University Hospitals of Morecambe Bay NHS Foundation Trust

Westmorland General Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Good
Surgery	Good
Maternity and gynaecology	Good
Outpatients and diagnostic imaging	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 Westmorland General Hospital in July 2015 we rated services as 'good' overall, although surgical services were rated as 'requires improvement' for being responsive to people's needs, and outpatients and diagnostic imaging services were rated as 'requires improvement' for safe.

There were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to referral to treatment times (RTT) n surgical specialities and suitability of premises within the outpatient department (OPD).

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 made the required improvements and rated WGH as 'goo' overall.

Our key findings were as follows:

- Staff knew the process for reporting and investigating incidents using the trusts reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- Patients were treated with compassion, dignity, and respect.
- Wards, outpatients, and theatre nurse staffing skill mix was variable during shifts, but measures were in place to ensure the safety of patients. Generally, on surgical wards, nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres, and found that numbers and skill mix appropriate at the time of inspection.
- Medical staffing was provided by consultants and doctors for elective activity between 08:00 and 18:00, Monday to Friday. All surgery was supported by a resident medical officer on a 24 hour basis.
- The hospital had an escalation policy and procedure to deal with busy times, and staff attended bed meetings in order to monitor bed availability on a daily basis.
- There had been no cases of clostridium difficile or Methicillin Resistant Staphylococcus Aureus (MRSA) in the surgical division at WGH between October 2015 and September 2016 .
- The hospital had infection prevention and control policies in place, which were accessible, understood, and used by staff. Patients received care in a clean and hygienic environment.
- Allied health professionals (AHPs) worked closely with ward staff to ensure a multi-disciplinary team (MDT) approach to patient care and rehabilitation.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options, and were supported to eat and drink.
- 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%.
- In outpatients, the overall environment had improved. We noted that space was still limited in some areas.
- In outpatients, there remained a shortage of some staff groups including occupational therapists, radiographers, and radiologists.

Summary of findings

- Leadership across the hospital was reported as good, staff morale had improved, and staff felt supported. All staff spoke positively about the service they provided for patients.

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

The trust should:

In surgery:

- Continue to sustain improvement in hand hygiene audit result.
- Continue improving venous thromboembolism (VTE) assessments.
- Continue improving Referral to Treatment Times (RTT) for patients and continue to implement trust-wide initiatives to improve response.
- Increase medical/orthogeriatricians input on surgical wards
- Ensure all transfers between locations are performed in line with best practice guidance and policy. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue with staff recruitment and retention.

In maternity and gynaecology:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.

In outpatients and diagnostic imaging:

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled, and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, ophthalmology, and allied health professionals.
- Continue work started to ensure that all premises used by the service provider are suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located for the purpose for which they are being used. This is particularly in relation to the macular clinic.
- Ensure that it meets RTT targets in outpatient clinics, and that it addresses backlogs in follow-up appointment waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	We rated surgical services as 'good' because:

- 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. All wards used the national early warning scoring (NEWS) system for recording patient observations, and systems for recognition and management of deteriorating patients. Infection prevention and control was managed effectively. We saw staff treating patients with compassion, dignity, and respect throughout our inspection.
- Ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients. Generally, nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres, and found that numbers and skill mix were appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times, and staff attended bed meetings in order to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used Enhanced Recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us that appraisals were undertaken annually and records for WGH showed that 82% of staff across surgical wards and theatres had received an appraisal, against the trust target of 95%. Appraisals were ongoing to the year end.
- Allied health professionals (AHPs) worked closely with ward staff to ensure a multi-disciplinary team (MDT) approach to patient care and rehabilitation.
- Between March 2015 and February 2016, patients at WGH had a lower than expected risk of readmission for non-elective admissions, and a lower than expected risk for elective admissions.

Summary of findings

- Evidence based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures. The Patient Reported Outcomes Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average, whilst hip replacement metrics showed mixed performance.
- The divisional management team had taken action to address the low referral to treatment targets (RTTs). This included a local amnesty with CCGs allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and provision of additional capacity (sub-contracting to the independent sector, additional activity sessions, and operating department efficiencies).
- For the period Q1 2015/2016 to the date of inspection, the trust had cancelled 561 operation 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 their elective admissions was worse than the England average.
- We saw that orthogeriatricians had contributed to the development of the care pathway of elderly patients. Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of their induction. All the staff we spoke with received training in and knew about safeguarding policies and procedures.
- Complaints were dealt with informally at ward level in the first instance, and, where necessary, escalated to ward managers and matrons, in line with trust policy. Complaints were discussed at monthly staff meetings, where training needs and lessons learning were also discussed. The directorate risk register was updated at governance meetings with action plans, which were monitored across the division.
- Leadership of the service was reported as good, staff morale had improved, and staff felt supported at ward level. All staff spoke positively about the service they provided for patients, and emphasised quality and patient experience.

However:

Summary of findings

- The National Oesophago-Gastric Cancer Audit (2015) data showed patients diagnosed after an emergency admission was 0.0% placing the trust within the lowest 25% of all trusts for this measure.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) risk and bleeding risk recorded within 24 hours of admission (95%), and 34 patients had VTE risk and bleeding risk reassessed 24 hours after admission (29%). Following poor audit results, the trust had established a VTE Lead, a VTE Policy (rewritten to comply with NICE guidance), and a steering group, and had developed standalone bridging guidelines. A VTE training package had been made available on the training management system, and there was a new VTE algorithm in the clerking documentation.

Maternity and gynaecology

Good

At our previous, in July 2015, we rated maternity and gynaecology services as 'good'. During this inspection, we again rated maternity and gynaecology services as 'good' because:

- There was a robust incident reporting procedure. Staff knew how and what to report as incidents. There was evidence that learning from incidents was shared with staff.
- The clinical area was visibly clean, and staff followed trust infection control procedures.
- Adult and neonatal resuscitation equipment was checked daily so that staff could be assured it was in good working order. There were systems in place to ensure stock items were available and within expiry dates.
- Medicines and intravenous fluids were stored appropriately.
- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, and legislation.
- The service had an infant feeding policy and was developing an infant feeding strategy.
- The caseload ratio of Supervisors of Midwives (SoMs) to midwives was 1:15, which was in line with the national recommendation for caseloads. Supervisors had met all of the requirements of the local supervising authority audit.

Summary of findings

- Helme Chase Maternity Unit was available 24 hours a day, seven days a week, for women choosing to give birth there.
- 100% of staff had received an appraisal.
- SoMs provided a 'birth afterthoughts' service, which provided women with an opportunity to discuss issues surrounding their care during pregnancy and birth.
- The trust was performing as expected in the CQC maternity survey.
- WGH scored better than the England average for privacy, dignity, and wellbeing in the PLACE survey in 2015.
- Women who had been assessed as low risk could choose home birth, birth in the midwifery-led unit at Helme Chase, or birth in one of the two consultant-led obstetric units at the trust.
- The service employed a range of specialist midwives for patients with complex care needs, or for those in vulnerable circumstances.
- The service had a robust system for monitoring, processing, and learning from complaints, which ensured that responses were sent in a timely manner, themes and trends were identified, and learning was disseminated to staff.
- Consultant-led antenatal clinics were held within the unit three times a week, which meant that all women using the service could choose where to receive antenatal care.

However:

- Although there was a plan, 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.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging services as 'good' because:

- During our last inspection we had identified concerns about the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and

Summary of findings

implemented an electronic records system for most outpatient areas. This was still being rolled out across all departments, but we found that there had been significant improvements in the availability of case notes. Staff were positive about the improvements in efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information.

- We found that there had been some improvements in diagnostic imaging staffing numbers since the previous inspection. When we inspected this time the department continued to work with vacancies, but a new rota system enabled it to make improvements.
- During our last inspection we had noted that there was no information available in the department for patients who had a learning disability, nor any written information in formats suitable for patients who had a visual impairment. At this inspection we saw hat there was a range of information available in different formats, and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- We noted that space was still limited in some areas and the service provision was physically constrained by the existing environment. However, the overall environment had improved, with changes in flooring materials. We found that overall access to appointments had improved, but performance was variable.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence-based and followed national guidance.
- Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department, along with preceptorships for all new staff to the department.
- We found that access to new appointments throughout the department had improved.

Summary of findings

- Overall, staff felt engaged with the trust and felt that there had been some improvements in service delivery since our previous inspection. There were systems in place for reporting and managing risks. Staff were encouraged to participate in changes within the department, and there was departmental monitoring at management and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings, with standard agenda items, such as incident reporting, complaints, training, and lessons learned.

However:

- There remained a shortage of some staff groups, including occupational therapists, radiographers, and radiologists. Some staff raised concerns about the sustainability of the team under prolonged staffing pressures.
- Some referral to treatment targets were missed, and follow-up appointments continued to suffer backlogs and delays.

Westmorland General Hospital

Detailed findings

Services we looked at
Surgery; Maternity and Gynaecology; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Westmorland General Hospital

Westmorland General Hospital (WGH) is located on the edge of the Lake District. It has around 43 beds and provides a midwifery-led unit, elective surgery, a chemotherapy unit, and a wide range of outpatient services. It is also home to a minor injuries unit, GP-ed medical wards, mental health wards, and a renal unit, all of which are provided by other NHS Trusts.

At the time of our inspection, the hospital provided elective surgical services in urology, ophthalmology, trauma and orthopaedics, and general surgery. The hospital had two wards, general surgery, and trauma and orthopaedics, and four theatres. Surgical services were managed divisionally across all three trust locations rather than by single location.

Helme Chase Maternity Unit was a stand-alone midwifery-led unit within WGH, and was part of the University Hospitals of Morecambe Bay (UHMB) NHS Foundation Trust. Community midwife antenatal clinics were held within the unit during weekdays, together with a small number of consultant obstetric and gynaecology clinics. The unit had three birthing rooms, one of which had a birthing pool. In addition, there was a 'home-from-home' room, which could also be used a birthing room if needed.

Outpatient services were part of the core clinical services directorate. There were nurse-led clinics for diabetes, lung clinics, gastroenterology clinics, respiratory clinics, and rheumatology clinics. Other clinical support services included occupational therapy, physiotherapy, nutrition and dietetics, and pharmacy services. Outpatients offered 'one-stop' clinics for ophthalmology, cardiology, respiratory, thyroid and urology. The trust had a patient contact centre at WGH, which dealt with outpatient bookings, and two virtual booking centres in other parts of the trust. The patient contact centre dealt with around 12,000 calls a month.

Diagnostic imaging at WGH provided plain film x-rays, fluoroscop, and ultrasound. A private mobile MRI service was provided seven days a week. Diagnostic imaging services were managed by the trust core service management team, including a clinical director who was also a consultant radiologist. Diagnostic imaging services were available for outpatients and from 8.30am to 5pm on weekdays with hours extended to 7.45pm on Mondays for outpatients and patients referred by their GPs. For inpatients and trauma there was a 24 hour, seven days a week plain film and ultrasound service, and radiographer-led fluoroscopy. A breast-screening service was provided on weekdays. Pathology services offered biochemistry, haematology including transfusion, microbiology, and phlebotomy. Histology and immunology were provided by neighbouring acute trusts. The pathology service managed around five million tests a year, and all equipment had recently been transferred to a managed service.

Detailed findings

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: 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
- Outpatient and diagnostic imaging services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included 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.

Facts and data about Westmorland General Hospital

Westmorland General Hospital (WGH) is one of three acute hospitals forming University Hospitals of Morecambe Bay NHS Foundation Trust. It has 43 beds.

There were 36,460 surgical spells within the trust in the year preceding our inspection, with 8,000 of these performed at WGH.

Detailed findings

Between April 2015 and March 2016 there were 111 births at the Helme Chase Maternity Unit.

Our ratings for this hospital

Our ratings for this hospital are:

	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	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Westmorland General Hospital (WGH) provided elective surgical services in urology, ophthalmology, trauma and orthopaedics, and general surgery. The hospital had two wards, general surgery and trauma and orthopaedics, and four theatres. Surgical services were managed divisionally across all three locations rather than by single location. There were 36,460 surgical spells within the trust in the previous year, with 8,000 of these performed at WGH.

During this inspection we visited surgical Ward 6 (trauma and orthopaedics, and rehabilitation) and Ward 7 (general surgery, breast surgery and urology) and the Day Surgery Unit. We observed care being given and surgical procedures being undertaken in theatres. There were 34 beds are located within two wards.

We spoke with 19 patients and relatives and 22 members of staff. We observed care and treatment,and looked at 18 care records.

We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of findings

The overall surgery rating from the 2015 inspection was 'requires improvement'. Actions the trust was told it must take were:

- Ensure there were systems in place to identify themes from incidents and near miss events.
- Ensure all theatres were monitoring compliance with '5 steps to safer surgery'.
- Ensure all staff understood the process for raising safeguarding referrals (in the absence of the safeguarding lead).
- Reduce and improve readmission rates.
- Ensure there were clear risk assessments in place for situations where practice deviated from the guidance.
- Continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

During the 2016 inspection we found that these actions had been taken. There were systems in place to identify themes from incidents and near miss events. We saw improved audits for '5 steps to safer surgery', and had discussions with staff about the process and procedure for raising safeguarding referrals. There were risk assessments and escalations plans in place for situations where practice deviated from guidance. Readmission rates had been worse than the England average in 2015. In 2016 we found that, Between March 2015 and February 2016, patients at had a similar expected risk of readmission for non-elective

Surgery

admissions compared to the England average, and a higher expected risk for elective admissions compared to the England average. We found tha, although the culture of the surgical division was much improved, work was ongoing with further improvement required.

We rated surgical services as 'good' because:

- 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. All wards used the national early warning scoring (NEWS) system for recording patient observations, and systems for recognition and management of deteriorating patients. Infection prevention and control was managed effectively. We saw staff treating patients with compassion, dignity, and respect throughout our inspection.
- Ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients. Generally, nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres, and found that numbers and skill mix were appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times, and staff attended bed meetings in order to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used Enhanced Recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us that appraisals were undertaken annually and records for WGH showed that 82% of staff across surgical wards and theatres had received an appraisal, against the trust target of 95%. Appraisals were ongoing to the year end.
- Allied health professionals (AHPs) worked closely with ward staff to ensure a multi-disciplinary team (MDT) approach to patient care and rehabilitation.
- Between March 2015 and February 2016, patients at WGH had a lower expected risk of readmission for non-elective admissions than the England average, and a lower expected risk for elective admissions than the England average.
- Evidence-based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures. The Patient Outcomes Reporting Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average, whilst hip replacement metrics showed mixed performance.
- For the period Q1 2015/2016 to present 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.
- We saw that orthogeriatricians had contributed to the development of the care pathway of elderly patients. Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of their induction. All the staff we spoke with received training in and knew about safeguarding policies and procedures.
- Complaints were dealt with informally at ward level in the first instance, and, where necessary, escalated to ward managers and matrons, in line with trust policy. Complaints were discussed at monthly staff meetings, where training needs and lessons learned were also discussed. The directorate risk register was updated at governance meetings, with action plans monitored across the division.
- Leadership of the service was reported as good, staff morale had improved, and staff felt supported at ward level. All staff spoke positively about the service they provided for patients, and emphasised quality and patient experience.
- We found that ward managers were clear about transfer protocols and the level of patient acuity accepted at WGH. The ward manager and RMO felt able to challenge inappropriate transfers to and from the hospital. Staff stated that patients who did not meet the criteria would not be accepted as an inpatient. There were procedures and protocols in place, which were accessible to all staff on the intranet.

However:

Surgery

- The National Oesophago-Gastric Cancer Audit (2015) data showed patients diagnosed after an emergency admission was 0.0% placing the trust within the lowest 25% of all trusts for this measure.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) risk and bleeding risk recorded within 24 hours of admission (95%), and 34 patients had VTE risk and bleeding risk reassessed 24 hours after admission (29%). Following poor audit results, the trust had established a VTE Lead, a VTE Policy (rewritten to comply with NICE guidance), and a steering group, and had developed standalone bridging guidelines. A VTE training package had been made available on the training management system, and there was a new VTE algorithm in the clerking documentation.

Are surgery services safe?

Good

We rated safe as 'good' because:

- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system, and feedback was given from a senior level. Patients at risk of falls, pressure ulcers, and urinary tract infections had robust electronic care management plans. The prevalence rate for pressure ulcers and falls with harm Had both shown a reduction over time, whilst catheter-acquired UTIs had shown an increase in prevalence.
- Records showed risk assessments were completed at each stage of the patient journey from admission to discharge, with a National Early Warning Score (NEWS) system used for the management of deteriorating patients. We observed theatre staff practice '5 Steps to Safer surgery', and complete the World Health Organisation (WHO) checklist appropriately.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training. Mental capacity assessments were undertaken, and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- Planned staffing levels for wards worked on a one to eight ratio. In times of greater patient need, ward staff ratios increased or ward beds were closed. We reviewed the nurse staffing levels on all wards that we visited, and within theatres, and found that levels were variable due to both nursing and medical staff shortages. However, the trust was actively recruiting to these posts. As at July 2016 the trust reported a vacancy rate of 4.1% for qualified nurses and 4.6% for consultant medical staff.
- The hospital had an escalation policy and procedure to deal with busy times, and bed management meetings were held to monitor bed availability, on a daily basis.

However:

- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous

thromboembolism (VTE) risk and bleeding risk recorded within 24 hours of admission (95%), and 34 patients had VTE risk and bleeding risk reassessed 24 hours after admission (29%). Following poor audit results, the had trust established a VTE Lead, a VTE Policy (rewritten to comply with NICE guidance), and a steering group, and had developed standalone bridging guidelines.A VTE training package had been made available on the training management system, and there was a new VTE algorithm in the clerking documentation.

Incidents

- Definition of Never Events has changed. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event. The trust had been made aware that it must ensure that systems were in place to identify themes from incidents and near miss events, following the 2015 inspection.
- Between September 2015 and August 2016, WGH reported no incidents which were classified as Never Events for surgery.
- In accordance with the Serious Incident Framework 2015, the surgical directorate reported one serious incident (SI) which met the reporting criteria set by NHS England, between September 2015 and August 2016. This incident was reported as a 'surgical/invasive procedure incident meeting SI criteria' under log number 2016/14120.
- Duty of Candour requirements were explicitly stated within the trust 'Being Open/Duty of Candour Policy', on the trust intranet, and in training and trust incident policies. Matrons and directorate managers received e-mail notification if an incident was graded moderate or above. Serious Incident report templates were revised for falls, pressure ulcers, and general incidents to include a section to record that apologies and explanations were given to patients and/or their relatives.
- We saw evidence of Duty of Candour requirements being met, and staff were able to articulate action they would take in relevant circumstances. Staff gave an example in which a patient had been admitted for a primary total hip replacement, having undergone a satisfactory pre-operative assessment six weeks prior. The patient had become very anaemic due to perioperative blood losses, and developed pre-renal acute kidney injury. We were told that staff had been open and honest with the patient, explaining what had gone wrong, why that had happened, and how the issue would be resolved.

