the anaesthetic team in order to medically optimise them and assess suitability for surgical management;
- National hip fracture data base (NHFD) figures are discussed regularly in the orthopaedic business meetings and lessons learnt are shared

Actions were consistent with the key performance indicators and recommendations identified within the NHFD (2018), for example:

- ‘Hospitals should examine their own NHFD data in dashboards and run charts and those with poor rates of orthogeriatric assessment should consider the implications of this for the quality of initial assessment, preoperative optimisation, perioperative medical care, rehabilitation, discharge planning, and survival that are described in this report’.
- ‘Hospitals should examine their own NHFD data in dashboards and run charts and those with poor performance should establish what proportion of delays in surgical operations are the result of avoidable inefficiencies in preoperative planning or in the organisation of theatre lists’.
- ‘Those providing or commissioning hip fracture services must examine their run charts and dashboards, and challenge units which report low rates of THR in eligible cases, or low
rates of SHS for A1/A2 fractures – such findings would suggest that these groups of
patients are not being treated in a cost-effective way that is in line with NICE guidance’.

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, 74.8% of patients undergoing a major resection had a post-
operative length of stay greater than five days. This was worse than expected. The 2016 figure
was 70.7%.

The risk-adjusted 90-day post-operative mortality rate was 2.6% which was within the expected
range. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 19.7% which was within the expected
range. The 2016 figure was 21.9%.

The risk-adjusted 30-day unplanned readmission rate was 9.4% which was within the expected
range. The 2016 figure was 10.2%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major
resection was 52.7% which was within the expected range. The 2016 figure was 51.8%.

*(Source: National Bowel Cancer Audit)*

**Oesophago-Gastric Cancer National Audit**

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted
proportion of patients diagnosed after an emergency admission was 0.0%. 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
0.0%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%.
This was similar to 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.

*(Source: National Oesophago-Gastric Cancer Audit 2016)*

The trust confirmed an action plan was in place to address issues identified through the audit.
Actions included, for example:

- further assessment of case ascertainment rates;
- review local protocols and referral processes to ensure patients diagnosed with high grade
dysplasia are discussed at a specialist MDT;
- coordinate the patient pathway to avoid patient waits longer than necessary to start
treatment; and
- ensure surgical teams regularly monitor markers of quality of surgery and act when any
concern arises.

**National Emergency Laparotomy Audit**

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%.
Royal Lancaster Infirmary

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 81 cases.

The site 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 57 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 28 cases.

The risk-adjusted 30-day mortality for the site was within the expected range, based on 123 cases.

(Source: National Emergency Laparotomy Audit)

The trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:

- All patients listed for emergency laparotomy to have a calculated score on risk in terms of morbidity and mortality (P-Possum) performed, and a printed copy documented in the notes by the on-call registrar;
- All patients listed for emergency laparotomy to have a documented risk (percentage) of peri-operative death entered in the patient notes, together with an entry indicating that the patient has been consented; and
- Analyse deaths for audit year 2016-2017 and present at surgical audit meeting

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
- 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 for groin hernias was about the same as the England average. For hip replacements, performance was about the same as the England average. For knee replacements, performance was about the same as the England average. 
(Source: NHS Digital)

Competent staff

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for surgery also includes data for critical care.

As at September 2018, 75.6% of staff within surgery at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,055</td>
<td>794</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>18</td>
<td>17</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,073</td>
<td>811</td>
<td>75.6%</td>
</tr>
</tbody>
</table>

(Source: Data request- P43 Appraisal Compliance 2017 to date)

At the time of inspection, the trust provided information that showed the completion rate for bands 1 to 7 had increased to 80% and the completion rate for bands 8a had reached 100% resulting in an overall rate of 80%.

We discussed the rates of appraisal completion with senior managers. We were informed that appraisals were undertaken on the anniversary of the start date of a member of staff. At the time of inspection, the completion rate was above the expected rate and trajectory (75%) to meet trust targets.

Multidisciplinary working

Staff told us multidisciplinary team meetings were held each week where different specialities attended, for example occupational therapists, speech and language therapists and consultants. 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 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. Dietitians completed reviews of patients referred for their input.

Seven-day services

The trust monitored its working scheme against NHS Services, Seven Days a Week Clinical Standards. The standards highlight how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams.

‘Keogh’ ward rounds are part of the Keogh seven-day services standards, a set of guidelines developed to address variations in care for patients admitted to hospital in an emergency at the weekend.

‘Keogh’ ward rounds were introduced at the hospital in January 2017 for orthopaedic patients and had improved care at the hospital by standardising patient reviews and building communication for patients and clinicians. The ward rounds also helped to improve patient flow through the hospital as patients receive the right care at the right time from the right clinician.

The trust was working to achieve the ‘Keogh’ standards for delivery of seven-day services by the end of the 2019/20 financial year.

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 staff seven days per week and occupational therapy staff were available Monday to Saturday. On-call rota arrangements were in place for out of hours.

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 languages other than English but were assured they were available on request and saw that all available leaflets stated they could be accessed in different languages and formats.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

At the time of inspection, we were provided with information that showed 79% of staff in the care group had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training.

Patient led assessments of the care environment (PLACE) showed the hospital scored 65% for meeting the dementia needs of patients (national average 79%). The trust had developed action plans from these assessments monitored by matrons.
We discussed the application of the MCA and DoLS with staff on wards and we were given inconsistent information. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained. We did not receive assurance that MCA assessments were formally recorded as we did not find completed assessment forms in relevant patient records in all instances.

Staff we spoke with said that DoLS were completed by nursing staff but we were unable to find applications in all relevant patient records we reviewed as they had not been completed, even though ward staff indicated that the patient should have a DoLS in place or was under constant supervision.

Staff we spoke with told us they held best interest meetings for patients who lacked capacity to make decisions for themselves, however we did not see evidence in all relevant patient records we reviewed to support this. There was no evidence of capacity assessment in the records where DNACPR forms were in place. There was no additional information in place in the records to support a ‘yes/no’ answer.

We raised these issues with the senior management team at the time of inspection.

The trust had Mental Capacity Act (July 2018) and Deprivation of Liberty Safeguards (July 2018) policies in place and staff had accessible guidance and information if needed.

The MCA policy defined staff responsibilities, enabling people to make decisions, capacity assessments, documentation required, consent, best interest decisions and statutory duties. The DoLS policy defined what is a deprivation of liberty, who is covered by DoLS, when a DoLS should be used, applying for standard and urgent authorisations and support available through the application process.

### Is the service caring?

**Compassionate care**

**Friends and Family test performance**

A breakdown of FFT performance can be found below:

**Royal Lancaster Infirmary**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>% of respondents recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Case</td>
<td>1368</td>
<td>36%</td>
<td>88%</td>
</tr>
<tr>
<td>RU Acute Surgical Unit</td>
<td>1224</td>
<td>45%</td>
<td>87%</td>
</tr>
<tr>
<td>RU Ward 33 General Surgery</td>
<td>447</td>
<td>32%</td>
<td>85%</td>
</tr>
<tr>
<td>RU Ward 35</td>
<td>418</td>
<td>55%</td>
<td>97%</td>
</tr>
<tr>
<td>RU Ward 34</td>
<td>403</td>
<td>36%</td>
<td>87%</td>
</tr>
<tr>
<td>RU Ward 36</td>
<td>211</td>
<td>31%</td>
<td>90%</td>
</tr>
<tr>
<td>RU Admission Lounge</td>
<td>116</td>
<td>130%</td>
<td>100%</td>
</tr>
<tr>
<td>RU Female Day Surgery Unit</td>
<td>112</td>
<td>63%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Wards with a response rate of less than 100 have been removed.

| Key | 100% | 50% | 0% |

(Source: NHS England Friends and Family Test)

National data (NHS England, July 2018) showed 95% of respondents were highly likely or likely to recommend surgical services.
At the time of inspection, we confirmed that the FFT score of respondents highly likely or likely to recommend ward 36 was 92%. The response rate for FFT completion was 40%, higher than the England average of 25%. Each ward displayed their friends and family test results as well as ‘two minutes of your time’ feedback and ‘you said, we did’ responses.

Displays within wards showed overwhelmingly positive comments from patients and all patients confirmed their care and treatment was effective. All patients spoken with commented that staff were friendly, supportive, caring and respected their privacy and dignity. Staff 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.

We saw staff responded promptly to call bells or requests for assistance and had enough time for patients and introduced themselves; this was confirmed by all patients spoken with. All patients 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.

Patient led assessments of the care environment (PLACE) showed the hospital scored 75% for caring (national average 84%). Actions had been identified based on these assessments and had been taken forward by matrons, staff and patient environment services managers.

**Emotional support**

There was a room available on wards visited for the use of patients and families and for staff to hold discussions with patients if they were distressed. Ecumenical chaplaincy services were available and easily accessible when requested. The chapel was available on site and was open for all faiths.

Staff knew of active support groups for patients that provided emotional support as well as practical advice. 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.

The trust used the ‘butterfly’ system to identify patients with a dementia. We saw this in use in all wards and heard staff speaking to patients in a kind and respectful manner.

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

Through reviewing patient notes and observation of interactions staff had with patients we were assured staff had tried to understand patient needs and of those close to them.

All patients spoken with told us they knew what was happening with their care and what their treatment plans were. 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.

The wards worked with relatives, different services and staff to organise and manage discharges. This process was managed by discharge co-ordinators on wards and had improved discharge timescales and minimised patient waits.
All wards involved relatives in the care of patients. Staff were flexible with visiting times, provided information regarding current care and treatment and displayed information regarding dementia care. The trust supported ‘John’s Campaign’, a national initiative to encourage carers to support and stay with people with dementia while they are in hospital.

### 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 a five-year trust strategic and operational plan which included surgery and a care group business plan was also in place. Senior managers described working with business managers, the clinical director and matrons to plan services.

The senior management team confirmed the care group’s priority was to deliver high quality, safe services that meets the needs and expectations of patients through the ‘Better Care Together’ programme. This is a clinically led, health economy-wide integrated care community that is the main route through which the trust’s long-term future is delivered. A strategy to support ‘Better Care Together’ had been developed to provide staff, local communities and regulators with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

The majority of inpatient elective surgery had been transferred from the two main sites in Lancaster and Barrow in Furness to Westmorland General Hospital. Focusing elective surgery on one site rather than three sites had the aim of increasing the quality of care and outcomes for patients. This ensured that the care group had enough permanent specialist staff to cover rotas effectively across two sites, mitigating the need to cancel operations at short notice. Further, surgical teams have become more proficient through concentrating specialist services at either Royal Lancaster Infirmary or Furness General Hospital.

The senior management team was aware of the logistical and recruitment issues posed by the trust’s geography and could give examples of how they had worked hard to mitigate this, for example by ensuring that all senior staff worked across the whole bay and all three sites.

Systems were in place to assist in the delivery of care to patients in need of additional support. For example, patients with a learning disability were flagged on the trust’s electronic system so that the learning disabilities matron was aware of any admissions and could ensure their care was appropriate.

#### Meeting people’s individual needs

The care group had created a surgical emergency ambulatory care unit to improve patient experience, improve patient flow, avoid unnecessary admissions, and better use staff resources.

This also helped the care group further move to a seven-day service. The initiative has resulted in reduced attendances in the emergency department, improvements in patient flow and reduced surgical admissions.

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, and the trust used the ‘butterfly’ system to identify patients living with dementia. Specialist qualified learning disability and mental health nurses had been recruited to
ensure individual patient needs were met. We saw care support workers were providing support to bays of six vulnerable patients at risk of harm, supporting them with meals and drinks and engaging them in conversation. This has resulted in reductions in falls and pressure ulcers.

The hospital had introduced standardised products, designated storage areas and created education packs for pressure relieving products. Pictorial booklets had been created for each ward and visual clocks trialled which indicated when a patient last had pressure relief. Pocket mirrors had been purchased to check patients’ heels. These initiatives had resulted in increased periods of days free from acquired pressure ulcers.

In response to patients who also had challenges based on their eyesight negatively impacting on their experience in hospital, the ophthalmic nursing team had timetabled slots to allow the outreach of skills to patients on wards at the hospital. This resulted in a holistic approach to patient care and better supported patients’ needs while they were being treated for other conditions.

There were a variety of patient information leaflets available in wards which could also be provided in other languages and formats if required. A comprehensive and user-friendly booklet to support patients awaiting surgery had been developed. This provided patients with clear information to support their preparation for surgery and improve the patient experience and enable informed choices as well as better theatre use.

Staff had access to specialist advice within the hospital, for example, tissue viability, mental health and pain relief. Staff we spoke with told us they could contact 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’ religious needs, dietary requirements, and hearing, sight or language difficulties were identified through assessments recorded on the electronic patient record. 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 with a dementia, learning disabilities or mental health conditions. Wards and departments were accessible for patients with limited mobility and people who used a wheelchair.

Wards had literature and resources available for people living with dementia and those caring for them. Ward areas were dementia friendly, i.e. red door frames and toilet seats. We saw wards and departments had areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms. Staff we spoke with showed us resources they used for patients living with dementia. They had access to books, photocards, playing cards and dominoes.

Patients requiring supervision to prevent falls were supported and we observed staff using appropriate distraction techniques with patients.

Staff could give examples of when reasonable adjustments had been made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients’ care and emotional needs. An example given was the arranging and holding a wedding on the ward. This was confirmed through feedback from patients and relatives spoken with during the inspection.
Access and flow

Average length of stay

Trust Level

From June 2017 to May 2018, the average length of stay for elective patients at the trust was 3.3 days, which is lower compared to the England average of 3.9 days. The average length of stay for all non-elective patients at the trust was 5.6 days, which is higher compared to the England average of 4.9 days.

Elective Average Length of Stay – trust level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>4.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Urology</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>General surgery</td>
<td>2.4</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at the trust was 4.4 days, which is higher compared to the England average of 3.8 days.
- The average length of stay for urology elective patients at the trust was 2.0 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for general surgery elective patients at the trust was 2.4 days, which is lower compared to the England average of 3.9 days.

Non-Elective Average Length of Stay – trust level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>General surgery</td>
<td>4.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>10.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is similar compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.0 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at the trust was 2.6 days, which is similar compared to the England average of 2.9 days.
Royal Lancaster Infirmary

From June 2017 to May 2018, the average length of stay for elective patients at Royal Lancaster Infirmary was 4.2 days, which is similar compared to the England average of 3.9 days. The average length of stay for all non-elective patients at Royal Lancaster Infirmary was 5.5 days, which is higher compared to the England average of 4.9 days.

**Elective Average Length of Stay - Royal Lancaster Infirmary**

![Bar chart showing elective average length of stay for different specialties at Royal Lancaster Infirmary and England average.]

**Note:** Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at Royal Lancaster Infirmary was 6.1 days, which is higher compared to the England average of 3.8 days.
- The average length of stay for general surgery elective patients at Royal Lancaster Infirmary was 3.1 days, which is lower compared to the England average of 3.9 days.
- The average length of stay for urology elective patients at Royal Lancaster Infirmary was 2.1 days, which is similar compared to the England average of 2.5 days.

**Non-Elective Average Length of Stay - Royal Lancaster Infirmary**

![Bar chart showing non-elective average length of stay for different specialties at Royal Lancaster Infirmary and England average.]

**Note:** Top three specialties for specific site based on count of activity.

- The average length of stay for general surgery non-elective patients at Royal Lancaster Infirmary was 3.5 days, which is similar compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Royal Lancaster Infirmary was 10.7 days, which is higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at Royal Lancaster Infirmary was 2.5 days, which is similar compared to the England average of 2.9 days.

(Source: Hospital Episode Statistics)
Staff told us discharges were organised and managed during daily and weekly ward meetings and multidisciplinary team meetings on the wards and staff worked with the ward based discharge co-ordinator to ensure discharges happened as effectively as possible. Discharge co-ordinators developed relationships with local social services and care homes to facilitate discharges.

The trust had developed a performance dashboard to improve patient flow and which gave a summary of performance for a range of measures, including elective metrics at care group level. The dashboard allowed performance to be reviewed at trust, care group, specialty, site and individual consultant. The dashboard reported metrics, for example, cancer waits (seven days, sixty-two days), referral to treatment time and waiting list size.

A theatre dashboard had also been created and utilised data from the electronic theatre module to plan theatre sessions, scheduling and to challenge inefficiency (e.g. start and finish times, turnaround times between patients, cancellations).

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From August 2017 to July 2018, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which is worse than the England average of 67.0%.

*(Source: NHS England)*

**Referral to treatment (percentage within 18 weeks) – by specialty**

Performance for the ENT specialty was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>66.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>73.9%</td>
<td>76.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>65.0%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.4%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>45.5%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>39.5%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>
We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the care group. From August 2017 to July 2018 the trusts performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.

At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve waiting list size and RTT waits. Senior management explained that bed pressures, nurse and theatre staffing had impacted on RTT waiting times.

**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.

From July 2016 to June 2018, the percentage of patients at the trust whose operation was cancelled and were not treated within 28 days was lower than the England average. In Q1 2018/19, the trust cancelled 77 surgeries. Of these, all were treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days** - University Hospitals of Morecambe Bay NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust showed a similar trend to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. In Q1 2018/19, less than 1.0% of elective operations at the trust were cancelled.

**Cancelled Operations as a percentage of elective admissions** - University Hospitals of Morecambe Bay NHS Foundation Trust

(Source: NHS England)
Learning from complaints and concerns

From July 2017 to June 2018, there were 120 complaints about surgery. The trust took an average of 33 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 35 days.

Of the 120 complaints received during the 12-month period, 27 (22.5%) related to a diagnosis problem, 23 related to adverse outcomes following an operation (19.2%), 11 related to treatment given (9.2%) and 10 (8.3%) related to operation cancellation. A breakdown of complaints at Royal Lancaster Infirmary can be found below:

**Royal Lancaster Infirmary**

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Problems</td>
<td>18</td>
</tr>
<tr>
<td>Operation - Adverse Outcome</td>
<td>14</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>7</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>7</td>
</tr>
<tr>
<td>Operation (IP) Cancellation</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Treatment</td>
<td>4</td>
</tr>
<tr>
<td>Attitude of Staff - Nursing</td>
<td>4</td>
</tr>
<tr>
<td>Attitude of Staff - Doctor</td>
<td>2</td>
</tr>
<tr>
<td>Attitude of Staff - Consultant</td>
<td>2</td>
</tr>
<tr>
<td>Communication/Info to Patients</td>
<td>2</td>
</tr>
<tr>
<td>Inadequate Care/treatment</td>
<td>2</td>
</tr>
<tr>
<td>Transfer Arrangements</td>
<td>2</td>
</tr>
<tr>
<td>Waiting Time for Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Access to Services</td>
<td>1</td>
</tr>
<tr>
<td>Administrative Procedures</td>
<td>1</td>
</tr>
<tr>
<td>Appointment (OP) Cancellation</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>1</td>
</tr>
<tr>
<td>Cancellation of Admission</td>
<td>1</td>
</tr>
<tr>
<td>Operation (IP) Delay</td>
<td>1</td>
</tr>
<tr>
<td>Personal Records (Medical)</td>
<td>1</td>
</tr>
<tr>
<td>Waiting Time Outpatient Appt</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

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

Staff and ward managers confirmed 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 was also given at staff meetings.
All wards had patient information leaflets available and displayed posters for the patient advice and liaison service.

**Number of compliments made to the trust**

From July 2017 to June 2018 there were 300 compliments recorded in surgery, of which 118 compliments were recorded at the Royal Lancaster Infirmary.

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

**Is the service well-led?**

**Leadership**

The care group had a triumvirate management structure in place with clear lines of responsibility and accountability. The care group was managed by an overall senior leadership team which included a clinical director, associate chief nurse and assistant director of operations. Each ward visited had a ward manager in place, ward sister and a matron with overall management responsibility.

The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care. During our meeting the team were aware of the main risks affecting service delivery and could explain the actions they had taken to mitigate.

Staffing levels were planned so that ward managers were given management time with other senior nurses in their teams. All ward managers and sisters said they were supported well by their matron and the senior management team. They said members of the board, particularly the chief executive, were visible and approachable.

During this inspection we saw matrons regularly on wards and were told some matrons had undertaken clinical duties to cover staff shortages.

**Vision and strategy**

We discussed the care group vision and strategy with the senior management team. The current strategy was designed to provide services on an elective and acute basis, reconfigured over the three sites, concentrating non-elective services on the two main sites. Emergency pathways were in place and all emergency orthopaedic procedures were carried out at Royal Lancaster Infirmary and Furness General Hospital.

The senior management team acknowledged the difficulties in covering the anaesthetic rota at Furness General Hospital and informed us that recruitment had recently been made ensuring the rota would be covered across the trust through the re-alignment of staff across the trust.

We asked senior managers about planning the services and were told there was a five-year trust strategic and operational plan which included surgery and a care group business plan was also in place. Senior managers described working with business managers, the clinical director and matrons to plan services.

The senior management team confirmed the care group’s priority was to deliver high quality, safe services that meets the needs and expectations of patients through the ‘Better Care Together’ programme. This was a clinically led, health economy-wide integrated care community that was the main route through which the trust’s long-term future is delivered.
A strategy to support ‘Better Care Together’ had been developed to provide staff and local communities with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

Culture

All staff we spoke with during the inspection told us there was good teamwork, openness and morale was good. We held focus groups with staff before this inspection. There was an overwhelmingly positive view of how much the trust had improved in terms of clear leadership, motivation, recognition of achievement and teamwork.

Staff told us the care group had strong leadership and senior managers were visible and engaged with staff. We interviewed 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 reiterated that high quality care was a priority. All staff were clear about their roles and responsibilities, patient-focused, worked well together and felt they received appropriate support from management to allow them to perform their roles effectively.

Nursing staff reported a positive culture and good working relationships between staff groups. Ward managers 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 monthly surgery governance and assurance meeting for the care group. Minutes confirmed the meetings were well attended and discussed issues around workforce effectiveness, safety, experience and efficiency (WESEE). Specifics included compliance with training, audits, incidents, RCAs, risk registers, IT and updates to national guidance.

There were departmental governance meetings which provided information to the monthly surgery and governance assurance meeting which then reported by exception to the surgery management board. In addition, there was also a weekly meeting for service managers, matrons and corporate support teams which was chaired by the associate director of operations.

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 governance meetings and quality and safety meetings. The senior management team were able to describe the risks to services, for example referral to treatment performance.
The care group risk register 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 meeting referral to treatment targets, medical and nursing recruitment, anaesthetist recruitment, meeting screening standards and referral to treatment targets within the breast screening unit and achieving planned income and expenditure. 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. This ensured patients who had a disability, impairment or sensory loss were given information that they were able to access and understand. The care group also developed and implemented a specific surgical pathway for adults with learning difficulties.

To support information management the trust had policies in place for information sharing (July 2018), information risk (February 2018) and information security (February 2018).

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**

The trust had developed a patient and public involvement strategy (January 2018). This confirmed the trust commitment to engage effectively with the local community, ensure stakeholders were aware of the trust’s work, successes and challenges. It specifically expressed the trust’s commitment to listen and learn from what local people say about services.

This achievement of the aims of the strategy were supported through national and local satisfaction surveys, patient experience information panels, patient stories and diaries and feedback through comments, concerns, compliments and complaints from individual service users and members of the public. People using the service were encouraged to give their opinion on the quality of service they received. The care group carried out ‘two minutes of your time’ surveys to gather feedback on services from patients.

Leaflets about the friends and family test, and the Patient Advice and Liaison Service (PALS) were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards and letters displayed at the entrances to wards. The care group facilitated a listening event for breast care patients in October 2018 in response to issues raised by a member of the council of governors.
We saw staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families. Matrons and ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.

**Staff engagement**

The national NHS staff survey (2017) showed the trust scored 3.79 (out of five) for an overall indicator of staff engagement. This is the same (3.79) when compared with other trusts of a similar type.

We were told the care group had improved leadership and accountability to create a better culture for staff. Specific changes had been made, such as increasing the numbers of clinical leaders within theatres, the introduction of a staff voices forum, ‘back to the floor’ sessions for the senior management team, weekly discussions about good and bad behavioural practice and sessions to promote the trust behavioural standards framework.

The staff voices forum was an open session for staff to drop in and discuss their issues. Concerns raised had been acted upon and feedback given.

Senior managers 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 manager, receive feedback and discuss concerns. Staff we spoke to said they felt appreciated by the ward manager and sisters and senior managers and felt listened to when they raised concerns.

**Learning, continuous improvement and innovation**

The care group had developed initiatives to improve and enhance care and treatment:

- Commitment to meeting the needs and expectations of patients through the ‘Better Care Together’ programme.

- The majority of inpatient elective surgery had been transferred from the two main sites in Lancaster and Barrow in Furness to Westmorland General Hospital. Focusing Elective surgery on one site rather than three sites had the aim of increasing the quality of care and outcomes for patients. The creation of a surgical emergency ambulatory care unit to improve patient experience, improve patient flow, avoid unnecessary admissions, and better use staff resources and the reduction in attendances in the emergency department, improvements in patient flow and reduced surgical admissions.

- Specialist qualified learning disability and mental health nurses had been recruited to ensure individual patient needs were met.

- Care support workers were providing support to bays of six vulnerable patients at risk of harm, supporting them with meals and drinks and engaging them in conversation. This has resulted in reductions in falls and pressure ulcers.

- The hospital had introduced standardised products, designated storage areas and created education packs for pressure relieving products. Pictorial booklets had been created for each ward and visual clocks trialled which indicated when a patient last had pressure relief. Pocket mirrors had been purchased to check patients’ heels. These initiatives had resulted in increased periods of days free from acquired pressure ulcers.
• The ophthalmic nursing team had timetabled slots to allow the outreach of skills to patients on wards at the hospital. This resulted in a holistic approach to patient care and better supported patients’ needs while they were being treated for other conditions.

• Wards and departments had areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms.

• A comprehensive and user-friendly booklet to support patients awaiting surgery had been developed. This provided patients with clear information to support their preparation for surgery.

• Reasonable adjustments had been made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients’ care and emotional needs. An example given was the arranging and holding a wedding on the ward.

