

University Hospitals of Morecambe Bay NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust	Good	
Are services at this trust safe?	Requires improvement	
Are services at this trust effective?	Good	
Are services at this trust caring?	Outstanding	
Are services at this trust responsive?	Good	
Are services at this trust well-led?	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

We found that the trust had significantly improved and rated it as good overall, with caring rated as outstanding and safe rated as requires improvement.

Our key findings were as follows:

- There had been significant improvements across most services in the trust since our last inspection in July 2015. This was particularly demonstrated in maternity and gynaecology, and end of life services.
- In medical, critical care, and end of life care services, there were a number of outstanding examples of

compassionate care and emotional support shown by all levels and disciplines of staff, who did not hesitate to go the extra mile to make a difference for patients and their loved ones.

- Leadership across the trust was good, managers were available, visible, and approachable; staff morale had improved significantly and they felt supported. Staff spoke positively about the service they provided for patients.
- Cross bay working as well as joint working between services had been significantly strengthened since the last inspection.
- There were good levels of staff engagement across the trust. Staff were proud of the organisation as a place to work. The NHS Staff Survey 2016 demonstrated many areas of improvement.
- The investment in leadership programmes was good, particularly at middle management level.
- Senior leadership was stable and had been strengthened since the last inspection.
- The trust valued and encouraged public engagement. There were many examples of good public engagement, particularly in maternity services.
- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The trust had infection prevention and control policies in place, which were accessible, understood and used by staff. Patients received care in a clean, hygienic and suitably maintained environment.
- The trust reported no incidences of Methicillin Resistant Staphylococcus Aureus (MRSA) infection between September 2015 and May 2016. Eight cases of clostridium difficile were reported in the same period.
- Nursing and medical staffing numbers had improved since the last inspection. However, there were still a number of nursing and medical staffing vacancies across the trust, especially in medical care services and the emergency departments. The trust had robust systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care.

Summary of findings

- The trust had improved compliance with mandatory training and appraisal targets in most services. Local support and supervision of junior staff had improved, and many areas had developed their own unit-specific competencies for training and development purposes.
- There had been an improvement in record-keeping standards across the trust, however, we identified some ongoing areas for improvement around legibility and trigger levels for early warning of deterioration, particularly in medical care services and the emergency department.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery services had improved since the last inspection. Information for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks against the England average of 75%.
- Access and flow, particularly in the emergency departments and medical care services, remained a challenge. The emergency department performance had deteriorated over the last 12 months. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.

We saw several areas of outstanding practice including:

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

Summary of findings

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

Importantly, the trust must:

In urgent and emergency care services:

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

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

In services for children and young people:

- Ensure there are sufficient nursing staff at Royal Lancaster Infirmary (RLI) to comply with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust was established on 1 October 2010 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. The trust operates acute hospital services from three main hospital sites:

- Furness General Hospital, Barrow in Furness, (FGH);
- Royal Lancaster Infirmary, Lancaster, (RLI); and
- Westmorland General Hospital, Kendal, (WGH).

In addition, outpatient services are provided at Queen Victoria Hospital in Morecambe (QVH), Ulverston Community Health Centre (UHC) and in a range of community facilities. We did not include these locations during this inspection visit.

The trust serves a population of around 365,000 covering South Cumbria, North Lancashire and surrounding areas, with services commissioned by Cumbria Clinical Commissioning Group and Lancashire North Clinical Commissioning Group. The trust has a total of 933 beds spread across core services:

- 382 Medical beds
- 347 Surgical beds
- 102 Children's beds
- 87 Maternity beds
- 15 Critical Care beds

Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspectors and a variety of specialists as follows: Nurse Manager, A&E Doctor, A&E

Sister, Critical Care Nurse, Advanced Paramedic, Doctor, Matron, Consultant General Surgeon, Lead Nurse Post Anaesthetic Care Unit, Critical Care Matron, Risk Midwife, Midwife Matron, Consultant Obstetrician & Gynaecologist, Neonatal Consultant, Locum Doctor, Paediatric Nurse, Consultant in Clinical Oncology, EOLC Matron, Outpatients Matron, Board Level Director, Director of Nursing and Quality, and Medical Director.

How we carried out this inspection

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

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

The inspection team inspected the following core services at Furness General Hospital and Royal Lancaster Infirmary:

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

At Westmorland General Hospital the following core services were inspected:

- Surgery
- Maternity and gynaecology

Summary of findings

• Outpatient and diagnostic imaging services

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

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

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

What people who use the trust's services say

- The results of the annual CQC Inpatient Survey 2015 showed that the trust performed about the same as other trusts for all 12 questions.
- The percentage of people recommending the trust according to the Friends and Family Test (FFT) was 95.9% at July 2016, compared to the England average of 95.4%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for seven of the 50 questions, in the middle 60% for 43 questions, and in the bottom 20% for no questions.
- The trust performed worse than the England average in the Patient Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to cleanliness (95% against 98%), food (84% against 88%), and facilities (90% against 93%). Privacy, dignity and wellbeing scored 86%, which was better than the England average of 84%.

Facts and data about this trust

- For the period 2015-2016, the trust had 89,618 A&E attendances, 700,277 outpatient appointments, 3,139 births, 960 referrals to the specialist palliative care team, and 2,086 critical care bed days. Between April 2015 and March 2016 there had been 1,438 inpatient deaths across the three hospital sites.
- The health of people in Cumbria is varied compared with the England average. Deprivation is lower than average, however about 14.7% (12,000) of its children live in poverty. Life expectancy for both men and women is lower than the England average.
- Between August 2015 and September 2016, the trust had one Never Event (in surgery) and 49 serious incidents.
- The trust reported 8,586 incidents, with 97% categorised as low or no harm.
- Mortality reduction had been sustained, with the Hospital Standardised Mortality Ratio (HSMR) showing that for 100 patients who die in an average hospital in England, between 80 and 90 die in the trust's hospitals.
- Between April 2015 and March 2016 there were 484 complaints about the trust. The Emergency Department at the RLI had the highest number of complaints (29 or 6%). Formal complaints had reduced by 25%.
- In the NHS Staff Survey (2016) the trust performed better than other trusts in four questions, about the same as other trusts in 24 questions, and worse than other trusts in six questions. The questions for which the trust performed better than other trusts were: Staff feel satisfied with the quality of work and patient care they are able to deliver (4% vs England average 4%); Staff working extra hours (68% vs England average 72%); Staff reporting errors, near misses or incidents witnessed in the last month (93% vs England average 90%); Staff experiencing physical violence from staff in last 12 months (1% vs England average 2%).
- The questions for which the trust performed worse than other trusts were: Quality of appraisals (2.92 vs England average of 3.06 – out of a score of 5); Staff

Summary of findings

witnessing potentially harmful errors, near misses, or incidents in last month (33% vs England average 31%); Staff/colleagues reporting most recent experience of harassment, bullying, or abuse (10% vs England average 35%); Staff/colleagues reporting most recent experience of violence (47% vs England average 54%); Staff experiencing harassment, bullying, or abuse from staff in last 12 months (29% vs England average 26%); Staff able to contribute towards improvements at work (66% versus England average of 70%).