Safety thermometer

- The wards and surgical areas participated in the NHS safety thermometer approach, displaying consistent data to assure people who used the service that the ward was improving practice, based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- This information was displayed in ward entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- Data from the Patient Safety Thermometer showed that the trust had reported a prevalence rate for surgery of 22 pressure ulcers, 13 falls with harm, and 12 catheter urinary tract infections, between September 2015 and September 2016. The prevalence rate of pressure ulcers and falls had fallen over time.
- Each ward at WGH recorded and displayed its own individual incidences of insignificant, minor, and moderate falls, CUTIs and pressure ulcers. We saw that individual boards at ward entrances showed no falls or incidents of infection in the month prior to our inspection.
- Information for the past year was displayed for monthly incidence of hospital acquired pressure ulcers, patient falls, and urine infections associated with catheter insertion.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) risk and bleeding risk recorded within 24 hours of admission (95%), and 34 patients had VTE risk and bleeding risk reassessed 24 hours after admission (29%). Following poor audit results, the trust had established a VTE Lead, a VTE Policy (rewritten to comply with NICE guidance), and a steering group, and had developed standalone bridging guidelines. A VTE training package had been made available on the training management system, and there was a new VTE algorithm in the clerking documentation.

Cleanliness, infection control and hygiene

- The trust had an infection surveillance programme and an infection control team in place. Policies were

available as paper copies and on the trust internet. Monthly reports were generated and reported for clostridium difficile (C difficile) infection and Methicillin Resistant Staphylococcus Aureus. (MRSA).

- We saw that the standard of environmental cleanliness was good across all wards that we inspected. Infection control and hand hygiene signage was consistently good, and we observed clear signage for isolation of patients in single rooms.
- The target for hand hygiene was 96%. The surgical inpatient centre (wards 6 and 7) did not meet the hand hygiene audit target in March 2016 (with results of 89%), and, on three occasions between February 2016 and July 2016, the day surgery unit did not meet the target (89%, 90% and 90%). The pre-assessment unit did not meet the hand hygiene target in March 2016 (83%). The remaing four of the seven departments consistently met the target.
- Environmental audits (July 2016) showed high levels of compliance with cleanliness measures at WGH: 98% for Wards 6 and 7; 100% for Ward 2; and 99% for theatres.
- Pre-operative screening for MRSA was carried out and there had been no cases of clostridium difficile in the surgical division between October 2015 and September 2016.
- Information from the 'Public Health England, surgical site infection (SSI) surveillance report' (December 2015) showed a rate of 2.8% for knee replacement and 4.3% for hip replacements in the previous four reporting periods across the division. The trust had reviewed these data and taken action to reduce incidences through analysis of cases, increased awareness, and training.
- Each ward had a daily, weekly, and monthly cleaning schedule for domestic staff, housekeepers and nursing staff.
- Incidence of infection and cleaning audits were displayed clearly at the entrances to all wards and surgical areas.
- We observed staff washing their hands, and all patients we spoke with told us that this was done without exception. Hand gel was available at the point of care, and staff used personal protective equipment (PPE) compliant with policy.
- Monthly environmental cleanliness audits showed compliance with hand hygiene techniques was between 90% and 100% (February to July 2016). The overall achievement was 99%.
- We saw clean equipment throughout surgical areas, and staff completed cleaning records and domestic cleaning schedules, and used a tape system which identified clean equipment.
- Wards had appropriately equipped treatment rooms used solely for aseptic technique and dressing changes. Nurse assessment of aseptic technique competence took place annually.
- Clinical and domestic waste disposal and signage was good. Staff were observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms, and the disposal of sharps followed trust policy.

Environment and equipment

- All wards and surgical areas appeared uncluttered and in a good state of repair. Wards had a spacious design and large floor plan. Additional storeroom capacity was available on all wards.
- We inspected resuscitation trolleys and suction equipment on the wards and found that all were appropriately tested, clean, stocked, and checked weekly, as determined by policy. Details were recorded within the ward areas. All equipment maintenance was up-to-date, and staff had attended medical device equipment training.
- Records showed that equipment was serviced and maintained within the necessary timescales. There was an electronic tracking system for disposable stores and equipment needs, and financial efficiency in supplies was overseen by the Theatre Supplies Group.
- A strategy for the prevention of slips, trips, and falls was in place. All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips, and falls.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 95.4% for cleanliness, and 87.9% for the condition of the environment.

Medicines

- In all wards, surgical areas and theatres, medicines were stored and locked away in line with policy, controlled drugs were safely stored, and records were kept, including a daily check. Clinical treatment rooms were locked for staff access.

- Medicine prescription records for individual patients were clearly written, and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Patients were able to bring in their own medicines and continue to administer those medicines, if it was safe to do so, subject to a robust risk assessment.
- Medication rounds were conducted with good practice principles, and wards had dedicated support from pharmacy.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics, and liaised with pharmacy prior to prescribing for MRSA and C. difficile.
- Staff were required to attend a mandatory yearly update on storage and recording of controlled drugs. Newly qualified staff were required to attend training and to complete the e-learning safe medicate programme, prior to being able to administer.
- Display boards in each ward manager's office had a mandatory training plan information and staff training data. An action plan was in place to achieve trust targets.
- The storage of medication in refrigerated units was monitored, and daily temperature checks were recorded. Where these were outside the correct limits action had been taken to check whether records were accurate or whether there was a fault with equipment.
- Drug cupboards were kept locked, contained no controlled drugs, and were checked weekly. Intravenous (IV) fluids were kept in a separate cupboard, and expiry dates were checked weekly. Controlled drugs cupboards were checked at the end of each shift and signed.

Records

- We looked at 18 sets of medical records across wards at WGH. All documentation checked was signed and dated, clearly stating named nurse and clinician.
- Patient medical notes were stored in lockable trolleys, and patient care charts were kept at the bedside for ease of access to staff. All documentation checked was signed and dated, clearly stating named nurse and clinician.
- WGH used an electronic recording system so that care plan and risk bundles were accessible in real time.
- Daily entries of care and treatment plans were clearly documented, and care plans and charts we reviewed had completed patient assessment, observation charts and evaluations, food and fluid balance sheets, consent forms, with mental capacity assessments where necessary, diabetes, and wound care charts, as applicable.
- All records we examined included a pain score, and allergies were documented in the notes. We observed patients wearing red wristbands to raise staff awareness of allergies.
- We reviewed handover sheets used by ward staff, and the Situation, Background, Assessment and Recommendation (SBAR) escalation documentation, which was effective in communication and decision-making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in patient's notes.

Safeguarding

- The trust had a clear safeguarding strategy and held safeguarding board meetings. Minutes and action plans were clear, and these meetings were well attended by senior staff from across the trust. These meetings provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- 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 for safeguarding adults level two was 94.3%, and for safeguarding children level two was 98.6%.
- The safeguarding adult's office received Multi-Agency Public Protection Arrangement (MAPPA) alerts every three months.
- Following our 2015 inspection, the trust was asked to ensure that all staff understood the process for raising safeguarding referrals. At this inspection we found that staff on the surgical wards understood their responsibilities, and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust.
- Information files were available at ward level with guides, advice, and details of contact leads, to support staff in safeguarding-related decision-making.

- The trust safeguarding committee discussed learning from serious case reviews and monitored the training dashboard that showed attendance at and compliance with safeguarding training.

Mandatory training

- The trust set a mandatory target of 95% for completion of mandatory training.
- The surgical division had an action plan in place, to achieve compliance with mandatory training targets by April 2017, and attendance at mandatory training programmes for all staff was monitored locally
- Equality and diversity, health safety and welfare, infection prevention and control, and information governance met or exceeded the target.
- The trust had adopted the ten key subjects defined in the NHS Core Skills Framework as its reference point for mandatory training. Equality and diversity, health safety and welfare, infection prevention and control, and information governance met or exceeded the target.
- Records showed that 100% of staff at WGH had attended the trust induction, 98% had completed equality and diversity training, 97.5% had completed health and safety training, and 95.6% had completed governance information training. Additionally, 98.9% of staff had attended adult basic life support training, and 97% had attended infection, prevention, and control training level one.
- Staff told us that they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks, and key trainer-delivered sessions. Staff said that they were supported with professional development through education.
- Staff said that hey had a good induction and preceptorship programme when joining the trust, and had attended local sessions and those provided at a trust level.
- We spoke with 22 staff and most told us that they were up to date with mandatory training, the access to the training system online was good,and they felt supported to attend training and mandatory update sessions. owever, some felt they were behind with training due to staff shortages.
- Practice Educators (PEDs) were in post for each division, and supported staff with all training, their continued professional development, and professional revalidation.

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 had sed its own version of an early warning system for 15 years. The strategy and processes for recognition and treatment of the deteriorating patient in surgery had been updated in August 2016, to align with national guidance, and change from the previous early warning score and 'track and trigger' system.
- The NEWS system allowed staff on the ward to record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients.
- We saw full completion of NEWS risk assessments and sepsis screening tools, and staff were able to demonstrate agreed escalation procedures as appropriate.
- Care planning was based on patients' assessed risk through comprehensive risk assessments, which included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST), and this helped staff identify patient nutritional needs. Pain scores and diaries for patients were available.
- Patients at risk of falls were identified and assessed on admission, and an individualised plan of care was put in place. We saw planned care delivered, for example, one-to-one nurse patient ratio, close observation, safety rails on beds, falls stockings, stickers to identify risk on electronic display boards, and nurse call system withn reach.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing, and patient assessment and screening. Policies were in place for the transfer of a deteriorating patient to Royal Lancaster Infirmary by emergency ambulance if needed.
- Hospital data (June 2016) showed 100% 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.
- Although t audit showed overall compliance at 98%, the whole team attended debrief on only 80% of occasions. Theatre staff were aware of this and had taken action to

increase attendance. During the inspection we observed that theatre staff followed the '5 Steps to Safer Surgery' process, and completed the WHO checklist appropriately.

- An audit of the hospital 'Physiological Observation Track and Trigger System' (POTTS) (June 2016) to monitor the patient's condition showed 97% compliance within day surgery, and 95% compliance within inpatient surgery against a trust target of 91%.
- We observed the checklist being used appropriately in theatre, and saw completed preoperative checklists and consent documentation in patient's notes. We also observed correct surgical site marking on a patient immediately prior to surgery.
- The ASA physical status classification system is a system for assessing the fitness of patients before surgery. The surgical wards at WGH did not accept patients at ASA level 3 (severe systemic disease) or with a Body Mass Index (BMI) over 40. It was stated that there was a formal written process in place with strict guidelines, which must be adhered to before a patient could undergo surgery at WGH, and that patients must be medically fit and stable.
- Patients were required to have an orthopaedic plan before they were permitted to transfer in, and completion of a transfer form, along with a conversation between the RMO/nursing staff and the clinician from the hospital requesting the transfer, was also necessary. In addition to this, a review by the medical team was required, as was the completion of blood tests, before the transfer.
- When patients deteriorated the consultant surgeon was contacted directly. There were an on-call orthopaedic and breast surgeons, out of hours. If a medical deterioration occurred the RMO would contact the medical registrar oncall at the Royal Lancaster Infirmary, for advice and information. If required the patient could be transferred. Orthogeriatricians visited the ward twice per week (Tuesday and Friday), and the RMO linked with orthogeriatricians if he had concerns between their visits.
- Sixteen patients were transferred from WGH to Royal Lancaster Infirmary from 1st July 2015 to 31st October 2016 with a transfer reason of 'specialist care required following deterioration'. Of those 16 transfers, three were trauma and orthopaedic patients, seven were urology patients, two were breast surgery patients, and three were general surgery patients.
- The wards were looking at linking with the GPs based in the Langdale Unit (step up/step down beds on the level above Ward 7) for additional medical support. However, this had not yet commenced and was still being considered.
- The resuscitation team on site included a band 6 nurse and a Resident Medical Officer (RMO). Both were trained in advanced life support. There were regular simulations of resuscitation emergencies.
- The staff we spoke with felt that medical cover was sufficient and safe for routine pathways.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- The trust had formal nurse staffing review processes in place, subject to regular review by the trust board. The surgical division had a funded establishment agreement based upon agreed methodology and professional judgment, supported by benchmarking, relevant national guidance, and acuity information.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours 24 hours per day, seven days per week, by senior nurses with access to an on-call manager.
- The planned qualified nursing staff levels across all wards was 57.3 whole time equivalent (WTE) between April 2016 and July 2016. The actual qualified staffing levels across the same period was 49.8 WTE.
- Figures provided showed planned non-qualified staff levels across all wards was 35.1 WTE between April 2016 and July 2016. The actual non-qualified staffing levels across the same period was 30.4 WTE.
- Numbers of staff on duty were displayed clearly at ward entrances.
- Staff explained that safe staffing levels were maintained through constant review and assessment of surgical activity and patient acuity.
- Matrons and ward managers told us that shortfalls in nursing cover were managed through daily bed and

cross-site meetings to meet demands in ward activity. Monitoring of actual against planned staffing levels took place on a shift-by-shift basis; this was reported monthly via NHS choices and the trust webpage.

- The trust had an established staff 'bank', which provided cover for short notice requests. The staff on the bank were trained and managed "in house". There was a texting system for short notice cover requests, to staff who were signed up to the system.
- Trust data (July 2016) showed a fill rate of 85% for qualified staff and 86% for unqualified staff across surgery within the hospital over the preceding four months. Ward and theatre managers told us that they had assessed surgical activity, and the numbers and acuity of patients, to determine safe staffing levels.
- We were told that staffing levels were based on a 60:40 ratio of qualified to unqualified staff. The nurse ratio was based on national guidelines of 1:8 patients. There was an online system of monitoring acuity on a daily basi, with 100% compliance. This ran alongside a dashboard of staffing to make it easy to work out staffing shortfalls and accurate, real-time ward acuity levels.
- Trust data (July 2016) showed a nurse vacancy rate of 4.1% at the hospital, and a trust-wide turnover rate of 8% for all staff groups. The trust reported that national and international recruitment campaigns were in place to address the gap in registered nursing.
- Agency usage in the theatre department at WGH was 7.6% over a 12 month period from April 2015 to March 2016, and 5.2% on wards 6 and 7 across the same period.

Medical staffing

- Trust data showed medical staffing skill mix was 47% consultant grade (national average 41%), 26% middle career (national average 11%), 14% registrar group (national average 37%), and 13% junior doctors (national average 12%).
- Medical cover was provided by consultants and doctors for elective activity between 08:00 and 18:00, Monday to Friday for orthopaedics. Cover for general surgery, urology, ophthalmology, and breast surgery was provided as scheduled. All surgery was supported by a resident medical officer on a 24 hour basis.
- Trust data (July 2016) showed a medical vacancy rate of 4.6% and a trust-wide turnover rate of 7.9% for all staff groups. The trust reported that national and international recruitment campaigns were in placeto address this gap.
- Surgical handovers took place daily and were consultant-led. Handover took place in private areas to maintain confidentiality. An electronic handover tool was used.
- Resident Medical Officers (RMOs) worked primarily with the surgical inpatients, conducting regular ward rounds and ensuring that all patients were well looked after. Any changes in a patient's condition were reported to the consultant or registrar based at Royal Lancaster Infirmary, and his/her direction followed in respect of further treatment.
- We were advised about the RMO recruitment process, which was through a GMC approved agency. The agency ensured that RMOs had undertaken all mandatory training, as well as advanced life support, immediate life support, and blood transfusion training. Prior to employment with the trust RMOs were DBS checked, and all trust protocols including escalation plans were provided to them, and a handover took place.

Major incident awareness and training

- The trust had major incident and business continuity plans in place, that included protocols deferring elective activity to prioritise unscheduled emergency procedures. Major incident plans had been reviewed and updated in August 2015. Maintenance of the plans was the responsibility of the Major Incident Steering Committee and they were reviewed at least every year.
- The trust defines a major incident as 'any accident or incident involving large numbers of casualties, where the location, number, severity, or type of live casualties requires extraordinary resources by one or more of the emergency services, the NHS, or Local Authority'.
- Potential risks were taken into account when planning services, and consideration was given at daily safety huddles to seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.
- The impact on safety when carrying out changes to the service and staff was assessed and monitored through robust, embedded assessments, staff engagement, and ongoing service monitoring.

Surgery

Are surgery services effective?

Good

We rated effective as 'good' because:

- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- The Enhanced Recovery pathway was applied for patients requiring hip and knee replacement, with multidisciplinary input from the pre-assessment team, nurses, physiotherapists, occupational therapists, consultants, orthogeriatricians, and anaesthetists. The pathway ensured each patient received continuing care, including preoperative assessments, perioperative admission, and postoperative discharge and follow up.
- Between March 2015 and February 2016 patients at WGHl had a lower expected risk of readmission for non-elective admissions and a lower expected risk for elective admissions than the England average.
- Pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively, which improved patient comfort.
- Thematic Reviews were undertaken as part of everyday practice and included falls, number of injuries and low harm incidents, waiting list office incidents, safeguarding referrals, and pressure ulcers.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, Great Britain and Ireland, and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients and staff ensured that patients were escorted through the care pathways, and each patient received continuing care, including preoperative assessments, perioperative admission, and postoperative discharge and follow-up.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The division had a formal clinical audit programme where national guidance was audited, and local priorities for audit were identified. These included audits focussed on compliance with consent, safeguarding, and do not attempt cardio-pulmonary resuscitation (DNACPR).
- Specific clinical audits had been progressed, for example, around the audit of supracondylar fractures according to guidelines and the use of proforma in the management of patients presenting with back pain.
- Staff actively monitored and improved patient outcomes and undertook opportunities to use care bundles, care pathways and performance dashboards to ensure that patient outcomes were monitored, reviewed, improved, and positive. The care bundles and pathways were in line with best practice procedures.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients. These showed 100% of NEWS charts had been correctly recorded and responded to within surgery at WGH.
- Each ward had identified a pain link nurse, and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- An audit of pain management in the recovery room recommended the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief. Staff asked patients regularly if they had any pain, so they could administer analgesia promptly or request an anaesthetic review.
- A dedicated pain team was accessible to provide education in respect of new equipment and

medications. The pain team visited patients with PCAs the day after surgery. The pain team was available Monday to Friday 8am to 5pm. Anaesthetists provided support with pain relief out of hours.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Staff identified patients at risk of malnutrition by working with patients and their families to complete a malnutrition universal screening tool (MUST) score.
- Snack rounds were carried out on all surgical wards to supplement scheduled meals, and ensure that patients had high calorie options throughout the day.
- Ward audits included checking whether patients had received a nutritional risk assessment on admission, and whether this risk assessment had been reviewed within the required timescales. We observed appropriately completed fluid balance charts and dietary intake charts. .
- The nutritional risk assessment identified the levels at which dietitian referral was recommended. The dietetics service received electronic inpatient referrals, and provided input to all wards as required.
- Arrangements were in place for when enteral feeding was required out of hours as part of a protocol to ensure that patients did not have to wait for a dietitian to be on duty.
- We saw a range of food choices, meals and snacks, safe storage, and an additional supply of crockery and cutlery that met the needs of patients with specific needs. Patients who required nutritional support were identified.
- Surgical pre-operative assessments performed by nursing staff offered tailored nutrition and hydration guidance to patients, and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Information and lessons learnt were shared at the clinical leaders, clinical managers, and nutrition link nurses forums, nutrition steering group, and with catering managers.
- Records showed patients were advised about what time they would need to fast from before surgery. Fasting times varied depending on whether the surgery was to be in the morning or afternoon.
- We reviewed 18 records and saw that nurses completed food charts for patients who were vulnerable or required nutritional supplements, and support was provided by the dietetic department.
- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- Between March 2015 and February 2016, patients at WGH had a lower expected risk of readmission for non-elective admissions, and a lower expected risk for elective admissions than the England averages. Non-elective urology had the largest relative risk of readmission at WGH.
- Results from the Patient Reported Outcomes 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 EQ 5D index and the Oxford score were slightly worse.
- WGH did not participate in the 2015 Hip Fracture Audit.
- The trust did not participate in the 2015 National Vascular Registry (NVR) Audit as the trust does not provide vascular services.
- WGH did not participate in the 2015 National Emergency Laparotomy audit (NELA) as WGH does not undertake emergency laparotomies.
- WGH theatre usage in June 2016 was highest in Theatre 2 and Theatre 3 at 80.9%, and lowest in the Theatre 1 at 76.1%. The operating time is calculated as time between anaesthetic being induced and operating ending.