• Albert’s campaign to improve hydration

• Food bank – supporting the local community

• Red box

• ICU follow-up clinic and café
Furness General Hospital

Date of inspection visit: 14 November to 14 December 2019
Date of publication: 15 May 2019

Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

There are Emergency Departments at both the Royal Lancaster Infirmary and at Furness General Hospital, with supporting medical and surgical assessment units and ambulatory care facilities. These are consultant led.

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

Activity and patient throughput

Total number of urgent and emergency care attendances at University Hospitals of Morecambe Bay NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018.
From August 2017 to July 2018, there were 93,223 attendances at the trust’s urgent and emergency care services as indicated in the chart above. The trust told us approximately 22,000 of these were children under the age of 18. Furness General Hospital (FGH) saw approximately 7000 children each year.

(Source: NHS England)

**Urgent and emergency care attendances resulting in an admission**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,360</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td>60,210</td>
<td></td>
</tr>
<tr>
<td>Referred^</td>
<td>6,976</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,985</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>163</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>1,517</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>550</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>69</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?

Mandatory training

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Although the trust only met the 95% target in two of the mandatory training modules, mandatory training figures were mostly only slightly below target with only health and safety, basic life support and general fire safety awareness below 90%

Trust level

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in urgent and emergency care inclusive of staff working in medicine is shown below. We requested this information just for urgent and emergency care at Furness General Hospital (FGH) broken down by staff group however the trust was unable to provide us with this information.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,251</td>
<td>1,285</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,228</td>
<td>1,282</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,178</td>
<td>1,284</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,168</td>
<td>1,281</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,061</td>
<td>1,179</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,142</td>
<td>1,289</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>882</td>
<td>1,107</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>978</td>
<td>1,273</td>
<td>76.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the 95% target was met for two of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the general fire safety awareness module, for which only 76.8% staff had completed the training at September 2018. Staff who had not undergone training were scheduled to attend training in the future.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for the medicine core service at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)
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 as at September 2018 at trust level for all staff in urgent and emergency care inclusive of staff working in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,174</td>
<td>1,275</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

In urgent and emergency care, the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was not much below the target.

We asked the department for additional information about safeguarding training. The department manager provided us with figures for the Emergency Department (ED). For adult safeguarding level one, compliance was 100%, for level two, 79% and for level 3, 88%. Other than for level one, this fell below the trust target of 95%.

Staff working in an emergency department are expected to hold at least level two safeguarding for vulnerable adults and level three safeguarding for children. The trust was unable to provide us with assurance that all appropriate staff had received training to the correct level.

However, when we spoke with two Registered Sick Children’s Nurses (RSCNs) they told us they had attended level three training and described the face to face course and content to us in detail. They were very aware of their responsibilities relating to children and young people who attended the department.

We spoke with other adult trained staff about safeguarding processes. We also spoke with the trust lead for safeguarding. Each could describe robust processes in place for making sure vulnerable adults and children were identified and action taken to protect them.

The department had a safeguarding nurse lead who also delivered safeguarding supervision to staff. Both they and the trust lead told us safeguarding supervision was a priority in the trust. This was corroborated by staff who told us they were offered safeguarding supervision, so they could discuss cases and share experiences.

We saw documentation in the department to support staff assessing children and the electronic medical record had mandatory fields staff had to complete as part of their nursing care and assessment. This made sure staff asked the most important and appropriate questions of parents and children.

Staff within the department could access a flow chart to guide them of any action they should take. It was accessible to staff at reception and throughout the department.
The department had two senior RSCN who oversaw safeguarding processes in the department and escalated problems to the trust wide safeguarding team. The trust safeguarding department liaised with school nurses and health visitors to ensure information was shared between organisations.

The trust held daily cross site safeguarding huddles. We attended one to observe what the meeting involved. We saw senior staff from the ED and trust safeguarding team discuss any safeguarding referrals from the previous day to make sure the appropriate action was taken for each one. Any feedback from multi agency meetings with the local authority and police was also shared with staff.

**Cleanliness, infection control and hygiene**

When we visited the department, we found it to be visibly very clean. Patient rooms were cleaned between patients and waiting area floors and seating were in excellent order. Patient toilets were clean.

Staff could call cleaners to the department if required however, cleaners worked across the trust and the department had a dedicated cleaner throughout our inspection.

We found the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces. The cleaning staff were very thorough.

There were cleaning schedules in place and we saw completed paperwork confirming that cleaning had been carried out. They were signed and dated. We saw staff completing the required tasks in line with schedules.

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 gloves, aprons and masks available to staff. We routinely saw staff using this. Latex gloves and other equipment were disposed of correctly during our inspection.

We noted all staff were bare below the elbow in line with infection prevention and control policies.

In the paediatric waiting area, toys were infection control compliant because they were made from washable and wipe clean materials and they had regularly been cleaned thoroughly.

Staff in the medicine directorate (of which ED is part) were meeting the trust’s training target of 85% for infection prevention and control although this information could not be split to specifically show compliance rates for ED at FGH.

The department had some solid walled cubicles for patients who required isolation for the prevention and management of actual or potential infection. Most cubicles had curtain fronts. Curtains were clean and easily replaced as and when required.

We looked at the areas where equipment was cleaned, and these were visibly clean and there were cleaning schedules in place for all equipment. Equipment in this area was clean and had ‘I’m clean’ stickers in place.

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

At the time of our inspection, the department was undergoing building work to expand the footprint, enable more cubicles, more resuscitation space, better facilities for patients and improve the general flow of the department. As a result, the department was working within a restricted footprint at the time of the inspection.

In its current layout, the department only had one resuscitation bay. This had been a long-standing challenge for the department. At the time of our inspection, the resuscitation bay was occupied because of an incident. This meant the department had no available resuscitation space if there was an emergency and no way of vacating the room in use. Once the new expanded department opened, this would no longer be a risk; however, there was a current risk that patients could not be managed in an appropriate place if they required resuscitation.

Consulting and treatment cubicles were an appropriate size and contained the necessary patient equipment. Most cubicles had solid walls. Some had solid doors, and some had curtains to maintain privacy.

All rooms had emergency buzzers. We noted buzzers were placed in reach of patients during our inspection.

The department had a room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination.

We found equipment in the department had been safety checked. All 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 that if one suffered a mechanical breakdown, a spare machine was available.

We checked some of the stock held in the store rooms. We found stock was all in date and rotated appropriately.

We looked at resuscitation trolleys. All trolleys were appropriately sealed. This meant that staff in the department did not have to carry out resuscitation trolley checks.

The waiting areas used by patients were spacious with sufficient seating for patients and relatives. They adult area had natural light making it a more pleasant environment for patients.

Both the adult and paediatric ED waiting rooms were close to the main entrance. The waiting rooms were clean, light and airy. There was a separate secure waiting area suitable for children and young people. The paediatric waiting room had glass walls and a door to make sure children were visible but separate from adults. It was decorated in a child friendly way.

The department had no specific room suitable for adult and paediatric patients with mental health conditions. The department currently used the relatives’ room next to the exit or one of the cubicles. These were not suitable rooms because they were not ligature point free, had standard furniture that could be used as a weapon, did not have two exits and did not meet PLAN (psychiatric liaison accreditation network) standards. We discussed whether there would be a designated mental health room that met PLAN standards as part of the new build. Staff in the department and senior managerial staff told us they had made a conscious decision not to have a mental health room and there were no plans for a designated room in the new build. Managers told us staff had access to ligature cutters to mitigate the risk of patients strangling or hanging themselves. We were concerned about this because there was no safe place for patients with a
mental health condition whilst they waited for assessment by the mental health team. This was still a risk for the patient, other patients and staff.

The trust had carried out training for staff about ligature point management and had a policy in place however, we still had concerns that patients were at risk of harm using ligatures.

The current layout in the department meant the more acutely unwell patients were accommodated closer to the nurse or doctor station. This meant they were constantly in sight of staff who observed for signs of changes.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored “about the same” as other trusts for all five of the five Emergency Department Survey questions relevant to safety.

<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>7.8</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>6.7</td>
<td>About the same as 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>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</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>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median in all twelve months from August 2017 to July 2018. In July 2018, the median time to initial assessment at the trust was 10 minutes compared to the England average of eight minutes. However, this was still better than the national target handover time of 15 minutes.
Ambulance – Time to initial assessment from August 2017 to July 2018 at University Hospitals of Morecambe Bay NHS Foundation Trust

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

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

Furness General Hospital

From September 2017 to August 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Furness General Hospital, with a performance ranging from 28% to 43%. It is important to note that turnaround time also includes time for the ambulance crew to prepare the vehicle ready to return to the road. Therefore, turnaround time is not always a good indicator of how quickly patients are handed over to the hospital.

In the latest month, August 2018, 34% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Furness General Hospital

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 July 2017 to June 2018, the trust reported 233 “black breaches”, with the highest number of breaches being reported in July 2017 (34), February 2018 (26), November 2017 (25), and

(Source: National Ambulance Information Group)
December 2017 (25). This information was not available split by site. The graph below however does show that the department had experienced black breaches not only over the winter period but throughout the year.

![Number of Black Breaches - UHMB NHS FT](image)

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

The department had a robust system in place for assessing patients who attended the department. Reception staff had received training about how to identify a poorly patient and used a flow chart to assist them. If they had concerns about the wellbeing of a patient they escalated this to the triage nurse if the patient had not yet been assessed, or to other staff if a patient deteriorated whilst waiting to see a doctor.

Patients were triaged on attendance by a qualified nurse who assessed each patient, gave pain relief if it was required and carried out basic observations. They could also request x-rays and perform tests such as electrocardiograms (ECGs). The triage nurse then categorised the patient about how urgently the patient needed to be seen.

The management team told us staff could only triage patients after they had been in post for more than 12 months. They were then supervised rather than having formal triage training. The management team acknowledged this presented a risk; however, the practice educator was working on developing training sessions for staff.

Nursing staff who carried out triage were experienced and deemed competent to fulfil this important role. Staff tended to do half shifts of triage and then moved to the department to undertake other duties.

We observed triage of walk in patients and ambulance patients and found the processes to be robust.

Patients with allergies were identified at triage and given a red wrist band to highlight the allergy.

The department used the National Early Warning Score (NEWS) to monitor patients. Dependent upon their NEWS score (a combination of observations used to calculate how unwell they are) we saw patients having observations carried out in a timely manner to make sure they were not deteriorating. Generally, the higher the NEWS score, the sicker the patient and the more
frequently they should be observed. When we looked at clinical records, we saw observation frequency was in line with NEWS scores.

The department had processes in place to manage deteriorating patients and took timely action to treat patients when this happened.

We looked at incidents recorded about the department over the previous 12 months. Some of these were raised by other departments about ED. We found 10 incidents classified as delayed diagnosis or delayed treatment. These included delays to commencing sepsis pathway (2), delayed administration of medication such as pain relief, antibiotics and blood pressure medication and observations missed. Therefore, although there was a system in place, there had been occasions when patients did not undergo observations or receive medication and treatment in a timely manner.

We spoke with staff about assessment, monitoring and escalation procedures. They could describe to us the action they would take to escalate patients. They told us, on the whole, they were able to take appropriate actions in a timely way to ensure patients were safe whilst in the department.

Nurse staffing

The trust reported their staffing numbers below for the period October 2017 to September 2018 for urgent and emergency care. As at September 2018, 81.5% of qualified nursing positions were filled across the whole trust. Nursing fill rates were good at Furness General Hospital with staffing numbers matching the planned establishment figures.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>39.4</td>
<td>37.9</td>
</tr>
<tr>
<td>Total</td>
<td>76.4</td>
<td>93.6</td>
</tr>
</tbody>
</table>

(Source: Data request - P16 Total Staffing)

The department employed clinical support workers (CSW), practitioners’ assistants, registered nurses, registered sick children’s nurses, emergency nurse practitioners and advanced clinical practitioners. Each had a different role in treating and caring for patients throughout the department.

We observed handovers between senior nurses and between staff nurses and saw that staff effectively communicated information about why patients were attending, and care needs of patients to colleagues starting the new shift or taking over responsibility for care.

We found the staffing levels and skill mix within the department were adequate and appropriate to meet the needs of patients who attended. Practitioner assistants had advanced skills, and most could work to a registered nurse level, other than working with medicines.

Vacancy rates
The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

We spoke with staff and managers in the department. They all told us there were no current nursing or health care assistant vacancies.

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

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in urgent and emergency care. This was better than the trust performance measure of 8.5%. Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

However, when we discussed turnover of staff, staff leaving and new staff starting, everybody we spoke with told us staff rarely left the department however there had been recent recruitment over the last 12 months.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in urgent and emergency care.

Unfortunately, due to the format of the data provided we are unable to provide figures at site level.

We discussed sickness levels with staff in the department and managers. They told us there were no real concerns about sickness levels in the department.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

**Bank and agency staff usage**

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 1,016 shifts for qualified nursing in urgent and emergency care were filled by bank staff and 1,255 shifts were filled by agency staff. In addition, 787 shifts remained unfilled by bank and agency staff.

For nursing assistants, 1,538 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 413 shifts were not filled by either bank or agency staff.
The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th>Qualified nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>601</td>
<td>0</td>
</tr>
</tbody>
</table>

The trust has attributed this to historic vacancies within the department. There was ongoing recruitment to ensure a zero vacancy rate.

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

There was a matron on site seven days a week with specific remit to support safe staffing.

**Medical staffing**

The trust has reported their staffing numbers below for the period October 2017 to September 2018 for urgent and emergency care. As at September 2018, 83.6% of medical and dental positions were filled across the whole trust. Medical fill rates were below establishment at Furness General Hospital at 86.9%.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>15.7</td>
<td>17.0</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

The department was not meeting the RCEM (Royal College of Emergency Medicine) standards which state an ED should have 16 hours of consultant cover each day.

The department was overseen by an associate specialist (one grade lower than a consultant). We had some concerns about there being no consultant oversight of the department. Staff told us the trust was looking at providing consultant support from Royal Lancaster Hospital (RLI) however this was not in place at the time of the inspection.

There was no paediatric lead doctor in the department and no paediatric specialist doctors however, all associate specialise doctors were trained in advanced life support (ALS) advanced trauma life support (ATLS) and advanced paediatric life support (APLS). Additionally, the department received good support from the paediatric ward if a seriously ill child was brought to the department.

During the inspection we observed medical and nursing staff working together to manage patients and we saw handovers between clinicians taking place. These were detailed, and enough information was provided to ensure the safety of the patient. Clinicians handed patients over to their peers individually rather than at one meeting.
Vacancy rates

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

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

From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in urgent and emergency care.

We discussed staffing and vacancies whilst in the department. The department was funded for three WTE (whole time equivalent) consultants however at the time of the inspection, there were no substantive consultants employed in the department. There was some occasional consultant cover from a recently retired consultant although this was minimal.

The trust told us it was in the process of recruiting some new staff and had made the decision to offer CESR (Certificate of Eligibility of Specialist Registration) posts with a view to developing associate specialists to become consultants within the department.

The trust had no vacancies at associate specialist grade, with eight funded and eight in post when we inspected. Some of the associate specialists covered the consultant rota.

The department was fully recruited for middle grade doctors and junior doctors and in the coming months was to receive additional medical staffing.

Turnover rates

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in urgent and emergency care. This was worse than the trust performance measure of 8.5%.

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

Sickness rates

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for medicine at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in urgent and emergency care.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

Bank and locum staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in urgent and emergency care from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.
Furness General Hospital

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>0</td>
<td>355</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>158</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>513</td>
<td>0</td>
</tr>
</tbody>
</table>

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

We discussed the use of locum staff with the management team. They told us the department had difficulty finding locums to cover shifts due to the remote location of the hospital.

Staffing skill mix

At June 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower. However, this information relates to the trust as a whole and was not provided for the FGH site.

Staffing skill mix for the 29 whole time equivalent staff working in urgent and emergency care at University Hospitals of Morecambe Bay NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>56%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>3%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>14%</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

The department used an electronic record keeping system to record patient attendances and monitor their progress through the department. The system could also record NEWS, Mental Capacity Act and Mental Health Act information and best interest decisions made for patients.

All members of staff were required to attend information governance training. We found 91% of staff had completed this training against a trust target of 85%.

Medical records management training was not included as mandatory training.
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 patients’ personal information was not seen by other patients in the department.

Once a patient was discharged from the department, the patient’s GP was sent a discharge letter. This included their treatment plan and any medication changes. Reception staff sent these out each day.

We looked at the records of seven patients, both adults and children, in detail. We found completion of records was consistent with no gaps in information.

All records had observations documented at the required frequency and there were appropriate gaps in time between sets of observations being carried out.

We were satisfied that the standard of record keeping was sufficient to keep patients safe and protect them from errors or harm.

**Medicines**

Staff attended medicines management training as part of their induction and were required to complete online training annually.

Incidents showed there had been 15 medication incidents in the previous 12 months. These related to prescribing errors, administration errors and dispensing errors. The incidents were reviewed by the patient safety manager for the department and lessons learned were displayed in the department to prevent further incidents.

Staff told us they disposed of controlled drugs (medicines that have very strict policies and procedures in relation to their management) in the trust approved way. Controlled drugs were strictly managed and recorded, and we saw evidence of this in drugs books.

We asked a CQC pharmacy inspector to visit the ED to look at the processes in place. They had no significant concerns about the department.

The department used an electronic refrigerated storage unit for medicines. Staff had to use either a password of finger print to access the unit. The unit was temperature controlled.

Medicines and sensitive medicines documentation were stored securely.

All the medicines we checked were in date and topped up daily by the pharmacy department.

Staff could access emergency drugs out of hours if needed and there was an on-call pharmacist to assist the department if needed.

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. Eligible staff had signed to say that they understood them and were working within their guidance. We looked at the PGDs in use in the department and found them all to be signed and dated by staff to show staff were competent to use them.

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 September 2017 to August 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 six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2017 to August 2018.

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

- Treatment delay meeting SI criteria: five incidents (83.3%).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results): one incident (16.7%).

Site specific information can be found below:

- Furness General Hospital: two incidents

(Source: NHS Improvement - STEIS)

The department reported 477 incidents in the 12 months from September 2017 to August 2018. Of the incidents reported, none were categorised as death or severe harm. There were eight classified as moderate harm, 116 low harm, 326 no injuries and 27 near misses.

The most common category of incident was operational issues (76) such as 12 hour breaches (9), Nursing shortages (25), followed by clinical assessment and treatment time (52) and antisocial behaviours (36). There were also 26 categorised as violent assault, six of which were staff to staff.

We spoke with staff about incident reporting. Both medical and nursing staff were aware of their responsibilities about reporting incidents. All said they could access the reporting system and understood how to complete an incident report.

Staff we spoke with told us they received feedback about incidents they had reported via email and about other incidents at handovers. Feedback and lessons learned were also disseminated at handover and there was a lessons learned notice board for staff to access.

Managers told us 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.

We looked at the root cause analyses and action plans of some incidents 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.
Senior staff in the department attended mortality and morbidity meetings and fed back information to staff at team meetings and huddles.

**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 the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

*(Source: NHS Digital - Safety Thermometer)*

**Is the service effective?**

**Evidence-based care and treatment**

Staff in the department used a comprehensive variety of pathways and National Institute for Health and Care Excellence (NICE) guidelines together with Royal College of Emergency Medicine (RCEM) guidance to support them to achieve effective outcomes for patients in their care.

We reviewed the stroke, sepsis, frail elderly and fractured neck of femur pathways. They followed best practice guidance and were in date.

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 access guidance to ensure patients were receiving best practice care and treatment.

New NICE guidelines were reviewed, reported on, and approved by the clinical governance committee and disseminated to staff via the noticeboard, emails, training, huddles and staff meetings.

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

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.7 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 (October 2016 to March 2017; published October 2017)*
We spoke with five patients and their relatives about hydration and nutrition needs. All told us they had been offered a drink. Some patients had been in the department for more than two hours and had been offered sandwiches.

We saw patients being offered food and drinks and staff told us that if patients needed to eat for medical reasons, food was available.

There were vending machines selling drinks and food in the waiting room. There were shops on site where people could 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. During the inspection we saw two patients on intravenous fluids. Their charts had been completed correctly.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.6 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.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

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. Smiley face charts were also used for children.

We saw staff had access to appropriate pain relief medication and patients were asked when they checked in at reception whether they had pain. This was communicated with the triage nurse who could give pain relief using a PGD if required.

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

We looked at seven patient records (adults and children) and in five records we saw pain scores were 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.

We asked five patients in the department if they had been asked about pain or offered pain relief and they all told us they had. We saw staff asking patients if their pain levels had changed as they carried out comfort rounds.
Patient outcomes

RCEM Audit: Moderate and acute severe asthma 2016/17

Furness General Hospital

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department at Furness General Hospital failed to meet any of the national standards.

The department was in the upper 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: 89.3%; UK: 77%.

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

- Standard 1a (fundamental): O2 should be given on arrival to maintain saturations of 94-98%. This department: 10.0%; UK: 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 12.0%; UK: 25%.
- 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

The department’s results for the remaining three standards were all within the middle 50% of results.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 26.0%; UK: 26%.
- 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: 9.1%; UK: 19%.
    - Standard 5b (fundamental): within 4 hours (moderate). This department: 24.3%; UK: 28%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Furness General Hospital

In the 2016/17 Consultant sign-off audit, the emergency department at Furness General Hospital failed to meet any of the national standards.
The department was in the upper UK quartile for all three standards that the hospital reported data for:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 43.6%; 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: 56.0%; UK: 12%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 37.0%; UK: 10%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Severe sepsis and septic shock 2016/17**

**Furness General Hospital**

In the 2016/17 Severe sepsis and septic shock audit, the emergency department at Furness General Hospital failed to meet any of the national standards.

The department was in the upper UK quartile for none of the audit standards:

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

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 42.6%; 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: 44.6%; UK: 64.6%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. This department: 0.0%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 15.8%; UK: 60.0%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 21.8%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 27.7%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 2.0%; UK: 18.4%.
- The department’s result for the remaining standard was in the middle 50% of results.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 33.7%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

The department had poor results in the RCEM audits overall. Not only did the department fail to meet standards, for national audits such as the severe sepsis audit, moderate to severe asthma audit or consultant sign off audit, they were in the lower quartile of hospitals nationally.
The trust provided us with evidence it had taken part in two RCEM audits in 2017/18, procedural sedation and pain in children. The reports showed the department had not met any of the standards in either.

We requested information from the trust about clinical audit within ED. The trust provided us with evidence that the department was taking part in this year’s RCEM audits. The audit plan also showed two re audits were planned in 2018/19. The trust provided us with action plans to ensure staff met RCEM standards for audits they undertook in 2016/17. However, the action plans were not robust or detailed and we were not assured by them.

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

From September 2017 and August 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally better than the England average. However, since April 2018 there has been an increase in the unplanned re-attendance rate at the trust.

In the most recent month of available data, August 2018, the un-planned re-attendance rate within seven days at the trust was 8.0%, which was similar to the England average of 8.1%. Site specific information was not provided to us by the trust and it mirrored the England average.

Unplanned reattendance can be an indicator of patients being discharged inappropriately such as before they are well enough.

**Unplanned re-attendance rate within seven days - University Hospitals of Morecambe Bay NHS Foundation Trust**

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

**Competent staff**

**Appraisal rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for urgent and emergency care also includes data for medicine.
As at September 2018, 73.3% of staff within urgent and emergency care services at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff. When we spoke with the leadership team, they told us the figure had increased to 84% as of November 2018 overall for staff.

The management team had a clear structure in place to ensure all staff had a planned appraisal and there was a list of who was responsible for the appraisal of which staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,063</td>
<td>776</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>25</td>
<td>22</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,088</td>
<td>798</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

(Source: Data request- P43 Appraisal Compliance 2017 to date)

When we spoke with staff they told us they had either had an appraisal or had one planned. Staff told us appraisals were productive and supportive.

The department had an induction package in place for new staff although this was out of date and needed amending.

Staff new to the department had one month of shifts when they shadowed other staff to orientate them to the department and make sure they were competent. Newly qualified staff had an induction package to complete and attended specific training. All staff who joined the department had a 12 month probation period during which they had regular meetings with the team leader.

The department had doctor teaching sessions where specific topics such as equipment, medical conditions or treatments were discussed. This ensured staff were up to date with new developments or techniques.

The department had a clinical nurse educator one day per week to ensure staff increased their skills and knowledge. They supported staff to develop and ensured staff remained competent in their roles.

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.

Some staff in the department spoke about additional competency training they had done such as masters degrees or advanced clinical practitioner training.

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.

There was a 24hr on call pharmacist to support the department to access any urgent medicines not readily available.

The department worked closely with the frailty team to support patients who had additional health and social care needs. The frailty team had a strong presence in the department after having recently been introduced. They were able to arrange access to equipment such as walking aids and could organise short term social care for patients. This meant 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 could access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. 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. When a patient new to the department was seen, the department always made sure they left with a passport in place if they did not already have one.

Patients could access support for addiction and substance misuse via the psychiatric liaison service and there was information about these services advertised around the department.

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 and leaflets advising patients about support services like drug and alcohol services around the department.

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

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

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 most cases this was implied consent and not documented however when an intervention was required, formal written consent was sought.

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. Patients confirmed this happened.

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 could 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 aged 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. The organisation had a robust process in place to monitor the DoLs process, follow up any urgent requests and ensure patients remained protected.

When we spoke with staff, they told us they would look to the senior clinicians on duty or the psychiatric liaison team for guidance.

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 or the same as the England average in all months from August 2017 to July 2018. In July 2018, performance at the trust was 88.9%, which is better than the England average of 86.7%.
A&E Friends and Family Test performance - University Hospitals of Morecambe Bay NHS Foundation Trust

(Source: NHS England Friends and Family Test)

During our inspection, we spoke with six 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, supportive and made them feel safe and included in their care.

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.

We saw examples of staff supporting relatives and showing empathy to them. We saw staff responding to a difficult incident in the department. They supported the family and each other with compassion, empathy and care.

When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel safe and cared for and we saw this in the way staff treated patients.

Patients and relatives, we spoke with told us they were kept comfortable and offered food and drinks while waiting for treatment in the department. We also saw patients who were waiting in the ambulance handover queue given drinks.

