North Cumbria University Hospitals NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow-up inspection from 6 to 9 December 2016 to confirm whether North Cumbria University Hospitals NHS Trust (NCUH) had made improvements to its services since our last comprehensive inspection, in April 2015. We also undertook an unannounced inspection on 21 December 2016.

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

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

There were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to staffing, safe care and treatment, person centred care, and assessing and monitoring the quality of service provision.

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

We found that the trust had improved in some areas. However, it remains rated as 'requires improvement' overall, with safe, responsive, and well-led rated as 'requires improvement', and effective and caring rated as 'good'.

Our key findings were as follows:

- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the trust, especially in medical care and surgical services, and services for children and young people, including the special care baby unit at Cumberland Infirmary (CIC).
- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes. The 'floor working' initiative within medical care did not support safer nurse staffing.
- Despite ongoing recruitment campaigns the trust had struggled to recruit appropriate clinicians in some specialities, particularly in medical care and services for children and young people. Medical staffing within these specialities remained reliant upon locum support, and was therefore vulnerable to changes in locum worker preferences or departures.
- However, within medical care services, particularly at West Cumberland Hospital (WCH), medical staffing had improved from the previous inspection with additional workforce assurance plans in place. This included securing long-term locum contracts, developing the composite workforce model, improving links with specialist trainees, and securing cross-site support from divisional clinician colleagues at CIC.
- Compliance against mandatory training targets was an issue in some services.
- Access and flow across the emergency department, medical care, surgical services, and outpatients remained a significant challenge.
- The trust had failed to meet the target to see and treat 95% of emergency patients within four hours of arrival. It was also failing to meet a locally agreed trajectory to see and treat emergency patients within four hours of arrival which had been agreed in conjunction with regulators and commissioners.
- We found that patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.
- Between 2015 and 2016 the trust cancelled 1,410 elective surgeries. Of these, 12% were not rescheduled and treated within 28 days. For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries and CIC cancelled 573 for non-clinical reasons.
- Referral to treatment time (RTT) data varied across specialities, particularly in surgical services.
- Patient flow initiatives within the medical division were not fully embedded and required improved

Summary of findings

coordination, ward staff engagement, and more timely discharge plans to be implemented. Medical outliers accounted for a significant proportion of the inpatients beds at WCH.

- From March to August 2016 there were a number of patients moving wards after 10pm at WCH.
- Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- Within outpatients there were a number of clinics cancelled within 6 weeks of the due date of the clinic across the trust, and there were no plans in place to address this issue. Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.
- There had been an improvement in record-keeping standards throughout the hospital. However, we identified some ongoing areas for improvement around accurate completion of fluid and food charts, risk assessments, and completion of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms, which did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded where appropriate.
- The senior team was aware of the challenges and issues within the organisation and had developed strategies and tightened governance processes to meet these challenges. However, these needed embedding.
- There was some improvement in strengthening of governance processes across the trust. However, within some services, particularly medical care and maternity, there were gaps in effective capturing of risk issues and in how outcomes and actions from audit of clinical practice were used to monitor quality.
- Staff morale was variable and staff did not always feel that their contribution was recognised and appreciated. Staff found the speed and number of change processes being implemented across the trust to be hurried and unsettling. This had added to the existing pressures and caused additional stress.
- A programme and range of staff engagement activities and initiatives had been implemented during 2016 but this was not yet fully embedded.
- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.

However:

- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The policy and activity around critical care patient transfer to other hospitals, including children and babies, when required were good.
- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff. Patients received care in a clean, hygienic, and suitably maintained environment.
- There were no cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) reported from November 2015 to October 2016. Trusts have a target of preventing all MRSA infections, so the trust met this target within this period. The trust reported nine MSSA infections and 23 C. Difficile infections over the same period.
- Safeguarding processes were embedded throughout the trust.
- 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 had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward-based staff when caring for someone at the end of life.
- Patients were positive about the care they received. Staff were committed to delivering high quality care. Staff interactions with patients were compassionate, kind, and thoughtful. Patient privacy and dignity was maintained at all times.
- Patient feedback was routinely collected using a variety of measures, including real-time patient experience.
- There had been significant changes in the senior executive team since our previous inspection. This included a new chief executive, medical director, and director of nursing. The chief executive had recognised

Summary of findings

the need to strengthen and develop clinical leadership within the organisation. The director of nursing had also been very proactive in trying to address the nursing workforce issues.
- Although the executive team members were relatively new they appeared to be credible, and there were positive comments overall from staff regarding their visibility.

We saw several areas of outstanding practice including:

- The trust was a National Patient Safety Awards finalist for 'better outcomes in orthopaedics'.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment knee surgery.
- An Honorary Professorship from the University of Cumbria had been received by a consultant for work on applying digital technologies in health care for an elderly population in a rural setting; a part of CACHET.
- There was a multinational, multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy. However, there were also areas of poor practice where the trust needs to make improvements.
- There were real strength of MDT working and positive patient outcomes in the stroke service.
- The 'expert patient programme' and 'shared care initiative' in the renal business unit exhibited real patient integration, empowerment, and care partnerships.
- There was a variety of data capture measures in use to monitor 'real-time' patient experience and collate patient feedback.
- There were innovative and progressive Frailty Unit projects at CIC.
- The growth, expansion, and development of the MPU service at CIC.
- The implementation of dance-related activities for vulnerable patient groups to stimulate social interaction, patient involvement, family partnerships, and exercise.

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

Importantly, the trust must:

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival, linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real-time events are recorded accurately, and this is demonstrated through audit.
- Take further steps to resolve the flow of patients into and out of the hospital.

In Medicine

- Ensure systems and processes are established and operated effectively to assess, monitor, and improve the quality and safety of the services provided, and evaluate and improve practice to meet this requirement. Specifically, review the escalation process involving 'floor working' to ensure that quality and safety of services are maintained
- Ensure sufficient numbers of suitably qualified, competent, skilled, and experienced persons are deployed across all divisional wards. Specifically, registered nurses to ensure safe staffing levels are maintained, especially in areas of increased patient acuity, such as NIV care and thrombolysis.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.
- Improve compliance against 18 week RTT standards for admitted patients for oral surgery, trauma and orthopaedics, urology, and ophthalmology.
- Improve the rate of short notice cancellations for non-clinical reasons specifically for ENT, orthopaedic, and general surgery.
- Ensure patients whose operations are cancelled are treated within 28 days.

In Maternity and Gynaecology

Summary of findings

- Review staffing levels, out-of-hours consultant paediatric cover, and surgical cover to ensure they meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour')
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures are effective.

In Services for Children and Young People

- Ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).
- Ensure nurse staffing levels in the Special Care Baby Unit (SCBU) adhere to establishment and meet recognised national standards.

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments in line with the Mental Capacity Act.

In Outpatients and Diagnostic Imaging

- Address the number of cancelled clinics in outpatient services.
- Ensure RTT indicators are met across outpatient services.

It is apparent that the trust is on a journey of improvement and progress is being made clinically, in the trust's governance structures and in the implementation of a credible clinical strategy. I am therefore happy to recommend that North Cumbria University Hospitals NHS Trust is now taken out of special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to North Cumbria University Hospitals NHS Trust

North Cumbria University Hospitals NHS Trust (hereafter referred to as 'the trust') was created in 2001 by the merger of Carlisle Hospitals NHS Trust and West Cumberland NHS Trust. It became a University Hospital Trust in September 2008.It is a provider of acute hospital services based at the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven. It also provides a midwifery-led maternity service at Penrith Community Hospital, which was not included in this inspection.

The trust has 590 inpatient beds across these three locations and employs over 4,600 members of staff (over 3,600 whole time equivalent).

The trust is not a Foundation Trust. Its main commissioner is Cumbria Clinical Commissioning Group (CCG), which commissions around 85% of its services, with NHS England commissioning a further 13%.

The trust serves a population of approximately 320,000 in the west, north and east of Cumbria, in the districts of Allerdale, Carlisle, Copeland, and Eden Valley. It also provides services to parts of Northumberland and Dumfries & Galloway. The community is thus spread over a large geographical area, with 51% of residents living in rural settings. Deprivation levels vary from relatively low to high. Ethnic diversity is low. Rates of homelessness and youth drinking are both significantly higher in north Cumbria than in the rest of England. Over 65s make up a larger proportion of the population than is the national average. The health of people in Cumbria is mixed, with five indicators scoring better and nine indicators worse than the England average; 12 indicators are not significantly different from the England average. Deprivation is similar to the England average and about 11,700 children (14.5%) live in poverty. Life expectancy for men is lower than the England average and life expectancy for women is similar to the England average.

The trust's annual turnover in the 2015/16 financial year (ending 31 March 2016) was £234m. The trust has been in deficit for most of the financial years since 2008 and that deficit has increased in each of the last three reporting years. For 2015/16 the deficit was £63m.

The trust was one of 14 selected for Sir Bruce Keogh's 2012 review of quality of care and treatment provided by those NHS Trusts and NHS Foundation Trusts that were persistent outliers on mortality indicators (known as The Keogh Review). Following the review, in July 2013, the trust was placed into special measures. The trust remains in special measures.

Recently, there have been significant changes to the senior executive team including a new chief executive, medical director and director of nursing. New non-executive directors have also been appointed.

West, North & East Cumbria was selected as one of three health economies in England to be part of the Success Regime programme in September 2015. Since then, the Trust has been working closely with health partners to create a sustainable clinical strategy for the future. As part of this work, options were presented in order to start the change process in the form of a public consultation which ran from September to December 2016 consulting on maternity services, paediatrics, stroke services, emergency & acute care, emergency general surgery & trauma & orthopaedics as well as community hospital inpatient beds. The outcomes of the consultation are currently concluding and the work will lead directly into the Sustainability & Transformation Plan (STP) which is the five-year forward view.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, Care Quality Commission

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Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included two CQC inspection managers, nine CQC inspectors, an expert by experience, and a variety of specialists including consultant medical staff, senior nurses, allied health professionals and governance experts.

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 eight core services at North Cumbria University Hospitals NHS Trust:

- Accident and emergency;
- Medical care (including older people's care);
- Surgery;
- Critical care;
- Maternity and gynaecology;
- Services for children and young people;
- End of life care;
- Outpatients.