Competent staff

- Staff appraisals were undertaken annually, and there were also informal one-to-one meetings for staff should they request these. Monthly staff meetings were taking place.
- At July 2016 the trust reported that 71 % of leadership appraisals and 82% of all other staff appraisals had been completed, compared to a trust target of 100% for leadership and 95% for other. The trust had implemented a new e-appraisal system for leadership appraisals and some appraisals in the 'other' category had had to be deferred due to acute service pressures.
- Staff told us that the appraisal process was helpful and allowed them to discuss developmental objectives. These were agreed between staff and managers. Staff

learning needs were identified during appraisal on an individual basis. Generic training needs were addressed through the trust and local induction, as well as ongoing mandatory training sessions and updates.
- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching, were well supported by the ward team, and could approach their seniors if they had concerns.
- Staff were advised of the Nursing and Midwifery Council (NMC) revalidation process through the trust intranet. New nursing staff underwent an induction programme and completed learning logs with a designated supervisor.
- Overall, staff felt supported with their training and in maintaining competence. We found that staff were encouraged to undertake additional eLearning courses when time allowed.
- Staff advised that supervision was undertaken frequently but on an informal basis rather than via formal one-to-one meeting. All staff said they could approach their line managers at any time, and speak openly and honestly about any concerns.
- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge, and experience to do their jobs.

Multidisciplinary working

- Nursing documentation was kept at the end of the bed and centrally within the wards, and was completed appropriately. Daily handovers were carried out with members of the multidisciplinary team (MDT) and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays, and dedicated pharmacy provision for each ward was planned.
- A Pharmacy Transformation Project was underway to focus the pharmacy workforce towards clinical activities, working more closely with patients, and working alongside doctors and nursing staff in clinical roles, to optimise medicines and secure better outcomes for patients. It included review of all non-clinical pharmacy services to identify those that might be stopped or delivered differently in future. The trust had developed a partnership with an external provider of pharmaceutical services, to provide on-site retail outlets and undertake dispensing for outpatients. Good progress had been achieved with seven day opening hours.
- Staff explained to us that the wards worked with local authority services as part of discharge planning, and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Protocols had been developed for the effective handover of patients to Royal Lancaster Infirmary when needed. These involved the identification of bed availability, NEWS assessment, and verbal, electronic and written transfer of information.
- We observed staff, including those in different teams and services, becoming involved in assessing, planning,and delivering people's care and treatment.
- There were established MDT meetings for care pathways, and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with patients, their families, allied health professionals, and the local authority when planning discharge of complex patients, to ensure the relevant care was in place, and that discharge timings were appropriate.

Seven-day services

- The elective orthopaedic theatre and surgical team had plans to deliver a seven day service from January 2017. Weekend morning capacity was currently utilised in theatres.
- A comprehensive transfer plan was in place for deteriorating patients to access emergency care seven days a week.
- Seven day rotas for consultant working had been introduced and were led by the trust's clinical team, to improve care for patients by having clinical decision-makers at the start of the patient pathway.
- There were dedicated physiotherapist and occupational therapists for each ward, available Monday to Friday. There was limited access to physiotherapists and occupational therapists at the weekend, and patients

were prioritised by level of need and orthopaedic plan of care and treatment. Prior to visiting patients the physiotherapists and occupational therapists received a handover from the weekday dedicated team.
- There was no speech and language support service at the weekends.
- There was a pharmacist on site Monday to Sunday, 9am to 5pm. A pharmacy technician attended the ward daily, to undertake medication reconciliation.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment, and we saw that these were available to staff, enabling effective care and treatment.
- We reviewed discharge arrangements, and saw that planning started as soon as possible for patients. Discharge letters were completed appropriately, and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to up to date information on ward performance against objectives, displayed at the entrance to the ward. Appropriate guidelines were available for staff to ensure they were working to best practice.
- All staff had access to policies, procedures, and NICE guidelines via the trust intranet site. The staff we spoke to stated that they were competent in using the intranet to obtain information.
- Drug charts, blood results, and x-rays were kept electronically in real-time and were available to both doctors and nurses as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the nurse or consultant responsible for the patient's care, and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- Consent, Mental Capacity Act (MCA), and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. MCA and DoLS assessments were included in risk assessments.
- We found policy and procedures were in place to ensure that capacity assessments and consent were obtained by middle grade level medical staff or above. Elective patients were informed about consent as part of their pre-assessment process, and were given information regarding risks and potential complications. However, most patients consented on the day of procedure.
- An action plan created to improve consent practice included the creation of patient information leaflets, procuring color printers for clinical areas-consent to be taken in the clinics with documentation of contact details, developing electronic consent forms, and the standardising of the consent process with clear documentation.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- We looked at 18 records and all patients had consented in line with the trust policy and Department of Health guidelines. All of the records we reviewed contained appropriate consent from patients, and patients described to us that staff took their consent before providing care.

Are surgery services caring?

Good

We rated 'caring' as good because:

- The Friends and Family Test (FFT) response rate for surgery at the trust was 31%, which was better than the England average of 29%, between October 2015 and September 2016. The monthly percentage recommended fluctuated between 82% and 100%.
- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating: 81% of patients stated they were involved in decision making; 89% said that they were given the name of their specialist nurse; 93% said that they were treated with dignity and respect; and 92% stated they received contact information.

Surgery

- We observed the treatment of patients to be compassionate, dignified, and respectful, throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- Patients and relatives said that they felt involved in their care and had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained procedures and treatment. Patients felt they were well educated, supported, and prepared for their surgical procedures.
- Patient and family feedback was very complimentary. Patients we spoke to said, “Service beyond amazing”, “polite nurses”, “can’t fault anything”, "communication good” and “treated perfectly”.
- Multi-faith spirituality groups were accessible.

Compassionate care

- The FFT response rate for surgery at the trust was 31%, which was better than the England average of 29%, between October 2015 and September 2016. The monthly percentage recommended fluctuated between 82% and 100%.
- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating:81% of patients stated they were involved in decision making;89%said that they were given the name of their specialist nurse;93%said that they were treated with dignity and respect;and 92% stated they received contact information.
- Similar results had been achieved in results displayed on all surgical wards and areas during our inspection.
- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and to give explanations for the treatment and care provided.
- We spoke to 19 patients and relatives, and they told us that staff were kind and caring.
- We spoke to 22 members of staff, and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals, and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people’s personal, cultural, social, and religious needs, and considered these when delivering care and planning discharge. We observed staff taking time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People’s privacy and dignity were respected when staff were assisting with physical or intimate care.
- Staff promoted independence and encouraged those in bed to take part in personal care, and to mobilise within their limits, and positively encouraged those patients who were having difficulty.

Understanding and involvement of patients and those close to them

- All patients we spoke with said that they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out, and did their best to keep them reassured.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to bring relatives or friends along to the consultation should they so wish.
- Patients felt they were well informed, supported, and prepared for their surgical procedures.
- Patients said staff took time to explain procedures, risks, and possible outcomes of surgery.
- Complex information was repeated more than once by different levels of staff so that patients understood their care, treatment, and condition. Patients and relatives felt involved in their care, and regular ward rounds gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients and their families received information in a way they could understand, and were knowledgeable about treatment, progress, and their discharge plan.
- Senior nursing staff were visible on the day of inspection and staff reported that the ward manager and matron were available for patients and their relatives. It was made clear to patients and visitors to the ward who was on duty, as this was displayed at the ward entrance.
- The trust used the Butterfly Scheme, which those who go into hospital with dementia, or acute or longstanding memory problems and confusion, could join. The

scheme alerts staff to the patient's condition, letting them know that the person may need extra care and attention to remain safe, by displaying a butterfly on the patient's electronic record.
- The trust offered a 'forget-me-not passport of care' for every inpatient admission. This could be completed by patients' families and carers, offering individual details about them, and so helping staff to care for them in a more personal way.
- Easier to access 'translation and Interpretation' services were available.

Emotional support

- Patients reported that staff spent time with them, and staff recognised the importance of time to care and support patients' emotional needs. Care plans highlighted the assessment of patients emotional, spiritual, and mental health needs.
- We were given information about support groups for patients. These included stoma care support groups, pain management groups, and open access to clinical nurse specialist helplines for surgical patients.
- An extensive multi-faith Chaplaincy service was available within the hospital. We observed Chaplains giving their support to patients and relatives. Patients and relatives said this was an extremely positive experience, and individualised support.
- Clinical psychology support services commissioned by the trust supported patients as necessary.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially.

Are surgery services responsive?

Good

We rated responsive as 'good' because:

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity, and commissioning requirements. This included changes in discharge procedures, such as the implementation of the 'Hospital Home Care Team ' and the Discharge Support Team, to enable more efficient and timely discharge with ongoing rehabilitation.
- The divisional management team had taken action to address the low achievement of referral to treatment targets (RTTs). This included a local amnesty with CCGs allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and provision of additional capacity (through sub-contracting to the independent sector, additional activity sessions, and operating department efficiencies).
- For the period Q1 2015/2016 to present 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 service was responsive to the needs of patients living with dementia and had identified dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best-interest decision meetings were required.
- Complaints had reduced from the previous year, were handled in line with the trust policy, and were discussed at all monthly staff meetings. This meant that training needs and learning could be identified, as appropriate.

Service planning and delivery to meet the needs of local people

- The trust was actively working with CCGs to provide an appropriate level of service, based on demand, complexity, and commissioning requirements. This included changes in discharge procedures, such as the implementation of the 'Hospital Home Care Team' and the Discharge Support Team, to enable more efficient and timely discharge with ongoing rehabilitation.
- The trust advised that delivery plans with three main objectives were in place: to implement the NHS Five Year Forward View; to restore and maintain financial balance; and to deliver core access and quality standards for patients.
- The surgical and critical care business plan for 2016/2017 incorporated the Better Care Together(BCT)restructuring of its healthcare for the local population, with a significant shift in emphasis on to community care.
- BCT aims to give greater support to patients in the community, reducing the need for hospital admissions, and creating a significant reduction in hospital beds. It

sees a key part of the success of this change being in the community partnerships that it can develop. Community partnerships alreday 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.

Meeting people's individual needs

- Surgical teams personalised patient care in line with patient preferences, and individual and cultural needs.
- Ward information boards identified who was in charge of each ward for any given shift, and who to contact if there were any problems.
- Leaflets were available for patients regarding their surgical procedure, pain relief, and anaesthetic. Alternative languages and formats were available on request.
- Ward managers were clear about zero tolerance of discrimination.
- There was good access to the wards. There were lifts available in each area, and ample space for wheelchairs or walking aids.
- The surgical division applied the 'This is me' personal patient passport/health record to support patients with learning needs and dementia. Symbols on electronic white boards identified special requirements such as dementia, falls risk, and dietary needs. Forget-me-not personal information booklets were used for patients with dementia, and 'John's Campaign' training was in place for all staff. The service was responsive to the needs of patients living with dementia and learning disabilities.
- The Care of the Elderly Team screened everyone for confusion, delirium, and undiagnosed dementia, as part of National Commissioning for Quality and Innovation (CQUIN), which also identified diagnoses of dementia, using specific admission documentation. This was part of a comprehensive elderly care assessment process. If the patient had a confirmed diagnosis of dementia, the patient was moved to the prescribed dementia care pathway and options were then discussed with carers. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment (AMT) was carried out and appropriate referral was made for diagnosis. The team was made up of band 6 nurses and physiotherapists, who supported the geriatricians to complete the assessment process.
- There was a matron for professional standards in dementia in post, who formed part of the Safeguarding Team. She managed the care of the elderly teams to ensure the appropriate care was put in place on assessment, and carer/family involvement was included. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best-interest decision meetings were required.
- WGH offered a dementia menu for those who needed it. With support from identification through the Butterfly Scheme, it encouraged families and carers to be involved in choosing from the menu and helping at mealtimes.
- The trust had launched a new dementia buddy programme, and had a waiting list for dementia buddy volunteers.
- There were no mixed sex accommodation breaches over the 12 month period.
- 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/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 offered the option of requesting a preferred translator, to ensure continuity.
- The wards and theatre areas had made changes to improve engagement with patients with a dementia, through, for example, the replacement of white crockery, appropriate easy to read clocks, coloured toilet seats, coloured and dementia friendly signage, room décor and furnishings, the creation of reminiscence boxes, and afternoon teas.

Access and flow

- Between April 2015 and March 2016 the average length of stay for surgical elective patients at WGH was 2.3 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 2.8 days, compared to 5.1 for the England average.

- The trust's referral to treatment time (RTT) for admitted pathways for surgery had been worse than the England overall 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%. Only ophthalmology and trauma and orthopaedics were below the England average for admitted RTT (percentage within 18 weeks).
- The divisional management team had taken action to address the low RTTs. This included a local amnesty with clinical commissioning groups (CCGs) allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and through provision of additional capacity (sub-contracting to the independent sector, additional activity sessions and operating department efficiencies).
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre Model (TPOT), and identification of outpatient efficiency improvement were developed.
- There were no 28 day breaches encountered for the year to June 2016.
- For the period Q1 2015/2016 to the date of inspection, the trust cancelled 561 operations on the day of surgery . Of the 561 cancellation, 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.
- Pre-operative assessment of elective patients was organised to take place as early as possible in the elective pathway, once patients were added to the waiting list.
- The orthopaedic service operated electively up to six days of the week. Elective admissions were planned based on consultant availability and complexity of the procedures. We found the trust had plans in place to increase the service, with a daily extra theatre list and by extending hours at the weekend.
- The elective ward had RMO support 24 hours daily with consultant input twice weekly. Work was ongoing to review the options available to the department, to enhance the care provided to patients, and to increase flexibility with theatre lists.

Learning from complaints and concerns

- Between October 2015 and October 2016 there were 15 complaints about surgical and critical care services at WGH. The hospital took an average of 30.47 days to investigate and close complaints. This is in line with its complaints policy, which states that complaints should be signed off by the formal CEO response letter, and must be 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. The Day surgery unit and cardiac centre had received the highest numbers of complaints (both four), and the main theme of complaints related to patient care and experience
- University Hospitals of Morecambe Bay (UHMB) had a centralised complaints team. This team lead on all complaints, with dedicated case officers. The investigation was documented using an electronic system. The 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.
- Complaints were discussed in ward meetings as a standing agenda item. A full report was provided monthly, quarterly and annually.
- All wards and departments had posters situated at their entrances clearly explaining what to do if unhappy with the care, services, or facilities provided. Contact details for PALS and Complaints were clearly listed. Wherever possible PALS would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff, who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS, and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as 'good' because:

- Senior managers had a clear vision and five year plan for the surgical service division. Staff were able to repeat and discuss its meaning. Joint clinical governance and directorate meetings were held each month.
- The directorate risk register was updated following these meetings, and we saw that action plans were monitored across the division. Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale were good, with staff supported at ward level.
- Staff spoke positively about the service they provided for patients, and emphasised quality and patient experience. Staff on the wards and in theatres worked well together, with respect between specialities and across disciplines. We saw examples of good team working on the wards, between staff of different disciplines and grades.
- Improvements compared with results from the 2014 survey were seen in other areas, such as staff feeling that they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, and an improved percentage of staff reporting most recent experience of harassment, bullying or abuse.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrated the views of people with safety, quality, activity, and financial information.

However:

- Staff told us they had been working in difficult circumstances during the last eighteen months, to cover staff and skill shortages. Staff said this had led to some staff working under extreme pressures for an extended period, to cover shifts.

Vision and strategy for this service

- The trust vision and strategy was displayed in wards, and staff articulated to us the trust's values and objectives across the surgical division. Staff demonstrated the values of the trust during the inspection, were clear about the trust vision, and understood their roles in contributing to achieving the trust-wide and directorate goals.
- We met with senior divisional managers, who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The management team had developed a Business Plan (2016-2017) for the division.
- The strategy detailed planned improvements in the delivery of services to patients through investment in nursing and medical staffing levels, improved governance, and strengthened clinical leadership, through the further development of clinical business units in each specialty in the division.
- The division had also aligned its strategy to the Better Care Together (BCT) initiative, which had been designed to bring together stakeholders in the delivery of health, by developing a workforce delivering a care model based on 'right person, right setting, right location, right time, and right skills'.
- The vision and strategy had been communicated throughout the division, and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust had a commitment to a people-centred approach, delivering high quality care with robust assurance and safeguarding, and we saw this in practice during the inspection. The divisional strategy included targets for compliance with mandatory training and the Behavioural Standards Framework.
- The surgical division had developed strategies aimed at, for example, working together with the medicine division to improve pathways and delivery for frail, elderly surgical patients, reducing avoidable harm, and using advanced nurse practitioners and surgical care practitioners to deliver follow-up chronic pain services

Governance, risk management and quality measurement

- We were told that wards received a monthly WESEE report, which included lessons learned feedback. Matrons disseminated information with ward staff at ward meetings and safety huddles.
- A clear responsibility and accountability framework had been established, and was referred to as 'board to ward'. Staff at different levels were clear about their roles and understood their level of accountability and

responsibility. It was highlighted that staff felt that openness and transparency had also improved, and that staff at all levels were eager to learn and improve their practice.