- The engagement score for this trust was 3.78, which is about the about the same as other trusts.
- The financial position for 2015/2016 showed:
 - Revenue: £275 million
 - Full Cost: £303 million
 - Deficit: £28 million

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as 'requires improvement' because:</p> <ul style="list-style-type: none">• Nursing and medical staffing had improved since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the hospital, especially in medical care services and the emergency department. Staffing levels and skill mix in emergency, medical and surgical care was below the actual planned levels at times despite the use of bank, agency and locums. There were also nurse staffing concerns in the neonatal unit at Royal Lancaster Infirmary.• Record keeping was variable in some services, in terms of nursing documentation and risk assessments. Care pathways were not always reviewed in the emergency departments.• Within the emergency departments, the outcomes of people's care were not always monitored regularly or robustly using the National Early Warning Score (NEWS) system. Failure to do this could prevent early recognition of a deteriorating patient.• There were processes in place for the checking of resuscitation equipment. However, in the emergency care departments, resuscitation checks were not consistently completed on a daily basis.• Within the trust's emergency departments, the median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period of August 2015 to July 2016. In July 2016 the median time to initial assessment was 16 minutes compared to the England average of seven minutes. The trust's performance had worsened over time with the median time increasing.• Within medical care services, there was inconsistency in the completion of multifactorial falls risk assessments. <p>However:</p> <ul style="list-style-type: none">• There were systems in place for incident reporting, staff received feedback and action taken to reduce the risk of reoccurrence. There was evidence of learning from incidents across the directorates. The requirements of Duty of Candour were followed and the trust's processes were open and transparent.	<p>Requires improvement </p>

Summary of findings

- The trust had infection prevention and control (IPC) policies which were accessible, understood and used by staff. Across the trust patients received care in a clean, hygienic and suitably maintained environment.

Incidents

- Between November 2015 and October 2016 the trust reported two incidents which were classified as Never Events. Never Events have the potential to cause serious patient harm or death. They are wholly preventable, where healthcare providers have implemented nationally available guidance or safety recommendations that provide strong systemic protective barriers
- Serious incidents were reported through the Strategic Executive Information System (STEIS). Between November 2015 and October 2016 the trust reported 40 serious incidents (SIs) which met the reporting criteria set by NHS England, in accordance with the Serious Incident Framework 2015,
- There were 7,659 incidents reported to the National Reporting and Learning System (NRLS) between November 2015 and October 2016. Proportions of incidents by severity were: severe 9 (0.1%); moderate 171 (2%); low 2085 (27%); and no harm 5389 (70%). There were five deaths reported by the trust over this period (0.1%).
- Staff used an electronic system to report incidents. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- There was a strong culture of reporting, investigating and learning from incidents throughout the trust. There was clear evidence that these serious incidents were robustly investigated. Staff told us that they always received feedback following investigations of incidents of harm or risk of harm. Learning from incidents was discussed and cascaded through several forums. They were discussed individually, displayed on a notice board in the staff area, and discussed in the clinical governance group meetings.
- The trust held a weekly patient safety summit involving all three acute hospitals' senior doctors, nurses and AHPs by teleconference or videoconference to review any harm (or near miss) incidents, within a week of that incident occurring. The detail relating to the incident was discussed along with any actions taken and confirmation of individual learning. The senior team leading the patient safety summit considered and promoted wider learning that couldn't be applied across the organisation, and monitored adherence to the Duty of Candour.

Summary of findings

- The Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) for the trust had been consistently good. The latest HSMR for 2015/16 showed a further improvement from 92 to 89, standardised against England data. The SHMI data also showed a significant improvement from 102 to 98, below the national and regional average. This equates to a reduction in patient mortality from 25% to 18.6%.
- Morbidity and mortality meetings were held across most services. These were not held for children and young people services, however perinatal meetings were held.
- In the CQC In-Patient Survey 2015, patients reported they felt safe during their stay in hospital (scoring 9.7 out of 10 in line with the national average).

Cleanliness, infection control and hygiene

- The trust had infection prevention and control (IPC) policies which were accessible, understood and used by staff.
- Across the trust patients received care in a clean, hygienic and suitably maintained environment.
- Results of the Patient-Led Assessments of the Environment (PLACE) 2016 showed that the trust scored 95 for cleanliness (England average, 98).
- There were no cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) reported between October 2015 and September 2016. Trusts have a target of preventing all MRSA infections, so the trust met this target within this period.
- Additionally, the trust reported 15 MSSA infections and 28 C.Difficile infections over the same period.
- The trust routinely monitored staff hand hygiene procedures, and compliance at the time of inspection was high in most areas.

Assessing and responding to patient risk

- The trust had recently introduced the National Early Warning Score (NEWS) risk assessment system for recognition and treatment of the deteriorating patient. Prior to this, the trust used a local version of an early warning system. The strategy and processes for recognition and treatment of the deteriorating patient had been updated in August 2016 to align with national guidance, and changed from the previous early warning score and 'track and trigger' system.

Summary of findings

- Patient safety was monitored through the completion of moving and handling assessments, falls risk assessments, the National Early Warning Score (NEWS) and Malnutrition Universal Screening Tool (MUST) assessments and by following infection, prevention and control measures.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- Within the emergency departments, the outcomes of people's care were not always monitored regularly or robustly, using the National Early Warning Score (NEWS) system. Failure to do so could prevent early recognition of a deteriorating patient.
- Hospital data (April/May/June 2016) showed 97% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saves lives', 2010) for note completion, sign in, time out and sign out.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states that a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Within the trust's emergency departments the median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period of August 2015 to July 2016. In July 2016 the median time to initial assessment was 16 minutes compared to the England average of seven minutes. The trust's performance had worsened over time with the median time increasing.
- Within medical care services there was inconsistency in the completion of the multifactorial falls risk assessment compounded by the transition from paper records to the electronic patient record. Therapists coordinated such assessments and discussed these at daily board rounds and multi-disciplinary team meetings. Nursing staff, however, could not provide evidence in the electronic patient record to confirm the assessment had been completed in all cases.

Nurse Staffing

- The trust used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. The funded staffing establishments for all general medical wards were based on "red rules", a minimum of a 60:40 qualified:unqualified split and a minimum of 1:8 registered nurse: patient ratio. Managers confirmed that, in higher dependency areas, multipliers were used to vary nursing establishment figures aligned to acuity and dependency measurement, for example in CCU.

Summary of findings

- As at July 2016, the trust reported a vacancy rate of 4.1 % in Registered Nursing and 6.4% in Registered Midwives. The trust reported that national and international recruitment campaigns were in place to address the gap in Registered Nursing.
- As at July 2016, the trust reported a trust-wide turnover rate of 7.9% for all staff groups. The trust reported that turnover is reducing in key areas and hot spots are being acted upon at a divisional level.
- Nursing and medical staffing numbers had improved since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the hospital, especially in medical care services and the emergency department. Staffing levels and skill mix in emergency, medical and surgical care were below the actual planned levels at times, despite the use of bank staff, agency staff and locums. There were also nurse staffing concerns in the neonatal unit at Royal Lancaster Infirmary. The trust had robust systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care.
- The trust met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 27 births, which was better than the RCOG recommendation of 1 midwife to 28 births.

Medical Staffing

- As at July 2016, the trust reported a vacancy rate of 4.6% in consultant medical staff. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing.
- At July 2016 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 also about the same as the England average.
- According to the College of Emergency Medicine (CEM) (2015) an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. This was not being met at either of the trust's emergency departments. However, there were recruitment plans in place. Locums and middle grade doctors were being used until permanent consultant posts could be filled.