Prior to the announced inspection we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included Cumbria CCG, 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 interviewed members of staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We used all of this information to help us decide which aspects of care and treatment to look at as part of the inspection.

We would like to thank all staff, patients, carers, and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Cumberland Infirmary in Carlisle and West Cumberland Hospital in Whitehaven.

What people who use the trust's services say

- In the June 2016 Annual CQC Inpatient Survey the trust scored 'about the same' as other trusts in each of the ten performance indicators used.
- In a survey of all women who gave birth in February 2015 (and January 2015 at smaller trusts) the trust scored 'about the same' as other trusts in each of the three performance indicators used.
- The percentage of people recommending the trust according to the Friends & Family Test was generally about the same as the England average (96%) between September 2015 and May 2016. However, from June 2016 there was a trend of decline, falling to 91% by October 2016.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions, and in the bottom 20% for eight questions.
- The trust performed better than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Food, Privacy/dignity/wellbeing, and Facilities.

Summary of findings

Performance improved in all four aspects of PLACE from 2015 to 2016. The greatest performance improvement in 2016 was related to facilities, which improved by 19%.

Facts and data about this trust

As noted above, the trust has three main locations:

- Cumberland Infirmary;
- West Cumberland Hospital; and
- Penrith Hospital.

The Cumberland Infirmary (CIC) provides a 24-hour Accident & Emergency (A&E) service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics. It has 410 inpatient beds and serves mainly the Carlisle and North Cumbria areas.

The West Cumberland Hospital (WCH) recently underwent phase one of a £90 million redevelopment, with the new building opening in October 2015. Planning for phase two of the redevelopment is underway. It is a general hospital providing 24-hour A&E, a consultant-led maternity unit and special care baby unit, a range of specialist clinical services, and outpatient clinics. It has 191 inpatient beds and serves mainly the Whitehaven and West Cumbria areas.

The trust's midwifery-led maternity service at Penrith Community Hospital was rated 'good' at the previous CQC inspection and was not visited as part of this inspection.

The trust has a total of 740 beds spread across various core services:

- 384 Medical beds (334 Inpatient, 50 day case);
- 203 Surgical beds (141 Inpatient, 62 day case);
- 59 Children's beds (51 Inpatient, 8 day case);
- 61 Maternity beds (61 Inpatient);
- 15 Critical Care beds (15 Inpatient);
- 18 Outpatients (18 day case);
- No beds could be identified for the End of Life Care service.

As at September 2016 the trust employed 3674.4 staff out of an establishment of 3928.2, meaning the overall vacancy rate at the trust was 6.5%.

In the latest financial year, 2015/16, the trust had an income of £234,067,000 and costs of £297,064,000, meaning it had a deficit of £62,997,000 for the year. The trust predicts that it will have a deficit of £49,500,000 in 2016/17.

Between April 2015 and March 2016 the trust experienced:

- 85,112 A&E attendances;
- 90,591 inpatient admissions (between April 2014 and March 2015);
- 334,090 outpatient appointments;
- 3,033 births; and
- 24,171 surgical spells.
- 1,185 inpatient deaths

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as requires improvement because:** • Nursing and medical staffing had improved in some areas since the last inspection. At the time of inspection the vacancy rate was 23% compared with 31% in April 2015. However, there were still a number of vacancies in particular, across medical and children and young people services. Locum medical staff were in place to cover these gaps. Nurse staffing had improved in some areas since the last inspection. At the time of inspection, there were 45.60 vacancies in nursing. However, there were still a number of vacancies, in particular, across medical, surgical, children, and young people's services, including the special care baby unit at the Cumberland Infirmary. Staffing levels and skill mix in medical and surgical care were below the actual planned levels at times, despite the use of bank and agency staff. • The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes. The 'floor working' initiative within medical care at CIC should be reviewed in order to support safer nurse staffing. • Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians in some specialities, particularly in medical care and services for children and young people. Medical staffing within these specialities remained reliant upon locum support, and was therefore vulnerable to changes in locum worker preferences or departures. • There was a lack of senior paediatric provision for advanced neonatal resuscitation out of hours, due to a lack of paediatric middle grade and resident paediatric consultant cover at CIC. This provision was available approximately 60% of the time at WCH. The lead midwife on shift in the delivery suite was the first line for neonatal resuscitation and was Newborn Life Support (NLS) trained. There were no midwives trained in advanced NLS. This was identified on the maternity risk register. Some incidents were reported with no adverse outcomes (this included occasions when paediatrics had been asked to attend an anticipated problem and then asked to stand down as not required). This was not in line with Safer Childbirth (2007) paragraph 4.4 (Paediatric staffing levels).	**Requires improvement** 

- The Consultant Surgeon on call provided surgical cover after 6pm for the Trust, based at the Cumberland Infirmary who is available for advice on individual case management and transfers of care if required. A standard operating procedure is in place to formalise this process. The Trust recognised that it did not fully meet the Royal College of Obstetricians and Gynaecologists guidelines. There had been no adverse incidents reported and patients had been safely transferred to CIC for their surgery. A formal risk assessment was in place and this was reflected in the risk registers for the service'.
- Compliance with documentation of NEWS was variable in medical care. This included evidence that full sets of observations were being recorded and trigger levels and care escalation to medical staff or nurse practitioner were being completed.
- Surgical debrief as part of Five Steps to Safer Surgery was only undertaken 14% of the time. A trust audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.

However:

- Within medical care services, particularly at WCH, medical staffing had improved since our previous inspection with additional workforce assurance plans in place. This included securing long-term locum contracts, developing the composite workforce model, improving links with specialist trainees, and securing cross-site support from divisional clinician colleagues at CIC.
- There were systems in place for incident reporting, and staff received feedback and information about action taken to reduce the risk of reoccurrence. There was evidence of learning from incidents across the directorates. The requirements of Duty of Candour were followed and trust processes were open and transparent.
- The trust had infection prevention and control (IPC) policies, which were accessible, understood, and used by staff. Across the trust patients received care in a clean, hygienic, and suitably maintained environment.

Incidents

- Never Events are serious incidents that are wholly preventable, where 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.

Summary of findings

- Between July 2015 and November 2016 the trust reported seven Never Events. Six of these incidents were for surgery. These were a wrong site block, a wrong site injection, a wrong implant, two retained foreign objects, a wrong site surgery, and one Never Event for Medicine, which was relating to a wrong route medication. There had been seven Never Events for Surgery between June 2015 and February 2016. These were a wrong site block, a wrong site injection, a wrong implant, three retained foreign objects, and one wrong site surgery.
- The trust had completed an external review regarding these Never Events. The findings from this were positive overall.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). In accordance with the Serious Incident Framework 2015, the trust reported 144 serious incidents (SIs) which met the reporting criteria set by NHS England, between July 2015 and June 2016. Of these, the most common type of incident reported was pressure ulcers (36.8%).
- There were 8,278 incidents reported to National Reporting and Learning System (NRLS) between July 2015 and June 2016. Proportions of incidents by severity were severe 44 (0.53%), moderate 442 (5.3%), low 2557 (30.9%), and no harm 5222 (63.1%). There were 13 deaths reported by the trust over this period (0.2%).
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- All divisions within the trust shared learning from incidents and when things went wrong at all levels. Management discussed outcomes at divisional meetings and matrons and ward managers shared learning and cascaded key information to their staff at ward meetings, through the patient safety newsletter, on the intranet, and by direct staff communications.
- The trust also held a weekly patient safety panel, which was attended by the director of nursing, clinical directors, and medical director. This panel discussed all incidents that had occurred in the previous week, with a formal report presented to the quality and safety committee.
- The safety newsletter was re-launched in November 2016 within the trust to cascade key information across the trust.
- Appropriate divisions held monthly mortality and morbidity review meetings, and these were well attended, in particular by junior medical grades.

Cleanliness, infection control and hygiene

Summary of findings

- The trust had IPC policies which were accessible, understood, and used by staff.
- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus, and Methicillin Resistant Staphylococcus Aureus (MRSA). These were available as paper copies and on the trust intranet.
- The trust had an infection surveillance programme and an infection control matron in place. An annual IPC report was presented to the board and monthly reports to the safety and quality committee.
- Across the trust patients received care in a clean, hygienic, and suitably maintained environment.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment, ventilated patients, ultra violet spray, and glow cleanliness. Compliance was high in most areas.
- Cannula and catheter care at WCH ranged from 67% to 100% and 25% to 100% respectively. Ward managers confirmed that best practice was reinforced following IPC audits, and, where findings were below standard, action plans were put in place to improve compliance in follow-up audits.
- Each ward had daily, weekly, and monthly cleaning schedules for domestic staff, housekeepers, and nursing staff. Cleaning and environmental audits were completed on a monthly basis and these showed that all wards met the hygiene target between February 2016 and August 2016.
- Incidences of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and departments. These showed compliance with clean commodes, hand hygiene, cannula, and catheter audits. Compliance at the time of the inspection was high in most areas.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- There were no cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) reported between November 2015 and October 2016. Trusts had a target of preventing all MRSA infections, so the trust met this target within this period.
- Additionally, the trust reported nine MSSA infections and 23 C. Difficile (C diff) infections over the same period.
- All trust C diff cases underwent a root cause analysis (RCA) using a proforma agreed across the local health economy and with Public Health England, which was uploaded onto a

database and reported generated themes. Each RCA was reviewed and a synopsis of each apportioned case was presented to the infection prevention control committee (IPCC) and the safety and quality committee.

- Results of the Patient-Led Assessments of the Environment (PLACE) 2016 showed that the trust scored 99 for cleanliness (the England average score was 98).
- A Healthcare Associated Infection Delivery Plan had been developed to ensure compliance with, for example, urinary catheter insertion techniques, hand hygiene, surgical scrub uniform policy, surgical site infection (SSI) national standards, cleaning standards, and learning from SSI RCAs.
- We observed staff washing their hands, and all patients we spoke with told us that this was done. Hand gel was available throughout the hospitals at the point of care, and staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout all areas and staff completed cleaning records and domestic cleaning schedules.
- Clinical and domestic waste disposal and signage was good. We observed staff disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms, and the disposal of sharps followed trust policy.
- SSI group meetings were held to reduce the incidence of infections through, for example, temperature monitoring, patient education, inter-operative practices, treatment rooms, pre-admission screening, SSI rates, and day zero practice.
- The trust report for April to June 2016 showed SSI rates of 1.73% for total hip replacements, 2.32% for total knee replacements, 1.72% for repair of neck of femur, and 2.85% revision of total knee replacements. No SSIs were recorded for revision of total hip replacements.