- The surgical division had a detailed risk register, which was thorough in identifying, recording, and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff told us was 'on their worry list'. The main concerns were linked to staff shortages at nursing and junior doctor levels. The register was updated regularly.
- Statistics showed that the number of risk reviews completed on time was at 94.1%. The risk register showed that there 86.3% of risks had open actions, and 88.9% of those showed progression.
- All senior staff in the service were responsible for the monitoring of performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information, and waiting time performance. The matrons conducted weekly audits of the ward areas with ward managers to measure quality.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrated the views of people with safety, quality, activity, and financial information.

Leadership of service

- The clinical director, divisional general manager, and assistant chief nurse led the surgical division. The surgical division comprised five matrons, five service managers, and eight clinical leads.
- Most staff we spoke with told us that they felt leaders had the skills, knowledge, experience, and integrity that they needed, both when they were appointed and on an ongoing basis. This included the capacity, capability, and experience to lead effectively.
- Staff said that leaders understood the challenges of achieving and maintaining good quality care, and had identified the actions needed to maintain and improve services.
- Senior team members were said to be visible and approachable. It was acknowledged that matrons, service managers, and the deputy chief nurse were very "hands on" in supporting the staff on the wards.
- The matrons met regularly with all of the divisional matrons and the deputy director of nursing. Information from these meetings was shared with ward managers, clinical leads, and ward staff, as necessary.
- The trust offered a range of management and leadership development programmes through ongoing work with local universities.
- A new quality ambassador scheme had been developed to help improve quality of care at WGH. The scheme gave staff the opportunity to explore and promote good practice, by understanding the way care was delivered in different settings and sharing good practice with colleagues across the two organisations.
- The medical staffing committee met every three months within working hours to encourage a high attendance rate. Meetings were said to be productive and accountable, with dissemination of progress and opportunity to interchange ideas. Clinical commitments were re-scheduled to help attendance, and management were said to attend every meeting. It was felt that the management team had 'done a good job', changing culture, communicating, making improvements, and managing engagement with medical staff.
- We found that ward managers were clear about transfer protocols and the level of patient acuity accepted at WGH. The ward manager and RMO felt able to challenge inappropriate transfers to and from the hospital. Staff stated that patients who did not meet the criteria would not be accepted as an inpatient. There were procedures and protocols in place, which were accessible to all staff on the intranet.

Culture within the service

- Staff told us that the division had strong leadership and most of the senior managers were visible and 'hands on'. This reflected the vision and values of the division and the trust. We interviewed number of staff on an individual basis and held group discussions throughout surgical wards, theatres, and units.
- Staff spoke positively about the service they provided for patients, and said high quality compassionate care was a priority.
- Most staff described good teamwork within the division, and we saw staff work well together; there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

- However, some staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages. Although staff were enthusiastic about their work, the service they provided, and, generally,he organisation they worked for, staff morale was variable. Nonetheless, staff morale had increased greatly on wards and in theatres.
- The trust supported the Nursing Times 'Speak Out Safely' campaign, encouraging staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity. Staff we spoke to told us they felt confident about speaking out.
- The trust had developed and implemented a Behavioural Standards Framework, to improve patient experience and 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.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the Friends and Family Test (FFT), and Patient Advice Liaison Service (PALS), and 'Tell us what you think?' questionnaires were available on all ward and reception areas. Internet feedback was gathered, along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients with the opportunity to express their views and opinions.
- Discussions with patients and families regarding decision-making was recorded in patient notes.
- The FFT survey was used to elicit patient feedback on: how likely patients would be to recommend the hospital to family and friends; respect and dignity; involvement in care and treatment; cleanliness; and kindness and compassion received. Test performance (percentage response rate) was 31%, which was better than the England average of 29%. The monthly percentage recommended fluctuated between 82% and 100%.
- These results were supported by feedback from patients during our inspection. Patients were very complimentary about the care and treatment received at both hospitals, and were very supportive of the services provided at the hospital.

Staff engagement

- Staff survey results, published in February 2016, showed that staff felt motivated at work and would recommend University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) as a place to work or receive treatment. The score for staff feeling motivated at work had risen 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 had risen 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 staff who felt they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, and an improved percentage of staff reporting most recent experience of harassment, bullying or abuse.
- Results also showed that staff felt 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.
- We saw senior managers communicate with staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held monthly staff meetings, at which key issues for continuous service development were discussed.
- All staff were invited to speak with the matron, and were able to voice their opinions, receive feedback, and discuss any concerns.
- Staff we spoke to said they felt appreciated and listened to, when they raised concerns.
- Staff said they were well supported when dealing with personal or family illness, and advised that the trust, as an employer, showed compassion, kindness, and support.

Innovation, improvement and sustainability

- At an operational level, flow was maximised by employing discharge co-ordinators. The role of the co-ordinator enabled improved communication between patient, ward staff, clinicians, Adult Social Care, and all Allied Health Professionals. We were told that having dedicated co-ordinators increased efficiency on the ward when planning and arranging appropriate discharges.
- The surgical wards had implemented safety huddles to improve communication and safety.

Surgery

- The electronic patient record enabled staff to document patient information in real time and the information was immediately accessible by all appropriate nursing, medical, and surgical staff.
- University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) 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 UHMB hospitals and in the wider local health economy.
- A dementia care volunteer ward programme had been launched, to support dementia patients, prevent isolation, encourage engagement, and provide 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.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT), and identification of outpatient efficiency improvement had been developed

Maternity and gynaecology

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Helme Chase Maternity Unit is a stand-alone midwifery-led unit within Westmorland General Hospital (WGH), and is part of the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB). Community midwife antenatal clinics are held within the unit during weekday, together with a small number of consultant obstetric and gynaecology clinics.

Between April 2015 and March 2016 there were 111 births at the unit.

The Helme Chase Maternity Unit has three birthing rooms, one of which has a birthing pool. In addition, there is a 'home-from-home' room which could also be used a birthing room if needed.

During our inspection we visited the midwifery-led unit and the antenatal clinic. We spoke with five members of staff, and one patient and her partner within the antenatal clinic. There were no patients within the midwifery-led unit at the time of our inspection. We looked at two sets of records for women who had recently used the maternity unit.

Summary of findings

At our previous inspection, in July 2015, we rated maternity and gynaecology services as 'good'. During this inspection, we again rated maternity and gynaecology services as 'good' because:

- There was a robust incident reporting procedure. Staff knew how and what to report as an incident. There was evidence that learning from incidents was shared with staff.
- The clinical area was visibly clean, and staff followed trust infection control procedures.
- Adult and neonatal resuscitation equipment was checked daily so that staff could be assured it was in good working order. There were systems in place to ensure stock items were available and within expiry dates.
- Medicines and intravenous fluids were stored appropriately.
- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, and legislation.
- The service had an infant feeding policy and was developing an infant feeding strategy.
- The caseload ratio of Supervisors to midwives was 1:15, which was in line with the national recommendation for caseloads. Supervisors had met all of the requirements of the Local Supervising Authority Audit.

Maternity and gynaecology

- Helme Chase Maternity Unit was available 24 hours a day, seven days a week, for women choosing to give birth there.
- All members of staff had received an appraisal.
- Supervisors of Midwives provided a 'birth afterthoughts' service, which provided women with an opportunity to discuss issues surrounding their care during pregnancy and birth.
- The trust was performing as expected in the CQC maternity survey.
- WGH scored better than the England average for privacy, dignity, and wellbeing, in the PLACE [patient led assessments of the care environment] survey in 2015.
- Women who had been assessed as low risk could choose between home birth, birth in the midwifery led unit at Helme Chase, and birth in one of the two consultant-led obstetric units within the trust.
- The service employed a range of specialist midwives for patients with complex care needs or for those in vulnerable circumstances.
- The service had a robust system for monitoring, processing, and learning from complaints, which ensured responses were sent in a timely manner, themes and trends were identified, and learning was disseminated to staff.
- Consultant-led antenatal clinics were held with the unit three times a week, which meant that all women could have choose where to receive antenatal care.

However:

- Although there was a plan in place which set out the principles and governance arrangements for a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust, further work was required to effectively capture and monitor outcomes.

Are maternity and gynaecology services safe?

Good

We rated safe as 'good' because:

- There was a robust incident reporting procedure. Staff knew how and what to report as an incident. There was evidence that learning from incidents was shared with staff.
- The clinical area was visibly clean, and staff followed trust infection control procedures.
- Adult and neonatal resuscitation equipment was checked daily so that staff could be assured it was in good working order. There were systems in place to ensure stock items were available and within expiry dates.
- Medicines and intravenous fluids were stored appropriately.
- The service assessed staffing numbers and skill mix using an acuity tool. Medical, nursing, and midwifery staffing levels were similar to or better than the national recommendations for the number of babies delivered on the unit each year.

Incidents

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff we spoke with told us incidents were reported using the trust's electronic system. Feedback was received about incidents they had reported, including details of any outcomes or investigations.
- There were no Never Events reported for Helme Chase Maternity Unit between September 2015 and August 2016. (Never Events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a Never Event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.)
- There were 114 maternity and 3 gynaecology incidents reported for Helme Chase Maternity Unit between

January 2015 and July 2016. Of these, 88 (75%) were no harm incidents, 22 (19%) were low harm, 1 (0.8%) was moderate harm, and 6 (5%) were classified as near misses.

- We saw that the local governance report from August and September 2016 was shared with staff, including community midwives. The report shared details of the number of incidents reported and common themes. We saw that learning from incidents was also shared, as part of the three minute briefing which was held daily with staff at all handovers, and also by email. The content of the three minute briefing changed weekly.

Safety thermometer

- Maternity service at UHMB took part in the national maternity safety thermometer scheme. The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. Data was collected on a single day each month to indicate performance in key safety areas. The maternity safety thermometer measures harms from perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby, and psychological safety.
- Trust-wide maternity safety thermometer data from August 2015 showed that 100% of women did not express concern over their perception of safety, and 92.9% of women did not experience any of the physical harms.
- Safety thermometer information was not displayed in any of the areas we inspected.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean, and staff demonstrated a good understanding of infection prevention and control.
- There were supplies of personal protective equipment, such as gloves and aprons, available in clinical areas, and we observed staff using them appropriately. Staff wore visibly clean uniforms, and observed the trust's policy of being bare below the elbows.
- Equipment had 'I am clean' stickers on display. These were visible, and documented the last date and time that the equipment had been cleaned. This meant that equipment was clean and ready for use.
- We observed that there were antibacterial hand-gel dispensers at the entrance to the unit and in the clinical areas. However, signage regarding hand washing for staff and visitors was limited.
- Data provided by the trust showed 100% compliance with hand hygiene audits for staff at Helme Chase Maternity Unit between March and July 2016.
- We reviewed an environmental audit from June 2016, undertaken as part of the trust-wide quality assurance accreditation scheme (QAAS). The unit was assessed against 15 standards and was found to be compliant in 14 out of the 15 standards.
- There were no cases of Meticillin Resistant Staphylococcus Aureus (MRSA) or C. Difficile within the maternity unit for the reporting period August 2015 to July 2016. MRSA is a bacterium responsible for several difficult-to-treat infections. C. difficile is an infective bacterium that causes diarrhoea, and can make patients very ill.
- WGH scored better than the England average for cleanliness in the PLACE [patient led assessments of the care environment] survey in 2015.

Environment and equipment

- Adult and neonatal resuscitation equipment was available within Helme Chase Maternity Unit. Daily checks were undertaken to ensure that equipment was present and in working order, and that consumables were in date. This meant that the equipment was ready to be used in an emergency.
- Midwives used pinard stethoscopes and sonic aid devices to monitor babies' heart rates whilst women were in labour. (A pinard stethoscope is a cone shaped tool midwives use to manually listen to the heartbeat of a baby during pregnancy.) There were no cardio-tocography (CTG) machines at this location. (CTG equipment is used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus.) Women whose babies required additional monitoring by use of a CTG machine were transferred to a consultant-led unit at either Royal Lancaster Infirmary or Furness General Hospital..
- There were 'grab and go' boxes for use in an obstetric emergency, for example, postpartum haemorrhage (bleeding after birth) and cord prolapse (where the cord is delivered before the baby). These boxes were checked to ensure essential equipment was present.

- There were systems in place to ensure stock items were available and within expiry dates.
- There were pool evacuation nets for water birth evacuation in the pool room in the birthing centre. Staff told us they had been involved in training scenarios for the use of the evacuation nets.
- Community midwives had access to emergency equipment bags, which were stored at Helme Chase. These bags were standardised across areas with checklists so that staff could be assured they would have the correct equipment for home births.

Medicines

- Medicines were managed and stored appropriately. Intravenous fluids and fridges used to store medicines were kept in a locked room, which meant they were protected from the risk of being tampered with.
- Fridge temperatures were checked on a daily basis, which meant staff could be assured that medicines were being stored at the correct temperature.
- Community midwives carried Entonox (a pain relieving gas), oxygen, and oxytocic drugs (to help control bleeding after birth) for use at home births. The oxytocic drugs were routinely kept in the fridge at the unit in a tamper proof 'grab and go' box. These drugs were collected from the maternity unit by one of the midwives on call prior to attending the woman's home.

Records

- Women using the maternity service were provided with their own set of hand held care records to bring into the hospital with them. The trust used the standardised maternity notes from the Perinatal Institute as hand held records. The hospital also held medical records relating to each woman.
- Child health records known as 'red books' were given to mothers for each new born baby following the completion of new-born and infant physical examinations.
- Data provided by the trust showed that 100% of staff had completed the information governance training.
- Records were audited every six months as part of the trust's quality assurance accreditation scheme (QAAS). The QAAS report used a RAG (red, amber, green) rating to indicate compliance with trust standards. We reviewed the QAAS report from July 2016, which showed record keeping at Helme Chase was all 'green'.
- At the time of our inspection there were no women using the maternity unit. We looked at two sets of records for women who had recently given birth at Helme Chase and found that these had been fully and accurately completed

Safeguarding

- Staff we spoke with were aware of the trust's safeguarding policy and reporting procedure, and had a good understanding of their own responsibilities.
- There was a trust-wide named midwife for safeguarding, and a full time safeguarding specialist midwife. There was good liaison with other specialist midwives, such as teenage pregnancy, mental health, domestic violence, and substance misuse.
- Midwives and health care assistants (HCA) received safeguarding training to level three as both e-learning and as part of one of the mandatory study days. Topics covered by the training included female genital mutilation (FGM), child sexual exploitation, and modern day slavery.
- Data provided by the trust for maternity showed, as of July 2016, 91% of staff had completed the adults and children level 1 training, 97% had completed the safeguarding children and young people level 2 e-learning, 78% had attended the safeguarding adults level two workshop, and 71% had attended the safeguarding children level 3 training. The trust target for compliance was 95% .Service leads told us that those staff who had not completed the training were booked to attend sessions in the following weeks.
- Women were screened for domestic violence at their booking appointment, and later in their pregnancy if they were alone. Staff told us that they worked closely with GPs, health visitors, and other agencies, where there were known safeguarding concerns.

Mandatory training

- Mandatory training was provided using either e-learning or study days. Staff accessed e-learning through a trust-wide training system, which sent email prompts when learning was due. Service leads had access to this information,and monthly reports were sent to the divisional monthly assurance meetings, in order to monitor mandatory training compliance.
- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution, and basic life support.

The trust's target compliance rate was 95%. Data provided by the trust for the maternity unit showed that training compliance rates were mostly in line with trust target, apart from adult basic and intermediate life support (81% and 62%), paediatric life support (67%), and manual handling (84%).

- At the time of our inspection there were three mandatory midwifery study days, which we were told would increase to four in the following months.

Assessing and responding to patient risk

- During the initial booking appointment, pregnant women were given hand-held maternity notes which included both antenatal and intrapartum care. Midwives took a full medical, obstetric, social, and family history, which included an assessment of emotional wellbeing. This assessment was used to classify the woman as presenting either low or high risk. The assessment included the woman's body mass index (BMI) and her risk for venous thromboembolism (VTE). VTEs are blood clots in the deep veins of the legs.
- Low-risk women continued with midwifery-led care, whilst high-risk women were referred to consultant-led care. This assessment was repeated later in pregnancy, to enable discussions of intended place of birth, and again when being admitted to the elivery suite, at a home birth, or if there were any changes in pregnancy.
- The Helme Chase Maternity Unit (HCMU) was only available to women who had been assessed as low risk. Ongoing risk assessments were carried out during pregnancy and labour. Women who no longer fitted the criteria for HCMU were diverted to one of the trust's obstetric units. Emergency transfers for women or babies were made by ambulance with a midwife escort, in line with the trust's transfer guidelines. Service leads told us the main cause of transfers to other units was for slow progress in labour, and approximately 39% of women labouring for the first time were transferred.
- Midwifery staff used an early warning assessment tool called the 'maternity early obstetric warning system' (MEOWS) to assess the health and wellbeing of women.
- Community midwives (CMW) gave us examples of the support given to women assessed as being high risk but who wished to have homebirth. CMWs would complete a 'homebirth additional needs' form and would involve a consultant obstetrician and a Supervisor of Midwives in discussions with the woman, to produce an individualised plan of care.

Midwifery staffing

- The maternity service used the National Birth-Rate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-Rate Plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient).
- There were 15.4 whole time equivalent midwives at Helme Chase Maternity Unit, which included community midwives. At the time of the inspection there were no vacancies.
- The birthing centre was staffed from 8am to 8pm, Monday to Friday, and from 9am to 5pm on Saturdays and Sundays, with one midwife and one support worker. There was a core of three midwives to cover these shifts, and gaps in the staffing rota were filled with bank staff or staff doing extra hours. Agency staff were not used at this location.
- Staff told us that daytime community midwife rotas were planned so another midwife would be given local, non-essential work. This midwife would then be available to be called in to the unit to assist with the care of women if required. Two community midwives would be on-call outside of these hours to provide care for women choosing a home birth or the maternity unit.
- Women received one-to-one care in labour. Staff told us that, due to the low numbers of women choosing to give birth at this unit, it was rare for there to be more than one woman on the unit at any one time. In the event of this happening, staff would ask another community midwife to come into the unit, or divert the woman to one of the consultant-led units if this was not possible.

Medical staffing

- There was no obstetric cover in the midwifery-led unit. In the event of a woman requiring an obstetric review, she would be diverted or transferred to Furness General Hospital or the Royal Lancaster Infirmary.
- Two consultant-led antenatal clinics were held in the maternity unit per week.

