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

### Facts and data about this trust

Blackpool Teaching Hospitals NHS Foundation Trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria, supporting a population of 1.6 million. The trust is a provider of specialist tertiary care for cardiac, haematology and cystic fibrosis services across this region.

The Trust provides a range of acute services to the 330,000 population of the Fylde Coast health economy and the estimated 11 million visitors to the seaside town of Blackpool. The trust also provides a wide range of community health services to the 440,000 residents of Blackpool, Fylde, Wyre and North Lancashire.

The Trust hosts the national artificial eye service, which provides services across England.

(Source: PIR context)

### Is this organisation well-led?

#### Leadership

Blackpool Teaching Hospitals NHS Foundation Trust was led by the chairperson and chief executive. The chairperson joined the trust in April 2012. The chief executive was appointed as interim chief executive in February 2016. This was made a substantive appointment in June 2017.
The chairperson and chief executive were supported by five directors. These were the director of operations, medical director, director of nursing and quality, director of finance (deputy chief executive) and an interim director of workforce and organisational development. There had been a stable leadership team since the previous inspection, with the exception of the chief executive and the director of workforce and organisational development. The chief executive officer had been the executive director of strategy and deputy chief executive officer at the trust prior to their appointment to their current role. The permanent appointment to the director of workforce and organisational development post was pending the wider decisions about the structure of an accountable care system across Blackpool, Fylde and Wyre.

There were clear structures and responsibilities for the directors. The director of nursing and quality had a wide remit, which included responsibility for quality and clinical governance. The executive team reported they worked well together and felt supported by the wider board.

There were seven non-executive directors with a range of skills. It was recognised that, due to retirement, there was no longer a non-executive director with a clinical background. There were plans in place to address this with the appointment of a further non-executive director planned for early 2018.

The trust had five operational divisions; a deputy director of operations, divisional director and an associate director of nursing led each of these. The divisions reported that the organisational structure was effective.

There was some evidence of collective leadership seen during the inspection. Collective leadership represents a new way of sharing power, ensuring that leadership and expertise are correlated at every level in relation to every task. It creates a culture in which high quality, compassionate care can be delivered. Divisional directors attended the non-public board meetings and there was wide membership of the Quality Committee. Managers felt able to challenge the board and felt this had improved over the last six months. A few members of staff expressed frustration at the pace of change.

The leadership team understood the challenges to quality and sustainability faced by the trust. They could articulate the detailed pressure points and became actively involved in supporting the system. For example, senior staff and directors worked clinically both in a planned approach and when required. Although this was understandable, there was a risk that this ‘hands on’ approach, distracted from their strategic role. That said, the directors were involved in external engagement and planning regarding the development of the accountable care system, so had competing demands.

During the inspection, we carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (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. The trust had an up to date, fit and proper persons procedure that detailed the requirements. The procedure applied to permanent and interim executive directors, non-executive directors, governors and very senior managers, which was more than required under the Fit and Proper Persons Requirement.

We found evidence that the trust complied with the Fit and Proper Persons Requirement with the exception of a lack of complete evidence of competency-based interviews and, in one file, verbal references had been taken and not fully recorded. We raised these issues at the time of the inspection and the trust took action to address these. We saw evidence of completed annual fit and proper person test self-declarations.
Most staff reported that the leaders were visible and approachable. Directors had a specific area of the trust where they were the identified link. Directors, non-executive directors and governors undertook a programme of walkabouts and reported these back at board meetings. These included community services, although some staff reported leaders were less visible particularly in the northern part of the area.

There was a strong sense of integration across both the acute and community services. Directors demonstrated an understanding of the quality of care across all sectors.

The trust had 33 governors and we spoke with a group of them during the inspection. They described an approachable leadership team and reported good engagement with the executive team.

There was a five-year workforce and organisational development strategy, developed in consultation with staff, which included leadership development and succession planning. We saw examples of staff accessing leadership development programmes.