Medicines

- The trust had an effective medicines governance and incident reporting structure.
- The trust had a medicines optimisation strategy. Reassessment in July 2016 demonstrated sustained improvement from the baseline audit completed in August 2013. In response to the Carter Report, the chief pharmacist was drafting the trust's Hospital Pharmacy Transformation Plan for Board approval and submission to NHS Improvement by 31st March 2017. However, this was being drafted whilst the trust-wide Strategy for Provision of Clinical Services was under review, making it difficult to assess the best use of resources.

Summary of findings

- The chief pharmacist told us that he had experienced difficulties in recruiting pharmacy staff and a Pharmacy Recruitment and Retention Strategy 2016–2021 had been drafted. At the time of our visit technician vacancies and long-term absence meant that pharmacists were not always able to provide the same level of clinical service to all wards. Additionally, there were insufficient specialised critical care pharmacist hours to meet with best practice guidance (The Core Standards for Intensive Care Units, Faculty of Intensive Care Medicine 2013). This meant that the pharmacist had less capacity to support clinical governance and guideline development. Nurse and pharmacist non-medical prescribers (NMPs) were actively used across the trust, but, at the time of our visit, there was no lead for NMPs and difficulty in identifying medical mentors for the provision of ongoing support to NMPs.
- On admission to the trust figures for medicines reconciliation and recording allergy status were broadly in line with the national average (Medicines Safety Thermometer). However, the trust did not have a seven day pharmacy service so, for patients admitted on a Friday evening, this could not be completed by a pharmacy until the following Monday, and use of summary care record was low within the trust (~32%; NHS England Medicines Optimisation Dashboard). On discharge the trust did not have the capability to produce electronic discharges to help ensure the timeliness and quality of medication-related information provided when transferring patients from secondary care to primary care. This had been highlighted in a recent audit completed by Cumbria CCG. The chief pharmacist advised that this would be addressed with the implementation of EPMA (Electronic Prescribing and Medicines Administration) at the trust. However, this was unlikely to happen before 2020. We saw that paper medicines discharge notes that were incorrectly badged to another trust were in use. We raised this during the inspection in order that this could be promptly addressed
- The trust provided all wards with a quarterly breakdown of its performance on medicines safety, assessing medicines reconciliation, omitted doses, controlled drugs handling, antibiotics prescribing, medicines training, and recording patients' allergies. The reports included comparisons with national and trust-level data and suggested targets for improvement. The trust had a local target of reducing the omissions of critical medicines from 8% to 4%. Trust data

(Quarter 2 2016-17) showed improvement with a trust average of 6%. However, overall completion rates for medicines-related training were below the trust target of 80% [73% for medicines management and 70% for calculating drug doses].

- The trust was meeting targets related to the choice of antibiotics but not those for recording the indication for antibiotics prescribing, or the stop date. However, revised prescription charts with a new antimicrobial prescription section were being rolled out. The antimicrobial committee reported early evidence of improved recording. The trust was unable to provide information about antibiotics prescribing or omitted doses for the critical care wards, as those wards were not included in the audit. A weekday daily microbiology round was completed on the critical care wards, providing some assurance with regard to antibiotics prescribing.
- Medicines safe storage was assessed as part of the trust's 15 steps audit. However, not all wards had completed this at the time of our visit. Concerns had been raised at the safe medicines practice group about medicines safety, medicines lockers, and the number of different medication storage systems currently in use on EAU at CIC. This had been escalated for action by the safety and quality committee.
- In relation to the use of high-risk medicines, trust data showed that chemotherapy was in the top three of trust reported medicines-related incidents. However, a project to implement electronic chemotherapy prescribing for all reportable systemic anticancer therapies (SACT) was on target for completion by March 2017. Action was also being taken to improve scheduling. At the time of our visit the aseptic manufacturing suite was not operational due to delays in recommissioning. The trust had appointed a new lead for oncology pharmacy to support the safe use of Chemotherapy and to oversee the Aseptic Suite. They were assessing manufacturing capacity and the impact of chemotherapy drug dose banding to support delivery of safe cost effective treatment.
- The trust had reported a 'Never Event' (Never Events are serious incidents that are wholly preventable, NHS England) involving administration of medication by the wrong route. The trust's investigation and sharing of learning was still in progress during our inspection, but early action had been taken to alert staff to the incident, highlighting key issues and directing staff to current medicines policy.
- The trust had service level agreements (SLAs) in place for the delivery of homecare medicine services (Homecare services can offer patients more choice and control, as they do not have to collect prescriptions from the hospital). The trust's homecare

pharmacist monitored these SLAs to help ensure the safety and quality of the service provided. There were plans to establish a homecare oversight group to further develop the homecare governance framework.

Assessing and responding to patient risk

- The trust used an early warning score risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient were embedded. Staff recorded observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- A trust audit (May 2016) measured compliance with the Five Steps to Patient Safety procedure. This showed 98% compliance with undertaking the team brief before surgery (previously 50%). The audit also showed 98% sign-in by the surgeon prior to anaesthesia at CIC and 96% at WCH.
- Time out was taken for all patients at the hospital with all members of the team listening and stopping and 100% responding as required.
- Debrief was undertaken only 14% of the time. However, when debrief was undertaken all staff were present. The audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads. A presentation provided by the trust highlighted that improvement work was underway.
- We observed the WHO checklist being used appropriately in theatres, and saw completed preoperative checklists and consent documentation, where applicable, in all patient notes that we viewed,
- Auditors completed a very detailed review of National Early Warning Score (NEWS) compliance on a monthly basis across the division. Between October 2015 and September 2016 auditors found that, on average, only 60% of patients had evidence of full sets of observations recorded. However, 97% of those patients had the correct NEWS score applied. Auditors also reported compliance with trigger levels and care escalation. Where NEWS triggers recommended referral to a junior doctor or nurse practitioner (scores of 5-6 or 3 in any one parameter) compliance was variable, ranging from 56% to 93%. Where NEWS triggers recommended escalation for senior medical review (scores of 7 or more) compliance ranged from 44% to 100%. Ward managers confirmed that audit findings were cascaded to staff at ward meetings to reinforce the importance of adhering to NEWS triggers and to ensure any deviations from the recommendations were duly documented by an appropriate responder.

Summary of findings

- The children's ward and staff from the A&E department used the paediatric early warning scores (PEWS); an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale, and additional information such as pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses, who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. PEWS charts were audited every month and staff from the children's ward achieved consistently high results.
- Clinicians transferred children who required paediatric intensive care to the regional tertiary care hospital. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without a paediatric nurse) until medical staff had secured appropriate retrieval or transfer arrangements to the tertiary hospital.
- There was a lack of senior paediatric provision for advanced neonatal resuscitation out of hours, due to a lack of paediatric middle grade and resident paediatric consultant cover at CIC. Currently this provision was available approximately 60% of the time at WCH. The lead midwife on shift on the delivery suite was the first line for neonatal resuscitation and was NLS trained. There were no midwives trained in advanced NLS. This was identified on the maternity risk register. Some incidents were reported with no adverse outcomes (this included occasions when paediatrics had been asked to attend an anticipated problem and then asked to stand down as not required). This was not in line with Safer Childbirth (2007) paragraph 4.4 (Paediatric staffing levels).
- The withdrawal of emergency surgery from WCH meant that there was no consultant surgeon on call after 6pm to manage obstetric emergencies. A consultant surgeon was available for contact on the CIC site for immediate management advice or action plan if indicated. A standard operating procedure was in place to formalise this process. The maternity risk register indicated that there were no known issues from this gap, although patients had been safely transferred to CIC for surgery.
- The majority of surgical procedures for children and young people took place at CIC and surgeons operated a dedicated child-only list on one full day, every two weeks. This did not include children under one year old or under one kilogram in weight, who were instead transferred to the local tertiary care centre. In some cases surgeons listed children on the same day as adults.

- Anaesthetists were competent to care for children and young people during surgery. Standards produced by the Royal College of Anaesthetics state every consultant anaesthetist should perform a minimum of 25 paediatric anaesthesia cases per annum. A senior clinician confirmed that the team met this standard. Paediatric consultants also provided additional support where necessary. Within the remit of non-specialist surgery, the clinical director told us that she was confident the team provided a safe and effective service.
- Until recently the trust had had a paediatric anaesthetist lead who held overall responsibility for sharing guidelines, attended clinical sessions, and maintained regular contact with paediatric surgical services across the North East of England. The trust was in the process of trying to identify a current member of the team to fulfil this highly specialised role. The clinical director acknowledged that it needed to ensure arrangements were made so that the new lead would have sufficient professional leave time to develop and maintain the skill base and spend an appropriate amount of time in a specialist centre for paediatric surgery.

Nurse staffing

- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels. The trust also monitored acuity and staffing levels using the safe care system twice daily in order to respond to fluctuations in patient need and changes to anticipated staffing levels.
- The trust reported overall establishment nurse staffing figures at August 2016 to be 357.83 whole time equivalents (WTE) working across the medical care division, of which there were 302.3 in post. This equated to a shortfall of 55.53 WTE across the division.
- The registered nurse shortfall within medical care at WCH was approximately 15 WTE across all wards (with the exception of the oncology suite) ranging from 6.01 WTE on EAU to 0.41 WTE on ward 2. All wards had appointed additional health care assistants (HCAs) in excess of establishment to support registered nurse vacancies: on ward 4, for example, an additional 5.07 WTE; and on ward 3 an additional 3.15 WTE.
- All medical wards visited at CIC confirmed they had registered nurse vacancies. The nurse staffing requirements had not been revalidated following significant ward reconfigurations throughout the medical wards at CIC.
- The majority of surgical wards were below the nursing establishment levels. The data for CIC showed that Beech B

required 14.4 WTE but had 11.72 WTE nursing staffing in post. Similarly, Beech D was 2.24 WTE short and Maple D was 6.49 WTE short. At WCH ward 1 required 20.86 WTE but had 17.68 WTE nursing staffing in post. Similarly, the day case unit had 7 WTE but required 8.93 WTE.