Major incident awareness and training

Maternity and gynaecology

- A business continuity plan for safe staffing was in place. This included the risks specific to each clinical area, and the actions and resources required to support recovery.
- There were escalation processes in place to activate plans during a major incident or internal critical incident.

Are maternity and gynaecology services effective?

Good

We rated effective as 'good' because:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, and legislation.
- The service had an infant feeding policy and was developing an infant feeding strategy.
- The caseload ratio of supervisors to midwives was 1:15, which was in line with the national recommendation for caseloads. Supervisors had met all of the requirements of the local supervising authority audit.
- Helme Chase Maternity Unit (HCMU) was available 24 hours a day, seven days a week for women choosing to give birth there.
- All members of staff had received an appraisal.

Evidence-based care and treatment

- The service used tools provided by the National institute for Health and Care Excellence (NICE) to aid the implementation of NICE guidance CG190 – intrapartum care for healthy women and babies.
- We reviewed the trust's guidelines for normal birth, which were in date and version controlled. However, although this guideline followed NICE guidance, it was trust-wide with no adaptation for home birth or the midwifery led unit. The guideline was divided into four separate documents: first stage; second stage; third stage; and water birth. Staff were unable to easily locate information, as they were required to search four documents.
- The maternity service used evidence based-birth centile charts from the Perinatal Institute, which identified which babies required enhanced observations.
- There was a clinical audit forward programme 2016/2017 for obstetrics and midwifery, trust-wide. This programme detailed plans for national audits, divisional priorities, and educational audits. The plan included the audit supervisor, completion date, and frequency.

Pain relief

- There was a birthing pool in the midwifery-led birthing centre that women could use as pain relief during labour. Data displayed in the unit during our inspection showed that 82% of all births for that month had been water births.
- Entonox (a pain relieving gas) was available in all of the birthing rooms. Stronger painkiller by injection was also available for women who required additional pain relief.
- As HCMU was a midwifery-led unit, women did not have access to epidurals. If women wished for this kind of pain relief, they would be transferred to either the Royal Lancaster Infirmary or Furness General Hospital.
- Midwives told us that they were developing their service by offering complementary therapies, for example, hypnobirthing, reflexology, and aromatherapy. Staff were in the process of being trained to offer this service to women.

Nutrition and hydration

- The trust had not registered to work towards the Baby Friendly initiative. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.
- There was an infant feeding policy. An infant feeding strategy was being developed with input from the Maternity Service Liaison Committee (MSLC) and as part of the trust's listening into action (LIA) project. Midwives and support workers received breastfeeding updates as part of mandatory study days.
- Trust-wide breast feeding initiation rates following delivery were above the trust target of 61% in eight of the 12 months from September 2015 to July 2016.
- Tongue tie clinics were held at WGH on Tuesdays and Thursdays as part of the maxillofacial service.
- Staff told us that snacks were offered to women 24 hours a day. A full range of meals was able to be ordered from the kitchen during the day, which included those suitable for different cultural and dietary requirements, for example, vegan or halal food.

Patient outcomes

- Between April 2015 and March 2016 there were 111 births at Helme Chase Maternity Unit.
- The normal vaginal delivery rate was 100%.
- Between April 2015 and March 2016 maternity services across the trust had experienced 13 stillbirths (4.1 per 1,000 births). This was lower than the England average for stillborn rates for 2015, which was 4.4 births per 1,000 births.
- Between April 2015 and March 2016 trust-wide, the average number of women sustaining serious perineal trauma during birth was three per month, which was lower (better) than the trust target of nine per month. Incident data provided by the trust for the period January 2015 to August 2016 showed that there were two cases of serious perineal trauma at HCMU.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening. The trust was meeting acceptable levels within six of the eight KPIs for which data was submitted for April to July 2016. The trust provided a copy of its action plan, and we saw that steps had been taken to improve performance, for example, a change of equipment had been made, and staff education to reduce the number of avoidable repeat new born blood spot tests was ongoing.

Competent staff

- There were 15 supervisors of midwives (SoM) within the maternity service at University Hospitals of Morecambe Bay NHS Trust. SoMs help midwives providedsafe care and were accountable to the local supervising authority midwifery officer (LSAMO). The caseload ratio of SoMs to midwives was 1:15, which was in line with the national recommendation for caseloads.
- The Local Supervising Authority (LSA) had audited the SoM service in September 2016, assessing it against six of the Nursing and Midwifery Council (NMC) midwife rules and standards (2012). The results of the audit showed that all of the rules had been met. Recommendations from the audit included a review of SoM caseloads which were not evenly distributed, and SoMs seeking assurance from the trust that recommendations made following investigations had been actioned.
- Newly qualified midwives completed a two year preceptorship programme, which provided a framework to develop staff from band five to band six within the maternity service. The programme included rotation across all sites within the trust, including the midwifery-led unit and the community team.
- Staff we spoke with told us they received an annual appraisal. The quality assurance accreditation scheme (QAAS) audit report from June 2016 showed 100% of staff had received an appraisal within the previous year.

Multidisciplinary working

- Staff told us there were good communication and working relationships within the maternity unit.
- Staff attended multidisciplinary skills drills days, which included midwives and community midwives, support workers, obstetricians, anaesthetists, and medical students.
- The practice development teams from maternity and the neonatal unit worked closely to co-ordinate training needs for their staff.
- Community midwives (CMW) told us there was effective communication with health visitors and GPs. Some CMW clinics were held within GP surgeries, which aided multidisciplinary working. GPs received electronic birth notifications and discharge letters for their patients.
- We saw evidence of multidisciplinary team meetings trust-wide for the service, which included governance, audit, perinatal, and guideline meetings.
- Safe active birth specialist midwives worked closely with women's health physiotherapists to plan and deliver the active birth sessions available to women. Physiotherapists delivered sessions to band five midwives as part of the preceptorship programme.

Seven-day services

- HCMU was staffed from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays and Sundays. Outside of these core hours, midwives operated an on-call rota for women wishing to labour and birth in the midwifery-led unit.
- Community midwives were available 24 hours a day, seven days a week, to facilitate home births.
- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided support to midwives at all times, and was also available to patients. The hand-held antenatal records included details of how to contact the on-call SoM.

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Access to information

- Trust policies and guidance were available on the intranet, to which all staff had access. Staff were able to demonstrate how they accessed guidance. We saw that there was an icon on computer screens, which made finding guidance quicker and easier for staff.
- Community midwives did not have remote access to guidelines but community staff told us they would use their mobile phones to check information or guidance.
- Women using the maternity service were provided with their own set of hand-held care records to bring into the hospital with them. These records included risk assessments, ultrasound, and blood test results. This meant all the information needed to deliver care and treatment was readily available to staff.
- There was a system in place to ensure women's medical notes were transferred to her chosen maternity unit at 36 weeks of pregnancy. Service leads told us they made arrangements to transfer medical notes by courier in the event that a woman was diverted to a different maternity unit.
- Staff told us that there were processes in place to ensure medical and hand-held records travelled with the women in the event of a transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had an awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- We reviewed the records of women who had given birth recently in the maternity unit, and saw that verbal consent was documented within the records.

Are maternity and gynaecology services caring?

Good

We rated caring as 'good' because:

- Supervisors of Midwives provided a 'birth afterthoughts' service which provided women with an opportunity to discuss issues surrounding their care during pregnancy and birth.
- The trust's feedback from the Maternity Friends and Family Test (FFT) was in line with the national average.
- The trust was performing as expected in the CQC maternity survey.
- WGH scored better than the England average for privacy, dignity, and wellbeing in the PLACE [patient led assessments of the care environment] survey in 2015.

Compassionate care

- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey, asking patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. Data specific to HCMU was unavailable as the response rate was too small to report separately.
- Between August 2015 and August 2016 the trust's Maternity FFT (antenatal) performance (% recommended) was generally similar to the England average. In September 2016 the trust's performance for antenatal was the same as the national average of 96%.
- Between August 2015 and August 2016 the trust's Maternity FFT (birth) performance (% recommended) was generally similar to the England average. In September 2016 the trust's performance for birth was 95%, compared to a national average of 96%.
- Between August 2015 and August 2016 the trust's Maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average. In September 2016 the trust's performance for postnatal community was 97% compared to a national average of 98%.
- The trust performed about the same as other trusts for 16 out of 16 questions in the CQC maternity survey 2015.

Understanding and involvement of patients and those close to them

- A woman and her partner we spoke with were positive about the care they had received in the antenatal clinic. They told us staff were polite and friendly and had been involved in the plan of care.
- Women were encouraged to visit the maternity unit for a tour before deciding where they wanted to give birth, and to familiarise themselves with the facilities.
- Staff told us there were no restrictions on the number of birthing partners or visitors women could have to support them whilst in labour.

Emotional support

Maternity and gynaecology

- We overheard a telephone conversation between a midwife and a woman seeking advice. The midwife was calm and supportive to the woman, taking time to listen, offering advice and encouragement, and checking the woman understood.
- Supervisors of Midwives provided a 'birth afterthoughts' service, which provided women with an opportunity to discuss issues surrounding their care during pregnancy and birth.
- Women were screened for conditions such as anxiety and depression as part of the maternity booking process.
- WGH scored better than the England average for privacy, dignity, and wellbeing in the PLACE [patient led assessments of the care environment] survey in 2015

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'good' because:

- Women assessed as low risk could choose from home birth, birth in the midwifery led unit at Helme Chase, or birth in one of the two consultant-led obstetric units across the trust.
- The service employed a range of specialist midwives for patients with complex care needs or for those in vulnerable circumstances.
- The service had a robust system for monitoring, processing, and learning from complaints, which ensured responses were sent in a timely manner, themes and trends were identified, and learning was disseminated to staff.
- HCMU was open 24 hours a day, seven days a week, to women booked to have their babies there.
- Consultant-led antenatal clinics were held within the unit three times a week, which meant that all women could chhose where to receive antenatal care.

Service planning and delivery to meet the needs of local people

- The service worked closely with commissioners and other stakeholders to build stronger relationships through the trust strategy 'Better Care Together' projects. This included implementation of an integrated maternity care pathway, equitable provision of midwife-led services, options for birth, and provision of neonatal transitional care in acute and community settings.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community.
- Through the Maternity Services Liaison Committee (MSLC), the service was working with North West Ambulance Aervice to increase awareness amongst ambulance crews of women's specific maternity needs.
- The service was working in partnership with Healthwatch and MSLC colleagues in developing the Healthwatch Maternity Matters Survey for the RCOG Implementation Review.
- The trust employed a wide range of specialist midwives who worked across the trust with women with complex needs and in vulnerable circumstances. There were 1.6 whole time equivalent (WTE) mental health specialist midwives, 1.4 WTE domestic abuse specialist midwives, and 1.4 WTE teenage pregnancy specialists, who provided care to a high risk population of teenagers. There was a full time Supervisor of Midwives (SoM), a bereavement midwife, and a safeguarding midwife. There was one full time midwife who worked with women living with blood born viruses or substance misuse.
- The trust had recently appointed two WTE 'safe active birth' specialists to support women to make individual birth choices, and support midwives to facilitate women's choices as safely as possible. These midwives were developing the hypnobirthing, aromatherapy, reflexology, and massage service for women, and promoting water births and home births, where appropriate.
- Women across the trust who had been assessed as low risk were given the choice of birthing at home, in the midwifery-led unit at Helme Chase, or in one of the two obstetric units at Furness General Hospital and the Royal Lancaster Infirmary.

Access and flow

- Helme Chase Maternity Unit was staffed between 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays and Sundays. Outside of these hours the unit was covered by community midwives operating an on-call rota.

Maternity and gynaecology

- Data provided by the trust showed that, between January 2015 and June 2016, the maternity service provided by UHMB had not been closed. There was an escalation policy for periods of peak workload within the service, which meant women might be diverted to the other units within the trust. Service leads told us it was made clear to women at booking there was a possibility they may be diverted to another unit, and a woman we spoke with confirmed this was the case.
- Community midwives held booking and routine antenatal clinics within the unit. The percentage of pregnant women accessing antenatal care who were booked for delivery by 12 weeks and six days between September 2015 and July 2016 averaged 90.6%, which was better than the trust target of 90%.
- Between October 2015 and September 2016 the percentage of women booking for antenatal care before 20 weeks was between 95.3% and 99%, which was better than the trust target of 90%.
- There were three consultant led obstetric and ultrasound clinics held within the unit; every Thursday and Friday and on alternate Mondays.
- The gynaecology service ran two colposcopy clinics on a Friday morning; one was consultant-led and one was nurse-led.
- There was no postnatal ward at Helme Chase. Staff told us women were discharged home from the maternity unit following the birth of their baby when they felt well enough but were never discharged before they were ready. This might be in the middle of the night if the woman wished.

Meeting people's individual needs

- Women were able to choose the most convenient place to access their antenatal care. Women with complex needs or who had been assessed as higher risk and so were not able to choose Helme Chase to have their baby, could still attend consultant-led antenatal clinic within the unit.
- Staff valued women's emotional and social needs, for example, the service had developed the dragonfly logo. The aim of this was to develop visual aids to alert staff that a woman had had a previous pregnancy loss. There were memory boxes available with items that could be kept, to serve as a memory of the baby.
- Bereavement services were available trust-wide and a Chaplaincy service was available to provide additional support.
- There was a range of information leaflets available to women. Staff told us that these leaflets were available in different languages if required.
- Staff told us that hey would book interpreters when needed or make use of a translation phone service for women who did speak English.
- Staff told us of a woman who was having difficulty with breastfeeding two days following the birth of her baby. She had visited the unit, and staff had been able to spend time offering reassurance and practical assistance.
- Women could access antenatal education, which was provided by midwives and which included active birth sessions with women's health physiotherapists. These were practical sessions where women could learn about positions for active birth and management of pregnancy associated musculoskeletal conditions.

Learning from complaints and concerns

- A Patient Advise and Liaison Service (PALS) was available at the trust for members of the public to raise a query or concern, to access information, or to make a formal complaint about the services provided to them.
- Complaints were dealt with in line with the trust's policy. Posters and leaflets were available in the clinical areas we visited. These allowed members of the public to identify how they might raise a concern or make a formal complaint.
- Data provided by the trust prior to the inspection showed that, from April 2015 to March 2016, there were two formal complaints for the service provided at HCMU. Both complaints related to consultant-led care. Learning from these complaints was identified, for example, improving staff's use of language and using terminology that women could easily understand.
- We saw that he local governance report from August and September 2016 was shared with staff, including community midwives. The report shared details of new complaints received and emerging themes.

Are maternity and gynaecology services well-led?

Good

We rated well-led as 'good' because:

- There was a clear vision and strategy for the service, which was linked to the National Maternity Review 2016. Governance structures and processes had improved. There was an effective governance framework to support the delivery of the strategy and good quality care. Performance measures were reported and monitored, and action was taken to improve services.
- The leadership structure had changed since the previous inspection. Leaders understood the challenges in the service and could identify the actions needed to address these. Staff said leaders were visible and approachable.
- Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.
- There were many examples of how women's views and experience were used to shape and improve the service and culture. Women and their families were involved in decision-making and in the planning and delivery of maternity care.

However:

- Although there was a plan which set out the principles and governance arrangements for a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University 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 the midwifery placements and extend the partnership to include paediatrics and anaesthetics.

Vision and strategy for this service

- 'Better Births Together' was 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. This would be achieved 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.
- The creation of a new maternity building with theatres and a delivery suite, in response to the Kirkup Repor, had commenced with a planned completion date of December 2017.
- 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 said 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 of the non-training grade doctors in obstetrics and gynaecology had honorary contracts with Central Manchester.
- The clinical director and clinical lead for obstetrics said they had attended clinical audit and effectiveness days and Human Factors training. Positive feedback was received. The attendance had been extended to include midwifery staff and non-training grade doctors.
- In a paper presented to the trust's Board in September 2016 a schedule of clinical placements had been agreed, with the first taking place on 7 October 2016. This was to provide opportunities for clinical observations, ward rounds, and attendance at complex clinics in areas of interest for medical staff. The activity would form part of annual appraisal and personal development plans. The paper acknowledged that partnership working was still evolving, with developments needed to formalise midwifery placements and extend the partnership to include paediatrics and anaesthetics.

Governance, risk management and quality measurement

- Clinical governance business partners were introduced into post in February 2016. This was an independent role providing a bridge between the corporate governance team and the women and children's division. The business partners reported to the director of governance. The governance partners sat outside of the division and covered cross-bay.
- There was a full time risk midwife and clinical lead to support the governance process.

- There was a weekly patient safety summit chaired by the medical director and chief nurse, to review all moderate and above incidents and near miss cases. Re-grading of incidents occurred where required to ensure accuracy.
- Moderate and above incidents (even if no harm) triggered a rapid review by a multi-disciplinary team.
- A three-minute briefing took place each day, and included clinical outcomes, learning from incidents, complaints, and any concerns. The brief was available on notice boards, and placed in a folder for community midwives to access.
- There were four levels of governance meetings using the trust standardised WESEE approach (workforce, experience, safety, effectiveness, and efficiency). Monthly meetings were held at ward level, by managers across the service, and by matrons and heads of service. These meetings fed into the divisional governance assurance group which, in turn, produced a monthly report to the trust's board. We reviewed a copy of a monthly report from August 2016 and saw it was RAG rated (red, amber and green), and included training, staffing, incidents, complaints, risks, financial performance, and effectiveness.
- The divisional governance and assurance group was attended by obstetric and paediatric leads, nursing and midwifery staff, the director of midwifery, and matrons. Attendance trackers were reviewed at each meeting to monitor attendance in line with the meetings' terms of reference.
- There was regular review of the divisional risk register. Actions taken were visible and the process was completed by removing risks from the register. Minutes showed that staff discussed risks at ward meetings. Maternity managers we spoke with had a good understanding of the risks to the service.
- The wards managed low-level incidents. At the time of inspection, 70% of level 1 and 2 incidents were reviewed within 20 days, against a target of 80%. Plans were in place to improve timeliness.
- Performance and outcome data were monitored using a maternity dashboard. The dashboard followed the RCOG guidance. There were some outcomes, such as admissions to intensive care and special care, and Hypoxic-ischemic encephalopathy (HIE), which were not included. The governance team acknowledged that the dashboard was ‘work in progress’ and gave assurance that audit and incidents would flag areas of risk.
- Supervisors of Midwives (SoMs) attended governance and risk meetings. The maternity risk management strategy described the framework of statutory supervision and the role of an SoM.
- SoMs were involved in incident investigations. At the time of inspection there was one SoM investigation that had been completed. The SoM investigation was aligned with the trust investigation. SoMs were involved in investigations for other trusts.
- Band 5 midwives and new starters were encouraged to spend a day with the governance and audit team during their induction and supernumerary period.
- The clinical director had attended a clinical audit and effectiveness meeting at Central Manchester, where guidelines and a Never Event were discussed. The learning was brought back to UHMB and used to quality assure its processes.
- There were quarterly labour ward forum meetings. Minutes showed that obstetric, anaesthetic, and paediatric issues were discussed. There was good multidisciplinary attendance.