**Vision and strategy**

The trust had identified four values; people centred, positive, compassion and excellence. We found staff were aware of the values, there was supporting literature available and staff reported the values were embedded in the appraisal process.

During the inspection in 2014, we were unable to identify a clear vision or strategy to support the trust. At this inspection, we found that a trust vision and five-year strategy had been developed in consultation with staff, patient representative groups and external stakeholders. Some staff and governors we spoke with confirmed they had been involved in the discussions about the trust vision and strategies.

Blackpool Teaching Hospitals NHS Foundation Trust had a strategic vision for 2020 which was ‘As a high performing trust, operating as part of an integrated care system, we will provide high quality, safe and effective care. This will be achieved in a financially sustainable way, through our skilled and motivated workforce’. The strategy had been developed to align with those of external partners.

A clear, concise quality strategy covered the period 2016 to 2019. This identified the trust’s ambition to provide the best patient care that is informed, timely and safe. The quality strategy demonstrated an interrelationship with the trust vision and key goals. There were clear timescales on progress reported to the board. However, it was not clear how the strategy aligned with the structure of board minutes. Divisional strategies were mostly in place to support the trust strategy.

Priorities for medicines optimisation were included within the trust’s hospital pharmacy transformation plan. However, identification of risk and governance around delivery of transformation priorities was unclear. The director of pharmacy told us that implementation of electronic prescribing and medicine administration was a key priority. Electronic prescribing was included in the trust’s NHS England ‘fast follower’ proposal to try to secure funding for the roll out of digital processes.

The trust had a dementia strategy (2016 to 2019) that identified key action areas. We saw evidence of implementation.

There was a five-year human resources strategy, which had recently been rewritten and had involved a number of consultations with staff to inform the strategy.
Culture

There was strong patient focus, which included the wider community. We found the culture centred on the needs and experience of people who used services. Most staff felt positive and proud about working for the trust and their team, although a few staff, particularly medical staff based in the acute hospital, were less positive and raised this with us during the inspection. The governors said that the trust was open and transparent and that the level of patient experience had improved, but that there were pockets where the culture was not quite as good. Senior leaders recognised there was a tension in the delivery of finance and quality responsibilities and that this was the challenge for the organisation. Senior staff felt that quality was always the priority, whilst this was not always recognised as the case by divisional teams.

There was a freedom to speak up guardian at the trust. The freedom to speak up guardian at the trust had an intranet page and staff could use this to raise a concern. This could be done anonymously; there was also a phone app and a dedicated email address. There were 12 speak up champions in the trust at the time of the inspection and there were 14 people waiting to be trained. The champions were from a number of staff groups including allied health professionals, nurses, biomedical scientists and administration staff. There were two doctors on the waiting list for training; one was a consultant and the other was a middle grade doctor. The freedom to speak up guardian reported to the strategic workforce committee.

There was also a guardian of safe working. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. They met with the junior doctors at their forum every three months to promote their role and to engage with the junior doctors. They used surveys and focus groups to identify any areas of concern. Reports were also used to look at areas in the hospital where doctors were consistently working extra hours and appropriate staffing measures could be put in place. The guardian of safe working said the role had highlighted areas of concern of medical staffing and that this had been viewed positively by the consultants. They also said that they were happy to raise concerns about medical staffing with the board and the executive team.

The trust had revised their whistle blowing policy and had produced leaflets and a manager’s guide to raising concerns. Concerns raised at the trust included issues relating to policies and procedures, behaviour, recruitment processes, patient safety, quality, staffing, patient experience and service procedures. The freedom to speak up guardian provided a number of examples of changes made following the reporting of a concern.

A previous whistle blower had recently been involved in making a video for Health Education England with a colleague from another trust. The video was to be used at staff induction.

In the 2016 NHS staff survey, the trust performed about the same as other trusts regarding experiencing harassment, bullying or intimidation from staff in the last 12 months. This was the same as the previous year; an action plan was in place to address concerns raised.