- At the time of the inspection baseline nursing establishments across the majority of clinical areas were being reviewed and increased to meet patient demand and take into account sick and study leave.
- Although nurse staffing and establishment was good in critical care with low vacancies and sickness rates, staff (including members of the critical care outreach team [CCOR]) would be moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this affected the morale of nursing staff in the unit, although patient safety was felt to not be compromised. We also noted in rotas we reviewed that it was frequently not possible to protect the provision of a supernumerary coordinator role when staff were moved. Staff we spoke with also confirmed this to be a regular occurrence.
- The trust met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG) guidance Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour with a ratio of 1 midwife to 27 births, which was better than the RCOG recommendation of 1 midwife to 28 births.
- Neonatal nurse staffing at CIC met the British Association of Perinatal Medicine (BAPM) recommendations most of the time. BAPM recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care. In August 2016 fill rates for SCBU confirmed an average of 107% for registered nurses during the day and 99% at night.
- As the unit was nurse-led there should have been a qualified in specialty (QIS) band 7 senior nurse on every shift. However, out of eight senior nurses, four had recently left the service, which meant the unit struggled to ensure there was adequate cover. The lack of a senior nurse meant two band 6 nurses were rostered on each shift. An escalation policy and pathway for staffing was displayed in the staff office and was available on the trust intranet. However, not all staff were aware of it.
- The RCN Defining Staffing Levels for Children and Young People's Services (2013) guidelines recommend one member of nursing staff should be supernumerary and external to the nurse rota. The children's ward at CIC did not meet this RCN standard. The ward manager only had one management day each week and was part of the main rota at all other times.

Summary of findings

Medical staffing

- Medical staffing skill mix across the trust varied across grades compared to the England average at 39% consultant (national average 43%), 16% middle career (national average 10%), 26% Registrar group (national average 35%), and 20% junior doctors (national average 11%). As of June 2016 the proportion of consultant staff junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.
- As of September 2016 the trust reported a vacancy rate of 8.9% in surgical staff at CIC, with a turnover rate of 23.6% between April 2015 and March 2016.
- Between April 2015 and March 2016 the trust reported a bank and locum usage rate of 18 %. Maternity and medicine reported the highest bank and locum usage rates of 26% for the trust, whereas surgery had the lowest bank and locum usage rate at -18%.
- As of November 2016, the trust reported a vacancy rate of 23% compared to 31% in April 2015.
- In November 2016, the turnover rate was 31.6% compared to 45.2% in April 2015. April 2015
- Between April 2015 and March 2016, the trust reported a sickness rate of 1%.
- Within critical care, consultant staff to patient ratios were in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- Within medical care services, particularly at WCH, medical staffing had improved from the previous inspection with additional workforce assurance plans in place. This included securing long-term locum contracts, developing the composite workforce model, improving links with specialist trainees, and securing cross-site support from divisional clinician colleagues at CIC.
- Recent medical recruitment processes had seen the appointment of physicians in respiratory care, cardiology, acute medicine, oncology, and histology in the last 18 months. Divisional leads acknowledged this was an ongoing process, with vacancies remaining in most specialisms across both divisional sites.
- Where substantive posts remained vacant the trust had secured long-term locum contracts to support stability within the service. The trust had also appointed a professor of medicine who was involved in the care at WCH.

- The medical care division had partnered with colleagues at a neighbouring NHS trust to support haematology and cancer services. The division had also worked with primary care colleagues to utilise GP trainee clinicians and develop this workforce within the service.
- In September 2016 the trust reported a vacancy rate of 21% in children's services, across both CIC and WCH. The trust relied upon locums to support the children's ward and outpatient department and SCBU. Between April 2015 and March 2016 the trust reported a locum usage rate of 25%. The turnover rate during the same period was 46%.
- Within children's services CIC had a full complement of consultants in post (7 WTE, inclusive of a recent appointment). In addition, there were two GP trainees, a specialist trainee, a locum trust doctor, five medical students, and a paediatric nurse practitioner.
- WCH had one full time substantive consultant in post. There were five senior locum doctors (four consultants and a middle grade), many of whom were on long-term contracts or had worked at the trust for more than six months. Senior clinicians told us they were confident the care they provided was safe. However, they acknowledged the fragility of the service due to the reliance on locum medical staff.
- The majority of consultant job plans provided for 10-11 programmed activities each week. However, in reality most were voluntarily working in excess of this, in the region of 11-12.5. This meant the consultant team did not meet all Royal College of Paediatric and Child Health (RCPCH) Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within their contracted hours.
- Recruitment to substantive posts was ongoing within services for children and young people. However, managers told us they had very clear expectations and would not appoint clinicians who did not meet the specific criteria of the role.

Equipment & environment

- In all services there was adequate equipment to support the delivery of safe care. The trust performed better than the England average in the Patient Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to facilities (96% against 93%).

- Although the critical care unit at CIC was modern in design it would not meet current national standards for new buildings and environment. (HBN 04-02). The senior team had submitted proposals which outlined the plans for unit upgrade and expansion.

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. Learning from serious case reviews was monitored, and there was good staff attendance at and compliance with safeguarding training.
- The trust had an executive lead and a designated team for safeguarding across the organisation.
- Safeguarding training plans and schedules were displayed in ward offices and held centrally by the training department.
- Trust data (November 2016) showed that 67% of medical and nursing staff had attended safeguarding adults level 2 training and 62% had attended safeguarding children level 2 training. The percentage of staff who had completed level 3 was 63%. The trust had set a target of 80% for completion of safeguarding training by the end of March 2017.
- On the wards staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt that safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice, and details of contact leads to support staff in safeguarding decision making.

Duty of Candour

- Most staff knew of the duty of candour requirements and of the trust policy. Junior staff understood that this involved being open and honest with patients. Ward managers were aware of the duty of candour, and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.

Are services at this trust effective?
We rated effective as good because:

Good

Summary of findings

- The trust was actively involved in local, national, and international audit activity and followed recognised guidance that provided an evidence-base for care and treatment. New evidence-based techniques and technologies were used to support the delivery of high-quality care.
- There were opportunities to participate in benchmarking, peer review, accreditation, and research.
- There were good patient outcomes recorded in the national stroke audit, renal registry report, rheumatoid and early inflammatory arthritis report, and oxygen audits. The division reported improvements in lung cancer and inflammatory bowel disease standards from the previous audit window.
- Patients informed us their pain was managed well and, overall, their nutritional and hydration needs were met.
- The trust had a clear policy to provide guidance for obtaining consent from patients within the organisation.
- There were many examples of multidisciplinary working to secure good outcomes and seamless care for patients. Staff in all disciplines worked well together for the benefit of patients. There were trust wide multidisciplinary teams with established links to local speciality teams across acute and community settings.

However:

- Improvements in patient outcomes in some national audits were static or below the England average. The trust had implemented action plans to improve in areas highlighted by audit findings.
- The trust did not have a dedicated paediatric anaesthetist lead. Following the departure of the previous post-holder, the trust was aiming to appoint a clinician from the current consultant anaesthetist team. A senior clinician acknowledged robust training and support would need to be established to ensure the new lead was able to develop and maintain the specialist skill base to fulfil the role effectively.
- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.

Evidence based care and treatment

Summary of findings

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- Local policies, which were accessible on wards and departments and on the trust intranet site reflected up-to-date clinical guidelines.
- The trust was actively involved in local and national audit programmes, collating evidence to monitor and improve care and treatment. Divisions across the trust compiled an annual clinical audit report of activity that specified a range of completed, planned, and ongoing evidence-based reviews. The trust was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management devices (CRM), diabetes, acute coronary syndromes, and the falls and fragility fracture audit programme (including hip fractures).
- The trust had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow, for example, ambulatory care and hot clinics.
- The trust had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. Staff fed these into the respective business units and incorporated them into local quality improvement projects.

Patient outcomes

- WCH took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the hospital achieved grade B in the latest audit (April 2016 and June 2016). Compared with the previous quarter there were improvements in five of the domains plus the key indicator level for patient-centred performance. Team-centred and patient-centred specialist assessments improved from a grade D in January to March to a grade B. Team-centred performance saw improvement in three domains and decline in two.
- In June 2016, following SSNAP findings, the occupational therapy (OT) team completed an audit of patient and staff involvement in group work for patients receiving stroke care. The team identified that the sessions met national standards. However, it considered there were more effective ways in which resource could be channelled to improve and develop group therapy sessions. New group therapy sessions were being considered, and we were able to see the new dance group therapy session during our inspection at CIC.

Summary of findings

- The trust did not take part in the 2015 Heart Failure Audit.
- WCH also took part in the Myocardial Ischaemia National Audit Project (MINAP) 2013/14. WCH scored better than the England average for one of the three metrics and similar to the England average for the remaining two. The metric 'patients seen by a cardiologist or member of the team' had improved when compared with the 2012/13 audit.
- WCH also took part in the 2015 National Diabetes Inpatient Audit (NaDIA). It scored better than the England average in four metrics and worse than the England average in 13 metrics. The indicators regarding 'seen by MDFT within 24 hours', 'foot risk assessment during stay', and 'foot risk assessment within 24 hours' were the three lowest scoring metrics compared with England average scores.
- CIC took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the hospital achieved grade C in the latest audit (April 2016 and June 2016). Compared with the previous quarter there were improvements in four of the domains, including the key indicator level for both patient-centred and team-centred. Ratings in the remaining six domains remained the same.
- CIC also took part in the Myocardial Ischaemia National Audit Project (MINAP) 2013/14. CIC scored better than the England average for one of the three metrics; 'percentage of STEMI patients referred for or had angiography'. The metric 'patients admitted to a cardiac ward or unit' had seen performance worsen between 2012/13 and 2013/14.
- CIC also took part in the 2015 National Diabetes Inpatient Audit (NaDIA). It scored better than the England average in two metrics and worse than the England average in 15 metrics. The indicators regarding 'seen by MDFT within 24 hours', 'overall satisfaction', and 'staff awareness of diabetes' were the three lowest scoring metrics compared with the England average.
- In the National COPD Audit Programme 2014, WCH scored a total of 27 points across the five domains (less than the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and managing respiratory failure/oxygen therapy. There were low scores against the senior review on admission and access to specialist care domains. In response to the results the division had compiled a very detailed and thorough action plan to address areas for improvement.
- In the same COPD Audit Programme 2014 CIC scored a total of 31 points across the five domains (less than the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and managing

respiratory failure/oxygen therapy. There were low scores against the senior review on admission and access to specialist care domains. In response to the results the division compiled a very detailed and thorough action plan to address areas for improvement.