Summary of findings

- Within critical care consultant staff to patient ratios were in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- The trust provided 52 hours of consultant presence on the labour wards each week. This was achieved by new consultants having resident night shifts on the delivery suite as part of their job plan. This was in line with the recommended RCOG safer staffing standards for a service delivering fewer than 3,000 births per year.

Equipment & Environment

- In all services there was adequate equipment to support the delivery of safe care. However, the trust performed worse than the England average in the Patient Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to facilities (90% against 93%).
- There were processes in place for the checking of resuscitation equipment. However, in the emergency care departments, resuscitation checks were not consistently completed on a daily basis.
- At FGH, the emergency department pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN15-01:Accident and Emergency Departments 2013)
- In its Estates Strategy 2015 to 2025, the trust acknowledged that there are insufficient cubicles during busy periods at FGH. The risk associated with having only one resuscitation cubicle was acknowledged and was on the risk register. There were plans to commence the expansion of the emergency department at this hospital in December 2016.
- A project was in place to improve facilities for patients requiring stroke care at RLI, by building a new acute stroke unit during the winter of 2016. This would also allow the development of the coronary care unit (CCU) from its previous eight beds to an 11-bedded area adjacent to the new Lancaster Suite.
- The trust had opened a new frail elderly unit (AFU) for older person's care at RLI in March 2016, and physiotherapy services were to move from medical unit one into a new therapies unit in medical unit two in 2017. This would allow the medical division to develop a new diabetic centre on the site vacated by medical unit one.

Safeguarding

Summary of findings

- The trust set a mandatory target of 95% for completion of mandatory safeguarding adults and children (level 1 and level 2) training, and at July 2016 the trust completion rate was 91% for level 1 and 92% for level 2.
- The trust had a designated lead for safeguarding supported by a specialist team with responsibility for children.
- All staff we spoke with knew the trust safeguarding policy, how to access relevant information using the trust intranet and where to seek guidance for any out-of-hours concerns.
- Staff used 'flags' or icons on the electronic patient record (EPR) to highlight adults who were vulnerable or who had particular needs.

Duty of Candour

- Staff knew of the Duty of Candour (DoC) requirements and of the trust policy. Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- Staff discussed incidents where DoC applied with the Patient Safety Summit Team at its weekly meetings. The Patient Safety Team monitored the completion of the DoC requirements monthly.
- Clinical divisions within the trust completed a quarterly audit of DoC completion, which they presented to the serious incident review and investigation panel and then onward to the Quality Assurance Committee and the Board as part of the quarterly incident report.

Are services at this trust effective?

Good



We rated effective as 'good' because:

- The trust was actively involved in local, national and international audit activity and followed recognised guidance that provided an evidence base for care and treatment. New evidence-based techniques and technologies were used to support the delivery of high quality care.
- There were opportunities to participate in benchmarking, peer review, accreditation and research.
- Patient outcome measures showed the trust performed mostly within the national averages when compared with other hospitals. Where outcomes were worse than the national average the trust ensured measures were in place to make improvements.

Summary of findings

- The trust had a clear policy to provide guidance for obtaining consent from patients within the organisation.
- There were many examples of multi-disciplinary working to secure good outcomes and seamless care for patients. Staff in all disciplines worked well together for the benefit of patients. There were trust-wide multidisciplinary teams with established links to local speciality teams across acute and community settings.

However:

- Improvements in patient outcomes in some national audits were static or below the England average. The trust had implemented action plans to improve in areas highlighted by audit findings.

Evidence based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- The trust participated in the national Royal College of Emergency Medicine (RCEM) and Trauma Audit and Research Network (TARN) audits so it could benchmark practice against other emergency departments.
- The trust was actively involved in local and national audit programmes, collating evidence to monitor and improve care and treatment. Divisions across the trust compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and ongoing evidence-based reviews. The trust was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management (CRM), cardiac arrest, Parkinson's, pneumonia, heart failure, diabetes, acute coronary syndromes, falls and fragility fracture audit programme (including hip fractures) and gastrointestinal bleeding.
- The trust had developed a number of evidence-based condition-specific care pathways to standardise and improve patient care and service flow. In ambulatory care, for example, there were pathways for low risk pulmonary embolism and low risk upper gastrointestinal (GI) haemorrhage.

Patient outcomes

- FGH took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade D in the latest audit, which covered April 2016 to June 2016. Furness General Hospital's overall scores have

Summary of findings

remained static for the last three quarters. The patient- and teamcentred performance domains improved in scanning, occupational therapy and physiotherapy, however they reduced in the stroke unit and discharge processes.

- FGH results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four standards relating to in-hospital care and six of seven standards relating to discharge. Received echo and received discharge planning both scored particularly well at 100%. Cardiology inpatient scored poorly at 36.2% against the England and Wales average of 48.1%.
- FGH took part in the 2013/14 Myocardial Ischaemia National Audit Programme (MINAP) and scored better than the England average for one out of the three metrics. This metric was Non-ST-elevation myocardial infarction ('nSTEMI) patients that were referred for or had angiography (including after discharge)'. The metric 'nSTEMI patients seen by a cardiologist' scored particularly poorly compared to the England average. However, there was improvement in all three metrics compared to 2012/13 site level results.
- FGH took part in the 2015 National Diabetes Inpatient Audit (NaDIA). The trust scored better than the England average in 11 metrics and worse than the England average in six metrics. The metrics relating to foot risk assessment scored particularly poorly.
- In the National COPD Audit Programme 2014, FGH scored a total of 24 points across the five domains (less than the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and scored well in managing respiratory failure/oxygen therapy, however, poor scoring was recorded against senior review on admission, access to specialist care and integrated care. The service also received a red-flag alert defined as a unit without an ICU outreach service for critically ill cases requiring ICU management.
- RLI took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade D in the most recent audit (April to June 2016). There had been no change in the overall scores for the last three quarters. The domain referring to occupational health fell in grade from B to C whilst discharge processes rose from B to A. Team-centred scanning also saw a rise from grade C to B.

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- The stroke team worked with A&E colleagues to develop a 'code stroke alert' bleep system which identified when a patient would benefit from thrombolysis. The team also hoped to work with the local ambulance service to progress direct computerised tomography (CT) scanning access.
- The divisional stroke team developed an action plan to review and progress improvements in stroke services following the recent SSNAP outcomes report. At RLI, the nurse specialists had provided training to A&E staff to improve early identification of stroke patients who would benefit from prompt access onto the stroke pathway. The service had extended the role of the advanced nurse practitioner to sign CT requests therefore progressing scanning investigations more efficiently. Staff worked closely with therapy colleagues to improve referral pathways and therapy activity with speech and language, physiotherapy and occupational therapy. The stroke team worked closely with network colleagues to share best practice and to improve patient outcomes across the region.
- RLI's results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four of the standards relating to in-hospital care, and in six of the seven standards relating to discharge. Input from specialist and received echo both scored particularly well at 99.5%. Cardiology inpatient scored low at 12% versus the England and Wales average of 48.1%.
- RLI took part in the 2013/14 MINAP audit and scored better than the England average for two of the three metrics. Both metrics also showed improvement when compared to the 2012/13. The only metric not to score better than the England average was 'nSTEMI patients admitted to cardiac unit or ward', which saw a very small decrease when compared to 2012/13.
- RLI took part in the 2015 National Diabetes Inpatient Audit (NaDIA). The trust scored better than the England average in 13 metrics and worse than the England average in four metrics. The metrics relating to foot risk assessment scored particularly low.
- In the National COPD Audit Programme 2014, RLI scored a total of 33 points across the five domains (in line with the national median score of 33). The respiratory service scored well across all domains (non-invasive ventilation services, managing respiratory failure/oxygen therapy, access to specialist care and integrated care) but recorded poor scoring against senior review on admission.
- Between March 2015 and February 2016, patients at RLI had a similar expected risk of readmission to the England average for

Summary of findings

non-elective admissions and a higher expected risk for elective admissions. Trauma and Orthopaedics had the largest relative risk of readmission for both non-elective and elective admissions.