The department had received compliments from patients waiting in the department for more than one day about how staff had supported their privacy and dignity.

During our time in the department, we saw patients being treated with dignity and respect. We were given examples of staff who were skilled in communication skills showing patients privacy and dignity. Although initial triage was completed at the side of the reception desk, we observed staff ensuring the patients had privacy and dignity. Staff we spoke with told us if it was inappropriate to triage the patient in this environment, they would use a private room.
While observing care delivery, we did not see or hear patients being offered chaperones. We did hear staff asking for verbal consent to commence procedures or tests.

**Emotional support**

Staff told us about how they would support patients who were distressed, by chatting to them, trying to distract them and making sure they were clear with patients when discussing treatment and they were understood. Patients told us they felt safe and supported by staff. Patients gave us examples of being listened to and involved in the planning of their treatment and care.

We saw examples of bravery certificates and colouring sheets used with paediatric patients to reassure them.

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

During our inspection, staff gave us examples of staff from other departments attending the unit to offer emotional support to patient’s families during a difficult time.

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 better than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for none of the questions and about the same as other trusts for the remaining 23 questions. The trust performed better than other trusts for the question “Did hospital staff take your family or home situation into account when you were leaving the emergency department?”.

<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>4.0</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>8.6</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>8.2</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>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining 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>9.1</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>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.8</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>8.3</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>9.0</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>8.2</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>9.3</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>7.5</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>7.2</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>8.3</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>9.2</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>9.2</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>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>6.6</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
--- | --- | ---
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 6.6 | About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.3 | About the same as other trusts
Q45. Overall | 8.4 | About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patients we spoke with told us they felt involved in their care. We were given an example of a patient with a learning disability being fully included in their care, talked to directly by staff and supported in their treatment plan.

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. 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.

Is the service responsive?

Service delivery to meet the needs of local people

The trust involved patients and families when developing leaflets and investigating some complaints to help reflect the views of local people who had used the service. Staff gave an example of identifying a theme of incidents and involving relatives to support shaping the service going forwards.

The care group (which included Urgent & Emergency Care and Medicine core services) had appointed a matron for service user and public engagement. Staff told us this job role will set up a group of patients and families to be involved in the development of services.

The trust was implementing new estates plans to the department and this work was ongoing. Staff told us there had been some local media coverage on the radio publicising the changes that were being made. Staff told us that the security on site did not meet their needs. There was one security guard on duty for the whole site on a night time and none during the day.

Unit leaders told us when there were local events on or peak times in their activity, extra staff were put on to the rota and overtime was offered, especially if the event fell on a weekend. Due to the geography of the area, there were some regular big events that resulted in accidents and injuries and this was accounted for in the planning of service delivery.

Staff we spoke with during the inspection told us they felt local services didn’t meet the needs of patients. The local population were directed to the emergency department by many local health
and social care services because there were no other local minor injuries units to attend. Staff also told us there were poor relationships with local residential homes because of issues with discharge of patients. However, the unit managers had a weekly meeting with the local ambulance trust. They discussed any issues being experienced to come to solutions. This has encouraged a good working relationship between the services.

There were separate adult majors, adult minors and paediatric waiting areas. In the paediatric waiting area, we saw books, toys, colouring books, a TV, DVDs for different ages, sensory lights a wall mounted iPad and a projector. The children’s waiting area was closed at night because items had been broken. The minors waiting area was separate to the majors waiting area and was shared with the fracture clinic. All waiting areas were visible from the reception desks and in majors, the receptionists and triage nurse could visually monitor patients.

Vending machines were available in the adult waiting area for drinks and snacks.

We saw a children’s information board with details of how to access the children and adolescent mental health service (CAMHS). This included a crisis assessment and interventional service flow chart.

There was a private relatives room. There was no tea and coffee making facilities but staff we spoke with told us they offered drinks and snacks to relatives using this room. It was a pleasant environment; however, the room was next to the main door in the majors waiting area which could be busy. Although there were blinds on the external windows, the internal windows had a frosted pattern on the glass so could still be seen through. There were leaflets in the relatives’ room for local services and charities. There was no designated viewing room, however the department used the dignity in death symbol, a dragonfly, and a ‘do not disturb’ notice for rooms with deceased patients.

Staff identified to us they were aware the facilities in the department did not meet the needs of patients living with a mental health condition. The service did not have a designated mental health room. The relatives room was used for mental health patients, unless staff felt they were at risk. In that case, the patient would be taken into the department, so they could be monitored and observed. Staff gave us an example of removing all ligature points from a room and giving a patient one to one observation because of their risk level. Staff identified the specific rooms they would allocate to a mental health patient if they needed to be observed.

Senior leaders told us the new building design included rooms which would meet the PLAN4 ligature free standard and could be used for patients living with a mental health condition when required. Senior leaders told us they engaged with mental health patients and completed a 15 steps programme to gain feedback from this patient group on the development of facilities.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all 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>7.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q11. Overall, how long did your visit to the emergency department last?  

<table>
<thead>
<tr>
<th>Percentage</th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3</td>
<td></td>
</tr>
</tbody>
</table>

Q20. Were you given enough privacy when being examined or treated?  

<table>
<thead>
<tr>
<th>Percentage</th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.3</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The trust computer software had a flagging system that could alert staff to specific needs of patients who had attended before. For example, patients with an existing dementia diagnosis had a butterfly flag on the system which alerted staff to their needs and patients with a known learning disability had a flag which alerted staff to their care plan. There was also a “familiar faces” scheme in the department where patients who attended the department regularly had care plans put in place. This made sure they were managed quickly and appropriately and signposted to other services as appropriate.

The trust had access to interpreting services for people whose first language was not English. Most staff we spoke with were aware of how to access telephone interpreters however due to the local demographic, rarely needed to do so. Staff told us they did not know how to get leaflets in a language other than English, however they knew who to ask for help. Staff told us they could access specialist nurses to help patients living with hearing conditions and communication needs.

We spoke with staff about patients living with complex needs, dementia, or a learning disability. All staff told us they would treat patients as individuals, would try to involve family and carers in discussions about care needs and would access any passports or flags on the computer system to find out more about the patient.

There were sensory items in the emergency department like beads and shells for patients living with dementia. Staff we spoke with told us there were specialist nurses who came to the department to assess patients living with dementia and to put a plan in place with them.

Staff told us the frailty service was being implemented on this site.

We spoke with staff whose lead roles were mental capacity, mental health and deprivation of liberty who worked with the emergency department. They told us about their involvement in regular service user meetings and this included multiagency responsive meetings that police and housing representatives attended. If a patient was subject to a Deprivation of Liberty Safeguard (DoLS) the specialist nurses added a starburst to the computer system. This allowed all staff to clearly see the current status of the patient.

Staff we spoke with said that speciality staff provided excellent support to the department and there was a key performance indicator (KPI) for them to attend within one hour of referral. This supported responsive services to all patients and those with complex needs.

We saw an example of a patient who was attending the emergency department with complex needs who also had an appointment in another department that day. Staff prioritised the patient’s overall needs to ensure they were seen by both departments.

Generally, patients living with learning disabilities who had visited the trust before 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. If a patient had not visited the department before, staff would make sure the patient did not leave without a passport in place. The triage system for patients under the age of 18 had a specific question on if there was a learning disabilities passport in place for this patient group. Staff found this useful.
Staff we spoke with told us they had protocols in place to ensure patients who needed it could be isolated. They gave us an example of a time when a patient needed to be isolated to ensure there was infection control in place and to keep other patients and staff segregated from the symptoms the patient presented with.

The trust had developed a frailty team on the Furness General Hospital site. The computer system had a flag for patients aged over 65. They completed a frailty questionnaire and if they scored a certain threshold, the emergency department staff contacted the frailty team who assessed the patient. This system had been in place for two weeks and staff we spoke with were aware of the system, although it was not yet fully embedded into the team. The trust also had a frailty pathway for patients over the age of 75. This was used at the triage stage and followed national guidelines. These two assessments were also combined and patients who met specific criteria were referred to the geriatric team for a comprehensive assessment which could include home support, rehabilitation or hospital admission.

The department had direct links to the psychiatric liaison team and triage nurses could refer patients directly to this team. The department also referred patients directly to alcohol and substance abuse services and there was further information about this pathway available on the intranet for staff.

There was sufficient paediatric nurse cover in the department meaning the needs of local children could be met in the department by staff on duty. The paediatric nurses were new to the department and were making changes to make the unit more child friendly. Staff told us paediatric nurses were having input into the equipment for the paediatric resuscitation bay that was being built and they were looking at getting funding for more sensory items for the department.

The trust engaged with the local Clinical Commissioning Group (CCG) where they could raise concerns and enquiries about local care. This meant there was a mechanism to engage with local services to improve care.

The trust had a chaplaincy service available on the Furness General Hospital site. The service was recently reviewed to assess the local belief needs and provision of the service to meet them. There were volunteer representatives from a variety of faith and belief groups on the volunteer visiting team who could support people whatever their belief or non-belief. Funding had been approved to improve and upgrade worship facilities in April 2018 at this site.

**Access and flow**

The department waiting area had a flow chart for patients and relatives which told them what happened in their journey in the emergency department. This managed patient expectations of the department’s flow.

At the time of our inspection we spoke with staff about flow through the department. Staff told us the main barrier was bed capacity in the department as there was only one resuscitation bay. The service was undergoing building and estates work to address this issue and the department was due to open in April 2019 with increased resuscitation beds.

Staff told us the flow could be affected if a patient was waiting for some speciality input. For example, the mental health team would not see patients who were intoxicated, therefore a bed could be taken up while waiting for the patient to be able to be assessed. Staff also gave us examples of times when patients were waiting to be moved to the surgical or emergency assessment units but did not meet specific criteria, such as being suitably dressed or with unmanaged pain. We discussed these examples with senior leaders during our inspection and
were told a flow chart had been developed for escalation to the surgical assessment unit which was ready to be released and there had been ongoing work with the local ambulance service to encourage patients to bring what they would need for a hospital stay, with them.

Staff we spoke with said patients were generally treated in a timely way in the emergency departments but the department struggled when it was busy and if the resuscitation bay was occupied and another emergency patient came into the department. Although staff were proactive at moving patients to ensure care could be given in an appropriate place. We observed an example of a time when the resuscitation bay was occupied and could not be accessed. Staff told us their contingency plan during this time.

Staff told us there were appropriate contingency plans in place for accessing the department during the building work. Although this meant patients arriving by ambulance were held in the main department, we saw evidence that this was appropriately managed. However, staff we spoke with also told us when the department was busy, patients were sometimes assessed and treated in the corridor.

The department had a flow co-ordinator and nurse in charge who were responsible for flow through the department. The nurse in charge wore a red arm band to identify their role and attended the bed meetings. Bed meetings were attended by senior staff across the trust who could influence discharges and free up beds, however some staff told us it didn’t seem like much came from this when the site was in escalation.

If the department became busy in one area, for example majors, the nurse in charge moved staff to accommodate the peak appropriately.

From our observations during the inspection, we saw patients waiting in the corridor on trolleys or in wheelchairs during a peak of activity. Ambulance staff told us they often had to wait with patients as they could not be handed over. We observed proactive management of patient flow when the department was busy, and no cubicles were available. The resuscitation bay was kept empty for emergencies.

However, staff gave us an example of patients waiting up to 80 hours for a bed with a local mental health trust.

We observed the patient flow co-ordinator locating beds and deciding with the nurse in charge if patients waiting for a cubicle in the department could be transferred to other areas, for example the surgical assessment unit, to actively try and prevent breaches. Breach times were clearly identified on the white board. The electronic board and whiteboard were used together to monitor patients and wait times and we observed them being updated regularly. We also observed patients breaching the national standard because they were waiting for beds in other departments.

From what we saw, appropriate information and communications were updated on the patient flow board with information about assessment, admission and discharge details changed accordingly.

We observed handovers between ambulance staff and emergency department staff and found they were sufficiently detailed and appropriate. Staff checked patients’ observations and patients were prioritised based on their medical need and not the time spent waiting for a bed.

We were assured there was an embedded process for managing the corridor or for escalating when the corridor became too busy. We observed the nurse in charge and other staff monitoring the condition of patients waiting with ambulance staff for a bed. We saw the bed priority change depending on the observations of patients and this was well communicated with the patient flow co-ordinator. The trust sent us evidence of ongoing work to define and embed escalation triggers for the emergency department; these were in draft form.
During our inspection, we observed the emergency department and speciality staff were responsive to pre-alert patients arriving by ambulance. We observed speciality staff in the department and staff told us they did not have long waits for speciality doctors.

Staff told us there was a clear pathway for paediatric patients and paediatric medical staff. During the inspection we saw paediatric nurses were embedded into the emergency department. Staff told us the paediatric team were called to the department in the event of a paediatric arrest or seriously ill child. We saw an example of a paediatric pre-alerted patient arrive in the department. The paediatric speciality medical staff arrived before the patient, so the patient was assessed and treated quickly and appropriately. Staff told us patients being transferred to the paediatric department was a smoother transition now and this helped with patient flow through the department. There was a paediatric consultant available during the day and a paediatric registrar during the night on call from the paediatric ward. Paediatric patients could be fast tracked to the paediatric department provided triage and observations were completed and it was appropriate to do so.

We saw evidence of patient pathways being followed. For example, the department had a pathway in place for direct admission to another local hospital for patients with a potential myocardial infarction (MI) or chest pain and a pathway for paediatric consultants to attend the department to ensure prompt paediatric admission if it was required. We saw staff follow other pathways and this was an embedded process. We also saw bleep and referral systems in place, for example to the early pregnancy assessment unit and out of hours GP. This meant appropriate patients were streamed to the required service, so they received appropriate assessment and to reduce the capacity impact on the emergency department.

There was an alert system for deteriorating patients in the waiting area. The triage nurse and reception staff were well placed to monitor patients in the waiting area. We saw an example of a patient who was deteriorating; this was dealt with promptly and quickly and the patient was moved onto a trolley in the majors’ unit where they could be monitored.

Staff told us the computer system was slow and in peak times this was frustrating. Staff told us they had access to patient’s GP records and said that all local GPs used their laboratory for blood results. This meant the medical staff could access appropriate test results for patients.

The trust used technology to link with the local ambulance trust. There was a system in place to show the presenting complaint of an incoming patient and their estimated time of arrival. The trust displayed live A&E waiting times on their website. These were regularly updated. This was displayed alongside information about the “Think! Why A&E” campaign and information on wellbeing and mental health helplines. This meant members of the public could access up to date and useful information and alternative treatment available without attending the emergency department.

**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 five months over the 12-month period from September 2017 to August 2018. The standard had not been met since January 2018. At the trust, the median time from arrival to treatment has also been greater than the England average since February 2018.

In the most recent month of available data, August 2018, the median time to treatment at the trust was 64 minutes compared to the England average of 56 minutes.
Median time from arrival to treatment from September 2017 to August 2018 at University Hospitals of Morecambe Bay NHS Foundation 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.

When looking at four-hour target performance, the trust consistently breached the 95% standard from September 2017 to August 2018. Furthermore, the trust’s four-hour target performance was worse than the England average in 10 of the last 12 months. A large improvement in the trust’s performance can be seen between March 2018 and May 2018 where the percentage of patients seen within 4 hours increased from 76.3% in March 2018 to 90.6% in May 2018, however, performance has declined since this point.

Four-hour target performance - University Hospitals of Morecambe Bay NHS Foundation Trust

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

We requested information from the trust about the four hour performance target for individual sites. The data provided by the trust also includes attendances to the Ophthalmic CAS clinic which does not fall under the scope of the inspection.

The performance data provided ranged between 76.24% in January 2018 and 93.10% in November 2017. The data shows the Furness General Hospital site consistently did not meet the national four hour performance target of 95% in any month. It is unclear what the impact of the inclusion of the ophthalmology CAS clinic data has had on performance.
Furness General Hospital*

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendances</th>
<th>Breaches</th>
<th>4 hour performance</th>
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</thead>
<tbody>
<tr>
<td>Sep-17</td>
<td>2742</td>
<td>336</td>
<td>87.75%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>2884</td>
<td>270</td>
<td>90.64%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>2725</td>
<td>188</td>
<td>93.10%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>2978</td>
<td>485</td>
<td>83.71%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>2824</td>
<td>671</td>
<td>76.24%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2606</td>
<td>415</td>
<td>84.08%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>3010</td>
<td>688</td>
<td>77.14%</td>
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<tr>
<td>Apr-18</td>
<td>2962</td>
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<tr>
<td>May-18</td>
<td>3409</td>
<td>274</td>
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</tr>
<tr>
<td>Jun-18</td>
<td>3234</td>
<td>295</td>
<td>90.88%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>3484</td>
<td>525</td>
<td>84.93%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>3177</td>
<td>351</td>
<td>88.95%</td>
</tr>
<tr>
<td>Total</td>
<td>36035</td>
<td>4990</td>
<td>86.15%</td>
</tr>
</tbody>
</table>

* includes Ophthalmic CAS Clinic (type 2)

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

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

Over the winter months there was an increase in the percentage of patients waiting more than four hours from the decision to admit until being admitted at the trust, following a similar trend to the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals of Morecambe Bay NHS Foundation Trust
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from September 2017 to August 2018, 214 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 March 2018 (78 patients), January 2018 (37 patients) and February 2018 (25 patients).

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

We requested information from the trust about 12 hour waits from decision to admit.

The data showed Furness General Hospital site had patients breaching 12 hours 9 months of the 12 month period.

Furness General Hospital

<table>
<thead>
<tr>
<th>Date</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sep-17</td>
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</tr>
<tr>
<td>Oct-17</td>
<td>3</td>
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<tr>
<td>Nov-17</td>
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</tr>
<tr>
<td>Dec-17</td>
<td>5</td>
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<tr>
<td>Jan-18</td>
<td>28</td>
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<tr>
<td>Feb-18</td>
<td>3</td>
</tr>
<tr>
<td>Mar-18</td>
<td>8</td>
</tr>
<tr>
<td>Apr-18</td>
<td>7</td>
</tr>
<tr>
<td>May-18</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>0</td>
</tr>
</tbody>
</table>
Staff we spoke with gave an example of patients living with a mental health condition, waiting more than 80 hours for a bed in a mental health trust.

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

From September 2017 to August 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment has fluctuated month on month. The percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment has been better than the England average in all months from April 2018 to August 2018.

In August 2018, the percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was 0.0%, compared to the England average which was 2.1%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals of Morecambe Bay NHS Foundation Trust

Median total time in A&E per patient (all patients)

From September 2017 to April 2018, the trust’s monthly median total time in A&E for all patients was worse than the England average. Since May 2018, the trust’s monthly median total time in A&E for all patients has been similar to the England average.

Over the last 12 months, median total time in A&E for all patients at the trust was highest in March 2018 (187 minutes compared to the England average of 160 minutes). Since then, there has been a decrease in the trust’s monthly median total time in A&E for all patients to a level that is similar to the England average. In August 2018, the trust’s monthly median total time in A&E for all patients was 149 minutes compared to the England average of 146 minutes.

Median total time in A&E per patient - University Hospitals of Morecambe Bay NHS Foundation Trust
Learning from complaints and concerns

During our inspection we saw there were mechanisms in place to allow patients to give feedback. The service had a patient survey which was completed by text, phone or paper copy. Paper copies were put into a comments box at reception. There was also a complaints board in the waiting area which kept patients up to date about actions the trust had taken as a result of complaints.

Staff we spoke with during the inspection told us learning from complaints was cascaded to staff on shift handovers, by email and during the monthly nursing and reception staff meetings. There was a meeting for different staff specialities where lessons learned were cascaded by the unit manager. There was a board outside of the staff areas displaying lessons learned, where recent learning from complaints and incidents was displayed. During the inspection, we saw 11 examples of lessons learned on the board ranging from April 2018 to October 2018. It gave brief details of the incident, action taken, and any further learning identified. Staff told us the board was updated regularly and themes were discussed at the nursing staff team meetings. Paediatric nurses attended all team meetings if there was a paediatric learning incident and gave feedback and teaching if required. Staff told us there was a morning huddle and learning from incidents was cascaded here as well.

Staff gave us examples of learning implemented from these complaints and gave us examples of action taken following one of these complaints. Staff also told us if they were involved directly in a complaint where lessons could be learned, they completed a reflective piece with the unit manager. Staff gave examples of improvements that had been made in the department following lessons learned reflections and sharing experiences as a staff group.

Junior doctors had mandatory teaching alternate weeks and weekly departmental training. This included case studies, lessons learned and learning from complaints from speciality departments.

Ambulance staff we spoke with told us they felt able to raise clinical or operation concerns easily, and they were listened to.

The unit manager met monthly with the patient safety manager to discuss governance, alerts, incidents, complaints, audits and risk. The outcomes of these meetings were updated on the lessons learned board and staff told us it was clear, visual and easy to read.
We reviewed an example of a complaint response from the emergency department at Furness General Hospital as part of the inspection. The response followed the trust’s guidance about how to respond to complaints, however the response time was outside of the trust’s set timescale.

**Summary of complaints**

From July 2017 to June 2018, there were 71 complaints about urgent and emergency care services. The trust took an average of 38 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days. Of the 71 complaints received during the 12-month period, 27 (38.0%) related to a diagnosis problem and nine (12.7%) related to discharge arrangements. A breakdown of complaints by site can be found below.

**Furness General Hospital**

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Problems</td>
<td>12</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of Staff - Doctor</td>
<td>2</td>
</tr>
<tr>
<td>Attitude of Staff - Admin</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Communication/Info to Patients</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate Care/treatment</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>1</td>
</tr>
<tr>
<td>Over 12 Month Complaint</td>
<td>1</td>
</tr>
<tr>
<td>Premises - Access to</td>
<td>1</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>2</td>
</tr>
<tr>
<td>Waiting Time for ED Department</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From July 2017 to June 2018, there were 126 compliments in urgent and emergency care. The breakdown by site is shown below:

- Furness General Hospital: 36 compliments
- Royal Lancaster Infirmary: 90 compliments

We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

The department was overseen by a clinical lead, matron and two operational managers who were responsible only for the FGH department.

The ED had a senior nurse lead in post to oversee the daily management and requirements of the department.

We met with these staff and found them to fully understand the challenges of the department in relation to performance, demand, staffing and risks. They presented a cohesive team committed to the ED and its staff.

All staff we spoke with during the inspection told us that they felt very well-led at a local level and had no concerns with their line managers. They told us the management team was approachable and supportive and their door was always open. Some staff told us they continued to work in the department because of the nursing leadership in place.

Similarly, medical staff told us their leadership was inclusive and provided good direction within the department and strong representation for the department within the wider trust. Leaders were supportive and committed to teaching. Our only concern was that there was no substantive consultant working in the department and leadership was provided by an associate specialist grade doctor. However, medical staff we spoke with about this told us they were not concerned and felt fully supported in their roles.

Staff told us they felt able to suggest new ways of working and try new things to improve patient experience or the efficiency of the department. For example, staff had been involved in the new design of the department.

Staff we spoke with told us that senior executives from across the trust visited the department at least once each month. Staff knew who the chief executive was because they visited regularly.

Vision and strategy

The management team had a clear vision for the service and was working with other departments within the hospital as well as local providers and commissioners to ensure services met the needs of the local populations.

Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was underway to manage demand and ensure patients saw the most appropriate clinician for their needs, quickly.

The department was undergoing a programme of work to extend the A&E to make sure it could meet the needs of the local population and cope with increasing demand on services.

The team involved in designing the department came up with plans designed to future proof the department and help to manage increasing demand on urgent and emergency care services in a safe, effective and efficient way. The new department incorporated facilities dedicated solely to the urgent and emergency care needs of the local population.

The management team were working to ensure that the service was sustainable for the future. This included developing new roles such as nurse practitioners who, in the future would be able to work within the junior doctor rota.
Culture

We spoke with a number of staff from different disciplines about the culture of the department. All staff described the department as friendly and ‘like a family’. The wider team worked and socialised together and there were very good working relationships.

Clinical support workers, junior doctors, and nurses told us senior clinicians were keen to share their knowledge with colleagues. Staff 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 staff focus was on treating patients in an efficient way however staff also took time to support each other through difficult and stressful times. We witnessed an example of this at the time of our inspection. The night shift had experienced two deaths, and these had upset staff. Colleagues pulled together to talk about the deaths and offer comfort to each other. The team leader also organised a debriefing session for staff and although their door was always open, made it clear to staff that this was especially so if they needed support following the deaths.

The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked together to ensure patients received good coordinated care. Staff were very committed to the care of patients and we were told of examples when staff had worked extra hours or stayed late to be with a patient.

Staff we spoke with told us they could report concerns and incidents 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 and line managers.

Governance

Nursing and medical staff all took responsibility for patient safety. The department also had a patient safety lead who managed incidents, investigations, safety and quality of patient care.

The department had governance leads who attended clinical governance, patient safety and mortality and morbidity meetings where information about complaints and incidents was shared. We saw minutes of these meetings and spoke with staff about them.

Information from committees such as complaints, learning from deaths and learning from incidents was regularly discussed with staff and placed on the lessons learned notice board. The department produced a regular newsletter for staff to brief them about the latest complaints and incidents.

The department arranged additional training for staff when this was identified as an outcome from complaints or incidents.

There was a process in place to ensure all relevant NICE guidance, patient safety and drug alerts were assessed and implemented, and staff were aware of any changes. A member of clinical staff took the lead; however, we saw other staff of different disciplines contributing to the knowledge resources such as patient pathways.
Staff could access up to date information about care and treatment online in the department and there was detailed information about treatment pathways and medicines as well as links to the original guidance source.

There was a process in place for ensuring the results of radiology investigations were followed up and any “missed abnormality” was assessed and brought to the attention of the patient in a timely manner. Where abnormalities had been missed, staff involved were informed and offered additional support.

**Management of risk, issues and performance**

A departmental risk register was in place and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department. These risks mostly correlated with the risks we observed during our time in the department.

The risk register was updated regularly and there were details about mitigating actions in place, action plans and the person responsible for actions was identified. The staff we spoke with were clear about the risks the department faced.