- The trust provided evidence for the UK Renal Registry 18th Annual Report (published in 2016) to support benchmarking against quality of care standards. There were positive findings for the division with good mortality data, good proportion of patients on home therapies or who receive transplantation early, and good practice identified with calcium, phosphate, bicarbonate, and anaemia management. The report identified high incidence of tunnel neck lines (TNLs) usage and the team was working with vascular colleagues to reduce the number of patients relying on this access.
- In the Rheumatoid and Early Inflammatory Arthritis Report, published in 2016, the trust reported good outcomes against the NICE quality standards covering time to disease-modifying anti-rheumatic drugs (DMARDs), access to education on first consult, treatment response target, and urgent access for advice. The division recommended improved access time to first assessment and to progress an annual review clinic.
- Between March 2015 and April 2016 patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions. Relative risk of readmission for general surgery and trauma and orthopaedics both had similar performance to the trust level.
- In the 2016 Hip Fracture Audit the risk-adjusted 30-day mortality rate was 6.7%, which falls within expectations. The 2015 figure was 6.2%. The proportion of patients having surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. The 2015 figure was 62.4%, so the 2016 figure showed considerable improvement.
- The proportion of patients who did not develop pressure ulcers was 94.7%, which falls in the middle 50% of trusts. The 2015 figure was 97.7%.
- The average length of stay was 16.7 days, which falls in the middle 50% of trusts. The 2015 figure was 15.1 days.
- The trust showed marked improvement from 2015 for the perioperative medical assessment rate, although all other

measures had deteriorated since the 2015 audit results. Case ascertainment also dropped from 98.1% in 2015 to 92% in 2016, although the trust's figure was higher than the England and Wales aggregate of 90.7%.

- In the 2015 Bowel Cancer Audit 55% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than than the national aggregate. The 2014 figure was 52%.
- In the 2015 National Vascular Registry (NVR) audit the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.6% for abdominal aortic aneurysms, indicating that the trust performed within expectations. The 2013 figure was 3%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex-adjusted proportion of patients diagnosed after an emergency admission was 9.9%. This placed the trust within the middle 50% of all trusts for this measure. The 90-day post-operative mortality rate was not reported for this trust in the audit.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%; significantly lower than the national aggregate.
- In the 2015 National emergency Laparotomy Audit (NELA) at CIC the trust achieved a green rating (>70%) for five measures, an amber rating (50-69%) for two measures, and a red rating (<49%) for three measures. The final case ascertainment rate was rated as green. The rating represents a score of between 80-100%. In the 2014 NELA, 11 of 28 services were found to be available and two were available on request.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the Hip Replacement (EQ VAS) and Knee Replacement (Oxford Knee Score) indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Groin Hernia (EQ-5D Index) showed fewer patients' health improving than the England average although slightly fewer patients' health worsened than the England average. The remainder of indicators were in line with the England averages.
- Theatre utilisation at CIC ranged from 50.1% to 76.5% during the period June 2016 to August 2016. Theatre 5 had the lowest

average utilisation over the period at 55.4%, while theatre 7 had the highest (74.3%). Overall average utilisation rates trust-wide had decreased over the 3 month period, from 64.1% in June to 56.6% in August 2016.

- There was consistent data collection and submission of Intensive Care National Audit and Research Centre (ICNARC) data within the trust, with a dedicated member of staff in post to support this. Within CIC and WCH patient outcomes were comparable with or better than national and local critical care unit performance for April 2016 to September 2016. At CIC unit mortality had improved since our last inspection and was good in comparison with other units as reported to ICNARC. The patient unplanned readmission rate within 48 hours of discharge from the unit was also monitored and compared with the national average for the same time period.
- The trust participated in the national neonatal audit programme (NNAP). Results from the 2015 audit identified a number of areas of good practice. The neonatal unit at CIC was compliant with the NNAP standard for 98-100% of babies to have their temperatures recorded within an hour of birth. There was also a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission in 99% of all cases. This was above the northern neonatal network (NNN) and national averages (of 93% and 88% respectively).
- There were also areas for improvement. The proportion of babies under 33 weeks gestation who were receiving any of their own mother's milk at discharge from SCBU was 54%. Although this was below the national average of 65%, it was above the NNN average of 46%. In addition, 94% of babies with a gestational age of under 32 weeks or under 1501g at birth had undergone retinopathy screening in accordance with national guidelines. The trust had an action plan to address all of the areas of concern.
- The trust had participated in the End of Life Care Audit: Dying in Hospital in 2016 and performed similarly to the England average for three of the five clinical indicators.

Multidisciplinary working

- There were many examples of multidisciplinary (MDT) working to secure good outcomes and seamless care for patients across the trust.
- Medical and nursing staff across the trust worked closely together and with other allied healthcare professionals such as dieticians, physiotherapists, and speech and language therapists.

- Within services for children and young people there were good working relationships with child and adolescent mental health services (CAMHS) and social services.
- There were clear internal referral pathways to therapy and psychiatric services.
- The trust had a multi-agency steering group. There was representation on this group from all relevant divisions within the trust. At the time of the inspection the group was refreshing discharge procedures, including working with adult social care colleagues.
- Many adult wards had developed strong links with community colleagues when implementing discharge plans and care packages. This was particularly apparent on EAU and CCU with strong links to community specialist nurses and primary care colleagues.
- The stroke team within the trust was part of the North West Network multidisciplinary collaboration model for stroke care.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Records showed that patients had consented to surgery in line with Department of Health guidelines. This included risks, benefits, and alternative options for treatment.
- The trust had a consent to examination and treatment policy and included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.
- Staff were aware of the safeguarding policies and procedures and had received training. As at August 2016, Mental Capacity Act (MCA) training had been completed by 91% of staff. Deprivation of liberty training had been completed by 79% of staff. The trust had set a target of 95% for completion of this training by the end of March 2017.
- Safeguarding and MCA guidance was available across the trust. Staff referred to ward-based documents and the trust intranet to show us the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues.
- Staff provided us with examples of deprivation of liberty safeguards, explaining steps taken to identify and support patients who may not have the capacity to consent.

- However, for patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded.

Are services at this trust caring?

Good

We rated caring as good because:

- 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.
- Every patient we spoke with felt their privacy and dignity had been respected and was happy with the quality of care received.
- There were positive results in the NHS Friends and Family Test (FFT) and good recommendation rates for the service.
- The service reported good outcomes in the Patient-Led Assessment of the Care Environment (PLACE) 2016 survey.
- Feedback from patients and their family members was consistently positive about the care received, and the trust used real-time surveys to gather this feedback.
- Wards across the trust advertised 'you said, we did' actions on noticeboards at ward entrances to report on changes made following patient feedback on care.
- There was evidence of patients and their relatives being involved in the development of their care plans throughout all services within the trust.
- Staff considered physical, emotional, and social elements of wellbeing equally. Patients and family members were included when discussing care decisions and treatment plans.

Compassionate care

- Staff across the trust considered the patients to be central to everything they did and there was a determination to ensure care delivered was of a high standard.
- The trust's FFT performance (% recommended) was generally about the same as the England average between September 2015 and May 2016. However, between June 2016 and October 2016 there had been a trend of decline. In the most recent period, October 2016, trust performance was 91%, compared with an England average of 96%.
- The trust also collated 'real-time' patient feedback to inform service delivery and care improvements. A 'two minutes of your time' survey was completed on a monthly basis across all wards

within the trust. The survey covered six core questions relating to patient experience and quality of care such as 'were you treated with dignity and respect?', 'were you involved in decisions about your care and treatment?', 'did you receive timely information?', and 'were you treated with kindness and compassion?'. Patients were asked to rate each question on a scale of 1 to 10 (with 10 being high). Additionally, patients were given the option to provide general comments about the care received as part of the survey or to underpin their scores. Overall, most wards reported positive results, which reflected in patient ratings that were consistently above 9 out of 10.

- The trust also utilised face-to-face and real-time surveys, in which patients were asked to comment upon quality indicators, overlapping and extending upon the 'two minutes of your time' survey, such as pain control, medicines, and noise at night. Overall most wards reported consistently positive feedback and scores overall were in excess of 9.5 out of 10.
- Wards across the trust advertised 'you said, we did' actions on noticeboards at ward entrances to report on changes made following patient feedback on care.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions, and in the bottom 20% for eight questions. The trust performed in the top 20% for 'patient did not think hospital staff deliberately misinformed them', 'patient never thought they were given conflicting information', and 'all staff asked patient what name they preferred to be called by'.
- The trust performed better than the England average in the 2016 PLACE survey for assessments in relation to privacy, dignity, and wellbeing, scoring 90%, which was better than the England average of 84%. Performance had improved in this aspect of PLACE from 2015 to 2016.
- In the CQC Inpatient Survey 2015 the trust performed better than other trusts in two of the 12 questions examined by the CQC and about the same as other trusts for nine questions. There was no data available for the trust for the remaining question, which related to discharge delays. The trust performed in the top 20% for' after you used the call button, how long did it usually take before you got help?' (care and treatment question area) and 'how long was the delay?' (leaving hospital question area).

Understanding and involvement of patients and those close to them

- Staff across the trust informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks, and the likely time to be spent in hospital.
- 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 educated, supported, and prepared for their surgical procedures.
- Senior clinical staff availed themselves to answer any questions or concerns from patients and family members. Staff informed us that relatives could book appointments to meet with medical and nursing staff at a time convenient to them.
- In the renal service the team had embraced the 'expert patient programme' and 'shared care initiative' to promote patients' empowerment and involvement in their care. This involved individual education packages, assessment of competence, support to carry out self-care procedures, and integration with other patients.
- Patients stated that they were given time to speak with nurses and doctors about their care. However, within medical care services, patients commented that staff were very busy and did not always have time to spend at the bedside.