- Patients at FGH had a lower expected risk of readmission than the England average for non-elective admissions and a lower expected risk for elective admissions. Elective Trauma and Orthopaedics had the largest relative risk of readmission.
- In the 2015 Hip Fracture Database Annual Report for the trust, the proportion of patients having surgery on the day of or day after admission was 67.4%, which does not meet the national standard of 85%. The 2015 figure was 60.5%. The perioperative medical assessment rate was 87.7%, which does not meet the national standard of 100%. The length of hospital stay was 28.1 days, which falls in the worst 25% of trusts. The 2015 figure was 25.4 days. There were 310 cases in the audit, and case ascertainment was 83.1% in 2015, which was lower than the national aggregate of 90.7%.
- In the 2015 Bowel Cancer Audit for the trust showed that 75% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2014 figure was 52%. The Risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2014 figure was 3.4%. The Risk-adjusted 2-year post-operative mortality rate was 24.7%, which falls within the expected range. The 2014 figure was 26.7%. The Risk-adjusted 90-day unplanned readmission rate was 16.8%, which falls within the expected range. The 2014 figure was 14.3%. The Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 56%, which falls within the expected range. The 2014 figure was 59%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0% for the trust. This placed the trust within the lowest 25% of all trusts for this measure. The 90-day post-operative mortality rate was not reported. The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%, in line with the national aggregate.
- Results from the Patient Outcomes Reporting Measures (PROMS) from April 2015 to March 2016 for Groin Hernia metrics and Knee Replacement metrics were about the same as the England average whilst Hip Replacement metrics had mixed performance with EQ VAS being better than the England average, whilst the EQ 5D index and the Oxford score were slightly worse.

Summary of findings

- The trust did not participate in the 2015 National Vascular Registry (NVR) audit.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed the trust achieved a rating of over 70% for five measures and had a good rating for nine out of 10 elements of the audit.
- Between March 2015 and February 2016 there were a higher percentage of patients aged under one year readmitted following an emergency admission (5.8%) than the England average (3.4%), and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission (3.9%) than the England average (2.8%).
- Between April 2015 and March 2016 the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, with a readmission rate of 11.9% against an England average of 16.6%.
- The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy. Data showed a readmission rate of 35% against an England average of 29.3%.
- The trust participated in clinical accreditation and peer review schemes, including Clinical Pathology Accreditation (CPA), and its successor ISO 15189 Medical Laboratories.

Multidisciplinary working

- There were many examples of multi-disciplinary (MDT) working, to secure good outcomes and seamless care for patients across the trust.
- The emergency department at FGH provided an acute service for patients who had had a stroke. A specialist nurse attended the department to give advice and support the care of the patient. A stroke pathway was in place 9am to 5pm Monday to Friday. Out of hours, the stroke specialist doctor on call was contacted and the care of the patient discussed via telemedicine, which is a video conferencing service.
- A Rapid Enhanced Assessment Clinical Team (REACT) visited the emergency department at RLI. The team comprised a nurse, a physiotherapist, and an occupational therapist. The team assessed patients and was able to put in place support at home if needed.
- Our observation of practice of the Children and Young People service, review of records and discussion with staff, confirmed that effective MDT working practices were in place. There were processes in place for transition.

Summary of findings

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Records showed patients had consented to surgery in line with Department of Health guidelines. This included the risks, benefits and alternative options for treatment.
- The trust's consent policy had a section specifically about children and young people. However, documentation within children and young people services referred to Fraser competence when discussing consent rather than Gillick competence. Fraser competence only relates to consent for contraceptive or sexual health advice.
- Staff were aware of the safeguarding policies and procedures and had received training. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- Safeguarding and MCA guidance was available across the trust. Staff referred to the DoLS flowchart to detail the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues.
- Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. We saw evidence of mental capacity assessments completed in medical records.
- Staff accessed the Safeguard Team if concerned about a patient, and they confirmed that its responses were prompt.

Are services at this trust caring?

We rated caring as 'outstanding' because:

- The trust's commitment to deliver quality compassionate care was echoed by all staff across the organisation. There was a real desire and determination from staff at all levels to ensure patients received the care they needed.
- Feedback from patients and their family members was consistently positive about the care received and there were a number of examples highlighting staff going 'the extra mile' to deliver.
- Staff considered physical, emotional and social elements of wellbeing equally and without exception. Patients and family members were included when discussing care decisions and treatment plans.
- We observed staff delivering care with sensitivity, clinical staff interacting with patients respectfully and non-clinical staff providing emotional support.

Outstanding



Summary of findings

- There were a number of successful innovations relating to compassionate care for patients, particularly within end of life care.
- There was evidence of patients and their relatives being involved in the development of their care plans throughout all services within the trust.
- The trust's bereavement service had excellent feedback regarding the emotional and practical support offered to relatives following the death of their loved ones.
- There were positive results in the NHS Friends and Family Test and good recommendation rates for the service. The service reported good outcomes from the National Cancer Experience Survey 2015, the Patient Led Assessment of the Care Environment (PLACE) 2016 survey and the endoscopy service.

Compassionate care

- The trust's commitment to deliver quality, compassionate care was echoed by all staff across the organisation. There was a real desire and determination from staff at all levels to ensure patients received the care they needed.
- A bereavement service including bereavement nurses and officers to support relatives through the practical and emotional aspects of bereavement had been introduced by the trust.
- There were a number of innovations relating to compassionate care for patients at the end of life. The trust had adopted the 'dragonfly' as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- The trust also used canvas property bags with a dragonfly symbol, so staff knew that those collecting property had been recently bereaved. In addition bereavement staff sent out forget-me-not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands. This was a service provided by an external organisation, with funding provided by the trust.
- The bereavement team, Chaplaincy and specialist palliative care team worked together to promote compassionate care at

Summary of findings

the end of life. A particular innovation relating to this had been the development of death cafés. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death cafés for the public as part of 'dying matters week' and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.