Leadership of service

- The leadership structure had changed since our previous inspection. The Women’s and Children’s Division was led by a clinical director (CD) who reported to the trust medical director. The director of midwifery and gynaecology (DOM) reported to the executive chief nurse. A divisional general manager supported the directors.
- The DOM had attended the North West head of midwifery group for external support, however, it was not clear what external peer review was provided.
- There were three maternity matrons and a gynaecology matron covering each site, whowere accountable to the DOM.
- The clinical lead for obstetrics and gynaecology was accountable to the clinical director.
- Staff said they had regular access to the matron and manger who were on site every day. The DOM was visible each week and had an office on the ward.
- Medical staff said that they had good support from the clinical director. Consultant job plans were completed.
- Divisional leads had regular meetings with the matrons; the DOM met with them weekly and there were other

regular meetings with the clinical director and the divisional general manager. Matrons said they were supported and well informed, and could escalate their concerns to divisional leads.
- The matron for HCMU was also responsible for community midwives and antenatal clinics across the trust.
- There was strong local leadership in the maternity unit. Staff told us the DOM was visible and approachable, and they felt supported by managers.

Culture within the service

- Staff said they were engaged and well supported by managers. There was a feeling amongst teams that they were working more effectively with all grades of staff and cross-bay.
- Between April 2015 and March 2016 the trust reported a turnover rate in the women's and children's division of 9.38% for all staff groups. The trust reported that turnover was reducing in key areas, and hot spots were being acted on at a divisional level.
- Data provided by the trust from May 2015 to April 2016 showed women and children's division attendance was 95%. This was slightly lower than the trust target of 96%, but was an improvement on the previous year's figure of 94.2%.
- Midwives and support staff spoke positively about the care they provided for women. Staff reported positive working relationships, and we observed that staff were respectful towards each other.
- Both leaders and staff understood the value and importance of raising concerns. Staff we spoke with said they could approach their ward manager or matron about any issues of concern. Managers and matrons demonstrated to the inspection team their desire and willingness to listen to staff.

Public engagement

- The service took account of the views of women through an active Maternity Services Liaison Committee (MSLC). The minutes from January to July 216 showed that areas such as breastfeeding, performance, antenatal education, and patient experience were discussed.
- Maternity services were part of an 'Always Event' pilot site by 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.
- Open and honest care stories were included in the monthly women and children's newsletter. Stories came from the "listen with mother" birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- The SoMs worked closely with the MSLC chair. For example, a mystery shopper audit was developed to review how long it took to contact an SoM for debrief.
- The service presented a conference in the North West to create greater awareness of cardiomyopathy and pregnancy for obstetricians and midwives.
- 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 to attend an MDT infant feeding 'Big Conversation' to represent a wide range of service user experience.
- There was service user representation on the National Maternity Review and the Better Births Transformation programme.
- The Down Syndrome Association provided a "tell it right" workshop for MDT staff in relation to breaking bad news.
- Some of the women we spoke with across the trust thought that the HCMU was closed overnight. Staff we spoke with told us this public perception was because of media reporting when the staffing arrangements for the unit changed in December 2014. Staff told us that they were working hard to change this perception. Open evenings had been held for women and their families to promote the unit. Social media was also used to promote the service.
- The trust released a new look website for maternity services in October 2016,which gave information about the service provided at HCMU and the consultant-led units.

Staff engagement

Maternity and gynaecology

- Staff we spoke with were proud of their maternity unit and the service they offered, and thought it was a very good place to work.
- The practice development midwife told us that the strategic partnership had led to a 13-month development programme for labour ward co-ordinators. Co-ordinators would work closely with the maternity unit at Lancashire Royal Infirmary.
- Whiteboards were up in all departments, covering information on the division's top three priorities. There was a divisional newsletter, which included good news stories and celebrated success.
- The trust provided data from the June 2016 staff survey of the women and children's division. The survey showed that 84% of staff would recommend the trust as a place to receive treatment, and 66% would recommend the trust as a place to work. Although there was a low response rate, these figures had significantly improved from September 2015, when those responses had been 67% and 40% respectively.
- Staff were involved in Listening into Action projects to improve the quality of maternity services. There were a number of projects, such as developing a strategy for breastfeeding, scanning capacity, and fluid rehydration for Hyperemesis (severe nausea during pregnancy).

Innovation, improvement and sustainability

- The service showed good progress against its maternity improvement plan. For example, the development of the maternity strategic partnership was progressing and was monitored by the Maternity Strategic Partnership Committee. A paper to the trust's Board (September 2016) acknowledged that this work was still evolving, with developments needed to formalise the midwifery element of the placements with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust, and to extend the partnership to include paediatrics and anaesthetics.
- The service was one of only 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-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 using maternity services.
- Staff told us of plans to redevelop some underused areas of the maternity unit to create a community hub and provide space for antenatal education, a breastfeeding café, and postnatal drop-in clinics.

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) provide outpatient and diagnostic services at the Royal Lancaster Infirmary (RLI), Furness General Hospital (FGH), Westmorland General Hospita (WGH), Ulverston Health Centre, and the Queen Victoria Centre.

Between July 2015 and June 2016 there were 700,277 outpatient attendances at the trust. Of these, 156,134 were at WGH. Outpatient services were part of the core clinical services directorate. There were nurse-led clinics for diabetes, lung clinics, gastroenterology clinics, respiratory, and rheumatology clinics. Other clinical support services included occupational therapy, physiotherapy, nutrition and dietetics, and pharmacy services.

Outpatients offered 'one-stop' clinics for ophthalmology, cardiology, respiratory, thyroid, and urology.

The trust had a patient contact centre at WGH, which dealt with outpatient bookings, and two virtual booking centres in other parts of the trust. The patient contact centre dealt with around 12,000 calls a month.

We visited the main outpatient department, ophthalmology outpatients, and audiology outpatients.

Diagnostic imaging services were mainly provided from three locations: Royal Lancaster Infirmary; Furness General Hospital; and Westmorland General Hospital, with a limited service at Ulverston Community Health Centre and Queen Victoria Hospital at Morecambe. Diagnostic imaging at WGH provided plain film x-rays, fluoroscopy, and ultrasound. The acute clinical work, including fluoroscopy, was concentrated at the two main sites (RLI and FGH), which offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures. A private mobile MRI service was provided seven days a week at WGH. Diagnostic imaging services were managed by the trust core service management team, including a clinical director who was also a consultant radiologist.

Diagnostic imaging services were available for outpatients and from 8.30am to 5pm on weekdays, with hours extended to 7.45pm on Mondays for outpatients and patients referred by their GPs. For inpatients and for emergency minor injuries there were a 24 hour, seven days a week, plain film ultrasound service, and radiographer-led fluoroscopy service on site. A breast screening service was provided on weekdays.

Pathology services offered biochemistry, haematology including transfusion, microbiology, and phlebotomy. Histology and immunology were provided by neighbouring acute trusts. The pathology service managed around five million tests a year, and all equipment had recently been transferred to a managed service.

During the inspection at WGH we spoke with 10 patients, five relatives and 28 members of staff, including nurses, clinical support workers, allied health professionals, and doctors. We observed the diagnostic imaging and outpatient environments, checked three paper-based patient records and thirteen electronic medical records, checked equipment in use, and looked at information provided for patients.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients and diagnostic imaging services as 'good' because:

- During our previous inspection we had identified concerns about the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and implemented an electronic records system for most outpatient areas. This was still being rolled out across all departments, but we found that there had been significant improvements in the availability of case notes. Staff were positive about the improvements in efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information.
- We found that there had been some improvements in diagnostic imaging staffing since our previous inspection. When we inspected this time, the department was continuing to work with vacancies, but a new rota system had enabled the department to make improvements.
- During our previous inspection we had noted that there was no information available in the departments in a format suitable for patients who had learning disabilities, nor was there any written information in a format suitable for patients who had visual impairments. During this inspection, we saw that there was a range of information available in different formats, and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- We noted that space was still limited in some areas, and the service provision was physically constrained by the existing environment. However the overall environment had improved, with changes in flooring materials. We found that overall access to appointments had improved, but performance was variable.
- Outpatient and diagnostic services were delivered by caring, committed,and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence-based and followed national guidance.
- Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department, along with preceptorships for all new staff to the department.
- We found that access to new appointments throughout the departments had improved.
- Overall, staff felt engaged with the trust and felt that there had been some improvements in service delivery since our previous inspection. There were systems to report and manage risks. Staff were encouraged to participate in changes within the department, and there was departmental monitoring at management and board level, in relation to patient safety. The service held monthly core clinical governance and assurance meetings, with standard agenda items such as incident reporting, complaints, training, and lessons learned.

However:

- There remained a shortage of some staff groups, including occupational therapists, radiographers, and radiologists. Some staff raised concerns about the sustainability of the team under prolonged staffing pressures.
- Some referral to treatment targets in a small number of specialties were missed, and follow-up appointments continued to suffer backlogs and delays.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as 'good' because:

- The departments used an electronic system to report incidents. All the staff we spoke with knew how to use the system if they needed to. Managers and governance leads investigated incidents and shared lessons learned with staff.
- The trust had reviewed its staffing investment to develop the allied health professional workforce to meet the growing demand for services. Diagnostic imaging services were working proactively to train staff to work across modalities, and to take on extended roles. National shortages meant that recruitment was difficult but there had been some improvements.
- Staffing levels in outpatients were flexible to meet the different demands of clinics and patients. There were sufficient staff to make sure that care was delivered to meet patient needs.
- Incidents were reported using the hospital's electronic reporting system. Incidents were investigated, and lessons learned were shared with staff. Cleanliness, hygiene, and maintenance of equipment in the departments all met acceptable standards. Personal protective equipment was readily available for staff, and was disposed of appropriately after use.
- Staff were aware of the various policies designed to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed.
- During our previous inspection we had identified some improvements with the timely availability of case notes and test results in the outpatients department. During this inspection we found that there had been sustained improvements following the roll-out of the 'Paper Lite' project, which ensured that electronic information was available for patients. This project was almost fully implemented and staff were very positive about the improvements in efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information. We also found that improvements in the processes for reporting and learning from incidents had been maintained.
- Staff in all departments were aware of the actions they should take in the case of a major incident.

However:

- We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the area where the Macular eye clinic was held. This was located on the first floor away from the main outpatient area. At our previous inspection the manager had told us that the location of the clinic presented operational difficulties, such as in managing the skill mix of staff between the two areas, as well as not being fit for purpose with regard to Health and Safety standards. It was confirmed at the time that health and safety risk assessments had been carried out. At this inspection there appeared to have been no progress made in improving this environment.
- We found that, although recruitment had been successful in some areas, there remained a shortage of occupational therapists, radiographer, and radiologists.
- We found poor stock control of sterile equipment in main outpatients, and one item of sterile kit was identified as out of date. Staff addressed this during our inspection, and no more items were found to be out of date.
- No staff who provided care and treatment for children in outpatients or diagnostic imaging had completed Safeguarding Children level 3 training. Only one member of the team in diagnostic imaging had been identified to complete this, but this was out of date at the time of our inspection

Incidents

- The departments had systems to report and learn from incidents and to reduce the risk of harm to patients. The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and knew how to report incidents. They also confirmed they had received training in completion of incident forms through the online system. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.

Outpatients and diagnostic imaging

- Never Events are serious incidents that are wholly preventable. There were no Never Events in outpatients between September 2015 and August 2016.
- The outpatient services reported no serious incidents between September 2015 and August 2016.
- There were 251 reported incidents across the trust in outpatients between August 2015 and July 2016. Three of these were classed as severe, 9 were classed as moderate, 218 were classed as low risk or no harm, and 21 were classed as near miss incidents.
- We reviewed outpatient meeting minutes from February 2016 and May 2016 and found that patient safety incidents were a standing agenda item at the meetings.
- Outpatients and diagnostic services staff attended a patient safety summit, which was a meeting held to discuss incidents and root cause analyses. Serious incidents would then be discussed at a trust 'serious incident requiring investigation' meeting.
- We were told that staff received feedback from incidents and learning from incidents through a 'lessons learnt' bulletin and through team brief, which was sent out monthly.
- Some staff had received risk incident training, and we were told by team leaders there were good links with the risk office at the trust.
- We were told by team leaders in outpatients that they encouraged staff to report incidents, and that team leaders provide feedback to staff.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents', and provide to reasonable support to those persons. Staff had been trained and were aware of their responsibilities in terms of the Duty of Candour regulations, and all staff described an open and honest culture. Staff told us about the policy and procedures they followed, including writing letters to patients, and offering an apology and information regarding incidents and complaints.

Diagnostic imaging:

- There had been three radiological incidents reported under ionising radiation medical exposure regulations IR(ME)R across the trust for the six-month period between January and June 2015. Managers told us that these were classified by their medical physics expert as low or no harm and were attributed to plain film and CT procedures, and all were due to wrong exposure settings by the operator, with larger than intended doses of radiation to the patients. The radiation protection adviser (RPA) report included guidance on prevention of recurrences. The department informed patients when unnecessary exposure to radiation had taken place and gave equivalent everyday examples where possible of how much radiation they had received. They ensured that Duty of Candour requirements were met, and offered patients the chance to discuss incidents further if they wished.
- Radiology discrepancy incidents were discussed by case review with radiologists and reporting radiographers. Sonographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams.
- Staff told us that safety and security did not cause concerns for staff. Staff in the breast screening department occasionally worked alone, but they could access support from the main x–ray department if they had concerns after vetting referrals.

Cleanliness, infection control and hygiene

- Hand Hygiene results between February 2016 and June 2016 showed positive results for all outpatient areas except WGH main outpatients, where, in April 2016, the score achieved was 70%, and, in June 2016, was 87%. The target was 96%. All other areas between February 2016 and June 2016 were 100%.
- Infection, prevention, and control mandatory training was 100% for both level 1 and level 2 training. This was above the 95% target set by the trust.
- An information board on display in the ophthalmology clinic at WGH showed 100% compliance for both cleanliness and hand hygiene in September 2016.
- Hand Sanitizer was available throughout outpatients.
- Physiotherapy had a daily domestic clean.
- 'I have been cleaned stickers' were not in use at WGH.
- All areas visited during our inspection were clean and tidy.
- Staff in outpatient and diagnostic imaging departments that we visited adhered to 'bare below the elbow' guidance. Hand cleaning technique guidance was displayed in the outpatient department.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.

- Personal protective equipment (PPE), such as gloves and aprons, was used appropriately in most areas and was available for use throughout the departments, and, once used, was disposed of safely and correctly. We observed PPE being worn by staff when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw that treatment rooms and equipment in outpatients were cleaned regularly.

Diagnostic imaging:

- Staff cleaned and checked diagnostic imaging equipment regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly and safely.

Environment and equipment

- There were ten consulting rooms in outpatients at WGH. There were two electronic check-in desks and a reception area available for patients. A small, children's play area was available in the main outpatient reception. When patients were called for their appointments they were transferred to a second, smaller seating area whilst waiting to be called by staff.
- Waiting areas had seating, magazines were available, and wheelchairs were available in main outpatients reception area.
- At our previous inspection it had been noted that an area of the floor in outpatients department was carpeted and so did not meet infection prevention and control standards. Managers confirmed that the Queen Victoria Hospital still had carpet on the floor>,This was on the risk register, and managers told us they were waiting for funding for this. WGH had new laminate flooring.
- Most equipment we checked during our inspection had been PAT tested.
- The environment in physiotherapy was tidy, and there was a seating area at the reception area of the department. The department had three private cubicles, and other treatment areas all had curtains to ensure privacy was maintained.
- The Audiology seating area was tidy with enough seating.
- The environment of the ophthalmology clinic was not always suitable for the clinics offered. Staff told us the waiting area was often very full and there was a lack of private consulting rooms in the department. A ward bay was used to provide some services in the department, and this reduced the confidentiality of patients. Staff told us the reception desk in ophthalmology outpatients was not suitable because confidentiality was not always maintained. However, managers confirmed that this was being replaced. In order to expand capacity, a room was being converted into a treatment room. A carpet was still in place in the department, however, managers confirmed that this would also be replaced.
- The departments provided single sex and individual toilets. Disabled toilets had alarm calls and rails fitted, and there was a baby nappy changing area. All toilets had hand basins, hot and cold water, and supplies of hand soap and paper towels.
- We saw, and staff confirmed, that there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- The departments had specially equipped play areas for children, with some good quality toys. There was also a small waiting area orientated towards children attending with adults.
- We checked the sterile equipment in the main outpatient department and found several items to be out of date. Staff told us they would check the expiry date on all items and review the stock control processes. When we returned later in the week stock issues had been resolved.

Diagnostic imaging:

- The trust had a managed contract for its Picture Archiving and Communications System (PACS). All equipment had maintenance contracts, and ultrasound kit had recently been refreshed across all sites.
- During our observations we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging department.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation, and dosimeter audits were used to collate and check results. Results were within the acceptable range.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory

checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- Risk assessments were carried out, with ongoing safety indicators for all radiological equipment, processes, and procedures. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room 'no entry' signs were clearly visible and in use throughout the departments at the time of our inspection.

Medicines

- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and, where appropriate, locked fridges. We saw the record charts for the fridges, which showed that temperature checks were carried out daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date. Prescription pads were stored securely.
- PGDs (patient group directions) for drugs and contrast agents used in the outpatients, physiotherapy, and diagnostic imaging departments were in place and had been reviewed appropriately.

Diagnostic imaging:

- In the diagnostic imaging department some interventional procedures required sedation and pain relief, including via the use of controlled drugs. These medicines were prescribed and administered by the consultant radiologist carrying out the procedure. All medication used was documented and a controlled drugs book was kept with patients during procedures. Monthly stock checks were made and expiry dates were checked. We saw evidence of dated and signed checklists.