When we spoke with the management team, they could clearly tell us about the risks posed to the department and how these were being addressed.

Managers regularly discussed the problems the department faced, such as waiting time breaches to identify any themes. They took actions to address issues, such as bed shortages across the hospital by meeting three times daily to discuss bed management.

The department had a process in place to escalate the status of the department if it was under pressure. When the department was under pressure the escalation level was increased, triggering extra support for the department from senior managers and departments from around the hospital.

**Information management**

The department collected information used to monitor and manage performance. There were robust 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.

The department used several 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 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.

There were large monitors in clinical areas that showed the status of patients in beds and cubicles in the department. Although it displayed patient information this was an area the public could not access. Thus, the privacy of patients in the department was protected.
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 including data protection and confidentiality was monitored and any incidents reported appropriately.

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 terminals unlocked left unattended.

During the inspection, we saw that TV screens were present to display waiting times in the waiting area. The TV screens also displayed public health messages.

**Engagement**

Staff told us they had been involved in the design of the extension of the department. This showed that staff were valued, and their opinions were important.

Staff told us that they were kept informed about opportunities to progress such as training and promotion opportunities at daily handovers, via emails and through huddles.

The department participated in the friends and family test and CQC surveys but had not carried out any local surveys in relation to the quality of urgent and emergency care services.

Staff from the department had taken part in trust wide engagement exercises such as online surveys. However, there had been no specific engagement work carried out with staff within the department.

It was unclear other than through observation and open discussions within the department how managers gauged staff morale, job satisfaction or physical and mental health needs of staff although from our observations and discussions with staff, staff were happy working in the department.

**Learning, continuous improvement and innovation**

Staff in the department regarded continuous learning and improvement as important to the sustainability of the department and the improvement of patient safety and satisfaction.

Staff were encouraged to develop their skills and knowledge through training.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment across three sites; Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital.

At Furness General Hospital, there are 128 medical beds including the acute medical unit.

In addition to general medicine and care of the elderly, medical specialties, which are provided cross bay include stroke, respiratory, cardiology, diabetes and endocrinology, gastroenterology, dermatology and rheumatology. Neurology and nephrology services in-reach from the Royal Preston Hospital.

Cardiology has a cardiac catheter lab at the Westmorland site and has strong network links to the Cardiac Centre in Blackpool.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 38,562 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 20,025 (51.9%), 463 (1.2%) were elective, and the remaining 18,074 (46.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine with 19,868 admissions
- Gastroenterology with 6,052 admissions
- Medical oncology with 4,070 admissions

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Staff were required to complete mandatory training in topic areas such as infection prevention and control, manual handling and information governance. Training was provided by either e-Learning or face to face.

Staff we spoke with said they were up to date with their mandatory training and could easily track which training they had done and which they needed to do on the electronic reporting system. Ward managers could view both individual and team performance on the electronic system.

Staff we spoke with on the wards told us they did not complete specific Mental Health Act or Mental Capacity Act training however, they said aspects of both were covered under safeguarding training.

The Psychiatric Liaison (PL) team had commenced delivering full day mental health training sessions and dates were planned for December, January and March. The PL team told us they also offered additional ad hoc training in response to need or if it was identified as an action following an incident or complaint investigation.
Trust level

The trust set a target of 95% for completion of mandatory training. The trust was not able to provide the data broken down by hospital site.

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,251</td>
<td>1,285</td>
<td>97.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,228</td>
<td>1,282</td>
<td>95.8%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,178</td>
<td>1,284</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,168</td>
<td>1,281</td>
<td>91.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,061</td>
<td>1,179</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,142</td>
<td>1,289</td>
<td>88.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>882</td>
<td>1,107</td>
<td>79.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>978</td>
<td>1,273</td>
<td>76.8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for two of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for the general fire safety awareness module, for which only 76.8% staff had completed the training at September 2018.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency services at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

Safeguarding

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team in the trust and told us they were approachable and gave clear advice. Policies and links to multi-agency safeguarding procedures were on the intranet and accessible for staff. We reviewed these and found they were in date.

Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children and confirmed they had received feedback about the investigation.
Senior staff confirmed that the trust was compliant with the process around allegations of abuse by staff, and how they conformed to multi-agency procedures. A policy was in place 'managing allegations against staff and volunteers' (2015). This included reporting to the Local Authority under the Local Authority Designated Officer (LADO) process. The trust worked in partnership with two local authorities and the safeguarding team met regularly with the safeguarding adult’s manager within adult social care regarding concerns.

Relevant staff undertook Level 2 safeguarding training for adults and children. Managers told us this included female genital mutilation, sexual exploitation, counter terrorism (PREVENT) and domestic abuse. However, some ward staff were not aware of the wider family issues of vulnerability, such as young people who may have to be young carers of their patients. Some staff we spoke with were less clear about the issue and reporting of female genital mutilation (FGM).

The trust was involved in the implementation of electronic referrals to social care. This meant that referrals were timely, more secure and quality could be audited.

Staff training for children and adults safeguarding was currently being redesigned by the safeguarding team to fulfil the requirements in the Intercollegiate Document (2014).

## 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 as at September 2018 at trust level for all staff in medicine inclusive of staff working in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,174</td>
<td>1,275</td>
<td>92.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still high at 92.1%.

Unfortunately, the data submitted by the trust was not in a format that allowed a breakdown by staff group to be provided. The training data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

The trust also provided information on compliance with Safeguarding Children and Adults Level 2 training for medical wards at Furness General Hospital. Compliance was high with three wards exceeding the trust target of 95%.

<table>
<thead>
<tr>
<th>Ward/Area</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit</td>
<td>88.2%</td>
</tr>
<tr>
<td>Ambulatory Care Unit</td>
<td>100.0%</td>
</tr>
<tr>
<td>Complex and Coronary Care Unit</td>
<td>100.0%</td>
</tr>
<tr>
<td>Endoscopy Unit</td>
<td>95.8%</td>
</tr>
</tbody>
</table>
### Cleanliness, infection control and hygiene

All areas we visited were visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

We saw that personal protective equipment, such as gloves and aprons, were available for staff and used appropriately. Handwashing facilities and alcohol gel were available either within each bay and side room or next to the entrance. We saw that there was a cytotoxic spill kit available.

We saw staff washing their hands and they adhered to the trust policy of bare below the elbows. However, we observed that not all medical and nursing staff on the acute medical unit (AMU), ward 7 and ward 9 decontaminated their hands between every patient contact.

Wards displayed their schedule of cleaning which was based on risk. We saw that the Complex and Coronary Care Unit (CCCU) was classed as very high risk and had an appropriate cleaning schedule displayed.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. We saw that patients with neutropenic sepsis were also nursed in side rooms on the oncology ward and appropriate signage was in place with the door closed.

Wards were audited monthly for compliance with infection prevention and control standards. Audits for August 2018 showed that compliance was high on medical wards at Furness General Hospital with scores ranging between 97% and 100%. Ward displayed their most recent scores on notice boards at the entrance.

### Environment and equipment

All wards we visited were uncluttered, tidy and well organised.

We checked 20 pieces of equipment which included hoists, blood pressure monitors, syringe drivers and chair scales. We found they were clean, tested for electrical safety and maintenance tested within timescales with stickers applied to inform staff.

Staff carried out daily checks of emergency equipment on wards. Resuscitation trollies were security tagged to ensure they had not been tampered with. We checked the contents of one trolley and found all consumables and supplies in the trolley including the emergency drugs box were intact and in date. All emergency equipment such as defibrillators and suction machines were checked and correctly maintained. However, the top of some trollies were dusty.

Equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions.

A room was available on ward 6 which had an overhead hoist and could accommodate a bariatric patient.
The therapy gym was not located near to the stroke ward, this meant that therapy staff were required to take the patient to another part of the hospital, on another level if they needed to use the gym facilities.

On most wards we saw that products such as bleach were safely stored away in a locked cupboard marked Control of Substances Hazardous to Health (COSHH) within the domestic store room. However, on ward 6 we saw that the door to the domestic store was wedged open and detergents and cleaning materials were on a shelf, easily accessible to patients which posed a risk to vulnerable patients.

All equipment used in the endoscopy suite was sterilised through a central sterilising service and was delivered to the unit clearly labelled with the expiry date.

We saw appropriate segregation of clinical waste and disposal of sharps. Sharps bins were correctly assembled, dated and signed with a temporary closure in place.

### Assessing and responding to patient risk

Measures were in place to ensure that staff assessed and responded to patient risk. Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk.

The trust used the updated version of the National Early Warning Score (NEWS2) to measure whether a patient’s condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. Staff used a paper version of the NEWS2 chart to record patient observations. The NEWS2 charts we reviewed were completed correctly and showed that when the patient’s score increased staff had taken the appropriate action to escalate. The Trust’s own audit of NEWS scores for the medical wards showed that compliance was above 90% on all wards.

Staff we spoke with had a good awareness of sepsis and the guidelines for detection. Medical staff we spoke with told us they had undertaken mandatory training in sepsis. A sepsis screening tool was used for patients with fever symptoms or who were clearly unwell with abnormal observations. If the patient was found to meet the criteria for sepsis they were immediately put on the sepsis pathway.

The trust had two Sepsis/AKI practice educators whose role was to provide training and support to staff. They followed up any incidents where a there had been a missed opportunity to use the sepsis pathway for a patient. The trust had undertaken an audit of the recognition and management of sepsis which showed improvement since the 2017 audit. We saw the report included recommendations, plans to share results with relevant staff and plans to re-audit.

Wards displayed the number of falls and pressure ulcers which had occurred on the ward for that month. Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments.

Patients with a high risk of falling were given red anti-slips socks and were placed in a supervision bay close to the nurses’ station so they could be easily monitored. We saw that walking aids were within easy reach of patients.

Psychiatric liaison services for adults were provided by an agreement with two local NHS Foundation Trusts. The teams provided both adult and older peoples liaison services across the emergency department and the wards, 24 hours a day, seven days a week.
There was a mental health assessment on the system that could be used. This was completed for patients with known mental health concerns or when the admission/general assessment indicated a concern around mental health. Risk management plans captured actions to manage the risk of self-harm such as the use of observations or removal of potentially dangerous items.

Nurse staffing

Nurse staffing levels were good on the medial wards we visited. On the day of inspection, we found that actual registered nurse staffing levels met planned levels on most wards. The exception to this was the night shift on CCCU and the late shift on wards 7 and 9 which were short of one registered nurse. When a ward was short of a registered nurse we saw that additional unqualified nursing staff were allocated. Additional care support workers were also allocated to wards with patients at high risk of falls, for example ward 6 (stroke/elderly care).

The ward manager was included in the nursing numbers on some wards and we saw they were dealing with telephone queries and questions from medical and nursing staff which meant it was difficult for them to undertake clinical duties.

Matrons we spoke with told us that nurse staffing was improving at this hospital. They had previously made the decision to close some beds due to staffing levels but were in the process of re-opening them.

Wards had a discharge co-ordinator and we also observed nursing apprentices, nursing associates and student nurses caring for patients on the wards.

The hospital was still actively recruiting registered nurses and had recently recruited three overseas nurses who were waiting to complete their exams to join the UK register. Qualified nurses had also been recruited from India and the Philippines.

Matrons and specialist nurses worked ‘cross bay’ but other nursing staff stayed on a specific hospital site.

The number of registered nurse vacancies on wards varied. For example, staff reported there were no vacancies on AMU, CCCU and the endoscopy unit. Ward 6 had 10 vacancies, but staff told us this was an improvement on previous staffing numbers and they were still actively recruiting. Ward 7 had approximately 40% nurse vacancies however, this was an improvement on the 60% nursing vacancy they had earlier in the year.

There were a number of advanced care practitioners who supported ward staff to manage complex patients. For example, there were two ANPs for the stroke service and two for the respiratory service.

The trust used the Safer Care Nursing Tool (SCNT) to monitor staffing levels and patient acuity on a shift by shift basis. Ward managers completed this twice a day and the information was reviewed daily by matrons and senior nurses to assess staffing levels. Any concerns were escalated via the patient flow meetings which were held five times daily.

The trust had commissioned a nurse staffing levels review for 2018/19, undertaken by an external provider. The biggest identified risk was that the trust did not have a safe nurse staffing policy or a staff rostering policy in place. The review concluded it was not clear how or when the risk was escalated when there were low nurse staffing levels. We saw that the trust had action plans in place to rectify this.
The trust reported their staffing numbers below, for the period October 2017 to September 2018 for medicine. As at September 2018, 87.6% of qualified nursing vacancies were filled across the whole trust. Nursing fill rates at Furness General Hospital were at 84.1%.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th></th>
<th></th>
<th>October 2017 - September 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
<td>Fill rate</td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>128.8</td>
<td>152.3</td>
<td>84.6%</td>
<td>129.6</td>
<td>154.1</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 13.5% for qualified nursing staff working in medicine.

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

Information provided by the trust showed that for Furness General Hospital the vacancy rate for qualified nursing staff working in medicine for October 2018 was 8.1%.

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 5.1% for qualified nursing staff working in medicine. This was better than the trust performance measure of 8.5%.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 3.8% for qualified nursing staff working in medicine.

(Source: Data request- P19 Sickness)

Information provided by the trust showed that for Furness General Hospital the sickness rate for qualified nursing staff working in medicine for the period September 2017 to October 2018 was 4.7%.

The trust measured attendance and had a target of 95.6%.
**Bank and agency staff usage**

The trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 668 shifts for qualified nursing in medicine were filled by bank staff and zero were filled by agency staff. In addition, 2,740 shifts remained unfilled by bank and agency staff.

For nursing assistants, 5,241 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 1,268 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th></th>
<th>Qualified nurses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
<td>Unfilled shifts</td>
<td>Bank shifts</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>5,241</td>
<td>0</td>
<td>1,268</td>
<td>668</td>
</tr>
</tbody>
</table>

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

**Medical staffing**

Medical cover at night between the hours of 9pm to 10am was provided by one registrar and one intermediate (F2/CMT) on site with a consultant on call at home. There was an additional junior doctor on a twilight shift until midnight. This team were responsible for responding to patients requiring urgent medical care on the acute medical unit (AMU), the Complex and Coronary Care Unit (CCCU) and all medical wards as well as the potential to be pulled into the Emergency Department. There was no hospital at night team or critical care outreach team on this site to support the medical team.

The trust informed us that in extreme circumstances such as when there was no night registrar available the consultant stepped in as a team approach.

At the previous inspection medical cover at night was one consultant on call with one registrar, one middle grade doctor and an FY1/FY2 on site so this had been reduced since then.

Consultant cover on ward 7 was provided by two respiratory and two rheumatology consultants.

CCCU had a lead consultant and a locum consultant, a registrar and a doctor in training (FY1). Staff told us patients were reviewed twice daily Monday to Friday. There was a consultant on call at the weekend who came on site to review any new admissions to the ward. The service operated a consultant of the week model.

There were three gastroenterology consultants, two respiratory consultants and three stroke consultants. Stroke consultants also reviewed general medical and care of the elderly patients.

The acute oncology team visited patients on the wards, but they did not become their patients, they stayed under the care of the admitting medical consultant, with the acute oncology team’s specialist input.
Medical staffing was on the risk register and the trust were actively recruiting to vacant posts. Medical staff we spoke with said it was difficult to fill vacant posts due to the location of the hospital.

The trust has reported their staffing numbers below for the following periods for medicine: From October 2016 to September 2017 and from October 2017 to September 2018. As at September 2018, 92.0% of medical and dental vacancies were filled across the whole trust. The fill rate for medical and dental staff at Furness General Hospital was low with only 64.1% of positions filled at September 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>44.2</td>
<td>52.5</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

**Vacancy rates**

The vacancy data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 6.3% for medical staff working in medicine.

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

Information provided by the trust showed that for Furness General Hospital the vacancy rate for medical staff working in medicine for October 2018 was 17.5%.

**Turnover rates**

The turnover data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 21.3% for medical staff working in medicine. This was better than the trust performance measure of 8.5%.

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

**Sickness rates**

The sickness data submitted by the trust has been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for urgent and emergency care services at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.1% for medical staff working in medicine.

The trust measured attendance and had a target of 95.6%.

(Source: Data request- P19 Sickness)

Information provided by the trust showed that for Furness General Hospital the sickness rate for medical staff working in medicine for the period September 2017 to October 2018 was 1.5%.

**Bank and locum staff usage**
Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we are unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust overall and for the Furness General Hospital covered by bank and medical locum staff in medicine from April 2017 to March 2018 can be found below.

**Trust wide**

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,949</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>11</td>
<td>801</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,464</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>4,214</strong></td>
</tr>
</tbody>
</table>

**Furness General Hospital**

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
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<tr>
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<td><strong>1,707</strong></td>
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(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

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

**Staffing skill mix for the 129 whole time equivalent staff working in medicine at University Hospitals of Morecambe Bay NHS Foundation Trust**

<table>
<thead>
<tr>
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<th>England average</th>
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<tr>
<td>Consultant</td>
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<tr>
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<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
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<td>22%</td>
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</table>
Records

Staff used a combination of electronic and paper records. We reviewed ten patient records (including electronic and the corresponding paper records) and 13 prescription charts at this hospital and found that in general the standard of record keeping was good.

All assessments were completed on the electronic system. This included the nursing assessment, VTE assessment, pressure ulcer risk assessment, nutritional risk assessment, falls risk assessment and care plans. If risk assessments scored highly on the system it automatically opened a care plan for that patient. Additional care plans could be added if needed, for example, a catheter care plan.

Paper records included the NEW2 chart, intentional rounding, glucose monitoring chart, food and fluid charts and stool charts. These were kept at the patients' bedside. Other paper records such as test results were stored in folders in moveable trolleys with lockable lids. We saw that the lids were closed when not in use, however, most of the trolleys were not locked. Trolleys were located near to the nurse's station to minimise the risk of being accessed by unauthorised people.

Matrons carried out monthly documentation audits on medical wards. The results of the audits were given a RAG rating so wards could easily see how they were performing and where they needed to improve. We saw that the medical wards at Furness had achieved a green or amber rating in the last year except for ward 9 which had been rated red three time out of 12.

Electronic patient records could only be accessed by authorised staff using a smart card. We saw one doctor had left a computer unattended with a patient's records on display and left their smart card in.

Medicines

Medicines were not always stored securely on every ward. On one ward we visited the door to the clinic room was open and some medicines, including intravenous fluids, were not in locked cupboards which meant access was not restricted to authorised staff. We checked a sample of medicines and found these to be in date. However, medicines that had a shortened expiry when they were opened or stored outside of a fridge, for example insulin pens, did not have a date
opened or reduced expiry date written on. This meant we could not be sure they were still suitable for use and staff told us they would be disposed of.

Minimum, maximum and current fridge temperatures were recorded daily but were not always within the required range. The temperature monitoring record stated what action should be taken if temperatures go out of range but we did not see evidence that this was being followed. Clinic rooms where medicines were stored were not temperature monitored so we could not be sure that they were being stored according to manufacturer’s requirements.

Controlled drugs were stored securely and daily stock level checks were completed on all wards we visited. However, on two wards records were not always completed accurately. When controlled drug balances were being transferred to a new record book, the signatures of the staff confirming the stock level was correct were missing. Medicines that are needed in emergency situations were easily accessible, stored securely and regularly checked for stock and expiry dates.

On one ward we found intravenous fluids containing potassium were not stored separately from other intravenous fluids. This posed a risk to patients as it would be easy for staff to select the wrong fluid which may lead to patient harm. We informed the ward manager of our concerns who said they would rectify the situation immediately.

Pharmacy staff checked medicine stock levels regularly to ensure they were available when needed and there was a process in place for nurses to order medicines that were not routinely stocked. There was a stock room and an on-call pharmacist for staff to access medicines and advice outside of normal pharmacy opening hours.

We reviewed 13 records on the electronic prescribing and administration system. Pharmacists and pharmacy technicians completed medicines reconciliation (the process of ensuring that the list of medicines a person is taking is correct) on the wards Monday to Friday. However, this was not always completed within 24 hours in accordance with national guidance. There was no ward based clinical pharmacy service at weekends. All patients had their allergies recorded on the electronic system. Patients had been assessed for their risk of developing a blood clot and, where appropriate, medicines were prescribed to prevent this. Medicines that require extra monitoring had appropriate documentation in place. There were no gaps in administration records indicating that people were receiving their medicines as prescribed. Antibiotics were prescribed and reviewed or stopped appropriately. Some patients were receiving oxygen therapy, but this was not always prescribed on the medication administration chart as stated in trust policy.

When patients lack mental capacity, they sometimes require their medicines to be administered covertly (disguised in food or drink). We saw evidence that the correct assessments were in place and that this was in their best interests. Staff were aware of the policy for this and had discussed how to administer the medicines, without reducing its effectiveness, with a pharmacist.

Nurses had access to instructions on how to prepare injectable medicines.

Chemotherapy treatment for patients attending the oncology day unit was made up at the hospital in Lancaster and transported to Furness. Staff told us this was not normally a problem but could be an issue in winter when the weather was poor.

Oxygen cylinders were stored appropriately and were all within their expiry date.

Incidents
Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system.

Incidents were reviewed and validated by ward managers who could escalate them if necessary. Incidents of moderate harm and above (including near misses) were discussed at the weekly patient safety summit.

Staff received automatic feedback on incidents they reported and learning from incidents was shared with staff at monthly ward WESEE governance meetings. Incidents were also discussed at handover and safety huddles on medical wards. Ward managers told us that if appropriate, staff would carry out a reflective piece of work to learn from incidents.

Staff we spoke with knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients when things go wrong. Ward managers were aware of the DoC and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.

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 September 2017 to August 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from September 2017 to August 2018.

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

- Slips/trips/falls meeting SI criteria with four (27% of total incidents).
- Pressure ulcer meeting SI criteria with four (27% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (20% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (13% of total incidents).
- Medication incident meeting SI criteria with one (7% of total incidents).
- Incident pending review with one (7% of total incidents).

Site specific information can be found below:

- Furness General Hospital: six incidents
- Royal Lancaster Infirmary: nine 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 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 13 falls with harm and 11 new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

Is the service effective?

Evidence-based care and treatment
Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the safeguarding children policy, the NEWS policy, sepsis policy, and information governance policy. All but one (information governance, which expired on 1 November 2018) were within their review date.

The care group’s WESEE report for October 2018 showed that the care group had a programme of reviewing practice against current NICE guidance. Where the Trust had rated themselves as partially compliant, a named individual was tasked with moving this to compliance and we saw evidence that this had taken place.

Matrons conducted monthly assurance audits which covered several areas including communication, medicines management, harm free care, safe clean environment and patient experience. Each ward was given a RAG rating depending on the results and actions to improve. The service was in a process of moving over to a new quality and assurance tool called My Assure.

Several medical wards at Furness General Hospital had been awarded with the Gold Standards Framework (GSF) accreditation in 2017. Staff were very proud of this and how they provided care for patients at their end of life.

Nurses at the oncology day unit had recently conducted a peripherally inserted central catheter (PICC) line audit and the results were to be presented at the next education evening. Staff told us the education evenings took place twice a year and were an opportunity to share best practice.

**Nutrition and hydration**

The Trust had a nutrition policy in place, supported by a multidisciplinary nutrition strategy group. Patients were screened using the Malnutrition Universal Screening Tool (MUST). We saw that these were stored in a patient’s electronic record and these had been appropriately completed. Any patient scoring medium and above was automatically referred to a dietitian for further input.

Meal times were protected, but friends and family were encouraged to stay and assist patients with feeding if they wished. We spoke to a total of 15 patients and their relatives, and all said that they were happy with the food choices available and that their portion sizes were good. Patients had a choice of menus and special dietary needs were catered for. Patients were assisted in their choices where required.

Patients dietary needs were clearly written on a whiteboard at the back of their bed to ensure they received the correct food, for example easy chew or pureed.

We saw that patients had access to drinks outside of mealtimes and that water jugs and cups were within reach. Two handled beakers with spouts were available for those who needed them, as was adaptive cutlery. Fluid intake and output was recorded on a fluid balance chart. We saw these had been completed and were up to date.

**Pain relief**

Patients had access to pain relief where required. We saw that pain scores were an integral part of the NEWS documentation and had been completed in the records we reviewed.

Patients we spoke with had no concerns about how their pain was managed. They said nurses were responsive if they asked for pain relief and checked with them regularly that they were comfortable.
Staff could refer patients to the acute pain nurse if they needed advice and help to manage their pain effectively.

**Patient outcomes**

The trust participated in local and national audit and used their results to drive changes to improve care and treatment. Local audit plans were comprehensive, and audits were completed and stored as part of an electronic audit system. We viewed a sample audit and saw that it had clear targets and deadlines, a named owner and associated action plan.

Occupational therapists used the therapy outcome measure (TOMS) to measure their patients progress. They told us they were exploring better ways to demonstrate their effectiveness.

The endoscopy unit was not accredited by the Joint Advisory Group on Endoscopy (JAG). The ward manager informed us this was because the building did not meet the requirements. To meet the requirements, the area would need a capital spend of approximately one million pounds. The unit manager told us they were meeting the standards for JAG in other areas.

Performance in national audit was reasonable (see below). The trust supplied us with a copy of their gap analysis following the National Audit of Inpatient Falls 2017. Despite outcomes being below the national aspirational standards, the trust had RAG rated themselves as already recording or meeting 17 of the 21 recommendations, the other four rated amber. Given the current position we did not feel this action plan offered sufficient challenge to improve.

Therapy staff told us that they were not commissioned to provide an early supported discharge service for stroke patients, however, therapists did provide a small community follow up service where possible.

**Relative risk of readmission**

**Trust level**

From May 2017 to April 2018, patients at the trust had a lower 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 Admissions – Trust Level**

![Graph showing relative risk of readmission](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a similar to expected risk of readmission for elective admissions

**Non-Elective Admissions – Trust Level**

![Graph showing readmission rates for different specialties]

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.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

**Furness General Hospital**

From May 2017 to April 2018, patients at Furness General 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 Admissions - Furness General Hospital**

![Graph showing readmission rates for different specialties]

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.

- Patients in gastroenterology had a 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.
- Patients in general medicine had a lower than expected risk of readmission for elective admissions.