Emotional support

- Patients received emotional support from chaplaincy and bereavement services, support groups, charity workers, and volunteer staff, as well as clinical staff.
- Staff offered patients and relatives private areas if they wanted time away from their bed areas to discuss personal matters.
- 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.
- The bereavement support in the unit was very good. The team ran a memorial service, which had been attended by over 80 people in the community whose relatives had received care and treatment in the critical care unit. Memory boxes were provided to patients' relatives and this work was a sustained approach since our previous inspection

Summary of findings

- Additional psychological support was assessed on an individual basis. Inpatient and GP referrals to a psychologist would be made by consultant staff. There was work ongoing to introduce follow up clinics but this had not been implemented at the time of inspection.

Are services at this trust responsive?

Requires improvement

We rated responsive as requires improvement because:

- The trust had failed to meet the target to see and treat 95% of emergency patients within four hours of arrival. It was failing to meet a locally agreed trajectory to see and treat emergency patients within four hours of arrival, which had been agreed in conjunction with regulators and commissioners.
- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended, so that the times recorded were not accurate.
- We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.
- Between 2015 and 2016 the trust cancelled 1,410 elective surgeries. Of these, 12% were not rescheduled and treated within 28 days. For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries and CIC cancelled 573 for non-clinical reasons.
- Referral to treatment time (RTT) data varied across specialities, particularly in surgical services.
- Patient flow initiatives within the medical division were not fully embedded and required improved coordination, ward staff engagement, and more timely discharge plans to be implemented. Medical outliers accounted for a significant proportion of the inpatient beds at WCH.
- From March to August 2016 there were a number of patients moving wards after 10pm at WCH.
- Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- Within outpatients there were a number of clinics cancelled within 6 weeks of the clinic due date across the trust, and there were no plans in place to address this issue. Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

However:

Summary of findings

The trust worked closely with its commissioners and external stakeholders on service redesign and the local health economy strategy.

- The trust had an escalation policy and procedure to deal with busy times, and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Services met the needs of people, particularly those patients with multiple and complex needs.
- Systems were in place for the management of complaints, and there was evidence of improvements following complaints. For the three months prior to our inspection the trust had responded to 100% of complaints within 30 days.

Service planning and delivery to meet the needs of local people

- The trust was working with partners involved in the 'Success Regime', established in the autumn of 2015, to review healthcare services across the region. These partners included Cumbria CCG, the West North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England, and neighbouring NHS Foundation Trusts.
- It was acknowledged by the trust that developing future services would render it better positioned to respond to the demands upon it, namely the needs of its population, geography, local infrastructure, and recruitment issues. The evaluation of any reconfigured services would need to involve a 'whole-system' model across multi-agencies. This was further emphasised in the regional sustainability and transformation plan (STP); an integrated health strategy for the region looking at acute and emergency care services, specifically developing new partnerships, and improving service design such as hyper-acute stroke services).
- Divisional management staff across the trust attended meetings with local CCG representatives in order to feed into the local health network and identify service improvements to meet the needs of local people.
- The trust had access to winter pressure escalation beds at WCH attached to an existing medical ward. When divisional managers opened the beds they tended to be staffed by existing ward-based staff from across the site. They were not in use at the time of our inspection.
- Staff in the newly-built endoscopy suite at WCH identified a recent change in service planning that had led to some service inefficiencies. Staff had observed an increased failure to attend

rate, which they suggested was due to patients not getting a choice of location for the procedure and some patients being referred onto wrong lists and so receiving incorrect preparations for their procedures. Staff considered this was due to the booking office being relocated to CIC.
- The trust was working with partners to progress the development of hyper-acute stroke (HASU) services at CIC.
- The trust had recently reconfigured elderly care services and opened a frailty assessment unit at CIC. This offered direct access and provided prompt, consultant-led geriatric assessment.
- Main oncology services were provided at CIC. The trust worked with colleagues in a neighbouring trust to provide radiotherapy services. The medical care division was preparing a business case to further develop cancer services at the CIC site.

Meeting people's individual needs

- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- An equality and diversity surgery nurse was raising awareness of the needs of transgender patients.
- Access to translation and interpretation services was available
- The Patient Advice and Liaison Service(PALS) assisted with the provision of interpreters. Sign language interpreters could also be provided for patients with hearing or speech-impairment who required a qualified communicator, 24 hours a day.
- The trust used 'This is me' passports to support patients who had particular needs as a result of a learning disability. These booklets, owned by the patients, detailed personal preferences, likes/dislikes, anxiety triggers and interventions, all of which were helpful in supporting patients during difficult periods.
- Leaflets were available for patients regarding their surgical procedures, pain relief, and anaesthetic. Alternative languages and formats were available on request.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.

Dementia

- The trust had a dementia strategy with a vision to "establish a programme of improvement to deliver best practice in dementia care consistently across the trust". The strategic goals were to ensure the divisions met the dementia dozen standards, to ensure ward environments were dementia friendly, and to ensure 100% compliance with trust dementia e-learning.

Summary of findings

- During the course of our inspection we observed various dementia initiatives in place to improve the care for this cohort of patients. These included dementia care bundles, John's campaign (a programme to reinforce corroboration and partnerships in care), forget-me-not (an awareness project to reinforce the needs of people living with dementia), and the butterfly scheme (a recognisable visual identifier which alerts staff that an individual has particular needs as a result of a dementia-related memory impairment).
- On ward visits we observed the butterfly symbol to be in use. However, we also noted that it was missing for some patients who were identified as living with dementia.
- A number of wards had made environmental changes to reduce conflict and anxiety such as pictorial signage, furnishings, decorations, and reminiscence triggers.
- A dementia working group had a detailed list of actions which had been in place since 2014. The same showed progression against key objectives and further activities under consideration. Current projects were looking to embed care partnerships with patients and their families, to improve dementia care bundles, and to enhance staff knowledge and awareness.
- The psychiatric liaison team was available for patients displaying confusion, delirium, and undiagnosed dementia as part of National Commissioning for Quality and Innovation(CQUIN), which also identified diagnosis of dementia using specific admission documentation. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment was carried out by nurses on the surgical ward and an appropriate referral was made for diagnosis.

Access and flow

- The trust had failed to meet the target to see and treat 95% of emergency patients within four hours of arrival.
- The trust was failing to meet a locally agreed trajectory to see and treat emergency patients within four hours of arrival, which had been agreed in conjunction with regulators and commissioners.
- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.

Summary of findings

- Between November 2015 and October 2016 the trust's RTT for admitted pathways for medical services had been better than the England overall performance. Additionally, the division showed no specialities below the England average for admitted RTT (percentage within 18 weeks) namely general medicine, rheumatology, thoracic medicine, geriatric medicine, gastroenterology, dermatology, and cardiology.
- Between April 2015 and March 2016 the average length of stay for surgical elective patients at the trust was 2.3 days, compared with 3.3 days for the England average. For surgical non-elective patients the average length of stay was 4.8 days, compared with 5.1 for the England average.
- At trust level general surgery had a longer average length of stay than the England average for both elective and non-elective admissions. Average length of stay for trauma and orthopaedics had contrasting performance, with elective admissions being shorter than the England average (2.9 days compared to 3.5) and non-elective being longer than the England average (9.3 compared to 8.8 days). Compared with the trust level, average length of stay at CIC was long for both elective non-elective admissions (at 2.5 and 5 days respectively).
- Three surgical specialties were above the England average for admitted RTT (percentage within 18 weeks). These were general surgery at 86.7% (England average 76.4%), ENT 85.8% (England average 70.3%), and urology at 81.4% (England average 80.2%).
- An action on the quality improvement plan stated the division aimed to achieve compliance with 18 week RTT for the incomplete pathway standard by September 2016. The status of this action remained 'in progress' at December 2016.
- Four surgical specialties were below the England average for admitted RTT (percentage within 18 weeks). Ophthalmology showed the poorest performance compared with the England average, with a marked deterioration in June and July 2016, when the percentages were 24.4% and 8.9% respectively. This speciality had improved in August, to 29.6%, but remained notably below the England average of 77.5%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive in hospital, after they have arrived in hospital, or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to

Q1 2016/17 the trust cancelled 1,410 surgeries. Of these, 12% were not rescheduled and treated within 28 days. The overall trend was that the trust had a much higher percentage of operations not treated within 28 days than the England average. Performance improved from Q1 2015/16 to Q3 2015/16. However, performance deteriorated again from Q4 2015/16 and was showing signs of deteriorating further.

- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short-notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend had followed a similar pattern to the England average, although the peaks and troughs were far more pronounced, particularly the increase in Q3 2015/16 (although it should be noted that industrial action was planned during this period and may have contributed to the sharp rise).
- For the period November 2015 to November 2016 CIC cancelled 573 elective surgeries for non-clinical reasons. WCH cancelled 292 elective surgeries for non-clinical reasons.
- Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges, and assess bed availability throughout the trust.
- The main reasons for delayed transfer of care at the trust was 'waiting for further NHS non-acute care' (35.9% compared to an England average of 18.3%) followed by 'awaiting care package in own home' (19.5% compared to an England average of 17.8%). This was recorded between August 2015 and July 2016.
- Bed occupancy rates were consistently below the England average between Q3 2014/15 and Q2 2015/16, with trust rates ranging from 82.8% to 85.7% in this time period. Between Q3 2015/16 and Q4 2015/16 the trust bed occupancy rates were about the same as the England average.
- Between August and November 2016 medical outliers on the designated outlier ward at WCH accounted for approximately 25% of the ward occupancy.
- The trust held local and cross-site teleconferences during the day to address access and flow issues. Senior nursing staff, matrons, and business managers attended to record bed

occupancy and availability, discharges, and pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day and prioritised actions to remove obstacles for patient admissions and discharges.