- The trust was nominated as runner-up in the Health Service Journal's 2015 compassionate care category for its bereavement service.
- We saw evidence of use of patient diaries in critical care. Patients were asked to bring diaries to follow up appointments after discharge from hospital and a critical care admission. This helped patients to better understand their experience, which supported recovery and rehabilitation. The diary supported individual care plans and we noted an example of support put in place for a patient who was worried about pets at home; relatives were involved in allaying the patients anxieties.
- Within critical care services at RLI staff had carried out role-play exercises and involved patients in order to develop a depth of understanding of the experience of being a patient in each bed space.
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between August 2015 and July 2016. In the latest period, July 2016, trust performance was 95.9 % compared to an England average of 95.4%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for seven of the 50 questions, in the middle 60% for 43 questions and in the bottom 20% for no questions.
- In the CQC's 2014 A&E survey, the trust scored about the same as other trusts for all of the 24 questions relating to caring.
- The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to privacy, dignity and wellbeing scoring 86% which was better than the England average of 84%.
- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all questions relating to caring.
- In the Endoscopy Survey at FGH published in August 2016, 91% of patients rated the care provided by the service to be eight (out of 10) or above, with 80% rating the service 10 out of 10. There were no experience scores below 6 out of 10. All patients confirmed privacy and dignity was maintained.

Understanding and involvement of patients and those close to them

Summary of findings

- The trust offered a ‘forget me not’ passport of care for every inpatient admission. This was completed by the families and carers, telling the staff how to care for the person in their unique way, offering individual detail to give a personalised approach.
- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- There was evidence of patients and/or their relatives being involved in the development of their care plans. Results from a bereavement survey carried out by the bereavement service showed that 98% of relatives stated that they felt involved in decisions about care.
- Specialist palliative care nurses and bereavement nurses had been trained in advanced communication skills. Communication skills training was available for all staff.
- Within critical care services at RLI senior staff had developed an electronic tablet “app” as a cognitive tool to be used by patients during their stay. This was as a response to patient feedback in follow-up clinics.

Emotional support

- Within medical care services, staff recognised the best person to provide emotional support at a particular time could come from a variety of sources and they did not discourage non-clinical staff from supporting patients within given boundaries. We observed cleaning and housekeeping staff take time to spend with patients who wanted to talk.
- Since May 2014 there has been Chaplaincy on all three sites with the lead Chaplain based at WGH. This has raised the profile of the Chaplaincy and its ability to engage with the spiritual needs of patients, families, and staff. The Chaplaincy service had restructured its work with its volunteers, increasing visibility, cultivating reflective practice, and raising cross-site awareness. It had developed training skills by hosting placement students. It had initiated a process of formalising links with key faith groups. Chaplaincy was identifying areas for research including mindfulness and spirituality and wellbeing.
- Multi-faith spirituality groups were held across the trust.
- The wards had ‘breaking bad news’ quiet room facilities for patients and their families.
- A remembrance service was held by the Chaplaincy every three months for those bereaved. We were also told that ‘shadow’ funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.

Summary of findings

- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one and support was offered at this time.
- Bereavement nurses worked closely with ward staff to provide support to both patients and relatives around issues of loss and other support needs. There was a library of books available for families to borrow, for example in relation to supporting children through bereavement and loss.
- The Chaplaincy service provided spiritual support for patients and their families and had a multi-faith prayer room. A team of volunteers worked with the on-site chaplain to provide this. The service had recently recruited an imam as a chaplaincy volunteer.
- The aim of the Chaplaincy service was to visit end of life care patients hospital once a week, to offer support and raise awareness of the service.
- All Chaplains were involved in delivering bereavement training to staff and they also attended MDTs. The Chaplain at RLI also hosted the death .
- The trust's bereavement service found that 92% of respondents felt they had received appropriate support from medical staff to deal with their feelings surrounding the death of their loved ones and 100% of respondents felt they had received appropriate support from nursing staff in this area.

Are services at this trust responsive?

We rated responsive as 'good' because:

- The trust worked closely with its commissioners and external stakeholders on service redesign and the local health economy strategy.
- The trust had improved and was now performing well overall with regard to how quickly patients could access care and receive treatment.
- There were processes in place to manage access and flow, with appropriate escalation plans in place, which were understood by staff.
- Services met the needs of people, particularly patients with multiple and complex needs.
- Systems were in place for the management of complaints, and there was evidence of improvements following complaints.

However:

Good



Summary of findings

- The trust was not meeting the Department of Health's standard that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

Service planning and delivery to meet the needs of local people

- The trust was actively engaged with the Better Care Together (BCT) strategy, bringing together a total of 11 local organisations including neighbouring trusts, clinical commissioning groups (CCGs), GP Federations, local authorities and the ambulance service to plan and deliver the BCT strategy.
- BCT was designed to provide integrated care closer to the community through changes to clinical pathways, aimed at reducing unnecessary interventions and, where clinically appropriate, introducing initiatives such as patient initiated follow-ups (PIFU). This worked alongside innovative, locality-based, out-of-hospital proposals to enhance locally-provided health services and facilitate management of long-term conditions closer to home, and to reduce the number of, predominately elderly, patients in acute hospital beds.
- Since BCT was developed it had evolved and work was ongoing to create an Accountable Care System to take responsibility for the whole health and care needs of the population. Clinical and operational partners were working across all the BCT work-streams to ensure safe and sustainable planning across entire pathways of care, with whole-system solutions to the challenges faced.
- Divisional management staff in the appropriate areas attended meetings with local CCGs in order to feed into the local health network and identify service improvements to meet the needs of local people.
- In planning and delivering services, the wider BCT strategy was heavily influential and several priorities were considered to ensure the needs of the local and regional population were being met.
- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the emergency departments service worked with external partners including general practices in a programme named Integrated Care Communities. This programme's aim was to proactively plan care for both frail and vulnerable patients and frequent attendees to prevent unnecessary attendances to the emergency department. This was supported by community paramedics and a telehealth project.

Summary of findings

Meeting people's individual needs

- A mental health liaison team was based in the emergency departments from 8am to 8pm each day and provided assessment for patients with mental health problems. Out of these hours the community based crisis team was contactable.
- The trust utilised the NHS Shared Business contract and regularly accessed services from two translation providers. The translation and interpretation service was available 24 hours per day and was booked by the ward or department calling the hospital switchboard. The switchboard held the corporate booking PIN and passcodes. For planned activity the translation service could be booked in advance. Pre-booking made available the option of requesting a preferred translator to ensure continuity.
- The trust had recently appointed a learning disability (LD) nurse specialist, for support where necessary. The LD nurse coordinated care for those patients with more complex needs. All LD alerts were sent directly to her and all reasonable measures were considered to assist the patient through their care pathway whilst hospitalised, and to support a smooth transition back into the community.
- Staff provided a 'passport' to patients with LD. This was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions which would be helpful in supporting the patient during difficult periods. The LD nurse specialist identified, in conjunction with carers and ward staff, which reasonable adjustments were required to support the patient whilst in hospital. This could be pre-visits to suites for procedures to support desensitisation, an offering of a side-room for privacy and to reduce anxiety, flexible visiting, carers staying with the patient overnight, and other individual preferences unique to that individual.
- Staff across the trust had built good working relationships the community LD teams and, where required, those teams would be invited to attend MDT meetings in order to effect a wider, holistic assessment and for involvement in any future ongoing care package.

Dementia

- The trust had a dementia strategy which was embedded across services.
- The trust's IT system had a flagging system that identified patients with dementia or a learning disability.