**Non-Elective Admissions - Furness General Hospital**
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 represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions.
- Patients in gastroenterology had a lower than expected risk of readmission for non-elective admissions.
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions.

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

**Furness General Hospital**

Furness General Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the hospital achieved grade C in latest audit, August 2017 to November 2017.

The hospital performed particularly badly for speech and language therapy and thrombolysis, achieving a grade E in team centred and patient centred performance. The hospital performed particularly well for standards by discharge achieving a grade A in the most recent audit for team centred and patient centred performance.

The Trust’s Quality Committee minutes noted that SSNAP data needed improvement and this was mainly due to a lack of therapy staff. Patients were not being offered a seven-day therapy service due to low staffing levels and a lack of thrombolysis trained staff in the emergency department meant that some eligible patients had not received this.
### Patient centred performance

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<tr>
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**Patient-centred total key indicator level**

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<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
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### Team centred performance

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**Team-centred total key indicator level**

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### Overall Scores

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**Case ascertainment band**

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**Audit compliance band**

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**Combined total key indicator level**

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(Source: Royal College of Physicians London, SSNAP audit)

**Lung Cancer Audit**
The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 94.3%, which met the audit minimum standard of 90%. The 2016 figure was 47.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 12.2%. This is worse than expected. The 2016 figure was not significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 63.5%. This is within the expected range. The 2016 figure was not significantly different to national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 83.0%. This is better than expected. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 is 36.7%. This is within the expected range. The 2016 figure was significantly worse than the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017 (Furness General Hospital)

The crude proportion of patients who had a vision assessment (if applicable) was 79%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 4%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 41%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 86%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates

Staff we spoke with during the inspection said they had received their appraisal with their line manager. Despite this, information provided by the trust (see below) showed that compliance was below the trust target of 95%.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data split by CQC core service. The trust has provided data split by clinical care group and therefore the appraisal data for medicine also includes data for urgent and emergency care.

As at September 2018, 73.3% of staff within medicine at the trust received an appraisal compared to a trust target of 100% for leadership staff and 95% for all other staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
</tr>
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</table>
Bands 1 to 7 and Band 8a+ with no staff responsibilities | 1,063 | 776 | 73.0%
Bands 8a+ With Staff Responsibility | 25 | 22 | 88.0%
Grand Total | 1,088 | 798 | 73.3%
(Source: Data request- P43 Appraisal Compliance 2017 to date)

Staff we spoke to were positive about the opportunities to develop and grow both within their current role and the wider trust.

Therapy staff told us they carried out regular supervision which included peer group and one to one supervision. This was structured for new starters. Therapy staff also provided in house competency training for example, tracheostomy training. They said it was sometimes difficult to secure funding for external training.

There was a rotation in place for band 5 therapy staff to rotate into community services as well as working within the hospital. Staff were supporting a band 3 physiotherapy assistant to complete training to become a qualified physiotherapist.

All band 5 and band 6 registered nurses on CCCU had completed step one competency training for adult critical care nurses to ensure they had the skills and knowledge to care for patients on non-invasive ventilation (NIV) and high-flow nasal oxygen safely.

Junior doctors had protected time for learning on Tuesdays. They told us they received regular clinical and educational supervision. They were able to attend the ‘Grand Round’ teaching session which took place regularly at the hospital.

New nurses on the oncology day unit attended oncology training courses in Preston once a week for around six months. A shorter more intensive course was also available at the Clatterbridge Cancer Centre.

Advanced nurse practitioners (ANPs) in speciality services such as stroke, gastroenterology and respiratory provided training and support to staff. The respiratory ANPs told us they provided training around the hospital which included the acute medical unit and the emergency department.

A registered nurse on ward 7 told us they could initiate bilevel positive airway pressure (BIPAP) on the ward and they were trained and supported by two specialist respiratory advanced nurse practitioners (ANPs). However, we requested information on the number of nurses who had up to date competencies in BIPAP on this ward and the trust were not able to supply this information as they did not capture it.

The discharge co-coordinator on ward 9 told us they had received a comprehensive induction which included observation of services outside the trust such as the hospice and local authority provisions.

We saw that there was an opportunity for staff to access leadership programmes. Staff were positive about these and told us it strengthened their existing role and prepared them for future roles.

The service supported therapy and nursing students on placements and in other developmental roles for example nurse apprentices. Practice education facilitators provide additional supervision and support to mentors in clinical practice who were supporting students in training.

It was unclear as to the arrangements for training and supervision for bank staff as some told us they were not included in any appraisal system.
Multidisciplinary working

All staff we spoke to were very positive about multidisciplinary team (MDT) working. All groups of staff said that relationships were strong.

The trust’s MDT working functioned on three levels, firstly MDT board rounds as part of the safer care bundle, secondly MDTs for medical tumour groups, and lastly, wider MDTs with partner organisations as part of ‘discharge to assess’ and reductions in medically fit for discharge levels within the hospital.

We saw good examples of MDT working. On ward 7 the respiratory consultants attend the daily board round alongside nursing staff, physiotherapy and occupational therapy staff, the social worker and the complex discharge team. The specialist respiratory advanced nurse practitioners based at Furness General Hospital worked closely with the community respiratory team and would sometimes visit patients at home.

An MDT board round was held at 10am on ward 6 (stroke and frail elderly) which included nurses, medical staff, physiotherapy, occupational therapy and speech and language therapists. Staff told us they worked well together but more therapy input was needed.

Patient records and discharge plans showed good evidence of MDT planning of care and treatment which included communication with outside agencies. The discharge co-ordinator on ward 9 could tell us of clear liaison processes and showed us the range of contacts available.

We were told that there were some delays in discharge of patients where social care actions were required to secure nursing homes. Sometimes this differed between the two local authorities served by Furness General Hospital.

We saw good links from the day oncology unit to the palliative care team and specific staff members such as clinical nurse specialists in lung cancer, breast care and Macmillan nurses.

The Ambulatory Care Unit worked closely with the Emergency Department to triage those patients who could be treated at the unit and assist in patient flow. We saw multidisciplinary working in the unit with the outreach respiratory team.

Seven-day services

There was a consultant on call 24 hours every day in AMU. The consultant on call was on site from 8am to 8pm seven days a week and then on call from home until 8am the following day. The consultant would review any new admissions at weekends and would see any patients who were deteriorating and of concern on other wards.

The trust was working towards achieving the Keogh standards by 2020. They acknowledged there were gaps in meeting seven-day standards and were looking for solutions. For the period April to November 2018, 84% of post take patients were seen by a consultant within 14 hours at Furness General Hospital.

There was no established 24/7 gastrointestinal (GI) bleed rota. Furness General Hospital had a standalone bleed rota made up of anaesthetists and gastroenterologists however, staff told us there were gaps on the rota. The unit manager of the endoscopy unit told us that discussions were taking place to plan an ‘across bay’ rota and this would be starting soon. If a patient had a GI bleed staff told us they would instigate the major haemorrhage protocol and contact the gastroenterology or surgical team. We saw a copy of the Upper Gastrointestinal Haemorrhage –
Medical and Emergency Guidelines. We were concerned that ward 9 which cared for gastroenterology patients did not have a major haemorrhage kit available on the ward.

The oncology day unit was open 8am to 6pm seven days a week. Consultant cover came from other hospital sites which included Preston and Lancaster.

Therapy staff provided services five days a week from Monday to Friday. The exception to this was the on call respiratory physiotherapy service, which was available out of hours. There were several vacancies in the therapy team and staff told us they found it difficult to recruit and retain staff due to the location of the hospital. Managers were aware of the shortage of therapy staff and they had formed an action plan to improve therapy input. The matron told us they were looking to develop generic workers who had therapy skills to work at weekends.

A specialist stroke nurse was available from 8am to 5pm seven days a week. The nurse carried a bleep and would be pre-alerted by the Emergency Department if a patient with a suspected stroke was due to arrive. Out of hours a telemedicine service was available to contact the stroke consultant on the region wide rota.

Computer Tomography (CT) scanning was routinely available from 8.30am to 5.00pm Monday to Friday. For out of hours and weekends staff would contact the radiologist on call.

**Health promotion**

The trust was a smoke free trust and information was provided to patients on the benefits of stopping smoking prior to their visit if attending for planned treatment. Signposting to stop smoking helplines was available.

On ward 6 we saw that staff had created a display board on the stroke pathway which gave information on risk factors and early warning signs of a stroke.

We saw a variety of leaflets available for patients and their families. Some were produced by the trust and some were from other agencies such as The Stroke Association and Dementia UK. The leaflets were on appropriate topics and neatly stored.

Health promotion and self-care were important factors in the success of the respiratory team outreach work. The team said they had reduced hospital admissions by 50%.

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

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with had a good understanding of consent and the principles of the Mental Capacity Act. They told us that had training as part of the mandatory Safeguarding Adults Level 2 training. The Trust’s yearly safeguarding report indicated that the intention for the coming year was to extend this to a ‘standalone’ session to facilitate more in-depth learning.
There was a specific consent form in use (consent form 4) for adults who were unable to consent to investigation or treatment. This was used when an adult patient lacked capacity to give or withhold consent to a significant intervention. The form included an assessment of the patient’s capacity, why the health professional believed the treatment to be in the patient’s best interests, and the involvement of people close to the patient. We saw this form being used in the endoscopy unit.

Applications for DoLS and mental capacity assessments were completed on the electronic records system. We reviewed two DoLS records including best interest and mental capacity assessments. These were of a good standard and fully and appropriately completed. Staff told us there was sometimes a delay in the local authority authorising DoLS which meant patients had been discharged before an authorisation had been received.

Guidance and support with completing these records was available to staff on the intranet. DoLS referrals were stored electronically, generating an automatic reminder should the application need extending seven days later. Staff confirmed that they were prompted to renew applications they had submitted. The safeguarding team held copies of all referrals. There was a DoLS lead in the trust who could be contacted for advice and who would be involved in future training.

Staff on wards were using a passport for patients with a learning disability and had access to a Matron for Learning Disability, Autism and Complex Needs for further advice on capacity in these patients.

Staff understood the Mental Health Act and when and how it should be applied.

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

Staff received training in MCA and DoLS as part of their Safeguarding Adults Level 2 training. The trust provided information on compliance with Safeguarding Children and Adults Level 2 training for medical wards at Furness General Hospital. Compliance was high with three wards exceeding the trust target of 95%.

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**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We spoke with 15 patients and relatives throughout the inspection. Patients and relatives told us that they had been treated kindly and that staff were polite and respectful.

All patients we spoke with were happy with the standard of care they received. They had drinks and call bells located within easy reach. Patients told us they felt they were in safe hands.

Comments from patients included ‘the nurses here are excellent’ and ‘my care has been outstanding’.

One relative told us that he felt the ward was like a family unit and felt very safe leaving their loved one there.

Staff on CCCU told us that a young patient had chosen the unit as their preferred place of death and they had supported the family with this. They provided a bed for parents to stay overnight so they could stay close during the patients last few days of life.
Although staff were caring, we noticed that they were not always able to respond quickly to the needs of patients. We heard call bells ringing for long periods on ward 7 and ward 9 as staff were busy and unable to respond.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia.

In the National Cancer Experience Survey 2017, 88% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital at this trust. This was a decrease compared to 93% in the 2015 survey.

In the Patient Led Assessment of the Care Environment (PLACE) 2018 survey, the trust scored 76% for privacy, dignity and well-being and 66% for dementia friendly environment. This was a lower score since our last inspection when scores had been 86% and 75% respectively.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 30% which was better than the England average of 25% from August 2017 to July 2018. For Furness General Hospital medical wards, the average response rate for the same period was 36% which is high.

**Furness General Hospital**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGH Ambulatory Care Unit</td>
<td>582</td>
<td>44%</td>
<td>96%</td>
</tr>
<tr>
<td>FGH Acute Medical Unit</td>
<td>531</td>
<td>37%</td>
<td>100%</td>
</tr>
<tr>
<td>FGH Ward 7 Gen Med/Elderly</td>
<td>225</td>
<td>31%</td>
<td>100%</td>
</tr>
<tr>
<td>FGH Ward 9 and Coronary Suite</td>
<td>215</td>
<td>25%</td>
<td>100%</td>
</tr>
<tr>
<td>FGH High Dependency Coronary Care Unit</td>
<td>198</td>
<td>54%</td>
<td>100%</td>
</tr>
<tr>
<td>FGH Ward 6 Gen Med/Elderly</td>
<td>146</td>
<td>24%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any National standard.

Wards with fewer than 100 responses have been excluded.

**Emotional support**

We saw that patients were well supported emotionally, and staff were caring and empathetic.

We saw staff offering emotional support and speaking to patients respectfully. The respiratory outreach team included access to psychology services for patients to provide a holistic approach to care. Staff told us that they worked closely with the bereavement service to provide care for those patients and relatives who were on the end of life pathway.

The trust used the butterfly system with which to identify patients living with dementia. We observed this in use across the care group. We observed and heard staff speaking to patients with dementia in a kind and respectful manner.

The oncology day unit provided a cold caps service (to minimise hair loss) and a wig fitting service was available to patients who had lost their hair. There was also a complimentary therapy room providing aromatherapy massage. Staff told us that a new psychology service was starting that week and the psychologist would visit the hospital once every two weeks.
Spiritual and pastoral support was available to patients, relatives, carers and staff. Chaplains were available to provide services for different faiths in the chapel or at the patient’s bedside. The chaplaincy held a list of local faith and belief group contacts which could be called upon if there was a specific need that could not be met from within the team.

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

Patients we spoke with told us that doctors, nurses and therapists discussed their treatment plan with them and involved them in decisions about their care. They spoke very highly of medical staff and said that doctors took the time to explain things properly.

Patients said they had an opportunity to ask the doctors questions and felt confident in their responses.

One relative told us they couldn’t be happier with the service that had been provided and they were always kept informed of what was happening.

Patients we spoke with in the endoscopy unit told us that staff had explained what would happen during all stages of the procedure and they found this reassuring.

We saw a ‘people important to our patient’ section within patient notes where discussions with the patient and their family had been clearly documented.

Visiting hours could be extended if a patient was on the end of life care pathway, or to accommodate relatives’ work patterns. This included relatives being present at mealtimes to assist with feeding if necessary.

The Trust supported ‘John’s Campaign’, a national initiative to encourage carers to support and stay with people with dementia while they were in hospital. The Trust used lanyards to identify carers and this enabled carers to have 24-hour access to those they were supporting. They were encouraged to become actively involved in the patient’s care. We saw carers wearing their lanyards and the staff we spoke to knew what this meant.

**Is the service responsive?**

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

The Trust had good oversight of service planning and was responsive to the needs of local people.

Leaders were aware of the logistical and recruitment issues posed by the trust’s geography and could give examples of how they had worked hard to mitigate this, for example by ensuring that all senior staff worked across the whole bay at all three sites.

The trust took an active role in the Morecambe Bay Integrated Care Community (ICC) entitled Better Care Together. A five-year plan had been developed, outlining the proposed transformation of patient pathways and moving care closer to home.

Furness General Hospital cared for a large rural community which held some geographical challenges. The hospital had strong links with other local hospitals for specialist services such as cardiology. The specialist stroke nurse told us there were regional discussions about the reconfiguration of stroke services and a hub and spoke model was being considered.

The service was planning to make changes to the configuration of medical beds at Furness General Hospital. The ward manager for AMU was involved with the planning process and told us of the plans for a new 30 bedded unit which would have 10 beds for acute medical patients and 20
short stay beds. The ambulatory care unit and the discharge lounge would be relocated next to the unit. The service was also in the process of implementing a frailty pathway.

The Ambulatory Care Unit was led by Advanced Nurse Practitioners (ANPs) and received direct referrals from GPs and from the Emergency Department. The service enabled non-critical patients to be seen quickly, treated and discharged on the same day which relieved pressure on the Emergency Department and the Acute Medical Unit. The unit had nine treatment chairs was open 9am to 6pm Monday to Friday and 8am to 2pm on Saturdays and Sundays.

The day oncology unit provided care for chemotherapy patients requiring chemotherapy treatment and rheumatology and neurology patients who required intravenous treatments. This enabled patients to be treated nearer to home as otherwise they would have to travel to a larger acute hospital in the area.

**Meeting people’s individual needs**

The service accommodated people’s individual needs. Patients with a learning disability or dementia were well supported and we saw several examples of this on medical wards.

The trust used a purple butterfly symbol to identify patients with dementia. This was an opt in scheme and required verbal consent from the patient or their relative. The butterfly was placed both above the patient’s bed and on their electronic record. This stayed in place if the patient was transferred to another ward and ensured that staff knew extra support and care was needed. We saw that forget-me-not dementia passports were in use and wards had dementia champions.

There was clear dementia friendly signage on toilet and bathroom doors to distinguish between male and female facilities. The signs were interchangeable and planned to ensure patients dignity was maintained.

Patients with a learning disability (LD) had their individual needs and preferences clearly documented. We saw an ‘LD passport’ was in use which contained comprehensive detailed information on the patient’s daily living and communication preferences. Staff on the wards had access to an LD clinical lead who provided advice and support. Wards had access to communication tools such as picture boards.

Visitors who had extended visiting hours were issued with a pass to ensure all staff knew this was the case. There was car parking assistance for these relatives.

Therapy staff organised group activity sessions for patients recovering from a stroke. They also ran a newspaper discussion group and a puzzle group for patients who wished to participate. Volunteers helped with these activities.

The Maple Suite on ward 9 was available for patients receiving end of life care. The suite had been adapted to look homely with colourful curtains, homely furniture and pictures on the wall. This was funded by an external charity. The room was decorated like a bedroom at home and had a TV, seating, a kitchenette and pull out bed for family members who wished to stay. If the patient had a dog, they were allowed to visit the suite. The trust used a ‘dragonfly’ system to identify those patients who were on the end of life pathway.

Staff could access telephone translation services or book a face to face interpreter. They could also book a face to face British Sign Language interpreter. Staff told us they had no problem arranging this.

Staff demonstrated an understanding of the needs of patients presenting with mental health needs. Staff gave us positive examples of working with providers of mental health services for the
benefit of their patients. One member of staff told us they had arranged for the mental health crisis team to visit their patient at home on the day of their discharge. This allowed them to go home early where they would be more comfortable speaking to team, rather than having to stay as an inpatient on the ward waiting for mental health input.

The trust had not declared any mixed sex breaches for medical care in the last six months but on the Complex and Coronary Care Unit (CCCU) we observed a lady being cared for in a four-bedded bay with three gentlemen. The lady was not receiving level 2 care. We spoke to the ward sister about this and they were unclear if this constituted a mixed sex breach. We raised this with the trust who assured us that in future they would ensure that they would report breaches against the guidance using the same practice as they used in the Intensive Care Unit, through their incident reporting system.

Access and flow

Patient flow was discussed at the bed meetings which were held five times a day. We attended a bed meeting at this hospital. The meeting was led by the hospital site manager and was attended by matrons for each clinical area and clinical service managers. Staff from Lancaster Hospital joined the meeting by phone. Flow through the emergency department and bed availability were discussed as well as staffing for each area.

The ward manager of AMU had visited Pinderfields Hospital to look at how they had implemented the SAFER patient flow bundle. The aim of SAFER was to identify discharges early in the day and work to achieve a timely discharge therefore improving patient flow and reducing patient length of stay. The SAFER project was in place on AMU and the implementation had been supported by NHS improvement.

The service had appropriate discharge arrangements in place for people with complex health and social needs. Discharge plans were discussed at daily multidisciplinary team board rounds on medical wards. Social care workers were involved in these discussions to ensure the correct services were put in place for the patient to be discharged home safely. There was a complex discharge team and wards had discharge co-ordinators to ensure discharge arrangements were made.

The trust had clear arrangements for ensuring medical outliers were seen daily by a relevant consultant or specialist registrar. Medical patients outlying on a non-medical ward were allocated to the designated consultant covering a specific area. There were 28 medical patients outlying on non-medical wards at the time of our visit. We looked the notes of seven of these patients and found they had been regularly reviewed by appropriate medical staff.

A seven-seated discharge lounge was open from Monday to Friday from 9am to 5pm. Patients transferred here to wait for transport home. A transfer handover sheet was completed for each patient to ensure their needs were met whilst waiting in the lounge.

Thrombolysis for stroke patients was carried out in the emergency department. Following thrombolysis patients were transferred to the CCCU for 24 hours or until they were ready to be stepped down to the stroke ward. Patients were reviewed regularly by a specialist stroke nurse who supported CCCU staff.

There was no cardiac catheter laboratory onsite. Patients with a serious heart attack caused by a complete blockage of the heart artery (known as a STEMI) were transferred to a specialist cardiac centre. There was a dedicated ambulance alerting system to take these patients to the cardiac centre in a timely manner. Both inpatients and new patients who had a heart attack caused by
narrowing of the heart artery (known as NSTEMI) would go to the cardiac catheter laboratory at Westmoreland General Hospital for diagnostic percutaneous coronary interventions.

The oncology day unit proved treatment to approximately 30 patients a day. If a patient deteriorated in the unit and was not well enough to go home, then they would be reviewed and admitted under a medical consultant.

We were told that systems were in place if it was considered unsafe to admit patients due to staff shortages. The service had previously made the decision to close some beds due to staffing levels and were in the process of opening them back up.

Average length of stay

Trust Level

From June 2017 to May 2018, the average length of stay for medical elective patients at the trust was 4.8 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.0 days, which is similar to the England average of 6.4 days.

Elective Average Length of Stay – Trust Level

![Graph showing average length of stay for elective specialties.]

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in general medicine is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

![Graph showing average length of stay for non-elective specialties.]

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 elective patients in general medicine is similar to the England average.
• Average length of stay for elective patients in gastroenterology is similar to the England average.
• Average length of stay for elective patients in geriatric medicine is lower than the England average.

**Furness General Hospital**

From June 2017 to May 2018, the average length of stay for medical elective patients at Furness General Hospital was 7.3 days, which is higher than England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.9 days, which is higher than England average of 6.4 days.

**Elective Average Length of Stay - Furness General Hospital**

![Bar chart showing elective average length of stay for different specialties at Furness General Hospital compared to England average.](chart)

*Note: Top three specialties for specific site based on count of activity.*

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.
- Average length of stay for elective patients in clinical haematology is lower than the England average.

**Non-Elective Average Length of Stay - Furness General Hospital**

![Bar chart showing non-elective average length of stay for different specialties at Furness General Hospital compared to England average.](chart)

*Note: Top three specialties for specific site based on count of activity.*
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in gastroenterology is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was generally better than the England average, with the trust performing better than the England average in all months other than January 2018. For the period

In the most recent month (July 2018), the trust’s referral to treatment performance was at 100% (17 admitted pathways), in comparison to the England average of 89.2%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties 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>Rheumatology</td>
<td>100.0%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>98.3%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.1%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moving wards per admission

From July 2017 to June 2018, 58.2% patients did not move wards during their admission, and 41.8% moved once or more at Furness General Hospital.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night
From July 2017 to June 2018, there were 3,292 patients moving wards at night within medicine at the trust and 1,429 of these were at Furness General Hospital.

Furness General Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Ward moves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit</td>
<td>1,061</td>
</tr>
<tr>
<td>High Dependency/Coronary Care Unit</td>
<td>162</td>
</tr>
<tr>
<td>Ward 7 Gen Med/Elderly</td>
<td>105</td>
</tr>
<tr>
<td>Ward 9 and Coniston Suite</td>
<td>74</td>
</tr>
<tr>
<td>Ward 6 Gen Med/Elderly</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,429</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Complaints were valued by the trust and information relating to these was disseminated at ward level using the WESEE governance tool. Learning from complaints was also shared at daily handovers.

Wards displayed their Friends and Family Test results and how many complaints and compliments they had received in the previous month. We saw posters and leaflets displayed on wards advising how to make a complaint.

Ward managers told us they received a low number of formal complaints and they tried to resolve issues with patients and relatives before they escalated. Ward managers could tell us what the main theme of complaints was for their area and what action they had taken to address this.

Thankyou cards were evident in staff areas to share positive feedback.

Summary of complaints

From July 2017 to June 2018 there were 81 complaints about medical care at this trust and 20 were related to Furness General Hospital. The trust took an average of 32.7 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 35.0 days.

Of the 81 complaints received trust wide during the 12-month period, 17 (21.0%) related to treatment given, 15 related to nursing care (18.5%), 10 related to diagnosis problems (12.3%) and nine (11.1%) related to discharge arrangements.

A breakdown of complaints at Furness General Hospital can be found below.

Furness General Hospital

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Given</td>
<td>6</td>
</tr>
<tr>
<td>Diagnosis Problems</td>
<td>3</td>
</tr>
<tr>
<td>Branding: Evidence Appendix</td>
<td></td>
</tr>
</tbody>
</table>

### Nursing Care

- Attitude of Staff - Doctor: 3
- Clinical Treatment: 2
- Communication/Info to Patients: 1
- Consent to Treatment: 1
- Discharge Arrangements: 1
- Personal Records (Medical): 1
- Waiting Time for Treatment: 1

**Grand Total:** 20

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

#### Number of compliments made to the trust

From July 2017 to June 2018 there were 173 compliments in medicine at Furniss General Hospital.

We are unable to draw any themes from the compliments data provided. However, the trust has stated that they carry out their own analysis of compliments, which is shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

### Is the service well-led?

#### Leadership

Medical care (including older peoples care) was provided within the medical care group. The care group was also responsible for providing emergency care and was led by a clinical director, a general manager and an assistant chief nurse.

Ward managers were effective and had good oversight of their areas. All ward managers we spoke with told us that their matron visited the ward every day and gave them good support. Without exception, staff told us they felt well supported to do their job and felt comfortable sharing any concerns with their immediate line manager.

Ward staff told us that they felt supported by the ward managers and that they thought senior managers were visible and accessible. Staff spoke highly of the Chief Executive Officer (CEO) and we observed photographs of the executive board and the CEO displayed around the hospital with clear explanations of their roles including their contact details.

The trust offered leadership courses in partnership with Kendal College and Lancaster University at levels three, five and seven, as well as bespoke internal programmes for those with specific requirements.