- Divisional managers across the trust worked with partners to look at projects to improve patient flow standards, facilitate an improved transition to discharge, and reduce delayed transfer of care. The trust had implemented the SAFER model (acronym for senior medical review, all patients having a discharge date, flow, early discharge and review). We identified this framework being referred to at the teleconferences. However, reference to the key model indicators were less apparent on ward and board rounds.
- The medicine division had developed a nurse-led ambulatory care model at WCH. The service provided treatment to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included patients requiring assessment and treatment for atrial fibrillation, cellulitis, low-risk chest pain, and pulmonary embolism. These pathways provided criteria to help staff identify patients who could be safely cared for in the ambulatory care setting without hospitalisation. The unit tend to see in the region of 200 patients a month (the range from May to October 2016 was 182 to 226). The unit was sometimes inappropriately used as a holding area for patients awaiting discharge.
- From March to August 2016 there were a number of patients moving wards after 10pm at WCH. The total numbers were low on the non-acute wards. However, in EAU and CCU these averaged 82 and 23 respectively.
- The trust's referral to treatment time (RTT) for non-admitted pathways between September 2015 and August 2016 was similar to the overall England performance. Eight specialities were above the England average and seven specialities were below the England average. For example rheumatology was at 96.9% against an England average 93.4% and ophthalmology was at 96.4% against an England average of 93.8% for non-admitted RTT performance.
- Data from the non-admitted RTT performance of specialties below the England average showed that urology was at 88.3% against a 90.3% England average and trauma and orthopaedics was at 93.8% against an England average of 90.1%.
- The trust's RTT for incomplete pathways between September 2015 and August 2016 was worse than the England overall

performance and worse than the operational standard of 92%. There were ten specialities above the England average for incomplete pathways for RTT, and there were five specialties that were below the England average for incomplete pathways for RTT. For example, dermatology was at 96.7% against an England average of 94.2%. However, ophthalmology was at 86.8% against the England average of 93.3% for RTT incomplete pathways.

- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- At Q2 2016/2017 the trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis. Before Q 2 the performance had shown a downward trend from Q3 2015/2016 to Q1 2016/2017.
- The trust previously performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. At Q2 2016/2017 the trust performance was slightly above the England average, at Q3 this was above the England average at 86.65%.In our previous inspection six-week diagnostic waiting times were raised as a concern. Data at this inspection showed that, between September 2015 and June 2016, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. However, in July 2016 and August 2016 the waiting times were better than the England average. Over a 12 month period From September 2015 to August 2016 there had been a trend of improvement.
- During our inspection we found that clinics had been cancelled within six weeks of the scheduled clinic date in outpatients. The trust was unable to provide the percentage of clinics cancelled. However, the number of these cancellations in July 2016 was 98. In August 2016 it was 71, and in September 2016 it was 175. In July 2016 148 clinics were cancelled more than six weeks prior to the scheduled clinic date, in August 2016 that number was 168, and in September 2016 it was 286. Information provided by the trust showed that the main reasons for cancelled clinics were industrial action, sickness absence, and locum medical staff turnover. There was no action being taken to address cancelled clinics in outpatients.

Learning from complaints and concerns

Summary of findings

- A comprehensive and current complaints policy covered the complaints management process for the trust.
- Between September 2015 and August 2016 there were 291 complaints about the trust. The trust took an average of 45 days to investigate and close complaints; this is in line with its complaints policy, which states complaints should be not be open for in excess of 50 days. The most common area of complaint was accident and emergency (58 complaints) followed by trauma and orthopaedics (32 complaints).
- For the three months prior to our inspection the trust had responded to 100% of complaints within 30 days.
- We reviewed 15 complaints. Each complaint was signed by the chief executive and contained a comprehensive response, an apology, and, where required, an action plan. There was also evidence of lessons learned in these responses.
- Ward meetings discussed complaints received as a standing agenda item.
- We reviewed complaints, and compliments were discussed. We saw evidence of audit activity and learning from complaints and clinical risk management issues.
- All wards and departments had posters situated at the entrance clearly explaining what to do if unhappy with the care, services, or facilities provided. Contact details for the Patient Advice Liaison Service (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 services at this trust well-led?

Requires improvement

We rated well-led as requires improvement because:

- The governance and risk strategy framework had improved since our previous inspection. However, further improvements and embedding of processes were required.

Summary of findings

- Progress against the Quality Improvement Plan (QIP) 16/17 had demonstrated progress in key areas such as the management of patients with sepsis and acute kidney injury. However, some areas of the QIP remained in progress and were not fully delivered at the time of the inspection.
- At the time of inspection the Perioperative Improvement Plan (PIP) was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the surgical division. Although most staff were aware of the plan they could not articulate specific outcomes.
- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services. Staff morale was variable and staff did not always feel that their contributions were recognised and appreciated. Staff viewed the decision regarding the nurse bank and nurses being paid at a mid-point band 5, irrespective of their substantive grade negatively. We were advised of ongoing bullying allegations within the theatre department at CIC. The Trust was aware of theatre staff being unhappy when requested to support core ward areas at times of staff shortage. We were assured that appropriate action plans were in place and being monitored'
- . We were assured that appropriate action plans were in place and being monitored.
- Staff found the speed and number of change processes being implemented across the trust to be hurried and unsettling. Staff confirmed this had added to existing pressures and caused additional stress and angst in some staff.
- The medical division risk register did not correlate with the top risks described by the divisional leads. There appeared to be some duplication of risks within the register, and risk rating calculations were confusing. There was a lack of detail to confirm action reviews and progress made.
- Although there was some improvement in cross-site working the cohesiveness of the two hospital sites for maternity services was not fully embedded.
- A programme and range of staff engagement activities and initiatives had been implemented during 2016 but this was not yet fully embedded.

However:

- The trust had developed a QIP to ensure implementation of its Clinical Strategy, Nursing, Midwifery, and Allied Health

Professionals (AHP) Strategy. Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis, and ongoing development of the Mortality and Morbidity Framework.

- The division had also developed a PIP in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- Regular divisional, emergency surgery and elective care business unit, safety and quality group, and clinical leads for National safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems, to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- Most area's risk registers were updated following the safety and quality meetings, with risks discussed and controls identified, and with progress against mitigation, risk grading, assurance sources, and gaps in control documented.
- There had been significant changes in the senior executive team since our previous inspection. This included a new chief executive, medical director, and director of nursing. The chief executive had recognised the need to strengthen and develop clinical leadership within the organisation. The director of nursing had also been very proactive in trying to address the nursing workforce issues.
- Although the executive team members were relatively new they appeared to be credible, and there were positive comments overall from staff regarding their visibility.

Vision and strategy

- The trust had developed a QIP to ensure implementation of its Clinical Strategy, Nursing, Midwifery, and Allied Health Professionals (AHP) Strategy. Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis, and ongoing development of the Mortality and Morbidity Framework.
- The surgical division had also developed a PIP in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance. At the time of

inspection this plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan they could not articulate specific outcomes.

- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.At our previous inspection we had identified that a credible clinical strategy must be in place. This was now in place but required further development, with some elements of the clinical strategy depending upon the outcome of the success regime.
- The Better Births Together benchmarking exercise was completed with the Clinical Commissioning Group (CCG) looking at a community midwifery model. The vision was to develop a community hub and to transfer services such as ultrasound in to these**.** the associate director of midwifery (ADOM) indicated that midwifery-led care was not well defined in the trust, and there was a need to change the ethos and re-engage with staff with a low-risk philosophy.
- The Child Health Clinical Business Unit strategy aligned with the trust vision to provide patient- centred and high-quality healthcare services, underpinned by the values of patients first, safe and high quality care, recognition of the importance of wider contribution, responsibility, accountability, and respect.
- Children's services, in conjunction with trust executives, had developed an internal success regime implementation plan, in which they highlighted eight objectives to support the changes being considered. These priorities focussed on developing self-care pathways, clarifying routes to access services, development of an integrated approach to the management of the sick child, plans for the management of long-term conditions, complex needs and vulnerable children, improving mental health services, improving multidisciplinary working, and optimising the use of telecommunications technology.

Governance, risk management and quality measurement

- The governance and risk strategy framework had improved since our previous inspection. However, the trust acknowledged that further improvements and embedding of processes were required.

Summary of findings

- The framework had received a review by the Good Governance Institute in 2016. This acknowledged that progress was being made but further work was required in some areas, which included embedding of trust values and the remit of the quality and safety committee.
- The Board Assurance Framework (BAF) was aligned to strategic objectives and we saw evidence that it was linked appropriately to divisional risk registers, which were regularly reviewed. A safety and quality quarterly report was presented to the trust board which included monitoring of the BAF.
- The quality and safety committee, a sub-committee of the trust board, received monthly reports from the clinical divisions regarding their quality and safety dashboards.
- Each division had a quality and safety board which reviewed complaints, incidents, and risk.
- Divisions held local risk registers and there was a clear process for escalation of risk**.** The medicine unit divisional risk register did not correlate with the top risks described by the divisional leads. There appeared to be some duplication of risks within the register, and risk rating calculations were confusing. There was a lack of detail confirming action reviews and progress made.
- Within maternity services there was some improvement in strengthening of governance processes but there were no indicators to ensure performance and understanding of risk or governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and systems to identify when action should be taken.
- Monthly speciality meetings across the trust were held, which discussed financial and clinical performance, patient safety, and operational issues.
- All business units produced integrated performance reports which gave progress updates on the relevant improvement and actions plan. These were presented to the trust board.
- A quality improvement board had been established to monitor progress with the QIP. This board included external stakeholders.
- The chief executive had introduced a clinical executive group (CEG). This group of senior managers, including clinicians, met weekly to discuss performance, quality, and operational issues.
- We reviewed root cause analysis reports from serious incident investigations. The reports included contributory factors and root cause analyses. Action plans were in place and changes to reduce the risk of recurrence were evidenced. Duty of candour was addressed, with specific details of when the patient and/or family were communicated with and given an apology.

Summary of findings

Leadership of the trust

- There had been significant changes in the senior executive team since our previous inspection. This included a new chief executive, medical director, and director of nursing.
- The senior team was aware of the challenges and issues within the organisation and had developed strategies and tightened governance processes to meet these challenges. However, these needed to be embedded.
- The chief executive had recognised the need to strengthen and develop clinical leadership within the organisation.
- The director of nursing had also been very proactive in trying to address nursing workforce issues.
- Although the executive team members were relatively new they appeared to be credible, and there were positive comments overall from staff regarding their visibility.
- The triumvirate management arrangement within divisions had also been changed and was continuing to be embedded at the time of the inspection.
- Senior staff were motivated and enthusiastic about their roles and had clear direction, with plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, skills, and experience.
- Staff said service leads and managers were available, visible across the trust, and approachable. Staff we spoke with told us that leadership of the service was better but required further improvement. Clinical management meetings were held and involved service leads and speciality managers.
- We found that leadership teams were aware of the challenges for their service and, in nearly all cases, these were reflected in risk registers.