Records

- The trust had almost completed the roll out of its 'Paper Lite' project, which ensured that electronic information was available for patients. Staff were very positive about the improvements in efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information.
- Case note availability audits were carried out on a monthly basis. Audit data between October 2015 and June 2016 showed that the trust was above its set targets of case note availability in outpatients. The target for case note availability in April 2016 was 96%. Data from May 2016 showed that outpatients across the trust had 99.3% of case notes available, and data from June 2016 showed that 99.48% of case notes were available.
- Records in outpatients were a mixture of paper and electronic. There were no concerns raised relating to access to records, during our inspection. Staff told us that, if electronic notes were not available, they would use paper notes, and if these were not available they would know whom to contact to address the issue. Where written notes were used, copies were scanned into the electronic system, for example, in physiotherapy.
- Staff told us they mostly used electronic records. However, a small number of clinics still used paper notes.
- In clinics that had not transferred to electronic notes, staff still used paper records. Staff and managers confirmed during the inspection that access to records had improved and there were no current concerns with access to records. Administration staff had been trained to scan documents onto the electronic system, thus reducing paper records.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information, and medical, nursing and allied healthcare professional interventions.
- There were no notes left in patient areas. The electronic record system meant that there was no patient information on display and, where recording sheets were used, they were kept face down and away from public view.
- We reviewed three paper-based and thirteen electronic patient records, which were completed with no obvious

omissions. Nursing assessments of blood pressure, weight, height, and pulse were routinely completed. We observed these checks being undertaken during our inspection.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically, and available to clinicians across the trust via PACS.
- Senior staff had undertaken a documentation audit to show radiographer compliance with completion of checks. There was good compliance with ID checks. However, the way this was done by individuals had previously varied, so some staff had been completing written checks and others had been completing electronic checks. It had been agreed that all staff must complete an electronic check and staff were found to be 100% compliant. Other points audited were patient pregnancy status, which showed 100% compliance, and image markers, which also varied according to the method used, but staff were 100% compliant across all methods.

Safeguarding

- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or if they had a query.
- The trust provided information on mandatory safeguarding training compliance rates against a target of 95%. Safeguarding adults core skills level 2 compliance in main outpatients was 93%, and safeguarding children and young people core skills level 2 was 100% compliant. Safeguarding adults and children core skills level 1 was 100% compliant. Compliance in the physiotherapy department for safeguarding adults level 1 was 100%, and compliance for safeguarding level 2 was 100%. In diagnostic imaging trust records showed that 100% of staff had completed level 1 safeguarding adults and children training, 96% had completed level 2, and no staff had completed level 3. Only one member of the team in diagnostic imaging had been identified to complete this level, but records showed this was out of date at the time of our inspection.
- Staff could describe the action they would take if patients 'Did not attend' on a number of occasions.

Mandatory training

- The trusts mandatory training target was 95%.
- The trust provided information on mandatory training compliance rates.
- In outpatients, equality, diversity and inclusion, health, safety and welfare, and information governance training levels all met or exceeded the trust target of 95%. Departmental fire safety and awareness compliance was 67%. Resuscitation and basic life support training compliance was 65%. Resuscitation and immediate life support was 60% compliant.
- Conflict resolution training was 94% compliant, and general fire safety awareness was 94% compliant.
- Mandatory training was a mixture of e-learning and face-to-face training. There was limited mandatory training offered at WGH. This had been raised with managers and managers were aware.
- Mandatory training records for the physiotherapy department were 100% compliant for fire safety, infection, prevention and control, manual handling, and information governance. Electronic reports could be ruan by managers to check mandatory training compliance rates for staff.

Diagnostic imaging:

- Compliance with manual handling training modules ranged from 81% to 100%. Equality, diversity,and inclusion mandatory training compliance was 100%, and information governance was 100% compliant.
- Departmental fire safety awareness training compliance was 100%. Resuscitation and basic life support training compliance was 95%. One person out of four was still due to complete intermediate life support training, so that compliance rate stood at 75%.

Assessing and responding to patient risk

- Staff were able to describe the action they would take if a patient deteriorated in their care in the department. Dependant on the deteriorating patient's situation, staff would do observations, contact the doctor, and/or call the crash team for an urgent response if required. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments.

- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms, and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- The DNA policy was part of the joint access policy.
- There was a clinical services team staffing escalation guidance document on display in the physiotherapy outpatient office, which showed the guidance to follow if staffing shortages were to occur.
- Staff incorporated assessment tools into patient pathways, following NICE guidance. An example of this was for chronic inflammatory skin disease.

Diagnostic imaging:

- Diagnostic imaging policies and procedures in the diagnostic imaging department were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations (IR(ME)R) to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were contracted from an NHS Trust in Manchester to support all trust sites. The RPA visited once a year.
- There were named certified Radiation Protection Supervisors (RPS) on each site to give advice when needed, and to ensure patient safety at all times.
- Two senior consultant radiologists within the trust were Administration of Radioactive Substances Advisory Committee **(**ARSAC) certificate holders for diagnostic imaging. One was based at Royal Lancaster Infirmary and the other at Furness General Hospital.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000. Local rules for each piece of radiological equipment were held within the immediate vicinity of the equipment.
- Staff asked patients if they were, or may be, pregnant in the privacy of the x-ray room. Therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not. For example, patients who were pregnant underwent extra checks.

AHP Staffing

- Staff in audiology told us there were no vacancies at WGH.
- Physiotherapy outpatients had a planned staffing establishment of 39.77 whole time equivalent staff and an actual staffing establishment of 33.56 whole time equivalent staff. Occupational therapy outpatients had a planned staffing establishment of 3.7 whole time equivalent staff and an actual staffing establishment of 3 whole time equivalent staff. Dietetics outpatients had a planned staffing establishment of 5.25 and an actual staffing establishment of 4.55 whole time equivalent staff.

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely. There were current vacancies,however, these were being recruited to.
- There had been difficulties in recruitment of qualified radiographers in the past, and managers told us the situation was improving slowly. Managers told us they were supportive of staff and most staff we spoke with were able to corroborate this.
- The trust had trained four radiographer advanced practitioners and a consultant radiographer who all reported general radiology images. There were two more advanced practitioners in training and another who was extending her current remit. Managers were aware that radiographer training was helping to reduce the burden on radiologists, but this also affected radiographer numbers, and further staff were required to backfill as staff qualified in advanced roles.
- Sonographers reported their own ultrasound scans. The trust had recently appointed a lead sonographer and had refreshed ultrasound kit across all sites.
- Advanced practitioners undertook fluoroscopy including hysterosalpingograms, barium swallows, and video fluoroscopy, in corroboration with speech and language therapists (SALT), to identify swallowing problems for stroke patients.

- Radiology managers told us that they also outsourced some radiographer reporting. An external company provided a radiographer who worked on a sessional basis on site,to report a wider range of examinations.
- Current staff were undergoing training to specialise in ultrasound.

Nursing staffing

- At previous inspections we had told the provider that it must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided. At this inspection department managers told us they regularly reviewed staffing and used an electronic tool to manage staffing throughout the clinics and services. There was no fixed staffing establishment for each day in main outpatients. However, we were told staffing was flexible in order to meet clinic needs.
- Outpatients did not use agency staff and rarely used bank staff to fulfill staffing requirements. The trust provided a staffing report from August 2016, showing that the establishment was 16.07 whole time equivalent staff and there were actually 15.28 whole time equivalent staff in main outpatients at WGH.
- There were five band five nurses in main outpatients. Staff told us that staffing generally felt alright.
- Specialist nurses would work in the main outpatients centre when there were specialist consultant clinics on.
- In a previous inspection, staff in the ophthalmology clinic had expressed concerns regarding the staffing establishment. At this inspection, managers in ophthalmology confirmed these were being addressed, registered nurse staffing levels were at full establishment, and there were no current concerns with staffing levels. The department was adding another treatment room to meet capacity, and new nurses were being trained to assist in this. Managers confirmed that recruiting was being completed across the trust, and staff would be allocated to the required clinic at the hospital where staff were required. The department was also able to use bank staff if required. Managers confirmed there were now enough registered nurses and clinical support workers for the current clinics offered, and the service was actively recruiting for the future clinics that were going to be offered.

Diagnostic imaging :

- Clinical support workers provided help and support to staff and patients where required.

Medical staffing

- Outpatients did not use locum staff.
- Medical staffing was organised and managed by individual specialties**.** Senior nurses across the trust outpatients told us they would log incidents where required and these would be forwarded to the individual specialities managing the clinic service to investigate.

Diagnostic imaging:

- At our last inspection we had told the trust it should consider its investment into the diagnostic and imaging services to respond to increased demand. Radiologist vacancies had been identified on the divisional risk register as a high risk, and there were ongoing vacancies within the radiology service. There was a continuing national shortage of radiologists, and managers told us that, by the time of this inspection, the trust had an establishment target of 19 WTE consultant radiologists to cover all sites. The trust had been able to fill three consultant vacancies so there were now 13 consultants in substantive posts. However, another 5.5 WTE vacancies remained. The trust had appointed an associate specialist and there were four part time locums.
- At the time of our inspection there were sufficient staff to provide a safe and effective service.
- A trust-wide duty radiologist role had been introduced, and all clinicians across the trust were encouraged to contact the person identified on the rota for advice and guidance rather than approaching individuals. This was a relatively new initiative and not all clinicians were compliant. However, staff told us it was helping.
- Radiology managers told us they used consultants with honorary contracts to provide reporting cover for general radiology images. They also described a ‘stable locum radiologist cohort’ who supported the departments on a regular basis.
- Diagnostic imaging plain film reporting was outsourced after 10pm Monday to Friday and at weekends. The trust used four companies on the NHS Framework. There were service level agreements and contracts including quality assurance measures in place for these. Managers told us that outsourced work comprised about 10% of all reporting. Trust consultant radiologists fed reporting discrepancies back to outsourcing companies.

Major incident awareness and training

Outpatients and diagnostic imaging

- Managers and staff in main outpatients told us the action they would take if there were to be a major incident. There was a designated allocation board in the department, and outpatients would take minor injuries.

Are outpatient and diagnostic imaging services effective?

We are unable to provide a rating for hospital outpatient and diagnostic imaging services.

However:

- Clinics in main outpatients were well managed and organised, and staff were able to plan resources effectively.
- Staff understood about consent and followed trust procedures and practice.
- Outpatient clinics ran every weekday, and some specialist clinics were held each Saturday. However, most activity happened between Monday and Friday, 9am to 5pm. Care and treatment was evidence-based, and targets were met consistently. Staff were competent, and there was evidence of multidisciplinary working across teams and local networks in some specialities. Doctors, nurses, and allied health professionals worked well together.
- Diagnostic imaging services for inpatients were available seven days a week.
- Staff felt supported by their line managers, who encouraged them to develop and improve their practice. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.
- Radiology staff were able to explain their safety protocols, and the local rules for use of equipment and practice within the area were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy.
- Competency assessments were in place for staff working in the radiology department. Staff we spoke with confirmed that they received one-to-one meetings with their managers, which they found beneficial.

Evidence-based care and treatment

- A clinical audit 2016/2017 programme was in place and documented diagnostic imaging planned audits and other speciality audit plans, such as pathology and audiology.
- Staff in physiotherapy told us they would discuss new guidelines during training sessions. Staff had a training session around every two weeks, where they would look at research and new guidelines.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the trust was as safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to lead on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R 2000 regulations.
- Procedures were in place to ensure the diagnostic imaging department was following appropriate NICE guidance regarding the prevention of contrast-induced acute kidney injury.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Paracetamol was provided to be prescribed and administered by staff in the outpatients department, if required. However, nurses told us they had not needed to provide it for some time. Records were maintained to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.

Outpatients and diagnostic imaging

Nutrition and hydration

- Water fountains were provided for patients' use, and there was a café staffed by volunteers where people could purchase drinks and snacks.
- We observed staff offering and providing patients with drinks and biscuits when they waited for extended times within the department.

Patient outcomes

- Between April 2015 and March 2016 the follow up to new rate at WGH was lower than the England average.
- The physiotherapy department's patient outcome data showed us that, in August 2016 and September 2016, 70% of patients at WGH improved and 30% did not improve. The data was from 30 patients.
- The percentage of patients waiting over 30 minutes to see a clinician was 12%, and the average length of time patients waited in the department was measured by the trust as 37 minutes.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity, and compliance levels were consistently high.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal. Appraisal rates for the main outpatient department were high. All members of staff had completed an appraisal. Staff told us that appraisals were held each year and provided an opportunity to discuss learning needs.
- The physiotherapy completed appraisal rate at WGH was 77%, and managers told us that other staff had their appraisals booked in. There was no formal clinical supervision in the physiotherapy department, however, staff were considering implementing groups to discuss case studies and practice, and staff had already attended a group to discuss clinical supervision.
- Staff we spoke with had undertaken additional training where required and felt managers would be supportive if training was requested, however, there was limited extra training for staff.
- Mandatory training was offered as e-learning or classroom training. Training completion rates could be checked through an online system. Some staff told us the electronic system could be improved. Most courses offered were at the Royal Lancaster Infirmary and Furness General Hospital which meant staff had to travel from Kendal for training. Limited courses were offered at WGH. Managers were aware of this and had raised it with training and development.
- There were no established models of regular nursing clinical supervision in use in outpatients. Clinical supervision sessions provide an opportunity for reflection in all aspects of nursing practice. However, managers confirmed they were aware of this and could describe the future plans of embedding the proposed trust clinical supervision policy into the outpatient department. Staff told us they had regular one-to-one meetings with their line managers.

Diagnostic imaging:

- Appraisal rates provided by the trust for diagnostic imaging were 67%. Managers told us that staff who had not yet completed an appraisal had been identified, and this would be completed before the end of the financial year.
- New radiology staff were assessed against radiology preceptorship competencies, and medical devices training was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal, and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements, and managers told us they regularly recruited new graduates from their student cohorts.
- The department provided local rules training trust-wide for clinical and non-clinical referrers and MRI safety.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers were trained to use each piece of new equipment by applications specialists from suppliers.

Multidisciplinary working

- Physiotherapy staff told us they worked collaboratively with occupational therapy staff and told us of examples where they had held joint clinics, and would offer this if required, however, these were not regular. Staff in physiotherapy and occupational therapy had worked together on a listen and action project to develop mallet finger care for patients. We were told this would lead to better patient outcomes.
- A range of clinical and non-clinical staff worked within the outpatients and diagnostic imaging departments. Staff were observed working in partnership with a range of staff from other teams and disciplines, including volunteers, radiographers, therapists, nurses, booking staff, and consultant surgeons.
- Dieticians worked in partnership with ophthalmologists and specialist nurses to provide nutritional information and guidance for patients in the diabetic retinopathy clinic.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- Staff were seen to be working across specialties, directorates and trust sites towards common goals. They asked questions and supported each other to provide the best care and experience for the patient.

Diagnostic imaging :

- Advanced practitioners undertook video fluoroscopy in corroboration with speech and language therapists (SALT), to identify swallowing problems for stroke patients.

Seven-day services

- Clinics were generally offered between 8:30am and 5pm Monday to Friday, and until 7.30pm on a Monday evening.
- Daily urgent appointments were available in the main ophthalmology department, and staff would put on extra clinics if required to meet demand.
- Managers displayed volunteer sheets for extra capacity clinic staffing with skill mix requirements noted. Staff could volunteer for extra shifts and were paid bank staff rates.

Diagnostic imaging:

- The diagnostic imaging department provided general radiography, ultrasound scanning, and fluoroscopy services for inpatients every day, and for outpatients and GP patients every week day. There was a rota to cover evenings and weekends so that inpatients could access diagnostic imaging services when they needed to.
- A private organisation provided magnetic resonance imaging (MRI) from a mobile scanner seven days a week.

Access to information

- Diagnostic results were available through the electronic system used in main outpatients, and staff with login access could view results as required.

Diagnostic imaging:

- Diagnostic imaging departments used a picture archive communication system (PACS) and a computerised radiology information system (CRIS) to store and share images, radiation dose information, and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports, and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make.
- There were systems in place to flag up urgent, unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing, diagnostic imaging, therapy, and Medical staff understood their roles and responsibility regarding consent, and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that consent was usually obtained verbally, although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Staff in outpatients and diagnostic imaging services had undertaken Mental Capacity Act and Deprivation of

Liberty Safeguards training. Most staff we spoke to told us they had a basic understanding and, if any queries were to arise in the outpatient setting, they would contact the named leads within the trust for advice.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'good' because:

- During the inspection, we saw, and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring, and compassionate at every stage of their journey, and patients were given sufficient time for explanations about their care and were encouraged to ask questions.
- People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.
- Patients we spoke with were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- There were services to emotionally support patients and their families. Patients were kept up to date, involved in discussing and planning their treatment, and were able to make informed decisions about the treatment they received.
- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk to about their condition. There was access to volunteers and local advisory groups to offer practical advice and emotional support to patients and carers.

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- Staff were able describe how they ensured privacy and dignity were respected. Staff made sure doors were closed when rooms were in use, and curtains in consulting and treatment rooms were used when required.
- Staff we spoke with could describe how they provided compassionate care to patients. Staff provided reassurance and support to patients and understood patient's different needs. Staff we spoke with felt patients received good care.
- Staff told us, and we saw, that they offered patients, families, and carers the department a quiet room for more privacy, if required.
- We spoke with 10 patients and five people close to them, and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with, and respecting patients' privacy and dignity throughout their visit to the department.
- Comments from the Friends and Family Test (FFT) survey were shared with staff at staff meetings,and results showed 99.2% of patients in outpatients in September 2016 would recommend the service. This was better than the England average of 92%.
- FFT data for the physiotherapy department was positive, with 100% of patients likely to recommend in September 2016.
- The FFT results for diagnostic imaging in September 2016 were: 88.2% would recommend the service to others; and 8.8% of patients would not.
- Managers told us a hearing loop was available in the main outpatient department and could be used if required. Staff had access to interpreter services and staff would usually organise a deaf interpreter before an appointment, if possible. Chaperones were available to patients.
- Staff told us that they would check that patients understood what had been said in the clinics and would support patients, families, and carers during clinics.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and

medical staff. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment.
- We observed examples in outpatients and diagnostic imaging where staff gave patients and families time and opportunities to ask questions.
- There were leaflets available in main outpatients and information stands, providing further information.
- Outpatient services had developed 'next step' cards and these were provided to patients in clinics, and provided further information on who to contact should they have further questions or enquiries.
- Staff in the contact centre told us they were looking to provide an appointment text reminder service. There was nothing in place at the time of the inspection, but the technology was set up.