Junior doctors we spoke with said they were well supported by senior medical staff and consultants said they had no problems with the senior management team.

Staff knew how to raise whistleblowing concerns and where to find information. The whistleblowing policy was accessible on the trust intranet. The trust had a freedom to speak up guardian who had
built on their role since 2015, and a mobile phone app allowed staff to contact them directly and anonymously. In October 2017, the Trust won the first ever national Freedom to Speak up Communications award for this dual approach.

**Vision and strategy**

The medicine care group strategy was underpinned by an operational delivery plan and was aligned to the trust’s strategic plan for 2016-2019. This delivery plan supported the wider Better Care Together health economy transformation programme. Work was ongoing with partners as part of Better Care Together to improve the service models for cardiology and respiratory conditions and admissions avoidance.

The care group’s strategic plan set out their priorities and contained appropriate planning including assessment and planning for risk, finance, estates and communications.

The trust’s values and expected behaviours were prominently displayed throughout the hospital. Mirrors prompted staff to stop and take a moment to think about how they reflected these values.

**Culture**

Staff spoke very positively about working at the trust and morale was high. Teams supported each other well and staff praised their colleagues for their teamwork and help. Staff told us that there had been a significant change in culture and staff no longer felt afraid to raise concerns and could be open and honest. They explained that years ago they felt there had been a blame culture but that this had now changed, and the emphasis was on learning when incidents occurred.

We heard from staff working at all levels on the medical wards that teamwork was very strong, and that staff weren’t afraid to ‘pitch in’ with tasks as needed. Ward leaders talked about their staff as their greatest asset and most valuable resource. Staff told us that they felt there had been a marked improvement in the culture of the organisation and that the behavioural standards had made a positive difference.

Ward managers told us that the culture on the wards was open and supportive and they were proud of their teams and the services they provided. Staff we spoke with were not aware of any issues of bullying.

We heard from nurses recruited from overseas that they had been made to feel welcomed into the trust, and they had felt supported professionally and on a personal level.

All staff told us that the communication between the trust sites was good and practices were consistent across areas.

Junior medical staff were a little wary of reporting all the hours they worked to be considered for extra pay or time off in lieu as this needed to be considered by senior staff and there were worries about adverse consequences. However, we heard that at Furness General Hospital they felt well supported and they were encouraged to develop.

**Governance**

There were clear governance structures for the medicine care group over the three sites. The trust used the WESEE framework which was a simple integrated reporting mechanism which began with ward managers and escalated through the governance structures to care group governance
and management meetings. Any issues requiring escalation were reported through to the Quality Committee. Information was cascaded back through to staff on the front line so that all staff knew how their areas were performing.

Wards held monthly WESEE governance meetings and Matrons received WESEE reports from each medical ward under their management which gave them an oversight of training, workforce, efficiency, safety, effectiveness and patient experience. Matrons met monthly to discuss and analyse the contents of the WESEE reports. If performance was slipping they submitted an improvement plan to the associate director of the medical care group.

Management of risk, issues and performance

Risks were recorded on the electronic reporting system and could be allocated to a care group, speciality or ward depending on the rating. Service risks were held on the medicine care group risk register. We reviewed the risk register and found that risks were regularly reviewed, each risk has a set of actions and timescales for completion and a named person to oversee. There was clear mitigation for most risks and an explanation was provided where it is not possible to mitigate. However, staff we spoke with on the wards were unclear how local risks were recorded and who was responsible for managing them. They did not have sight of the care group risk register.

The care group WESEE monthly report monitored areas such as mandatory training, incidents, lone working, efficiency, medication errors, document control, medicine audit exceptions, NICE alerts, claims and patient experience. This document did not clearly state what the targets were in all areas and there was no direction of travel visibly displayed to demonstrate whether performance was improving or deteriorating.

Individual wards received their own WESEE reports for review at monthly team meetings. Ward leaders told us that they had regular team meetings, and in some areas, these were held at different times of the day, including evenings, to maximise attendance. These were driven by the Trust’s WESEE reports.

Care group managers could view online reports to monitor performance in some areas. For example, the elective care performance dashboard showed live data and could be broken down by care group, speciality, site and to individual consultant. Targets against cancer wait times, referral to treatment time and waiting list size could be viewed. However, it was unclear how care group managers viewed and monitored their overall safety performance and what they measured this against.

There were clear plans for winter pressures and logistical arrangement of staff getting into work if extreme weather condition arose. Winter planning started in the spring. There were contingency plans in place with other hospitals should a major incident occur. This had been revised following a major incident last year.

Information management

The trust was using information management systems effectively and auditing this well. A recent move to an electronic audit proposal, registration, tracking and reporting system meant that leaders could track progress easily.

Staff told us they were provided with the right systems to do their job. The intranet was easy to navigate and find information, and the patient records system was clear and prompted staff to renew or refresh elements of patient care as appropriate. Access was also available where
needed to wider systems such as those used by adult social care teams and GPs. Ward managers had access to their staff’s electronic staff records so they could view appraisal, sickness and training rates.

A new electronic ‘review workspace’ was introduced for procedural documents enabling staff to view, review and comment electronically, saving time and reducing duplication of effort.

The trust’s Information Governance and Data Quality Committee monitored the implementation of the Data Quality Strategy. Information governance training rates were monitored at care group leadership level and was 89.8% in September 2018.

Engagement

The trust launched its new Patient and Public Involvement Strategy in 2018 which included a ten-point action plan for involvement. There was a recognition that different groups of stakeholders would want to be listened to in a variety of different ways and there was evidence of some innovative thinking around this including the use of patient diaries.

Patient experience was captured at a variety of levels and tools were provided to encourage ward staff to collect this. Patients were encouraged to share their experience not just through the Friends and Family Test but also drop-ins and stalls. Complaints and compliments were encouraged.

Patients were encouraged to participate in service user groups, for example the endoscopy user group, so they could contribute ideas to improve and develop services.

‘You said we did’ boards were used on wards to show patients what had changed because of sharing their experiences.

Staff we spoke with told us that generally they felt involved in service development and were consulted on services changes. They felt that they were listened to and any ideas they had about the development of their service seriously considered.

Consultants told us that the management team were positive, open and engaged with them regularly. They said they could discuss problems, felt they were listened to and worked well together as a team.

Matrons told us they tried to involve staff in service improvements or looking for solutions to problems which resulted in better staff engagement.

Several staff mentioned that the Chief Executive held regular ‘tea and a talk’ sessions and that they felt this was a good way of being heard. Awards evenings were held.

Staff were recognised and rewarded for long service and for their achievements at an annual awards night.

There was a guardian for safer working within the trust; however, some staff we spoke with were unaware of this.

Learning, continuous improvement and innovation

Staff were encouraged to submit new ideas on how to improve services in their areas of work to the ‘listening into action’ team who could offer advice and support to make changes happen. Funding for service improvement was also available to staff through a ‘Dragons Den’ style event.
We saw examples of service improvements and found a willingness from staff to implement changes which would lead to better services for patients. Some of these improvements were the introduction of the safer patient flow bundle and the frailty pathway, the introduction of the NEWS2 charts and the accreditation of the Gold Standards Framework for end of life care.

The specialist cardiac nurse told us about an app which was used to support patients with an irregular heartbeat (arrhythmia) in their own home. The app recorded the patient’s heart rhythm every 30 seconds, and this was uploaded to the trusts electronic system. The nurses could access this and then provide advice and guidance to patients.

Staff had supporting the ‘end PJ paralysis’ campaign to help patients and relatives understand the importance of moving regularly and wearing regular day clothes to promote independence and normal routines whilst in hospital.

Senior leaders told us that intensive leadership work at all levels had changed how teams see each other and the quality of conversation was far better. The care group had set up cost improvement ‘mini-companies’ to decide how to split their own budget and investment in a way that is better for patient care whilst making cost improvements. The companies co-designed the investment with the support of clinicians and held regular mini board meetings. As a result, change was clinically rather than financially driven, and the companies had overdelivered on the year’s cost improvements.
Surgery

Facts and data about this service

The trust delivers its surgical services across three sites; Royal Lancaster Infirmary, Furness General Hospital, and Westmorland General Hospital.

At Furness General Hospital, there are 92 inpatient beds accepting all surgical specialties; including urology one stop clinics. The surgical services are managed by the care group across all three acute hospitals.

Surgery at the trust includes most surgical specialties except for cardiothoracic, neurosurgery, plastics and vascular which are provided by other NHS trusts. The trust provides breast surgery at RLI and WGH but not FGH.

(Sources: Routine Provider Information Request AC1 - Acute context, Routine Provider Information Request- Sites tab)

The trust had 35,117 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,630 (27.4%), 21,086 (60.0%) were day case, and the remaining 4,401 (12.5%) were elective.

(Source: Hospital Episode Statistics)

The University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) was last inspected in October 2016 to confirm whether the trust had made improvements to its services since our previous comprehensive inspection in July 2015. At that time, surgical services at Furness General Hospital (FGH) received an overall rating of good, with all five key domains rated good in safe, effective, caring, responsive and well led.

Following our inspection of the service in 2016, no requirement notices were issued for surgical services at FGH.

Actions we said the hospital SHOULD consider taking to improve, were:

The trust was requested to:

- Continue to improve referral to treatment times (RTT) for patients and continue to implement trust wide initiatives to improve response
- Prioritise hip fractures (within 48 hours)
- Ensure all procedures were performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue to engage staff and encourage team-working to develop and improve the culture within the wards and theatre department
- Continue with staff recruitment and retention
- Improve the completion of NEWS
- Improve environmental cleanliness
- Improve the monitoring of fridge temperature and take action if temperatures exceed the expected range
At our most recent unannounced inspection, we followed key lines of enquiry and rated all five key domains; safe, effective, caring, responsive and well led.

On this inspection we visited the surgical services area on ward two (trauma and orthopaedics), ward four (patient progression unit, mixed sex) and ward five (surgical emergency ambulatory care, mixed sex). We also visited the main theatres which includes seven theatres, one of which is currently decommissioned for refurbishment. The unit had a recovery area with seven bays incorporating a dedicated paediatric bay and dementia friendly bay.

We observed care and treatment, looked at four complete patient records (and specific documentation in several others, including consent, mental capacity and deprivation of liberty safeguards documents) and five medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service.

We spoke with 12 patients and relatives and 20 members of staff and looked at six complete care records. We observed patient care, the environment within wards and theatres, handovers and safety briefings. We also reviewed the hospital's performance data in respect of surgical services.

**Is the service safe?**

**Mandatory training**

**Mandatory training completion rates**

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

**Trust level**

A breakdown of compliance for mandatory training courses as at September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>1,269</td>
<td>1,280</td>
<td>99.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>1,225</td>
<td>1,278</td>
<td>95.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>1,220</td>
<td>1,277</td>
<td>95.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>1,191</td>
<td>1,277</td>
<td>93.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>1,105</td>
<td>1,189</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>1,172</td>
<td>1,275</td>
<td>91.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>1,173</td>
<td>1,281</td>
<td>91.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>932</td>
<td>1,097</td>
<td>85.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for three of the eight mandatory training modules for which staff were eligible. The lowest completion rate was reported for Resus - Basic life support, for which only 85.0% staff had completed the training at September 2018.
The training data submitted by the trust had been split down into the clinical care groups at the
trust and we are therefore unable to split the data into CQC core services. The data reported
includes staffing figures for critical care at the trust.

(Source: Data request- P40 Core Skills Training Compliance 2017 to date)

At ward level ward managers told us their staff were either booked to receive training or had been
couraged to complete as soon as practicable. Staff we spoke with confirmed that training
completion was discussed at annual appraisals and throughout the year.

On inspection we discussed mandatory training compliance with individual ward and theatre
managers. We were assured that training was a priority and saw evidence via the trusts training
management tracker that compliance had increased since receiving the training data statistics as
above. The care group senior management team had initiated action to increase the levels of
compliance for mandatory training. Staff told us they could access the training management
system from home to complete in their own time. Staff training time undertaken at home could be
taken back as time owing.

Staffing issues sometimes impacted on staff being unable to be released for training, a practice
educator attended individual wards to train staff to remedy this issue.

The care group senior management team had encouraged staff to increase levels of compliance
and provided us with updated compliance figures as follows:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control (Core Skills) Level 1 E-Learning</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Module A and B</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Inclusion (Core Skills) E-Learning</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance (Core Skills) E-Learning</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution (Core Skills) Training (CRT)</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire - General Fire Safety Awareness</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety (NHS Core Skills)</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resus - BLS (Basic Life Support)</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust had aligned its mandatory training requirements to those outlined in NHS core skills
framework. Staff ‘job role’ being the key factor in determining which aspects of core skills
(mandatory) training individual staff will need to complete.

Any shortfall was addressed via care group teams who all had individual level trajectories in place
to achieve full compliance. This was monitored on a weekly basis and reported monthly at care
group governance and assurance groups and performance review meetings, and bi-monthly at the
workforce assurance committee. Care groups also reported to the education governance group on
a rotational basis to help with developing actions plans against any exceptions with regards to
compliance.
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 as at September 2018 at trust level for all staff in surgery care group (inclusive of critical care) is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Adults (NHS Core Skills) - Level 1</td>
<td>1,173</td>
<td>1,260</td>
<td>93.1%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was not met for the one safeguarding training module for which staff were eligible, although completion rate for this module was still high.

The training data submitted by the trust had been split down into the clinical care groups at the trust and we are therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

(Source: Data request - P40 Core Skills Training Compliance 2017 to date)

At the time of inspection, we were given information which confirmed 91% of eligible staff within the care group had completed safeguarding adults and children (NHS core skills) level two.

The care group also confirmed that 79% of eligible staff within the care group had completed safeguarding adults and children level three, including Mental Capacity Act and Deprivation of Liberty Safeguards training.

The senior management team confirmed the trust had systems and processes in place to protect patients from abuse. We saw that the trust had current ‘adults at risk’ and ‘safeguarding children’ policies in place that staff accessed on the trust’s intranet. The safeguarding operational group reported to the quality committee which reported to the board.

Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Staff were able to describe circumstances when they had made a safeguarding referral with the help of the central team.

All trust staff completed level one safeguarding children training within corporate induction. All relevant clinical staff and non-clinical staff who worked with adults and children and their carers completed level two safeguarding children and young people e-learning in accordance with intercollegiate guidance. Basic counter terrorism education within the e-learning module was also completed as part of induction training.

The trust had a lead nurse for adult and children safeguarding.

Staff had a good knowledge and understanding of the trust’s safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team in the trust and told us they were approachable and gave clear advice. Policies and links to multi-agency safeguarding procedures were on the intranet and accessible for staff. We reviewed these at the time of inspection and found they were in date.
Staff gave examples of what constituted a safeguarding concern and how they would raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children and confirmed they had received feedback about the investigation.

The trust was involved in the implementation of electronic referrals to social care. This meant that referrals were timely, more secure and quality was audited.

Staff training for children and adults safeguarding was currently being redesigned by the safeguarding team to fulfil the requirements in the intercollegiate document (2014).

Staff described 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**

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. The trust had an environmental cleaning policy which was in date, version controlled and had a review date (March 2020).

The theatre environment was clean, tidy and equipment was stored in designated areas. We observed that corridors were clutter free, equipment was clean and had dated stickers attached showing cleaning date and staff initials. Staff were able to explain the cleaning process for equipment and the environment.

Environmental cleaning audits were completed monthly. The latest audits (November) compliance results for theatres (100%), ward 2 (99.19%), ward 4(100%) and ward 5 (99.04%) showed all were meeting the trust cleaning standard. Hand hygiene audits showed 100% compliance within all surgical areas and action plans were discussed and monitored through ward meetings.

The patient-led assessment of the care environment (PLACE) assessment, which is patient led, assesses the quality of the patient environment on a yearly basis. The assessment does not cover clinical care provision, or evaluate how well staff are doing their jobs. The assessments involve members of the public, former and current patients and members of Healthwatch, who look at a selection of wards and departments against different criteria which is comprised of:

- Cleanliness
- Condition, appearance and maintenance
- Privacy, Dignity and Wellbeing
- Dementia
- Access
- Disability
- Food

The results highlight how the trust are performing individually and nationally to drive improvement across hospital sites, enhance services and better the patient experience.
The hospital scored 98.15% for cleanliness which is marginally lower than the national average of 98.47%. For condition, appearance and maintenance the trust scored 89.53% which is lower than the national average of 94.33%.

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 theatre 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 theatre environments, posters on hand washing were displayed. Sinks were available with adequate supplies of soap, paper towels and foot operated bins. 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 and theatre areas. We inspected resuscitation equipment in wards, theatres and surgical areas and confirmed daily checks had been undertaken. All sharps bins seen were properly assembled, stored off the floor, not over full and signed and dated.

We observed two laser machines within the theatre environment. We were assured that there was a radiation protection advisor service level agreement in place. The department had a laser protection advisor who was responsible for ensuring that laser local rules were in date and that all staff using the lasers had received appropriate training. Staff training records for laser use were logged/stored and updated with staff names, date/type of training and staff signature. Risk assessment tools were in place along with blinds, goggles (protective eye wear), door signage and lockable theatre entrances and exit doors. All patients receiving treatment by laser were logged using a laser card stating patient number and laser usage.

Staff we spoke with reported 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 safety checked.

All wards and surgical areas were uncluttered and in a good state of repair. Wards had a spacious design, large floor plan and storeroom capacity was available on all wards and theatre areas.

We were assured that medical engineers visit all areas of the hospital sites on an annual basis and undertake maintenance, asset validation and any required repairs to devices that are within
the clinical area; this also included the recording of any devices which were not currently on the medical engineering inventory and scheduling of these devices.

Any devices which required scheduling more frequently than annually were scheduled outside of the annual visit devices, for example, ventilators, incubators and other high-risk devices.

**Assessing and responding to patient risk**

The surgical care group 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 emergency gastrointestinal (GI) bleed. Theatre staff infrequently managed emergency GI endoscopy cases as routinely these were managed via the endoscopy unit; however, in the event of a GI bleed out of hours the team had completed a risk assessment and introduced a grab guide listing essential equipment and routine practice. Additional training had also been sourced for staff competency and assessment.

Within the electronic patient record there were a series of prompts 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, recorded patient observations using the updated version of the national early warning score (NEWS 2) system. The NEWS 2 electronic system had been introduced in October 2018 along with additional staff training. During the summer of 2018, the matron for acute care and wider team provided walkabout sessions across surgical ward areas at FGH to troubleshoot any areas of concern and to provide training on NEWS 2. NEWS 2 audit compliance results for November for ward 2 (orthopaedic: 90%), ward 4 (general surgery 91%), ward 5 (general surgery 92%), elective orthopaedic unit (94%), day surgery unit (94%) and patient progression unit (97%).

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 the National Institute for Health & Care Excellence (NICE) guidance issued in July 2016.

The policy required 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 2 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.

In addition, we saw that each ward displayed posters about the risk of sepsis. All staff we spoke with could describe what they would do to treat and escalate sepsis.

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 2 system. During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded.

Risks associated with falls, pressure ulcers, venous thromboembolism (VTE), catheter and urinary infections were assessed monthly using the NHS safety thermometer. Wards displayed the number of falls and pressure ulcers which had occurred on the ward for that month.
Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments.

The trust used specific guidance to raise staff awareness of pressure sore prevention. We saw evidence of pressure sore prevention guidance for staff which listed; definition, causes (shear, friction, moisture, risk areas) and how to prevent. The guidance described how to prevent pressure ulcers; encourage mobility, repositioning, timing, positions and skin assessment. Staff also had access to different coloured stickers to highlight patients at risk of pressure ulcers using a red, amber and green (RAG) rated system. This system advised staff of the need to change patient position by an allocated time and a specific position time change thereafter. The guidance also recommended if nutritional and pressure ulcer risks were identified, referral should be made to a registered dietician, specialist nurse and where appropriate the speech and language therapy team.

Patients with a high risk of falling were placed in a supervision bay close to the nurses’ station so they could be easily monitored. We saw that walking aids and nurse call bells were within easy reach of patients.

In theatres staff used the World Health Organisation’ (WHO) surgical safety checklist, ‘five steps to safer surgery’. The national safety standards for invasive procedures (NatSSIPs) incorporated the contents of the WHO surgical safety checklist. The standards require the checklist to be completed for every patient undergoing a surgical procedure (including local anaesthesia).

During inspection we were assured that individual patient surgical episodes were managed effectively using the WHO checklist. We observed a patient pathway from the ward into the anaesthetic room, intraoperatively and post operatively (recovery). The system was robust and managed according to hospital policy and process.

Local safety standards for invasive procedures (LocSSIPs) had been developed, e.g. counts of swabs, instruments and non-retainable items in operating theatres. The trust had refocused clinical teams in theatres to the five steps to safer surgery by providing training, working groups and a video to help staff understand the need to adhere to policy and process. Staff confirmed that they had received this training during our inspection.

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 demonstrating an overall average of 98%; with the exception of ‘did all team members stop to participate’ which scored 90%. On inspection we observed four procedures to monitor staff culture and understanding surrounding the WHO safety checklist; robust compliance was observed.

<table>
<thead>
<tr>
<th>Checklist – FGH</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did all members attend staff brief</td>
<td>100%</td>
</tr>
<tr>
<td>Has sign in of patient occurred prior to anaesthetic</td>
<td>100%</td>
</tr>
<tr>
<td>Prior to knife to skin was pre-surgery time out undertaken</td>
<td>98%</td>
</tr>
<tr>
<td>Did all team members stop to participate</td>
<td>90%</td>
</tr>
<tr>
<td>Were all elements discussed and undertaken</td>
<td>98%</td>
</tr>
</tbody>
</table>
Prior to closing was operation sign out undertaken

- Did all team members stop and participate: 100%
- Was the sign out conducted in clear, audible and concise manner: 100%
- Were all the elements of time out completed and signed: 100%
- Did all team attend debrief for learning lessons: 97%
- Overall average compliance: 98%

On inspection we were assured that audit data results were discussed with staff to learn and improve practice. Staff we spoke with were aware of the importance of the WHO safety checklist and the need to adhere to trust policy and process.

Senior management gave assurance that The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance was followed regarding consultant anaesthetist training surrounding advanced life support (ALS) training and difficult airway training. The guidance recommends that all anaesthetists should be trained and competent in resuscitation and should possess the teamwork skills necessary to work effectively as part of an emergency medical team. In-house training updates in resuscitation and regular team training events were instigated and practiced.

Consultant anaesthetists also undertook yearly difficult airway training and Practical Obstetric Multi-Professional Training (PROMPT).

Trust policy related to basic requirement for all consultant anaesthetists on the resuscitation team. Trust anaesthetists attended half day anaesthetic scenario training yearly facilitated by colleagues who were Advanced Life Support (ALS) and Advanced Paediatric Life Support (APLS) instructors which, included adult and paediatric advance life support and various anaesthetic emergency scenarios.

Theatre based scenario training with anaesthetic and theatre staff during auditing time was not currently formalised at all three sites, however, the trust intended to commence this in the future.

We saw evidence of trust policy relating to resuscitation, this policy was in date, version controlled and had a review date of April 2019.

**Nurse staffing**

The trust had reported their staffing numbers in the table below for the period October 2017 to September 2018 for surgery. As at September 2018, 83.8% of qualified nursing positions were filled across the whole trust. Nursing fill rates were below establishment at all three locations offering surgical services at the trust. Fill rates of 86.6%, 79.2%, and 90.3% were reported for Furness General Hospital, Royal Lancaster Infirmary, and Westmorland General Hospital respectively.

The trust was developing the registered nurse degree apprentice programme which will enable the trust to meet the future need for nurses not only in the trust, but more widely across the whole health and care economy. Meanwhile, the trust had seen more international recruits arrive in quarter one of this year than in the previous two years.

Nationally recognised models were used for safer staffing incorporating patient acuity tools, these were reviewed annually, and the safer staffing report was reviewed at the quality committee in
May and November each year. Daily reviews were led by matrons and senior nurses to assess staffing levels and any concerns escalated to patient flow meetings, held four times daily.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 to September 2017</th>
<th>October 2017 to September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>154.4</td>
<td>173.7</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>192.8</td>
<td>235.4</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>77.8</td>
<td>88.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>425.0</strong></td>
<td><strong>497.7</strong></td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

**Vacancy rates**

From November 2017 to October 2018, the trust reported a vacancy rate of 11% for qualified nursing staff working in surgery. The trust did not provide a target rate. This figure was a deterioration compared to the last report in 2016 where the vacancy rate figure was 4.1%

During inspection ward managers told us there had been international nurse recruitment from the Philippines. The trust accepted and trained cadets form Kendal College typically enrolling for pre-nursing, operating department practitioners and health care support worker roles.

The data reported included staffing figures for critical care at the trust.

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

**Turnover rates**

The turnover data submitted by the trust had been split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 7.31% for qualified nursing staff working in surgery. This was better than the trust performance measure of 8.5% and an improvement following the last inspection in 2016 which showed an 8% turnover rate.

(Source: data request)

**Sickness rates**

The sickness data submitted by the trust had been split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 6.03% for qualified nursing staff working in surgery.

The trust measured attendance and had a target of 95.6%.

(Source: data request)

**Bank and agency staff usage**
Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we were unable to calculate bank and agency usage as a proportion of the total shifts including permanent staff.

From April 2017 to March 2018, the trust reported that 3,944 shifts for qualified nursing in surgery were filled by bank staff and 4,627 shifts were filled by agency staff. In addition, 5,478 shifts remained unfilled by bank and agency staff.

For nursing assistants, 13,466 shifts were filled by bank staff and no shifts were covered by agency staff to cover sickness, absence or vacancy for nursing assistants. In the same period, 3,786 shifts were not filled by either bank or agency staff.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Nursing assistants</th>
<th></th>
<th>Qualified nurses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bank shifts</td>
<td>Agency shifts</td>
<td>Unfilled shifts</td>
<td>Bank shifts</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>4,365</td>
<td>0</td>
<td>1,140</td>
<td>1,339</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>8,446</td>
<td>0</td>
<td>2,341</td>
<td>1,971</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>655</td>
<td>0</td>
<td>305</td>
<td>634</td>
</tr>
<tr>
<td>Total</td>
<td>13,466</td>
<td>0</td>
<td>3,786</td>
<td>3,944</td>
</tr>
</tbody>
</table>

The trust had highlighted the five wards that have the highest bank and agency usage for qualified nursing shifts. Two of these wards were surgical, with high bank and agency usage in theatres at Furness General Hospital (FGH Theatre - General Dept.). The trust had attributed this to vacancies within the service and had highlighted plans to recruit staff to fill these vacancies.  