Summary of findings

- The 'Butterfly Scheme' was implemented, which, at a glance, created discreet identification via the Butterfly symbol for patients who had dementia-related memory impairment and wished staff to be aware of that.
- The Bay Dementia Hub was a service to help people who were worried about their memory, and residents diagnosed with dementia and their families and friends. This new initiative sought to build on the existing work of a dementia-specialist.
- At the RLI emergency department there was a specific 'dementia friendly' cubicle. This was painted a different colour and had a picture on the wall and a clock with clear numbers to help the patient distinguish between night and day. These changes were aimed at reducing anxiety.
- There was also a memory box containing objects such as a ration book and old pictures. This was used to reduce patients' anxieties about being in an unfamiliar place. The staff told us that this was a helpful tool and patients enjoyed looking through the items.
- There was a Matron for Professional Standards in Dementia in a post that formed part of the Safeguarding Team. She managed the Care of the Elderly teams to ensure that the appropriate care was put in place on assessment, and carer/family involvement was included. The trust had dementia champions.
- Staff across the trust ensured patients living with dementia were appropriately screened, treated for any underlying cause that may be contributory to a delirium, and signposted for further assessment if necessary. Where a patient was confirmed as living with dementia, the division had a designated care pathway supported by specialist practitioners from the care of the elderly team, therapists and specialist nurses.
- Staff within clinical areas recognised that meal times could cause concern for many patients and their family members. The division had adapted visual menus suitable for those patients who preferred hot finger food options and snacks, to improve calorific intake and the pleasure of eating. The division had also adopted 'John's campaign'; a formal recognition of the importance of families' and carer' involvement in care and decision making. The division offered open visiting and provided nominated persons, with a lanyard and badge to identify their involvement in the scheme.
- Some wards across the trust had undergone refurbishment to become 'dementia friendly' with appropriate signage to aid communication and perception, and with triggers for reminiscence such as music, photographs and decorations to encourage positive interactions and reduce environmental conflict.

Summary of findings

- All patients coded with a diagnosis of dementia from an inpatient admission were identified by the Care of the Elderly (COTE) team. A carer survey questionnaire was sent to the patients and their families or carers to ask if they had been adequately supported during the episode of care. Staff presented the feedback along with dementia audit findings to the ward managers in the quality committee report “I want great care” and published findings on ward information boards.

Access and flow

- The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016.
- The trust had been performing worse than the England average for all but three months of the 12 month period. Prior to June 2016 the trust’s performance followed the England average trend; after June 2016 the trust’s performance showed a downward trend whereas the England average showed a slight improvement.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met this standard for all months over the 12 month period.
- Between August 2015 and July 2016 performance against this standard showed a trend of improvement. In July 2016 the median time to treatment was 55 minutes compared to the England average of 62 minutes. Trends showed that the time to treatment had been slowly increasing over the time period and was in line with the England average.
- Between August 2015 and July 2016 the trust’s monthly median percentage of patients leaving the its urgent and emergency care services before being seen for treatment was better than the England average for the entire period. The trust’s performance followed a similar trend to the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. A ‘black breach’ occurs when a patient waits over an hour from ambulance arrival at the emergency department to being handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 black breaches in July 2016. There was an upward trend in the monthly number of black breaches reported over the period.

Summary of findings

- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average. Trust performance improved in May and June 2016 but declined from July 2016 onward.
- Between August 2015 and July 2016 the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. However, performance against this metric showed a trend of decline. In July 2016, the trust's median time in A&E was 151 minutes versus the England average of 146 minutes.
- The bed-management team observed flow within the emergency department, and meetings took place at least four times a day (more frequently if necessary) across the trust sites to understand the bed situation and enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- An escalation process was in place that gave staff actions for how to manage departments during periods of extreme pressure. This would involve help from the wider hospital teams, including bed managers, matrons and service managers, improving patient flow throughout the hospital, and specialist teams reviewing patients in the emergency department.
- Between October 2015 and September 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England average performance. The latest figures, for September 2016, showed that 100% of this group of patients were treated within 18 weeks, against the England average of 90%. The trust had consistently performed better than the England average in the 12 month period.
- There were no medical specialties below the England average for admitted RTT (percentage within 18 weeks).
- The latest figures, for July 2016, showed 100% of all medicine patients were treated within 18 weeks.
- There were medical outliers at both RLI and FGH. Medical outliers were cared for on 'buddy wards' to keep a particular specialism or cohort together in one location. This assisted non-medical ward-based staff to work with one particular medical team and assisted medical staff when reviewing outlying patients by keeping them together.
- The trust had employed a number of discharge coordinators to support patients in the transition from hospital care into the

Summary of findings

community. Not all wards had a discharge coordinator in post. However, all staff commented on the positive impact this role had had on ward pressures, progressing care packages and supporting patients and their families toward discharge.

- The reported reasons for delayed transfer of care (DTC) between July 2015 and June 2016 were patients awaiting nursing home placement or availability (38.3%) and awaiting residential home placement or availability (23.1%).
- Divisional managers worked with multiple partners to look at improvements in DTC. The priority of the group was to reduce unnecessary admissions in the first instance as it was found this patient cohort accounted for approximately 30% of in-patient bed occupancy. The project was six months old at the time of the inspection and work was ongoing. Divisional managers had also taken part in DTC rapid improvement events with community care colleagues and 'Hospital Home Care Team' projects. Outputs from these pieces of work had seen the division support social workers being integrated into the discharge team and care support workers being appointed into the Hospital Home Care Team.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery had been worse than the England average performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks versus the England average of 75%.
- The National Cancer 2 Week Wait target confirmed performance was 95.2%, 98.2%, 96.3%, 96.6% and 95.3% between April 2016 and August 2016 across the trust. The trajectory for 2016/2017 was 93.1% in eight of the twelve months, and has been exceeded.
- The National 18 week referral to treatment pathway performance against the sustainability and transformational fund (STF) trajectory showed that the trust achieved better than the trajectory of 88.6% in April, at 89.47%, and May at 89.71%.
- For the period Q1 2015/2016 to the date of inspection, the trust cancelled 561 operations on the day of surgery. Of the 561 cancellations all were rescheduled and treated within 28 days; this was better than the England average. The trust's cancelled operations as a percentage of its elective admissions was worse than the England average.
- The total number of on-day cancellations for non-clinical reasons for June 2016 was 55, which equated to 1.34%, with a year-to-date position of 0.93% against a new internal stretch target of 0.7%.

Summary of findings

- The key cancellation themes for June 2016 were: 19 due to lack of sufficient operating time; 13 associated with trauma impacting on electives; four due to bed shortage; eight associated with administrative/other issues; seven associated with technical issues in theatre ; and four associated with medical staff sickness or absence.
- The cancellation themes associated with the administrative/other issues r category were due to booking errors or availability of medical staff.
- There were no 28 day breaches encountered for the year to June 2016.
- The main reason for delayed transfer of care at the trust was 'awaiting nursing home placement or availability' (38.3 %), followed by was 'awaiting residential home placement or availability' (23.1 %). This was recorded between July 2015 and June 2016.
- Between Q3 of 2014/2015 and Q4 of 2015/2016, the trust's bed occupancy was lower than the England average, however, in Q1 of 2016/2017 the trust's percentage occupancy rose to 99.1% which is above the England average of 90.1%.