Emotional support

- Information was available in different clinic areas for patients. For example, the audiology outpatient department had an information leaflet for available for hearing loss, patient advice and liaison service (PALS) information on display, and a concerns and complaints board.
- We observed volunteers greeting most visitors to the department to ask if they needed help or directions.
- Patients told us that they felt supported by the staff in the departments.
- Staff made sure that people understood any information given to them before they left the departments.
- Emotional support for patients was available. For example, specialist nurses worked with the clinical teams in the eye clinics and were present for extra support when patients received bad news. Charity services and volunteers provided support and advice for patients in the eye clinics.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as 'good' because:

- The trust provided a range of specialist clinics for patients in the North West including Lancashire and Cumbria.
- We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and imaging sessions were added to meet demand, and waiting times for diagnostic imaging appointments were within acceptable timescales. Patients were able to be seen quickly for urgent appointments, if required.
- Clinics and related services were organised for some specialties so that patients were only required to make one visit for their investigations and consultation. Clinic and imaging appointments were rarely cancelled.
- The trust met most referral to treatment targets (RTT) in most specialties.
- Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays, for inpatients and outpatients.
- There were systems to record concerns and complaints raised within the department, review these, and take action to improve patients' experience.
- There was information available in the departments for patients with additional individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English.
- The outpatient and diagnostic imaging departments were able to access telephone translation services, interpreters, via the booking service in the contact centre, and sign language specialists for patients.

However:

- There were some specialties where the 18 week referral to treatment targets (RTT) were not always achieved and some backlogs for follow up waiting times.
- During our previous inspection we had noted that the trust needed to improve waiting times for patients once they arrived in the department. At the time of this

inspection information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic, and 19.6% of clinics started later than planned.
- In some areas, such as ophthalmology, there was insufficient space to manoeuvre and position a person using a wheelchair, in a safe and sociable manner.

Service planning and delivery to meet the needs of local people

- The trust served a mixed rural and urban geographical area of 1000 square miles. The trust's outpatient and diagnostic imaging services were located throughout the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Services were planned in line with regional commissioning plans, and the service senior managers produced an annual business plan from the trust five year plan.
- Clinics were booked 52 weeks a year, and the outpatient department had access to a room booking service which allowed it to monitor which rooms were available and book extra rooms for extra clinics, if required.
- Outpatients offered some clinics via video conferencing and was proposing to introduce this further.
- Clinical nurse specialists were available in some clinics.
- Between April 2015 and March 2016 the 'did not attend rate' for WGH was lower than the England average.
- The main outpatient service operated a Monday late night clinic until 9pm. We were told these were often for urology and ENT.
- The audiology clinics held two hearing aid repair clinics in Kendal on a regular basis. The service also held four outreach clinics to take the service closer to patients and respond to their needs.
- Outreach clinics were provided by physiotherapy in seven areas. These were generally held in general practitioner practices and health centres, and had been implemented to bring the services closer to patients. We were told staff were flexible about where patients were seen. Physiotherapy clinics were available from 7:30am to 5.30pm, Monday to Friday. Managers told us the 7:30am start was a positive aspect of the service as this requirement had been raised in patient feedback. Staff told us they would look at services again if patient feedback were to change.
- The outpatients department flexed capacity and staffing to meet demand. Extra clinics were added to ensure provision met demand.
- Clinics were organised to meet patients' needs. Some specialist one-stop clinics were organised so that all investigations and consultations happened on the same day. Clinicians, nurses, and therapists carried out joint assessments and treatment.
- Outpatients and diagnostic imaging departments were responsive to requests from clinicians to accommodate patients on two week waits and short notice additional clinics.

Diagnostic imaging:

- The radiology department had no dedicated porters to support patients and staff to ensure patients were in the right place at the right time for their procedure. We saw patients waiting on beds or trolleys during our inspection. However, staff told us there were plans to provide a more appropriate area for inpatients to wait with privacy and dignity.
- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals, and additional scanning sessions could be arranged to meet patient and service needs.
- Voice recognition was used in diagnostic imaging to enable a swift turnaround for reports and letters. Urgent reports were flagged for prioritisation . Diagnostic imaging reporting and record-keeping was electronic, and paperless methods were used to reduce time and administration requirements.

Access and flow

- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was better than the England average performance. The latest figures, for July 2016, showed that 92% of this group of patients were treated within 18 weeks.
- The RTT figures for incomplete pathways between August 2015 and July 2016 varied. The trust achieved the 92% target or above between August 2015 and December 2015. The RTT figures for incomplete pathways between January 2016 and July 2016 was between 89.5% and 91.9%.
- Between January 2016 and July 2016 there were 64,299 appointments from referral to first attended appointment in outpatients. We found that 71.10% of

patients were seen within five weeks of referral, 18.52% of patients were seen between six and 11 weeks, 5.92% were seen between 12 and 17 weeks, and 4.45% were seen at over 18 weeks.

- The two week wait from GP urgent referral to first consultant appointment figures varied between quarter 2 of 2015/2016 and quarter 1 of 2016/2017. We found that 90.7% of patients were seen within two weeks in quarter 2 of 2015/2016 and 92.5% of patients were seen within two weeks in quarter 3 of 2015/2016. The trust achieved the two week standard in quarter 4 of 2015/2016, with 95.1% of patients seen within two weeks, and the trust achieved the two week standard in quarter 1 of 2016/2017, with 96.5% of patients seen within two weeks.
- The trust achieved the standard of 96% of people waiting less than 31 days from diagnosis to first definitive treatment between quarter 2 of 2015/2016 and quarter 1 of 2016/2016. The trust was at 98.6% or above between these periods.
- The trust achieved the operational standard of 85% of people waiting 62 days from urgent GP referral to first definitive treatment between quarter 2 of 2015/2016 and quarter 1 of 2016/2017. The trust was at 86.3% or above during these periods.
- Information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic, and 19.6% of clinics started later than planned. Nursing staff informed patients of the waiting times verbally and displayed information on boards in the waiting areas.
- The most commons reasons for clinic cancellations were annual leave, clinic slot cancellations, and care provider unavailable.
- Patients were sent a letter confirming an appointment date., The letter had contact details for the trust and patients could call back and change their appointments, if required.
- Managers in the physiotherapy department told us the longest wait for an appointment at the time of inspection was around 15 weeks and the majority of patients were waiting around 10 weeks. WGH physiotherapy staff booked their own appointments.
- Managers confirmed a trust 'Did not attend' (DNA) policy was in place and included in the joint access policy.
- The trust provided information which detailed reasons for the failure to meet RTT targets. These included vacancies for clinical staff, and capacity and demand. The trust also gave details of some of the action being taken to address the RTT position, such as a business case for more staff.

Diagnostic imaging:

- Radiology managers told us that diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals, met national targets. Average wait times across all modalities for two week wait patients ranged between 3.9 days and 12 days. For inpatients the average wait for a scan was 0.2 days for general radiology. Average wait time for fluoroscopy was 0 days.
- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and seven-day working arrangements
- In the diagnostic imaging department reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays, for inpatients and outpatients.
- On the day of our inspection the breast screening clinic was staffed by one radiographer and a radiographer helper. Staff ensured good flow and limited waiting times for patients.

Meeting people's individual needs

- Outpatients provided 'one-stop' clinics for cardiology, respiratory, thyroid and urology.
- The trust provided rapid access clinics for a number of services such as cardiology, maxillo-facial, and ear, nose and throat.
- If clinics were running late, staff would inform patients and offer them a drink. There was a guidance document for staff to use on the action to take, depending on how late the clinics were running. For example, action to take if the clinic was running 15 to 30 minutes late, 30 to 60 minutes late, and later than one hour.
- The booking centre booked patient transport for main outpatients. Managers told us they would raise an incident form if transport was delayed.
- The physiotherapy department at WGH was able to keep patients informed of current waiting times, and displayed these on a board in the waiting area.
- Staff used the butterfly scheme to help identify patients with dementia, and staff could add information on their electronic systems if a patient had dementia. Staff had

access to a folder in physiotherapy which contained resources for learning disability patients, such as a pain score, body charts, and 'yes' and 'no' cards, which would be used if required.
- Outpatient services had developed 'next step' cards and these were provided to patients in clinics, and provided further information on who to contact if they were to have further questions or enquiries.
- There were several information leaflets provided in the outpatient waiting areas. Staff told us they could request and print 'easy to read' leaflets, if required.
- Staff could access private areas to hold confidential conversations with patients if necessary, and receptionists informed staff quickly if patients had communication difficulties.
- We saw that patients who were required to be at the hospital for long periods of time, for example, those with multiple appointments or who were waiting for ambulances, were offered a biscuit and regular drinks by staff.
- There was a limited supply of bariatric furniture, but one suitable examination bench had been provided recently. High rise furniture and equipment was available and accessible.
- Most departments were able to accommodate patients in wheelchairs and those who needed specialist equipment. However, in some areas, such as ophthalmology, there was insufficient space to manoeuvre and position a person using a wheelchair, in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets.
- Patients could access free internet via WIFI throughout the departments.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. However, booking staff had to rely on GPs and hospital referrers to ensure that the trust was aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly, and also to maintain patient confidentiality.

Diagnostic imaging:

- Patients with complex individual needs, such as those with learning difficulties, were given the opportunity to look around the department prior to their appointments. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.

Learning from complaints and concerns

- Between October 2015 and October 2016 there were 6 complaints about outpatient services at WGH. The hospital took an average of 29.17 days to investigate and close these complaints. This does complies with trust policy, which states that complaints should be signed off within 35 days of receipt, unless another timescale has been agreed with the complainant..
- The main themes of the complaints centred on patient care and delays to treatment.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments, and concerns were discussed at local team meetings, actions were agreed, and any learning was shared.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint.
- Patient advice and liaison service (PALS) information regarding complaints was on display throughout the outpatient departments.
- Outpatient services had developed 'next step' cards, and these were given to patients in clinics. They provided further information on who to contact if they were to have further questions or enquiries.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'good' because:

- The management structure was clear and all outpatient services were managed by one directorate with one common goal. Managers and staff talked of the trust's recent difficulties and their vision for the future of the departments. They were aware of the risks and challenges. Staff we spoke with felt supported by their local team leaders and managers, who encouraged

them to develop and improve their practice. Staff worked well together as a productive team and had a positive and motivated attitude. Teams were involved in planning improvements for departments and services.
- There was good communication between specialties and directorates. Staff felt proud to work for the hospital and felt they provided a good service to patients.
- There was an open and supportive culture, where staff discussed incidents, complaints, and lessons learned, and practice changed. All staff were encouraged to raise concerns. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.
- There were systems and processes in place for gathering and responding to patient experiences, and the results were well publicised throughout the departments.
- Local managers were active, available, and approachable to staff. Business continuity plans had been developed to manage incidents, accidents, and risks. Individual departments had good leadership, and management and staff told us they were kept informed and involved in strategic working and plans for the future.
- Regular daily meetings took place in all departments, where anticipated problems were discussed. The departments were mainly supportive of staff, who wanted to work more efficiently and were able to develop to improve their practice, be innovative, and try new services and treatments.
- We found that risks identified during our inspection were on the risk register.
- At previous inspections we had not seen evidence of clear plans to mitigate the identified risks. At this inspection, although progress was slow in some areas, there were clear plans for positive change.

However:

- The outpatient macular clinic area that had been recognised as requiring improvement over two years previously remained unsuitable to provide a safe, confidential, and dignified experience for patients.
- We were told that there were plans in place to progress change, but staff were frustrated that no action had taken place.

Vision and strategy for this service

- The core clinical services division had a vision which was 'providing the best services at the right time'. Staff we spoke with were aware of the Better Care Together (BCT) strategy and most could describe the strategy.
- A core clinical services business plan was in place for 2016/2017 and included outpatients and diagnostic imaging. The plan set out service development plans for outpatients and radiology services.
- The outpatient department was working towards 'choose and book' as part of the development plan.
- Staff told us that senior managers were approachable to ask questions or discuss their concerns.
- Staff told us that they had a flexible and effective room utilisation plan and full control to make decisions about how to use the rooms. Clinical specialty staff worked with outpatients department managers to inform them when rooms were not required, thus freeing up space for other teams.
- Staff told us that they regularly planned for the future, with the aim to provide an efficient, safe, and cost effective service. However, staff told us they felt frustrated that planned changes for better accommodation of services were not forthcoming.

Diagnostic imaging:

- The diagnostic imaging department had good leadership and management, and staff told us they were kept informed and involved in strategic working and plans for the future.
- The trust had a strategy for the introduction and continued use of more efficient and effective working, using information technology, such as electronic records and digital dictation systems. A new picture archiving and communication system (PACS) had recently been introduced and training was underway for staff across all trust sites. The system had been upgraded through a procurement process within the trust. Staff understood that the new system would improve accessibility and remote reporting in the future, although this depended on suitable broadband width, especially in rural areas.

Governance, risk management and quality measurement

- Managers we spoke with were able to describe the risks and challenges to their services and the action being taken to mitigate risks. Risks described, such as staffing, were documented on the risk register. Risks were

discussed at the monthly division governance assurance group meeting, which outpatient and diagnostic service managers attended. The core clinical services risk register was reviewed monthly.

- The condition of a treatment bench had been added to the risk register as it was broken. Staff confirmed a new bench had since been put in place, and managers told us they had requested that this item be removed from the risk register.
- There were governance arrangements in place for outpatients and diagnostic imaging. Governance was discussed at the division governance assurance group, which would then escalate governance concerns to the trust quality committee, which then escalated them to the trust board.
- Outpatients had a governance lead and a deputy governance lead in place.
- Learning from risks was shared across the organisation via newsletters, regular staff team meetings, and staff communication emails.
- The main outpatient department used the 'WESEE' document to record meetings and this included sections to follow, such as workforce and staffing, and training issues.
- Managers received weekly performance reports, which documented mandatory training and other operational reports. Managers from each directorate attended a monthly divisional governance and assurance group meeting. Information from this meeting would then be fed back to staff in the departments.
- Diagnostic imaging had a separate risk management group consisting of modality (specialist diagnostic imaging services, e.g. CT and MRI) leads, radiology risk assessors, and radiology protection specialists.
- In diagnostic imaging, radiation protection supervisors (RPS) from specialties within the department and across all sites, raised, discussed, and actioned risks identified within the department, and agreed higher level risks to be forwarded to the directorate clinical governance lead.

Leadership of service

- Staff told us they found the local managers of the service to be approachable and supportive. However, they felt there was limited interaction with senior management. Some staff knew who senior management were.
- Department managers and team leaders told us they felt supported by senior managers, managers were approachable, team working was good, and staff were happy in their roles.
- Department managers told us they regularly visited the different trust sites and there were no communication challenges between the different hospital sites. We were told there was always at least one registered nurse on duty at WGH, and usually at least two. Managers worked across sites between the Royal Lancaster Infirmary and WGH. Managers were on site at WGH at least once a week, and staff told us that managers were always available on the telephone. Managers told us that there had been a lot of change recently, and there had been challenges, but this was getting better. They told us that they had focused on developing team work.
- Managers at WGH told us that they encouraged staff to develop, and encouraged further training in staff. An example was to support registered nurses in the vascular clinic who would be able to assist further, for example, in bandaging. Tissue viability staff had been asked to provide support and train nurses in this. Staff were also encouraged to develop if they had a particular area of interest.
- Many staff we spoke with told us that they had worked at the hospital for several years. We observed good, positive, and friendly interactions between staff and local managers.
- Staff felt that line managers communicated well with them and kept them informed about the day-to-day running of the departments.

Diagnostic imaging:

- All of the staff we spoke with told us they were content in their role. They said that the diagnostic imaging department leadership was positive and proactive. Staff told us that they knew what was expected of staff and the department, and that every effort was being made to recruit and train more staff.

Culture within the service

- Managers told us that they encouraged team work throughout the outpatient departments and that, because of this approach, the culture had improved amongst the teams in the department. Managers felt

there was openness and honesty. They said that, in general, staff embraced change, could see the overall picture for improvements, and contributed to a 'can do' culture.
- Department managers told us that there were formal team meetings, howeve, it was difficult to have a set team meeting regularly.
- Staff we spoke with felt respected and valued, and were happy in their roles. Staff in main outpatients had received a trust star award for team effort during a previous winter period of challenging weather, where they had supported other care services in the community.
- Staff were proud to work at the hospital. They were passionate about their patients and felt that they worked in highly skilled teams. Staff told us that they would be proud if members of their family were to be cared for by staff in the department.
- We were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff. We saw that there was a positive, friendly, but professional working relationship between consultants, nurses, radiographers, and support staff.

Diagnostic imaging:

- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change, and able to question practice within their individual areas of work and suggest changes.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We saw patients completing feedback cards, which were available in all outpatient areas.
- Some services that we visited used 'I want great care' forms, which sought patient and carer feedback. These were then put into a suggestion box for the department.
- A patient user group had been involved in formatting patient letters and information provided by the contact centre.
- The hospital had received toys donated by charity for the radiology waiting room.
- A patient had asked if she could volunteer to support the breast screening service. She provided support in the breast screening reception area and told us that she had wanted to offer something to help the service.
- Staff were able to give us working examples of changes that had been made following patient comments.
- Friends and family test (FFT) data for the physiotherapy department was positive, with 100% of patients likely to recommend, in September 2016.

Staff engagement

- We were told that team leaders encouraged staff to share ideas and supported staff in implementing new ideas to benefit the service provided.
- The physiotherapy department staff had regular team meetings, where they were encouraged to incorporate training. These were organised every two weeks.
- Staff had been asked their views regarding information display boards in the department and where information should be displayed.
- Staff told us they held staff huddles each morning. We saw evidence of notes from meetings and information for staff on noticeboards.
- We met several volunteers who were proud to provide additional support for patients. Many volunteers were staff who had retired but wanted to continue to offer their support.
- Staff told us they were keen to work with consultants to develop new practices, including the extension of roles and the introduction of new procedures.

Innovation, improvement and sustainability

- The trust told us a partnership between the therapies team and a specialist hand surgeon had developed a 'One Stop Hand Shop' pathway. This was a 'Listening into Action' project for a new model for follow-up care following hand surgery. The project aimed to improve outcomes for patients, reduce the number of appointments, and free up consultant time, thus helping to meet the trust's RTT standards.
- Radiographers carried out extended roles with radiographer-led procedures, including barium swallows, hysterosalpingograms, and video-fluoroscopy, in partnership with speech and language therapists.
- A new children's waiting area had been developed, with a mural painted by a radiographer.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

In surgery services:

- Continue to sustain improvement in Ensure that hand hygiene audit results improve.
- Continue improving venous thromboembolism (VTE) assessments.
- Continue improving Referral to Treatment Times (RTT) for patients and continue to implement Ttrust-wide initiatives to improve response.
- Increase medical / orthogeriatricians input on surgical wards.
- Continue with staff recruitment and retention.
- Ensure all transfers between locations are performed in line with best practice guidance and policy. Where practice deviates from the guidance, a clear risk assessment should be in place.

In maternity and gynaecology services:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.

In outpatients and diagnostic imaging services:

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled, and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, ophthalmology, and allied health professionals.
- Continue work started to ensure that all premises used by the service provider are suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to the macular clinic.Ensure they investigate and close complaints in a timely way in line with trust policy.
- Ensure it they meets referral to treat targets in outpatient clinics and addresses backlogs in follow-up appointment waiting times.