Culture within the trust

- Staff morale was variable but this did not detract from a determination to ensure patients received the best care possible. Staff recognised the issues impacting on performance and morale but also considered there to be no quick fix for many challenges faced by the organisation. This was apparent in the NHS Staff Survey 2015 response, which reported that 85% of staff felt their role made a difference (lower than national average of 90%).
- Staff did not always feel their contributions were recognised and valued by senior leaders. Staff reinforced this by referring to a recent leadership decision to change remuneration payments for staff working additional hours to support the service.

Summary of findings

- Junior doctors expressed disapproval of the leadership team's management of medical rota deficiencies. Essentially, they considered divisional leaders 'passed the buck' for filling rota gaps to the junior doctors, with an expectation they would work additional hours or take time to find someone who would cover. They considered this to be taking them away from clinical duties and adding to existing working pressures. The doctors were of the view that this ought to be the responsibility of divisional managers or designated medical rota managers.
- Although there was some improvement in cross-site working the cohesiveness of the two hospital sites for maternity services was not fully embedded.
- There was an acknowledgement that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans. However, some staff told us they had been working in difficult circumstances during the preceding eighteen months to cover staff and skill shortages.
- The numbers of shifts not staffed to establishment across most surgical wards and areas, caring for medical 'outliers', and the high acuity and needs of patients all supported the view expressed by staff that they were working under pressure within the division.We were advised of ongoing bullying allegations within the theatre department at CIC. The Trust was aware of theatre staff being unhappy when requested to support core ward areas at times of staff shortage. We were assured that appropriate action plans were in place and being monitored.
- The trust's sickness levels between June 2015 and April 2016 were higher than the England average. Sickness levels ranged from a low of 4.32% in June 2015 to a high of 5.06% in February 2016.
- Most staff described good teamwork within the trust and we saw staff worked well together. We saw examples of good team working on the wards between staff of different disciplines.

Equalities and Diversity – including Workforce Race Equality Standard

- We found that the trust had a positive and inclusive approach to equality and diversity. We found that staff were committed and proactive in relation to providing an inclusive workplace.
- Governance arrangements were in place to ensure that the trust board received regular assurance that the trust was meeting its Public Sector Equality Duty.

Summary of findings

- This work was coordinated via the Equality & Diversity Steering Group (EDSG) which met quarterly and was a multidisciplinary group including external representatives from organisations such as Royal National Institute of Blind People, AWAZ Cumbria, and Cumbria Independent Living Forum.
- The Workforce Race Equality Standard (WRES) has nine specific indicators by which organisations are expected to publish and report, as well as put action plans into place to improve the experiences of their black and minority ethnic (BME) staff. As part of this inspection we looked into what the trust was doing to embed the WRES and race equality into the organisation, as well as its work to include other staff and patient groups with protected characteristics.
- The 2015/16 WRES data indicated that improvements had been made in some indicators (e.g. percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months) but there had been increases in BME staff reporting experiencing harassment, bullying, or abuse from staff in last 12 months, and personally experiencing discrimination at work from their managers/team leaders or other colleagues.
- Equality and diversity objectives had been developed to address issues raised in the WRES data. This was agreed by the executive team in May 2016 ahead of discussion at trust board in September 2016.

Fit and Proper Persons

- The trust met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We looked at employment files of all of the executive team members and non- executive directors. These had all been completed in line with the FPPR regulations.

Public engagement

- Staff and senior managers within the trust actively engaged with patients, family members, and the local population to canvas their opinions and obtain feedback on current services and future proposals.
- The focus of public engagement recently had been on the future proposals of Cumbria-wide healthcare provision and potential reconfiguration of services.

Summary of findings

- Patients and their families provided views and feedback on their experiences of using the service in the Family and Friends Test (FFT), through the 'two minutes of your time' survey, face-to-face and in real-time surveys. Patients could also leave feedback on comment cards and via the trust website.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.

Staff engagement

- In the NHS Staff Survey 2015, the trust performed better than other trusts in nine questions, about the same as other trusts in 17 questions, and worse than other trusts in six questions.
- Results from the 2015, NHS Staff Survey showed that the trust had improved in overall staff engagement (3.60). Although this was still lower than the national average (3.79), but staff also responded that: most problems were in putting themselves under pressure to come to work despite not feeling well enough; senior managers did not try to involve staff in important decisions; and there are not enough staff to support them to do their job properly..
- The NHS Staff Survey 2015, results showed that staff felt improved satisfaction with pay, managers taking an interest in health and wellbeing, incident reporting, acting on concerns, and prioritising the care of patients.
- The senior leadership team arranged staff forums and drop-in sessions. The trust chief executive held cross-site roadshows with recent topics covering staff support, staff morale, and generating cost savings. Some staff were critical of the format of these sessions, as more often than not they were unable to attend due to ward clinical duties and the agenda appeared driven by leaders as opposed to staff-led.

Innovation, improvement and sustainability

- The stroke team was part of the North West Network which provided a telemedicine (tele stroke) service across the region. This service provided rapid assessment of patients for consideration of thrombolysis.
- The medical care division was working on a number of improvement projects focussing on reducing patient harms and improving care pathways.
- Staff in EAU and CCU had forged strong links with community respiratory colleagues to promote transitional care for this cohort of patients across the region.

Summary of findings

- CIC was one of only 18 hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- The trust gained in-house Royal College of Surgeons accredited START surgery course for foundation doctors in surgery.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- An Honorary Professorship from the University of Cumbria had been received by a consultant for work on applying digital technologies in health care for an elderly population in rural setting; a part of CACHET.
- There was a multinational, multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- The trust was a National Patient Safety Awards finalist for 'better outcomes in orthopaedics'.
- A programme and range of staff engagement activities and initiatives had been implemented during 2016 but this was not yet fully embedded.

Overview of ratings

Our ratings for Cumberland Infirmary

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

Overview of ratings

Our ratings for West Cumberland Hospital

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

Our ratings for North Cumbria University Hospitals NHS Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

- The 'expert patient programme' and 'shared care initiative' in the renal business unit exhibited real patient integration, empowerment, and care partnerships.
- The trust was a National Patient Safety Awards finalist for 'better outcomes in orthopaedics'.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment knee surgery.
- An Honorary Professorship from the University of Cumbria had been received by a consultant for work on applying digital technologies in health care for an elderly population in rural setting; a part of CACHET.
- There was a multinational, multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- CIC was one of only 18 hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- There was real strength of multidisciplinary team working and positive patient outcomes in the stroke service.
- The 'expert patient programme' and 'shared care initiative' in the renal business unit exhibited real patient integration, empowerment, and care partnerships.
- There was a variety of data capture measures to monitor 'real-time' patient experience and collate patient feedback.
- There were innovative and progressive Frailty Unit projects at CIC.
- The growth, expansion, and development of the MPU service at CIC were impressive.
- The implementation of dance related activities for vulnerable patient groups stimulated social interaction, patient involvement, family partnerships, and exercise.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival, linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.
- Take further steps to resolve the flow of patients into and out of the hospital.

In Medicine

- Ensure systems and processes are established and operated effectively to assess, monitor, and improve the quality and safety of the services provided, and evaluate and improve practice to meet this requirement. Specifically, review the escalation process involving 'floor working' to ensure the quality and safety of services are maintained.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed across all divisional wards. Specifically, registered nurses to ensure safe staffing levels are maintained, especially in areas of increased patient acuity, such as NIV care and thrombolysis.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.

Outstanding practice and areas for improvement

- Improve compliance with 18-week referral to treatment standards for admitted patients for oral surgery, trauma and orthopaedics, urology, and ophthalmology.
- Improve the rate of short notice cancellations for non-clinical reasons specifically for ENT, orthopaedic, and general surgery.
- Ensure patients whose operations are cancelled are treated within 28 days.

In Maternity and Gynaecology

- Review staffing levels, out-of-hours consultant paediatric cover, and surgical cover to ensure they meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour')
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures are effective.

In Services for Children and Young People

- Ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).
- Ensure nurse staffing levels on SCBU adhere to establishment and meet recognised national standards.

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments in line with the Mental Capacity Act.

In Outpatients and Diagnostic Imaging

- Address the number of cancelled clinics in outpatient services.
- Ensure referral to treat indicators are met across outpatient services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.** The provider has not ensured the provision of appropriate care and treatment that meets peoples needs. Regulation 9(2). Reg. 9 (3b) - The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. Without limiting paragraph one designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; How the regulation was not being met: • The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard continuously between September 2015 and August 2016. • Between September 2015 and August 2016 performance against this metric showed a decline from September 2015 to January 2016. There was a general improvement from January 2016 to July 2016. However, this declined again in August 2016. In August 2016 the percentage of patients, admitted, transferred, or discharged within four hours was 90.1 % compared with an England average of 91.0%. • The locally agreed trajectory for the four-hour target as agreed with commissioners and regulators was not being met. • Four surgical specialities were not meeting the 18 week referral to treatment standards for admitted patients (oral surgery, trauma and orthopaedics, urology, and ophthalmology). • Short notice cancellations for non-clinical reasons were high, specifically for orthopaedic surgery.

This section is primarily information for the provider

Requirement notices

- A high percentage of patients were not receiving their procedure within 28 days of the initial cancellation.
- There were a number of cancelled clinics in outpatient services.
- There were a high number of medical outliers at West Cumberland Hospital.
- DNACPR forms were not fully completed in terms of best interest assessments in line with the Mental Capacity Act.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met: • Children and young people's services did not meet all Royal College of Paediatrics and Child Health (RCPCH) Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). Specifically, the unit did not meet: • Standard 1 – A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week; • Standard 3 – Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned; • Standard 4 – At least two medical handovers every 24 hours are led by a consultant paediatrician. • Out-of-hours consultant paediatric cover and surgical cover did not meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour').

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

Reg. 17 (2a, f) Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Evaluate and improve practice to meet this requirement.

How the regulation was not being met:

- There were gaps in how outcomes and actions from audit of clinical practice were used to monitor quality in maternity services.
- Escalation process, specifically 'floor working' initiatives across medical wards, were not effective.