Learning from complaints and concerns

- A comprehensive and current complaints policy covered the complaints management process for the trust.
- The trust had a centralised complaints team. This team led on all complaints with dedicated case officers. Investigations were documented using an electronic system. Responses went through a quality assurance process involving divisional general manager, staff involved, head of patient relations and final sign off by the director of governance.
- The trust's complaints policy states that complaints should be signed off by the formal CEO response letter, and signed by the Director of Governance, or other appropriate Director (nominated deputy), within 35 working days of receipt of the complaint, unless another timescale has been agreed with the complainant. Between 27 October 2015 and 27 October 2016 there were 504 complaints about the trust. During this period the trust took an average of 25.5 days to investigate and close complaints (adjusted to 29.36 days when taking into account extensions agreed in line with its complaints policy). The trust had seen an increase in the number of complaints received over the 12 month period. Medicine and surgery had the highest numbers of complaints.

Summary of findings

- We reviewed ten complaints. Each complaint was signed by the Director of Governance on behalf of the Chief Executive and contained a comprehensive response, apology and, where required, an action plan. There was also evidence of lessons learnt in these responses.

Are services at this trust well-led?

Good



We rated well-led as 'good' because:

- There was a clear vision and strategy for delivering high standards of patient care with quality and safety as a key focus.
- There were effective reporting arrangements and governance systems up to the board.
- There were good levels of clinical engagement and leadership across the trust. Staff were proud of the organisation as a place to work. The NHS Staff Survey 2016 demonstrated many areas of improvement including staff recommending the trust as a place to work or receive treatment, staff feeling supported, and staff making effective use of patient and service-user feedback.
- The trust valued and encouraged public engagement. There were many examples of public engagement in the development and delivery of maternity services, such as co-designing the new maternity unit, interviews for recruitment of new staff, including midwives and matrons, and the development of guidelines and strategies.
- There were many examples of innovation and improvement, for instance, the trust was one of only two NHS trusts in the country to launch a new quality ambassador scheme to help improve the quality of care provided across its services.

However:

- Although there was a plan within maternity services which set out the principles and governance arrangements for a strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust, further work was required to effectively capture and monitor outcomes. The trust acknowledged that partnership working was still evolving, with developments needed to formalise midwifery placements and to extend the partnership to include paediatrics and anaesthetics.

Vision and strategy

- The trust's vision and strategy was clearly articulated in its five year strategic plan, which was introduced in 2015. This also

Summary of findings

incorporated the Better Care Together (BCT) strategy, which was focussing on restructuring of the trust's healthcare for the local population, with a significant shift in emphasis on to community care.

- BCT aimed to give greater support to patients in the community, reducing the need for hospital admissions and creating a significant reduction in use of hospital beds. It saw developing community partnerships as a key part of its path to success. Community Partnerships already in place included the Hospital Home Care Team and the Discharge Support Team, which were integrated care teams working together to improve and quicken appropriate discharges in the community post-surgery.
- Each division had its own strategic plan which was linked to the trust's five year strategic plan.
- In the Maternity Strategy for 2016/2017, the key focus was to provide compassionate, high quality, evidence-based and safe maternity services, which met the needs of all women and their families. The trust planned to achieve this by working as a multi-professional team with communities to improve physical, social, mental and emotional health for women entering pregnancy.
- The strategy included a newly developed integrated maternity pathway for women and families across Morecambe Bay to ensure individualised, person-centred care. The use of the pathway was one of the priority projects for 2016/2018. As part of the maternity improvement plan, the service had developed a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust. The clinical lead for obstetrics told us that a memorandum of understanding (MOU) was in place with both tertiary centres. The MOU set out the principles of the partnership and governance arrangements. Consultants and almost all non-training grade doctors in obstetrics and gynaecology had honorary contracts with Central Manchester.
- Cross-bay working, as well as joint working between services, had been significantly strengthened since the last inspection.

Governance, risk management and quality measurement

- The governance and risk strategy framework had continued to improve since the last inspection and was now embedded. The framework had received a positive review by the Good Governance Institute in 2016.

Summary of findings

- The trust used a bespoke governance framework, incorporating workforce, efficiency, safety, effectiveness and patient experience. It was known by staff as “WESEE”.
- This governance framework was well structured and there were clear lines of responsibility and accountability from individual units or wards into the divisional management boards, then to divisional performance meetings before moving into the workforce, finance and quality committees, and then up to board level.
- Staff across the trust described the new governance framework as simple and effective. Staff confirmed that WESEE worked well on wards and had brought consistency and uniformity across the division in the last 12 months.
- We reviewed minutes of governance meetings under the WESEE framework, covering the set agenda items of workforce, efficiency, safety, effectiveness and experience. There was a clear process for sharing information (such as Board issues, divisional headlines and ward matters) through this process up and down the organisational structure.
- There was a trust wide Quality Assurance Accreditation Scheme (QAAS) to support the measurement of quality and effectiveness of care. Auditors rated wards according to compliance against national and best practice standards on a scale of good to inadequate.
- Divisions held local risk registers and there was a clear process for escalation of risk.
- The Board Assurance Framework (BAF) was aligned to strategic objectives and we saw evidence that it was linked appropriately to divisional risk registers, which were regularly reviewed.
- We reviewed 10 root cause analysis reports from serious incident investigations. The reports included contributory factors and root cause analyses. Action plans were concise and effective, and changes to reduce the risk of recurrence were evidenced. Duty of Candour was addressed, with specific details of when the patient and/or family were communicated with and an apology was given.

Leadership of the trust

- The senior executive team had been stable since the last inspection and had been strengthened by the appointment of two deputy chief operating officers. The senior team members were strong, visible and accessible.
- The triumvirate management arrangement had also been changed and strengthened and was continuing to be embedded at the time of the inspection.

Summary of findings

- There was a positive and challenging relationship with the non-executive directors.
- The investment in leadership programmes were good; it was clear learning was shared, and staff had a shared purpose and made an impact in practice. This was demonstrated in strengthened leadership capacity and capability at middle management level.
- Leadership development was a key strategy and priority in the trust for all levels of staff. Staff we spoke with reinforced that the strategy was applied to practice and clinical leaders were supported to attend NHS Leadership Academy programmes such as the Nye Bevan and Mary Seacole leadership programmes, and to undertake post graduate certificates (PgCs) in healthcare leadership. There was an ongoing commitment to staff attendance, and clinical leads had attended the Lancaster University Centre of Excellence for Training and Development (CETAD) PgC Professional Practice (Clinical Leadership) course, which was delivered by the trust.
- There had been significant investment in leadership within end of life services.

Culture within the trust

- Overall, we found the culture of the trust to be open and inclusive. The majority of staff that we spoke to felt that they were valued and respected by their peers and leaders. This included Black and Minority Ethnic (BME) staff.
- The majority of staff told us that the trust was a good place to work. They said that they felt supported in their work, there were opportunities to develop their skills and competencies and they were encouraged by senior staff.
- There was a desire from all staff we spoke with to provide effective care and treatment for patients.
- Overall we observed staff working well together and there were positive working relationships within multidisciplinary teams
- We asked staff at all levels about the morale of the hospital and they all said that morale was generally good and they worked as part of a team.
- However, there had been concerns about bullying at FGH in theatre and on a surgical ward. These concerns had been investigated and actions implemented to prevent bullying and harassment in the work place. Investigations were timely, detailed, and appropriate. Staff told us there was now higher morale and a better working environment, following resolution of individual behaviours.
- The trust had developed and implemented a Behavioural Standards Framework to improve patient experience and

Summary of findings

satisfaction, staff well-being and experience, partnership working, performance, and culture and to progress continuous improvement. The Behaviour Standards Framework was mandatory and incorporated into induction and appraisal.