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

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. Theatre staffing levels were planned according to the lists on a daily basis. Senior staff checked theatre staffing against surgical lists to plan one week ahead using the SNCT. The trust used situation, background, action, result (SBAR) notes for handovers which reduced patient risk.

Staffing was on the care group’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.

Nurse staffing levels continued to be a concern across the trust; senior management assured us that this remained high on the risk agenda. Vacancy rates had increased since the last inspection from 4.1% to 11%; however, 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 rotas.
Longer term plans had also been developed, such as vacancies advertised and international recruitment, implementation of the e-roster and escalation processes in place through the matron and associate director of nursing.

We were assured that safe staffing levels were maintained. On inspection each ward we visited we saw nurse staffing figures were displayed showing planned staffing numbers matched actual numbers.

The trust had initiated a student nurse four-year apprenticeship programme (‘grow your own’) that enabled healthcare assistants within the organisation to be seconded and trained.

Wards had a discharge co-ordinator and we also observed nursing apprentices, nursing associates and student nurses caring for patients on the wards.

Medical staffing

The trust had reported their staffing numbers below for the period October 2017 to September 2018 for surgery. As at September 2018, 90.5% of medical and dental positions were filled across the whole trust. Medical fill rates were below establishment at all three locations offering surgical services at the trust. Fill rates of 86.7%, 92.7%, and 74.0% were reported for Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital respectively.

Medical cover was available twenty-four seven.

<table>
<thead>
<tr>
<th>Location</th>
<th>October 2016 - September 2017</th>
<th>October 2017 - September 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual FTE staff</td>
<td>Planned FTE staff</td>
</tr>
<tr>
<td>Furness General Hospital</td>
<td>64.7</td>
<td>75.3</td>
</tr>
<tr>
<td>Royal Lancaster Infirmary</td>
<td>143.1</td>
<td>149.2</td>
</tr>
<tr>
<td>Westmorland General Hospital</td>
<td>3.3</td>
<td>4.5</td>
</tr>
<tr>
<td>Trust-wide</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>215.0</td>
<td>233.0</td>
</tr>
</tbody>
</table>

(Source: Data request- P16 Total Staffing)

Vacancy rates

The vacancy data submitted by the trust had been split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

From October 2017 to September 2018, the trust reported a vacancy rate of 8.92% for medical and dental staff working in surgery.

(Source: data request)
Turnover rates

The turnover data submitted by the trust had been split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

From October 2017 to September 2018, the trust reported a turnover rate of 12.93% for medical and dental staff working in surgery. This was worse than the trust performance measure of 8.5%.

(Source: data request)

Sickness rates

The sickness data submitted by the trust had been split down into the clinical care groups at the trust and we were therefore unable to split the data into CQC core services. The data reported includes staffing figures for critical care at the trust.

From October 2017 to September 2018, the trust reported a sickness rate of 1.90% for medical and dental staff working in surgery.

The trust measured attendance and had a target of 95.6%.

(Source: data request)

Bank and locum staff usage

Please note that the trust was unable to provide the total shifts available, including those covered by permanent staff. Therefore, we were unable to calculate bank and locum usage as a proportion of the total shifts including permanent staff.

The number of shifts at the trust covered by bank and medical locum staff in urgent and emergency services from April 2017 to March 2018 can be found below, as well as a breakdown by site and by staffing type.

The trust had highlighted the five wards that have the highest bank and medical locum usage, three of which were surgical. Medical locum usage was high on the following wards: FGH-Anaesthetic/Pain Relief Med St, Trauma & Orthopaedics at RLI, and Urology at FGH.

The trust had attributed this to vacancies within the service and have highlighted that recruitment in these areas had either been successful or is currently on going.

Trust Wide

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>1,083</td>
<td>0</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>21</td>
<td>1,301</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>1,140</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>3,524</td>
<td>0</td>
</tr>
</tbody>
</table>

Furness General Hospital

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>Bank shifts</th>
<th>Locum shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0</td>
<td>433</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>This Trust</td>
<td>England average</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Middle career^</td>
<td>26%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>10%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
<td></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 care group of surgery made use 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 could call for consultant support out of hours. 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.

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. Each surgical ward had a ‘buddy’ from the medical team who attend when requested to review patient outliers. This process was supported by a resident orthogeriatrician where needed.

The senior management team confirmed that the risk register identified ongoing national and local problems in recruiting medical staff (consultant and junior grades). It was recognised the care group had a significant challenge in meeting target staffing levels for medical staff and providing

<p>| | | | |</p>
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<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Grade</td>
<td>0</td>
<td>969</td>
<td>0</td>
</tr>
<tr>
<td>Junior</td>
<td>0</td>
<td>415</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>1,817</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)
sufficiently skilled rota cover, this had the potential for adverse impacts on patient outcomes and safety, service delivery and meeting staffing level standards. We were assured by senior management that recent medical recruitment had been positive with a number of consultant posts fulfilled and awaiting human resource approval.

The care group had developed initiatives to increase medical staff recruitment, for example, Medical Training Initiative for breast care, trauma and orthopaedics, and ear, nose and throat.

**Records**

The trust had introduced an electronic patient record for each patient as well as integrated patient assessment, enhanced patient pathways and bed management systems.

All assessments were completed on the electronic system. This included the nursing assessment, Venous Thromboembolism (VTE) assessment, pressure ulcer risk assessment, nutritional risk assessment, falls risk assessment and care plans. If risk assessments scored highly on the system it automatically opened a care plan for that patient. Additional care plans were added if needed, for example, a catheter care plan.

We reviewed six sets of nursing and medical records across wards and theatres 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. Each ward had a dedicated discharge coordinator to facilitate safe discharge. Patients and families were involved in this process to explore differing options available.

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 documentation audits undertaken identified fails in individual clinical areas (theatre department and ward 2 at FGH). Action plans were generated, monitored and staff training instigated to increase compliance.

We saw that records were consistent, fully completed and learning needs were addressed with relevant staff. Common issues were shared with staff at ward meetings. During inspection we were advised of a working group to improve recording on the electronic patient information system. Senior ward managers told us there was a working group which had led to improvements in that you can now follow the full patient pathway on the system.

There was a trust clinical records management policy which clearly outlined correct procedures for managing records and their retention period. The policy was available to all staff through the trust's document library and had recently been reviewed and approved.

The records processes were monitored by the cross-care group clinical records forum, which had clear terms of reference, and reported to the quality committee.

**Medicines**

We saw the trust had an up to date medicine policy that detailed the safe storage and management of medicines, including controlled drugs (CD).

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
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 did find some gaps for second signatures in the CD register on ward 2. We escalated this to the ward sister for immediate review.

During inspection in the theatre environment we inspected controlled drug (CD) cupboards for contents, expiry dates and management of controlled drugs. The CD cupboards were made of laminated wood; all CD cupboards inspected were lockable and fixed appropriately to internal walls. Daily stock level checks were completed twice daily. We were advised that the last CD drugs audit undertaken by pharmacy within the hospital had highlighted the need to replace the wooden cabinets with metal cabinets in alignment with current hospital policy. We were assured that a replacement role out programme had been approved and all CD drug cabinets within the theatre setting would be replaced by May 2019.

We found consistent practice across wards regarding the management of medicines. Trust policy identified arrangements for monitoring medicines which required refrigeration, maximum and minimum temperatures were recorded on wards and in theatres.

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 both mechanically (anti embolism stockings) and chemically (prescribed medication).

Pharmacy operate seven day services for supply and clinical advice. The trust in-patient pharmacies at FGH and RLI were open 9am to 5pm on Saturday and Sunday. WGH was serviced by the RLI Pharmacy at the weekend. The ‘to take home’ services supply to in-patients was fully available from the in-patient pharmacies during these hours. Out of these hours there was a provision of out of hours dispensing using kits on the ward, plus for the emergency departments out of hours prepared medicines for selected medicines. This ensured patients had access to the medicines they needed. An outpatient dispensing service was in operation Monday to Friday matching the hours for trust pharmacies with shorter opening hours on Saturday and Sunday. A senior pharmacist on-call service was operational for all clinical and specialist supply requests out of pharmacy opening hours.

**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 had the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2017 to August 2018, the trust reported three incidents classified as never events for surgery. One of the three reported never events occurred at Furness General hospital (surgeon was informed during surgery that the wrong procedure had been started, the surgeon then started to correct the initial surgery and begin the correct procedure).

We reviewed the root cause analysis (RCA) and comprehensive investigation (164833) carried out on this never event. The RCA detailed the background and summary of the event, the involvement and support of the patient, relatives and carers as well as the involvement and support of staff.
Contributory factors including root causes as well as lessons learnt and findings and conclusions were clearly identified.

Learning and change to procedures had been implemented. The consultant had undertaken reflective discussions with the clinical director. The root cause analysis highlighted the need to ensure verbalising incision at team brief and then at time out prior to ‘knife to skin’. Clear focus was required of the need to adhere to the WHO safety checklist 5 steps to safer surgery.

All three never events had full root cause analyses undertaken. Action plans have been developed and delivered. A thematic analysis had been completed and shared at the quality committee meeting in September 2018.

During inspection we spoke to theatre staff who assured us that never events were taken seriously and fully reviewed. Staff could explain lessons learnt and actions taken to prevent recurrence. Root cause analyses (RCA) findings were disseminated via surgery governance assurance meetings, ear, nose and throat meetings, theatre audit meetings and shared at the serious incidents requiring investigation (SIRI) panel meetings. Following RCA investigation, the trust completed an incident on a page encompassing incident type, review, recommendations, lessons learnt and actions taken. This information was given on one page ‘at a glance’ encompassing the incident and analysis.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

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

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

- Surgical/invasive procedure incident meeting SI criteria with seven (37% of total incidents).
- Pressure ulcer meeting SI criteria with four (21% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (16% of total incidents).
- Treatment delay meeting SI criteria with two (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (5% of total incidents).
- Operation/treatment given without valid consent with one (5% of total incidents).
- Medication incident meeting SI criteria with one (5% of total incidents)

Site specific information can be found below:

- Furness General Hospital: five incidents
- Royal Lancaster Infirmary: 11 incidents
- Westmorland General 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. We also observed ‘stop before you block’ posters within theatre and anaesthetic rooms.

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 duty of candour 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.

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 care group to discuss learning from incidents. Mortality and morbidity was discussed at regular mortality sub-committee meetings.

On inspection we discussed the safety alert management system process to ensure it was effective and well managed. There was a procedure and policy in place which included a section on escalation when there was a delay by care groups and departments to complete actions prior to the completion deadline.

During inspection we were assured of the Medicines and Healthcare Products Regulatory Agency (MHRA) safety alert process. An example of this was a gentamicin alert relating to prescribing and transcribing on the prescribing information platform. Staff could explain the process of the alert system, how the alert was disseminated and the action taken. Staff were also able to give examples of a medical device alert (MDA) and the action taken.

Safety alerts were documented in and managed through the alert module of the trust’s incident reporting system. Monthly safety alert performance data was reported as key performance indicators (KPIs) on the trust’s executive dashboard and quality committee dashboard. Exception reports and quarterly safety alert performance reports were submitted to the trust’s health and safety committee with medical device related safety alert exception and performance reports submitted to the trust's medical device management group.

The trust completed a summary dashboard of live performance for a range of metrics, including elective care metrics at care group level. The dashboard allowed performance to be reviewed at trust, care group, specialty, site and care provider by individual consultant.

The theatre dashboard was created to populate from the trust’s electronic reporting system. In July 2018, the electronic patient record for theatres progressed to a specific theatres module.

The theatre dashboard was actively used by clinical teams, booking teams and operational teams to plan theatres sessions. This included it being used during the theatre scheduling process.

The dashboard was used to challenge inefficiency, with the ability to reference specific theatres sessions including start times, finish times, turnaround times between patients (touch time) etc.

Metrics within the theatre dashboard included:

- Activity
- Trauma and Orthopaedic joint replacements
- Theatre calendar
- Timetable
- Pre-op call list
• Cancellations list
• Cancelled on the day
• Operations review
• Session review
• Timeliness
• Case opportunity
• Closed sessions
• Model Hospital – Touch time
• Theatre scheduling

Safety thermometer

The Safety Thermometer was 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 was intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection was 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 26 new pressure ulcers, 20 falls with harm and six new catheter urinary tract infections from August 2017 to August 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at University Hospitals of Morecambe Bay NHS Foundation Trust**

1. **Total Pressure ulcers**
   - (26)

2. **Total Falls**
   - (20)

3. **Total CUTIs**
   - (6)
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
(Source: NHS Digital)

Whilst the moderate pressure ulcer harms remain in single figures, the minor harms continue to fluctuate and were a focus for improvement. From April 2018 to date the trust had developed a robust methodology for reviewing pressure ulcers for both hospital and community acquired pressure ulcers. Any harms which caused moderate harm were subject to scrutiny through the patient safety summit.

Safety thermometer results were on display on each ward. These included staffing levels, days since the occurrence of pressure ulcers, falls and catheter acquired urinary tract infections (CUTI’s) 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.

**Incidence rate for pressure ulcers and initiatives taken to reduce.**

The trust used information to raise staff awareness about pressure ulcer prevention. Pressure ulcer rates were displayed on individual wards by using patient safety thermometer data. Staff we spoke with were aware of the importance of pressure ulcer prevention. In view of the number of pressure ulcers, the care group implemented review and improvement work which included learning from wards with low numbers of pressure ulcers and worked with the tissue viability matron to develop resource for staff on documentation and pressure ulcer equipment guides which were shared throughout care group.

<table>
<thead>
<tr>
<th>Month-Year</th>
<th>Bed Days</th>
<th>Pressure ulcer harms</th>
<th>as per 1000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-17</td>
<td>6599</td>
<td>8</td>
<td>1.21</td>
</tr>
<tr>
<td>Jan-18</td>
<td>7101</td>
<td>18</td>
<td>2.53</td>
</tr>
<tr>
<td>Feb-18</td>
<td>6413</td>
<td>9</td>
<td>1.4</td>
</tr>
<tr>
<td>Mar-18</td>
<td>7201</td>
<td>11</td>
<td>1.53</td>
</tr>
<tr>
<td>Apr-18</td>
<td>6577</td>
<td>6</td>
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<td>May-18</td>
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<tr>
<td>Jun-18</td>
<td>5922</td>
<td>9</td>
<td>1.52</td>
</tr>
<tr>
<td>Jul-18</td>
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</tr>
<tr>
<td>Nov-18</td>
<td>6264</td>
<td>12</td>
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</tbody>
</table>
Is the service effective?

Evidence-based care and treatment

The trust had introduced the ‘Gold Standards Framework’ to co-ordinate individual patient needs and communicate these to all staff. Patients identified for the framework would usually have one or more illnesses that may affect their life expectancy and result in rapid access to health care.

The framework ensured patients received the highest standard of care, focussed on their needs, wishes and symptoms. Individual plans were developed ensuring patients received the care needed in the place of choice. The electronic patient record prompted staff to ask for more detail about individual preferences, enabling teams to anticipate possible issues, listen better and communicate with others involved in care.

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 trust had care plans and pathways for a number of conditions including stroke, enhanced orthopaedic pathway, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis based on the acute toolkit, screening tool and care protocols.

The trust participated in the ‘Getting It Right First Time’ (GIRFT) project, commissioned by the Department of Health. This covered clinical areas to support the NHS in delivering productivity and efficiency improvements through identifying areas of unwanted variation in clinical practice and divergence from the best evidence. The trust had developed GIRFT projects within ENT, maxillo-facial, ophthalmology, trauma and orthopaedics and urology services.

We saw evidence of actions plans which incorporated trust metrics, England average, priority, deadline, clinical action owner, context/progress, and actions required. Each GIRFT was RAG rated. The RAG system was a popular project management method of rating for issues or status reports, based on red, amber, and green colours used in a traffic light rating system.

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.

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 2, 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 care group participated in 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 several 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.
The care group had an established national institute clinical effectiveness (NICE) guideline lead who maintained the responsibility for monitoring compliance and for ensuring evidence of compliance was robust and relevant to the recommendations and standards.

The care group monitored compliance against NICE standards through audit processes and other forms of compliance evidence, e.g. patient experience, patient information leaflets, safety incidents, complaints and compliments.

Gaps in practice were identified as part of the evaluation using the GAP analysis toolkit provided by NICE.

NICE guidance was reviewed at specialty meetings with the relevant clinical experts in attendance; care group procedural document meeting for any amendments to policy documents and then shared at care group governance and assurance meetings and clinical audit and effectiveness.

Implementation of NICE publications and quality standards policy sets a seven-working day acknowledge target and 35 working day completion target for all NICE guidance and any extension beyond those dates must be highlighted in care group reports.

NICE guidance was managed within the incident database and safeguard system and daily reports were available for the care group/guideline lead so they can review and monitor progress.

The annual forward audit plan identified which audits focus on NICE compliance and these are reviewed, alongside action plans, at clinical audit and effectiveness.

**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. All patients using healthcare and care services were screened to identify those who are malnourished or at risk of becoming malnourished.

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. The Malnutrition Universal Screening Tool (MUST) tool was used to identify adults who were malnourished or at risk of malnutrition. Patients were assessed regarding their nutritional needs and these were recorded in care plans; patients were referred to the dietician for additional advice if required.

We observed protected meal times were in place and saw patients supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking. 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 showed an overall satisfaction with food provided. The PLACE scores for ward food was 91.18% which was higher than the national average of 90.52%.

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.
Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. Patients assured us that food was warm, fresh and of good quality.

The trust had introduced an improved fluid balance chart and policy that included reference points for emergency conditions such as acute kidney injury.

**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**

**Trust level**

From May 2017 to April 2018, patients at the trust had a lower expected risk of readmission for elective admissions and a similar expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission](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*

- Urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
Non-Elective Admissions – Trust Level

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

- General surgery patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

Furness General Hospital

From May 2017 to April 2018, patients at Furness General Hospital had a lower expected risk of readmission for elective admissions and a lower expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Furness General Hospital

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

- Urology patients at Furness General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Furness General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
• Trauma and orthopaedics patients at Furness General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - *Furness General Hospital*

![Graph showing readmission rates]

*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*

- General surgery patients at Furness General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma and orthopaedics patients at Furness General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at Furness General Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.

**National Hip Fracture Database**

**Furness General Hospital**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 7.3% which was within the expected range. The 2016 figure was 3.5%.

The proportion of patients having surgery on the day of or day after admission was 80.8%, which failed to meet the national standard of 85%. This was within the top 25% of hospitals. The 2016 figure was 85.0%.

The perioperative medical assessment rate was 85.7%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 75.7%.

The proportion of patients not developing pressure ulcers was 94.0%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 94.1%.

The length of stay was 26.8 days, which falls within the bottom 25% of trusts. The 2016 figure was 28.2 days.

*(Source: National Hip Fracture Database 2017)*

The trust had introduced full time orthogeriatricians and the ‘consultant of the week’ working model which had improved co-ordination, review and consistency of care.

The trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:

- Audit number of patient deaths;
- Appoint site trauma lead;
• Record the American Society of Anaesthesiologists (ASA) physical status classification fitness of patients before surgery on the database and monitor on a monthly basis.

The following had been implemented to improve patient outcomes:

• Regular multidisciplinary team (MDT) meeting led by trauma lead and identifying every single breach of best practice tariff (BPT) and lessons learnt;
• An online dashboard had been set up which gave real time information about neck of femur fractures and BPT requirements – actions were taken daily by the trauma co-ordinators to meet BPT requirements;
• The ‘gold standard framework’ for patient scheme had been set up which facilitated hip fracture patients to be identified for next day’s trauma list and reviewed by the anaesthetic team in order to medically optimise them and assess suitability for surgical management;
• National hip fracture data base (NHFD) figures are discussed regularly in the orthopaedic business meetings and lessons learnt are shared

Actions were consistent with the key performance indicators and recommendations identified within the NHFD (2018), for example:

• ‘Hospitals should examine their own NHFD data in dashboards and run charts and those with poor rates of orthogeriatric assessment should consider the implications of this for the quality of initial assessment, preoperative optimisation, perioperative medical care, rehabilitation, discharge planning, and survival that are described in this report’.
• ‘Hospitals should examine their own NHFD data in dashboards and run charts and those with poor performance should establish what proportion of delays in surgical operations are the result of avoidable inefficiencies in preoperative planning or in the organisation of theatre lists’.
• ‘Those providing or commissioning hip fracture services must examine their run charts and dashboards, and challenge units which report low rates of THR in eligible cases, or low rates of SHS for A1/A2 fractures – such findings would suggest that these groups of patients are not being treated in a cost-effective way that is in line with NICE guidance’.

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, 74.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than expected. The 2016 figure was 70.7%.

The risk-adjusted 90-day post-operative mortality rate was 2.6% which was within the expected range. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 19.7% which was within the expected range. The 2016 figure was 21.9%.

The risk-adjusted 30-day unplanned readmission rate was 9.4% which was within the expected range. The 2016 figure was 10.2%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 52.7% which was within the expected range. The 2016 figure was 51.8%.

*(Source: National Bowel Cancer Audit)*

**Oesophago-Gastric Cancer National Audit**
In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0.0%. 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 0.0%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%. This was similar to the national aggregate.

This metric was 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 trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:

- Further assessment of case ascertainment rates;
- Review local protocols and referral processes to ensure patients diagnosed with high grade dysplasia are discussed at a specialist MDT;
- Coordinate the patient pathway to avoid patient waits longer than necessary to start treatment; and
- Ensure surgical teams regularly monitor markers of quality of surgery and act when any concern arises.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

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%.

**Furness General Hospital**

In the 2016 National Emergency Laparotomy Audit (NELA), Furness General Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 57 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 43 cases.

The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 40 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 22 cases.

The risk-adjusted 30-day mortality for the site was within the expected range, based on 57 cases.

The trust confirmed an action plan was in place to address issues identified through the audit. Actions included, for example:
• All patients listed for emergency laparotomy to have a calculated score on risk in terms of morbidity and mortality (P-Possum) performed, and a printed copy documented in the notes by the on-call registrar;

• All patients listed for emergency laparotomy to have a documented risk (percentage) of peri-operative death entered in the patient notes, together with an entry indicating that the patient had been consented; and

• Analyse deaths for audit year 2016-2017 and present at surgical audit meeting

**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 for groin hernias was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

*(Source: NHS Digital)*

**Competent staff**

**Appraisal rates**

This information was routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the
appropriate data split by CQC core service. The trust had provided data split by clinical care group and therefore the appraisal data for surgery also includes data for critical care.

As at November 2018, 79% of staff within surgery at the trust received an appraisal compared to a trust target of 95%. On inspection we were assured that individual units had planned appraisal interviews with staff to ensure protected time was available and rostered into off duty. Appraisal rates for medical staff was 93%

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Completion rate</th>
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<tbody>
<tr>
<td>Bands 1 to 7 and Band 8a+ with no staff responsibilities</td>
<td>1,055</td>
<td>794</td>
<td>73.0%</td>
</tr>
<tr>
<td>Bands 8a+ With Staff Responsibility</td>
<td>18</td>
<td>17</td>
<td>88.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,073</td>
<td>811</td>
<td>75.6%</td>
</tr>
</tbody>
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(Source: Data request- P43 Appraisal Compliance 2017 to date)

The trust record compliance with appraisal by care group and therefore presenting the data in the way requested may be anomalous with what was reported by care groups and indeed the trust.

Individual teams and care groups could monitor compliance rates via the training management system. Compliance was monitored monthly via care group management meetings.

At the time of inspection, the trust provided information that showed the completion rate for bands 1 to 7 had increased to 80% and the completion rate for bands 8a had reached 100% resulting in an overall rate of 80%. The compliance rate had remained the same since the last inspection in 2016.

We discussed the rates of appraisal completion with senior managers. We were informed that appraisals were undertaken on the anniversary of the start date of a member of staff. At the time of inspection, the completion rate was above the expected rate and trajectory (75%) to meet trust targets.

Senior theatre management informed us that theatre nurse staff appraisal compliance was 96.3% at the time of inspection.

**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.

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 offered
training to nursing staff where appropriate. Dietitians completed daily reviews of those patients referred for their input.

**Seven-day services**

Consultants provided seven-day cover for surgical wards and the assessment unit. On-call consultants covered weekends and nights and daily consultant ward rounds took place.

We were told that medical support was provided by foundation year 1 doctors and a senior review on Saturday and Sunday. Weekend ward cover was provided as part of general on-call with junior doctors providing 24 hours per day ward cover. Theatres had 24-hour shift cover plus a non-resident on call.

‘Keogh’ ward rounds are part of the Keogh seven-day services standards, a set of guidelines developed to address variations in care for patients admitted to hospital in an emergency at the weekend.

‘Keogh’ ward rounds were introduced at the hospital in January 2017 for orthopaedic patients and had improved care at the hospital by standardising patient reviews and building communication for patients and clinicians. The ward rounds also helped to improve patient flow through the hospital as patients receive the right care at the right time from the right clinician.

The trust was working to achieve the ‘Keogh’ standards for delivery of seven-day services by the end of the 2019/20 financial year.

There were dedicated physiotherapist and occupational therapists for each ward available Monday to Friday. There was limited access to physiotherapists and occupational therapists at the weekend and patients were prioritised by level of need and orthopaedic plan of care and treatment. Prior to visiting patients, the physiotherapist and occupational therapist received a handover from the weekday dedicated team.

Allied health professionals worked closely with ward staff to ensure a multi-disciplinary team approach to patient care and rehabilitation. We saw that orthogeriatricians had input into the care pathway of elderly patients.

The matron told us they were looking to develop generic workers who had therapy skills to work at weekends.

Main theatres were available seven days a week; offering waiting list initiative every Saturday across all specialities.