- The trust appointed a Freedom to Speak Up (FTSU) Guardian to enable staff to raise concerns in an appropriate and supported way.

Equalities and Diversity – including Workforce Race Equality Standard

- We found that the trust had developed a more positive and inclusive approach to equality and diversity since the last inspection. We found that staff were committed to and proactive in providing an inclusive workplace.
- The trust had an inclusion and diversity strategy 2016-2021 which was developed in partnership with Black and Minority Ethnic (BME) staff.
- Governance arrangements were in place to ensure that the trust board received regular assurance that the trust was meeting its Public Sector Equality Duty.
- The trust reviewed the inclusion and diversity strategy on a yearly basis to ensure it remained fit for purpose. The Towards Inclusion plan provided a one-year summary of outcomes that were planned for delivery during year one of the strategy (2016-17).
- As part of the new Workforce Race Equality Standard (WRES) programme, the trust had added a review of its approach to equality and diversity to its well led methodology. The WRES has nine specific indicators which organisations are expected to publish and report upon, and to use to put into place action plans to improve the experiences of Black and Minority Ethnic (BME) staff. As part of this inspection we looked into what the trust was doing to embed the WRES and race equality into the organisation as well as at its work to include other staff and patient groups with protected characteristics.
- The 2016 WRES data indicated that significant improvements had been made in some indicators (likelihood of being appointed from shortlisting; number of BME staff undergoing a formal disciplinary investigation process). However, there had also been an increase in the reporting by BME staff of bullying, harassment and abuse from managers, colleagues, and the public.

Summary of findings

- A WRES action plan had been developed in partnership with the Trust's BME networks to address this issue, and was agreed by the executive team in June 2015 ahead of publishing and discussion at Trust Board in July 2016. This was published on the trust's website.
- The trust had three inclusion networks which it was supporting: LGBT (supported by Lancashire LGBT), Disability, and BME (supported by the British Association of Physicians of Indian Origin). Each network had an executive sponsor to support and enable it to make change to improve employee and patient experience.
- The trust was working actively with the local branch of the British Association of Physicians of Indian Origin (BAPIO) to improve employee experience for all staff groups, but particularly those from a BME background.

Fit and Proper Persons

- The trust met 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 NHS providers are fit and proper to carry out this important role.
- We looked at employment files of all of the executive team and non executive directors. These were all completed in line with the FPPR regulations.

Public engagement

- The trust had a Patient and Public Involvement Strategy 2016 – 2018 which was monitored through the trust's governance framework.
- The trust had invested in and encouraged public engagement. This was particularly reflected in maternity services.
- The maternity service took account of the views of women through an active Maternity Services Liaison Committee (MSLC), known as 'Maternity Matters in Furness'.
- Members of the MSLC told us there had been a significant and positive change in public engagement within the previous year.
- Maternity services were part of an 'Always Event' project pilot site for NHS England in November 2015. The project was co-designed with those who used maternity services and frontline NHS staff, to identify an area of improvement that mattered to women and families. This included a pilot for partners to stay for 24 hours after the birth.

Summary of findings

- Open and honest care stories were included in the monthly Women and Children newsletter. Stories came from a “listen with mother” birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- There were many examples of service user involvement, such as co-designing the new maternity unit, interviews for recruitment of new staff, including midwives and matrons, and the development of guidelines and strategies.
- There were four user representatives on a group to develop the breastfeeding strategy. The chair of the MSLC was attending an MDT infant feeding ‘Big Conversation’ to represent a wide range of service user experiences.
- There was service user representation on the National Maternity Review and the Better Births Transformation programme.
- The Downs Syndrome Association provided a “tell it right” workshop for MDT staff in relation to breaking bad news.
- The trust used members of the public on patient panels to review their response to complaints and also used members of public as mystery shoppers to review the quality of care provided.
- Patient stories were regular agenda items at the executive board meetings.

Staff engagement

- In the NHS Staff Survey 2016 the trust performed better than other trusts in four questions, about the same as other trusts in 24 questions and worse than other trusts in six questions.
- The NHS Staff Survey 2016 showed more staff felt motivated at work and would recommend the trust as a place to work or receive treatment. The score for staff feeling motivated at work rose to 3.95 out of 5, compared with 3.81 in 2014, and the score for staff recommending the organisation as a place to work or receive treatment rose to 3.72 out of 5, compared to 3.47 in 2014.
- Improvements compared with results from the 2014 survey were seen in other areas, such as increasing numbers of staff feeling that they received support from their immediate line managers, and feeling that the trust made effective use of patient and service user feedback, and improved percentages of staff reporting recent experience of harassment, bullying or abuse.

Summary of findings

- Results also showed staff felt that the trust had improved in satisfaction with pay, managers taking an interest in health and wellbeing, incident reporting, acting on concerns, and prioritising the care of patients.
- The engagement score for this trust was 3.78, which was about the about the same as other trusts.
- The Listening into Action programme had delivered some clear, effective and significant quality improvements for the organisation and for patients across the trust.
- Overall, staff were more engaged and they valued initiatives such as the Listening into Action programme.

Innovation, improvement and sustainability

- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) had become one of only two NHS trusts in the country to launch a new quality ambassador scheme, to help improve the quality of care provided at its hospitals and in the wider local health economy.
- The dementia care volunteer ward programme had been launched to support dementia patients by preventing isolation, encouraging engagement, and providing support and stimulation.
- Each ward had electronic smart boards displaying patient information, enabling staff to receive 'live' patient information at a glance. The boards displayed minimal patient information, with coding known to nursing and medical personnel, such as a butterfly for dementia care and a dragonfly for end of life care, meaning that patient information was anonymous to onlookers.
- The maternity service had shown good progress against its improvement plan. For example, the development of the maternity strategic partnership was progressing and was monitored by the Maternity Strategic Partnership Committee
- Although there was a plan within maternity services which set out the principles and governance arrangements for a strategic partnership with Central Manchester and Lancashire NHS Trusts, further work was required to effectively capture and monitor outcomes. The trust acknowledged that this partnership working was still evolving, with further developments being necessary to formalise the midwifery placements and to extend the partnership to include paediatrics and anaesthetics.
- The service was one of three trusts which were successful in securing funding to pilot a maternity experience communication project. This was a patient-based, communication-improvement training tool for multi-

Summary of findings

professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements could be made for women who were using maternity services.

- The trust had recently appointed 'safe active birth' specialist midwives. Staff told us they would be focusing on developing pathways to help reduce the caesarean section rate. They had a regular slot on mandatory study days to promote their approach to midwives across the trust and offer support.
- The trust had taken part in delayed transfer of care rapid improvement events with community care colleagues, and Hospital Home Care Team projects. Outputs from these pieces of work had seen social workers integrated into the discharge team and care support workers be appointed into the Hospital Home Care Team.

Overview of ratings

Our ratings for Royal Lancaster Infirmary

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

Overview of ratings

Our ratings for Furness General Hospital

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

Our ratings for Westmorland General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for University Hospitals of Morecambe Bay NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the trust MUST take to improve

In urgent and emergency care services:

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

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

In services for children and young people:

Outstanding practice and areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the A&E. The trust breached this standard between October 2015 and September 2016. It had been performing worse than the England average and than this standard for all but three months of this 12 month period.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

There were insufficient numbers of nursing staff at Royal Lancaster Infirmary to ensure compliance with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.