There was no speech and language support service at the weekends. There was a pharmacist onsite Monday to Sunday, 9am to 5pm.

**Health promotion**

Patients said staff gave them advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards.

We saw a variety of leaflets available for patients and their families. Some were produced by the trust and some were from other agencies such as The Stroke Association and Dementia UK. The leaflets were on appropriate topics and neatly stored within wards and corridors.

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

At the time of inspection, we were provided with information that showed 79% of staff in the care group had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training.

Patient led assessments of the care environment (PLACE) showed the hospital scored 65% for meeting the dementia needs of patients (national average 79%). The trust had developed action plans from these assessments monitored by matrons.

Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training was delivered on the adult safeguarding level 2 training. There were plans to extend this to provide a more focussed training by the DoLS co-ordinator.

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 care group by the delirium team.

Staff told us best interest meetings were held for patients who lacked capacity to make decisions for themselves.

Patients detained under the mental health act had their rights explained to them and they were also given a copy of these rights. This was recorded within the patient’s record. The patient was then given a copy of this and encouraged to read and ask any questions if clarification was needed. The patient’s nearest relative was informed of the detention and was encouraged to discuss the patient’s rights with them. The safeguarding team and the mental capacity act, mental health advocacy and deprivation of liberty safeguards (MCA/MHA/DoLS) coordinator ensured the appropriate mental health act assessment was convened.

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. We saw evidence of a DoLS referral in place for a patient on ward two.

Staff at Furness General Hospital 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.

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.

Guidance and support with completing these records was available to staff on the intranet. DoLS referrals were stored electronically, generating an automatic reminder should the application need extending seven days later. Staff confirmed that they were prompted to renew applications they had submitted. The safeguarding team held copies of all referrals. There was a DoLS lead in the trust who could be contacted for advice and who would be involved in future training.

Staff on wards were aware of passports for patients with a learning disability and had access to a matron for learning disability, autism and complex needs for further advice on capacity in these patients.

Mental Capacity Act and Deprivation of Liberty training completion
Staff received training in MCA and DoLS as part of their Safeguarding Adults Level 2 training. The trust provided information on compliance with Safeguarding Children and Adults Level 2 training for surgical wards at Furness General Hospital. Compliance levels indicated 91% target in Safeguarding Adults level 2 training which was below the trust target of 95%.

A 79% compliance rate for MCA and DoLS level 3 was achieved which was below the trust target of 95%.

(Source: data request)

Is the service caring?

Compassionate care

Friends and Family test performance

A breakdown of FFT performance by site and ward can be found below.

Furness General Hospital

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<tbody>
<tr>
<td>FGH Ward 1 General Surgery</td>
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<td>94%</td>
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<tr>
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<tr>
<td>FGH Ward 3 Orthopaedic</td>
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<td>FGH Patient Progression Unit</td>
<td>116</td>
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Note - The formatting above was conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Wards with a response rate of less than 100 have been removed.

<table>
<thead>
<tr>
<th>Key</th>
<th>100%</th>
<th>50%</th>
<th>0%</th>
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(Source: NHS England Friends and Family Test)

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.

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.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients living with mental health needs, learning disabilities, autism or dementia.
Hospital services were utilising the system to measure cleanliness, environment, porter and catering services. The trust was engaged with the national ‘Always’ programme of work and had local ‘What Matters to You’ initiatives taking place.

Patient led assessment of the care environment (PLACE) assessments were completed regularly throughout the year along with one final assessment which assessed the trust environmental standards for privacy and dignity; the PLACE process provided motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The place score for privacy, dignity and wellbeing was 79.51%, which was lower than the national average of 84.16%. During inspection we observed staff demonstrating privacy and dignity awareness with patients.

**Emotional support**

There was a day room available on some wards we visited for patients and families to use. The trust used the butterfly system with which to identify patients living with dementia. We observed this in use across the care group. We observed and heard staff speaking to patients living with dementia in a kind and respectful manner.

During inspection we observed posters on display about carers support in Cumbria and Furness.

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 carer’s pass for families visiting wards for people living with dementia. The environment on ward two had been changed incorporating friendly colour schemes, signage, clocks crockery and dementia friendly menus. Individual wards we visited had posters about the Butterfly Scheme.

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**

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.

One patient we spoke with in theatre told us that staff had explained what would happen during all stages of the procedure and pathway and they found this reassuring and comforting.
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.

The wards worked with relatives, different services and staff to organise and manage discharges. This process was managed by discharge co-ordinators on wards and had improved discharge timescales and minimised patient waits.

The trust supported ‘John’s Campaign’, a national initiative to encourage carers to support and stay with people living with dementia while they were in hospital. The trust used lanyards to identify carers and this enabled carers to have 24-hour access to those they were supporting. They were encouraged to become actively involved in the patient’s care. We saw carers wearing their lanyards and the staff we spoke to knew what this meant. As part of the work with Johns campaign, staff told us that they involved patient’s families throughout the whole surgical pathway.

Staff told us they supported the ‘end PJ paralysis’ campaign to help patients and relatives understand the importance of moving regularly and wearing regular day clothes to promote independence and normal routines whilst in hospital.

**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.

The senior management team confirmed the care group’s priority was to deliver high quality, safe services that meets the needs and expectations of patients through the ‘Better Care Together’ programme. This was a clinically led, health economy-wide integrated care community that was the main route through which the trust’s long-term future was delivered. A strategy to support ‘Better Care Together’ had been developed to provide staff, local communities and regulators with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

The majority of inpatient elective surgery had been transferred from the two main sites in Lancaster and Barrow in Furness to Westmorland General Hospital. Focusing Elective surgery on one site rather than three sites had the aim of increasing the quality of care and outcomes for patients.

This ensured that the care group had enough permanent specialist staff to cover rotas effectively across two sites, mitigating the need to cancel operations at short notice. Further, surgical teams have become more proficient through concentrating specialist services at either Royal Lancaster Infirmary or Furness General Hospital.

Evening and weekend working was additional activity to support demand management.
The senior management team was aware of the logistical and recruitment issues posed by the trust’s geography and could give examples of how they had worked hard to mitigate this, for example by ensuring that all senior staff worked across the whole bay and all three sites.

**Meeting people’s individual needs**

The care group had created a surgical emergency ambulatory care unit to improve patient experience, improve patient flow, avoid unnecessary admissions, and better use staff resources.

The initiative had resulted in reduced attendances in the emergency department, improvements in patient flow, reduced length of stay and reduced surgical admissions.

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, and the trust used the ‘butterfly’ system to identify patients with a dementia. Staff told us they had mandatory training on dementia. The wards provided a care bundle for people living with dementia and there was a carer’s pass for families visiting wards for people living with dementia.

Specialist qualified learning disability and mental health nurses had been recruited to ensure individual patient needs were met. We saw care support workers were providing support to bays of six vulnerable patients at risk of harm, supporting them with meals and drinks and engaging them in conversation. This had resulted in reductions in falls and pressure ulcers.

The hospital had introduced standardised products, designated storage areas and created education packs for pressure relieving products. Pictorial booklets had been created for each ward and visual clocks trialled which indicated when a patient last had pressure relief. Pocket mirrors had been purchased to check patients’ heels. These initiatives had resulted in increased periods of days free from acquired pressure ulcers.

The theatre unit had a recovery area with seven bays incorporating a dedicated paediatric bay and dementia friendly bay. Additional lighting in the ceiling with child friendly pictures and dementia friendly lower level lighting had been ordered for both areas. We were assured that additional separation screens for the paediatric and dementia friendly bays had been approved and ordered which were decorated appropriately for children and older people. The recovery area also had dementia friendly equipment available to distract patients who may be confused, withdrawn or frightened post-surgery.

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. During inspection we observed a sign language interpreter working alongside a patient who required assistance during a local anaesthetic theatre procedure.

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 trust wide 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 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.

The PLACE audit score for dementia scored 68.18% which was lower than the national average 78.89%. The trust had developed action plans from these assessments monitored by matrons.

Additional recruitment of specialist qualified learning disability and mental health nurses to surgical wards and theatres had been implemented to ensure the specialist needs of specific patients were met. We were informed of an example of specialist care. A theatre nurse had developed a separate pathway for a patient living with a learning disability who was anxious about coming into hospital for an operation.

**Access and flow**

Patient flow was discussed at bed meetings which were held daily. The meeting was led by the hospital site manager and was attended by matrons for each clinical area and clinical service managers. Flow through the emergency department and bed availability were discussed as well as staffing for each area.

The service had appropriate discharge arrangements in place for people with complex health and social needs. Discharge plans were discussed at daily multidisciplinary team board rounds on surgical wards. There was a complex discharge team and wards had discharge co-ordinators to ensure discharge arrangements were made.

The trust had clear arrangements for ensuring medical outliers on surgical wards were seen daily by a relevant consultant or specialist registrar. Medical patients outlaying on a non-medical ward were allocated to the designated consultant covering a specific area.

The trust had developed a performance dashboard to improve patient flow and which gave a summary of performance for a range of measures, including elective metrics at care group level. The dashboard allowed performance to be reviewed at trust, care group, specialty, site and individual consultant. The dashboard reported metrics, for example, cancer waits (seven days, sixty-two days), referral to treatment time and waiting list size.

A theatre dashboard had also been created and utilised data from the electronic theatre module to plan theatre sessions, scheduling and to challenge inefficiency (e.g. start and finish times, turnaround times between patients, cancellations).

**Average length of stay**

**Trust Level**
From June 2017 to May 2018, the average length of stay for elective patients at the trust was 3.3 days, which was lower compared to the England average of 3.9 days. The average length of stay for all non-elective patients at the trust was 5.6 days, which was higher compared to the England average of 4.9 days.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>4.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Urology</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>General surgery</td>
<td>2.4</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at the trust was 4.4 days, which was higher compared to the England average of 3.8 days.
- The average length of stay for urology elective patients at the trust was 2.0 days, which was lower compared to the England average of 2.5 days.
- The average length of stay for general surgery elective patients at the trust was 2.4 days, which was lower compared to the England average of 3.9 days.

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>General surgery</td>
<td>4.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>10.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which was similar compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.0 days, which was higher compared to the England average of 8.7 days.
- The average length of stay for urology non-elective patients at the trust was 2.6 days, which was similar compared to the England average of 2.9 days.

**Furness General Hospital**

From June 2017 to May 2018, the average length of stay for elective patients at Furness General Hospital was 2.9 days, which was lower compared to the England average of 3.9 days. The average length of stay for all non-elective patients at Furness General Hospital was 5.8 days, which was higher compared to the England average of 4.9 days.
Elective Average Length of Stay - Furness General Hospital

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for trauma and orthopaedics elective patients at Furness General Hospital was 4.6 days, which was higher compared to the England average of 3.8 days.
- The average length of stay for urology elective patients at Furness General Hospital was 2.0 days, which was lower compared to the England average of 2.5 days.
- The average length of stay for general surgery elective patients at Furness General Hospital was 2.0 days, which was lower compared to the England average of 3.9 days.

Non-Elective Average Length of Stay - Furness General Hospital

Note: Top three specialties for specific site based on count of activity.

- The average length of stay for general surgery non-elective patients at Furness General Hospital was 4.9 days, which was higher compared to the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients at Furness General Hospital was 8.5 days, which was similar compared to the England average of 8.7 days.
- The average length of stay for ear, nose and throat (ENT) non-elective patients at Furness General Hospital was 2.2 days, which was the same as the England average of 2.2 days.
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 told us discharges were organised and managed during daily and weekly ward meetings and multidisciplinary team meetings on the wards and staff worked with the ward based discharge co-ordinator to ensure discharges happened as effectively as possible. Discharge co-ordinators developed relationships with local social services and care homes to facilitate discharges.

The trust had developed a performance dashboard to improve patient flow and which gave a summary of performance for a range of measures, including elective metrics at care group level. The dashboard allowed performance to be reviewed at trust, care group, specialty, site and individual consultant. The dashboard reported metrics, for example, cancer waits (seven days, sixty-two days), referral to treatment time and waiting list size.

A theatre dashboard had also been created and utilised data from the electronic theatre module to plan theatre sessions, scheduling and to challenge inefficiency (e.g. start and finish times, turnaround times between patients, cancellations).

Referral to treatment (percentage within 18 weeks) - admitted performance

From August 2017 to July 2018, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. In the most recent month, July 2018, the number of admitted pathways at the trust that were completed within 18 weeks was 49.9%, which was worse than the England average of 67.0%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Performance for the ENT specialty was above the England average for referral to treatment (RTT) rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>66.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>73.9%</td>
<td>76.7%</td>
</tr>
<tr>
<td>General surgery</td>
<td>65.0%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>
We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the care group. From August 2017 to July 2018 the trust’s performance for RTT in general surgery had declined compared to the last inspection figures in 2016 which showed an improvement against the England average of 75%.

At the time of the inspection the trust gave assurance that they continued to review ongoing validation, new ways of working, pathway development and partnership working with stakeholders to improve RTT. Work was ongoing to improve the size of waiting lists and referral to treatment times. Senior management explained that bed pressures, nursing and theatre staff shortages, laminar flow theatre breakdown and a mandate from NHS England to cancel elective operations during adverse weather conditions in 2018 impacted on RTT waiting times.

**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 had not been treated within 28 days of a last-minute cancellation, then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From July 2016 to June 2018, the percentage of patients at the trust whose operation was cancelled and were not treated within 28 days was lower than the England average. In Q1 2018/19, the trust cancelled 77 surgeries. Of these, all were treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days**

- University Hospitals of Morecambe Bay NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust showed a similar trend to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. In Q1 2018/19, less than 1.0% of elective operations at the trust were cancelled.

**Cancelled Operations as a percentage of elective admissions**

- University Hospitals of Morecambe Bay NHS Foundation Trust

<table>
<thead>
<tr>
<th>Department</th>
<th>Performance 2017</th>
<th>Performance 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.4%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>45.5%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>39.5%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

From July 2017 to June 2018, there were 120 complaints about surgery. The trust took an average of 33 working days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed within 35 days.

Of the 120 complaints received during the 12-month period, 27 (22.5%) related to a diagnosis problem, 23 related to adverse outcomes following an operation (19.2%), 11 related to treatment given (9.2%) and 10 (8.3%) related to operation cancellation. A breakdown of complaints by site can be found below.

**Furness General Hospital**

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Complaint (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Problems</td>
<td>8</td>
</tr>
<tr>
<td>Operation - Adverse Outcome</td>
<td>7</td>
</tr>
<tr>
<td>Treatment Given</td>
<td>3</td>
</tr>
<tr>
<td>Operation (IP) Cancellation</td>
<td>3</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>2</td>
</tr>
<tr>
<td>Discharge Arrangements</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Communication/Info to Patients</td>
<td>1</td>
</tr>
<tr>
<td>Appointment (OP) Delay</td>
<td>1</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate Care/treatment</td>
<td>1</td>
</tr>
<tr>
<td>Medication Error</td>
<td>1</td>
</tr>
<tr>
<td>Waiting Time Outpatient Appt</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

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

We asked staff and managers on wards and in theatres 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 was provided to staff at staff meetings.
Wards had patient information leaflets available for the patient advice and liaison service (PALS).

**Number of compliments made to the trust**

From July 2017 to June 2018 there were 300 compliments in surgery of which 27 compliments were recorded at the Furness General Hospital.

The care group had a system in place to encourage complaints and compliments with a view to improving services for patients.

We were unable to draw any themes from the compliments data provided. However, the trust had stated that they carry out their own analysis of compliments, which was shared during care group and corporate governance meetings and fed into the trust’s capital planning group to add evidence for major refurbishment programmes within the organisation.

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

**Is the service well-led?**

**Leadership**

The care group had a triumvirate management structure in place with clear lines of responsibility and accountability. The care group was managed by an overall senior leadership team which included a clinical director, associate chief nurse and assistant director of operations. Each ward visited had a ward manager in place, ward sister and a matron with overall management responsibility.

The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care. During our meeting the team were aware of the main risks affecting service delivery and could explain the actions they had taken to mitigate.

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 daily.

The trust offered leadership courses in partnership with Kendal College and Lancaster University at levels three, five and seven, as well as bespoke internal programmes for those with specific requirements.

Staff knew how to raise whistleblowing concerns and where to find information. The whistleblowing policy was accessible on the trust intranet. The trust had a freedom to speak up guardian who had built on their role since 2015, and a mobile phone app allowed staff to contact them directly and anonymously. In October 2017, the trust won the first ever national freedom to speak up communications award for this dual approach.

**Vision and strategy**
The senior management team confirmed the care group’s priority was to deliver high quality, safe services that meets the needs and expectations of our patients through the ‘Better Care Together’ (BCT) programme. This was a clinically led, health economy-wide integrated care community that was the main route through which the trust’s long-term future was delivered.

A strategy to support ‘Better Care Together’ had been developed to provide staff and local communities with an overview of the work of the programme, to share recommendations and to provide a focus for further discussion about the future of local health and care services.

Senior trust and care group managers were clear about the vision and strategy for the care group and identified actions for addressing issue. The trust vision and strategy was displayed in wards and staff demonstrated the values of the trust during the inspection and were clear about the trust vision and understood their role in contributing to achieving the trust wide and care group goals.

To support the delivery of BCT and staff engagement overall, the trust introduced the ‘Listening into Action’ approach, which was featured by the CQC as one of its ‘Driving Improvements in NHS Trusts’ case studies.

In January 2015, a new leadership structure for inclusion and diversity was introduced to commence a programme of work to support the trust on its journey to becoming ‘effortlessly inclusive’, leading to the approval (in September 2016) of a five-year inclusion and diversity strategy, developed in partnership with inclusion networks.

The care group’s strategic plan contained appropriate planning including assessment and planning for risk, finance, estates and communications. The trust’s values and expected behaviours were prominently displayed throughout the hospital.

The senior management team acknowledged the difficulties in covering the anaesthetic rota at Westmoreland General Hospital and informed us that recruitment had recently been made ensuring the rota would be covered across the trust through the re-alignment of staff across sites.

We asked senior managers about planning services and were told there was a five-year trust strategic and operational plan which included surgery and a care group business plan was also in place. Senior managers described working with business managers, the clinical director and matrons to plan services.

Culture

We found staff to be highly motivated and focussed on patient care and development of the service. In addition, we saw that staff spoke with each other and patients in a respectful way. Staff we spoke with told us that the culture had improved over the last two years.

All staff we spoke with during the inspection told us there was good teamwork, openness and morale was generally good.

Staff we met stated that staff morale had improved since the last inspection. The trust used a ‘star of the month’ system to highlight staff achievement and demonstrate appreciation. This involved staff submitting who they thought had made a positive impact on the ward and the sister displayed positive comments about this staff member along with a photograph on a display board. We observed this process on ward five and in main theatres. Staff we spoke with said this system inspired and motivated them.

Staff told us the care group had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held focus group discussions before the inspection. Staff spoke positively about the service they provided for
patients with high quality care being 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.

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.

The trust developed and implemented a Behavioural Standards Framework to improve patient experience and satisfaction, staff well-being and experience, partnership working, performance, culture and progress continuous improvement. The Behaviour Standards Framework was mandatory and incorporated into induction and appraisal. We saw evidence of this on poster displays around the hospital site.

**Governance**

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.

There were clear governance structures for the surgical care group over the three sites. The trust used the Workforce Efficiency Safety Effectiveness Experience (WESEE) framework which was an integrated reporting mechanism beginning with ward managers and escalating through the governance structures to care group governance and management meetings. Any issues requiring escalation were reported through to the quality committee. Information was cascaded back so that all staff knew how their areas were performing.

Wards held monthly WESEE governance meetings and matrons received WESEE reports from each surgical ward under their management which gave them an oversight of training, workforce, efficiency, safety, effectiveness and patient experience. Matrons met monthly to discuss and analyse the contents of the WESEE reports.

There were departmental governance meetings which provided information to the monthly surgery and governance assurance meeting which then reported by exception to the surgery management board meeting. In addition, there was a weekly meeting for the service managers, matrons and corporate support teams which was chaired by the associate director of operations.

We saw minutes from these meetings, for instance the SGAG meeting in November 2018 included a number of guest speakers discussing topics on consent, complaints and the Perioperative Quality Improvement Programme (PQIP). PQIP was a collaborative project between patients, surgeons, anaesthetists, physicians, nurses and allied health professionals. It was led by the health services research centre based at the Royal College of Anaesthetists.

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. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.
Senior staff in the service were responsible for the monitoring of performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance. The matrons conducted weekly audits of the ward areas with ward managers to measure quality.

The root cause analysis process was currently being modified using the incident reporting database system to add extra rigor in the form of an additional fresh eyes approach.

The listening to improve group was moving into the next phase of its work with greater focus on outcomes and measurement of improvements.

The trust had begun to improve training methodologies in response to increased and differing demand and had recently delivered webinar sessions in response to changes in the trust’s footprint.

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 the weekly governance meeting, then to the quality and safety meeting. The senior management team described the risks to services, for example referral to treatment performance. There was a monthly performance meeting for the surgical care group.

The leadership team received information to support them in managing risk, identifying issues, and assessing performance.

We spoke with members of the leadership team about how they measured quality and performance. The team had access to various sources of information, such as ward metrics, which captured a series of indicators ranging from documentation audits to hand hygiene. This information was examined, discussed and action taken through the meetings noted above.

The care group 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 in the surgical care group were: risk of not achieving the 18-week referral to treat (RTT) target, ongoing issues relating to recruitment of medical staff, ongoing national and local problems in recruiting anaesthetic staff (consultant and junior grades), ongoing national and local problems in recruiting ward nurses and current establishment whole time equivalent (WTE) staffing for breast surgery impacting on delivery of national screening 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.

Individual wards received their own WESEE reports for review at monthly team meetings. Ward leaders told us that they had regular team meetings, and in some areas, these were held at different times of the day, including evenings, to maximise attendance. These were driven by the trust’s WESEE reports.

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 and treatment of all patients. This ensured patients who had a disability, impairment or sensory loss were given information that they could 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.

The intranet was easy to navigate and find information, and the patient records system was clear and prompted staff to renew or refresh elements of patient care as appropriate. Ward managers had access to their staff’s electronic staff records so they could view appraisal, sickness and training rates.

The trust’s information governance and data quality committee monitored the implementation of the data quality strategy. Information governance training rates were monitored at care group leadership level and was 93.3% within the surgical care group in September 2018.

Engagement

Patient engagement

In February 2018, the trust launched a new patient and public involvement strategy along with a ten-point action plan to involve patients and the public in their local hospitals. The strategy is a public facing document and continues to provide a supportive and developmental direction of intent for putting patients and the public at the heart of its quality improvement work.

The aims of the strategy were supported through national and local satisfaction surveys, patient experience information panels, patient stories and diaries and feedback through comments, concerns, compliments and complaints from individual service users and members of the public. People using the service were encouraged to give their opinion on the quality of service they received. The care group carried out ‘two minutes of your time’ surveys to gather feedback on services from patients.

Staff we spoke with told us they felt involved in development of services and this promoted good team working.

Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.

Ward sisters were visible on the ward, which provided patients opportunity to express their views and opinions.

Leaflets about the friends and family test, and the Patient Advice and Liaison Service (PALS) were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards and letters displayed at the entrances to wards.

We saw staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families. Matrons and ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.

People using the service were encouraged to give their opinion on the quality of service they received.

Staff engagement
The national NHS staff survey (2017) showed the trust scored 3.79 (out of five) for an overall indicator of staff engagement. This is the same (3.79) when compared with other trusts of a similar type.

We were told the care group had improved leadership and accountability to create a better culture for staff. Specific changes had been made, such as increasing the numbers of clinical leaders within theatres, the introduction of a staff voices forum, ‘back to the floor’ sessions for the senior management team, weekly discussions about good and bad behavioural practice and sessions to promote the trust behavioural standards framework.

The staff voices forum was an open session for staff to drop in and discuss their issues. Concerns raised had been acted upon and feedback given.

Senior managers 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 manager, receive feedback and discuss concerns. Staff we spoke to said they felt appreciated by the ward manager and sisters and senior managers and felt listened to when they raised concerns.

Learning, continuous improvement and innovation

The surgical core service group had developed several initiatives to improve and enhance care and treatment

In October 2018 the trust rolled out a celebrating improvements and achievements booklet. The booklet included differing improvements which benefit patients, staff and the public across neighbourhoods and communities. The information included a snap shot illustrated overview of surgical care successes and improvements since 2016. Improvements made to the service can be seen below:

- New recruitment methods have been implemented with nine new recruits joining the care group in September 2018, with additional international recruits joining the trust between June and September 2018.
- Collection boxes were in place in each of the hospitals for staff to donate food, baby products and feminine products for a local women’s charity to support vulnerable groups in the community. We observed this in progress within main theatres, differing teams within theatre were holding a competition with a prize for the best dressed collection box. Staff praised this initiative and were proud of the work they had achieved in charity collections.
- Care support workers were providing support to bays of six vulnerable patients at risk of harm, supporting them with meals and drinks and engaging them in conversation. This has resulted in reductions in falls and pressure ulcers.
- A new ophthalmic outreach service had been implemented to support patient’s needs in hospital while they are being treated for other conditions.
- Patients were provided with clear, user-friendly information to support their preparation for surgery. This improved the patient experience and allowed the care group to better use theatre capacity and further enabled patients to make informed choices.
• The trust had implemented the World Health Organization’s (WHO) Surgical Safety Checklist into working practice. To enable safe working the trust provided training, working groups and a video to help staff. This was adopted to improve performance at critical times within a patient’s journey and reduced harm in perioperative care. The safety checklist improved outcomes for patients as well as a more efficient working environment for staff.

• Environment changes on ward two at FGH had been implemented using dementia friendly colour schemes, signage, clocks, crockery and dementia friendly menus. Volunteers from the Royal Voluntary Service supported patients with activities and held monthly tea parties. Theatre recovery and surgical wards at FGH had dementia trolleys. The trust had a focus on stimulation when patients were in hospital for long periods of time. Staff provided a quiet area or change of scenery to help enhance the patient’s day. As part of the work with John’s Campaign, the trust involved patients’ families throughout the whole surgical pathway.