At the last comprehensive inspection in 2014, it was reported that the hospital’s reporting of incidents was poor in some areas where some staff did not report near misses. At this inspection, we found that staff felt confident and were encouraged to report incidents via an electronic system. The trust was in the top 25% (3rd out of 136 comparable trusts) of reporters to the National Reporting and Learning System.

We found evidence that the trust were compliant with the duty of candour requirements. This states the trust must act in an open and transparent way about the care and treatment patients
receive and notify them, as soon as is reasonably practicable, after becoming aware that a notifiable safety incident has occurred, firstly in person and then in writing.

The trust had a ‘patient safety including being open and duty of candour policy’ which was available on the trust’s intranet. The risk department undertook monthly audits of compliance for all patient safety incidents recorded through the incident reporting system, which were graded as causing moderate to severe harm. Duty of candour compliance was also a standing agenda item on the monthly divisional risk governance group meetings. Between April 2016 and March 2017, the trust reported they had applied the duty of candour 173 times. Serious incidents were monitored corporately to ensure duty of candour was completed.

There were processes for supporting staff at every level with an appraisal to identify development they needed and support career development. We saw several examples at different grades where staff had been supported by the trust to develop their careers. The overall appraisal completion rate at the trust at 1 November 2017 was 80.1%. In the 2016 NHS staff survey, the trust performed better than other trust in the percentage of staff appraised in the last 12 months. However, they were worse than other trusts in the quality of appraisals. There was an associate medical director for revalidation and appraisal who contacted consultants who had not been appraised. The associate medical director worked with the General Medical Council employment advisor, if necessary. The medical director said that they had worked with neighbouring trusts on the quality of the appraisal.

The trust had an equality and diversity manager in place, whose role was to develop the equality and diversity agenda within the organisation. The director of nursing and quality was the executive lead for equality, diversity and inclusion.

The trust had an equality, diversity and inclusion policy which was reviewed in 2016; before this the policy was the equality and diversity policy and was widened so that it was more inclusive. Within the policy there was a clear focus on taking positive action to promote equality for all. This policy applied to those who were employed by the trust and those who were in receipt of healthcare. The nine key characteristics were clearly identified, roles and responsibilities were defined, definitions were provided and the process to follow if subjected to discrimination was clear. Within this policy, there were no reference to the other policies, for example freedom to speak up or bullying and harassment. We saw that both of these policies existed and were appropriate and within date.

An equality, diversity and inclusion strategy was in place as part of the Workforce Strategy (2014-19) which was refreshed in 2016. The strategy aimed to move the organisation ‘beyond compliance’ in terms of equality, diversity and inclusion. The achievement of the strategy was monitored through the equality, diversity and inclusion implementation group, which was chaired by the director for nursing and quality. The group was a sub-committee of the quality and safety committee.

We saw evidence and most staff told us that there were cooperative, supportive and appreciative relationships among staff.

From March 2016 to January 2017 sickness absence rates at the trust were consistently higher than the England average.
The trust scored same as expected in the GMC training scheme survey 2016 for all areas.

(Source: GMC- Trainee Survey (22/03/2016 - 11/05/2016)

Governance

Structures, processes and systems of accountability were in place to support the delivery of the strategy and good quality services. There were six sub-committees of the board, each chaired by a non-executive director. These were the Quality, Finance, Audit, Strategic Workforce, Strategy and Assurance and Remuneration Committees.
We saw that the Quality Committee, had 30 groups that reported directly to the committee. Whilst this arrangement appeared to work, we had some concerns regarding how manageable this was and how assurance was provided. For example, the medical director had board level oversight responsibilities for medication error incident reporting and learning systems. However, it was unclear how assurance was provided regarding delivery of the medicines safety work plan. The trust’s Medicine Management and Medication Safety Committee reported to the Quality Committee only by exception. Exception reporting had been noted as a concern by the Quality Committee and a recommendation made that reports should also include ‘notable information’. Additionally, the Medicine Management and Medication Safety Committee did not include a patient representative. [NHS England Patient Safety Alert March 2014. Improving Medication Error incident and reporting].

There was a recognition there was further progress to be made in the committee structures, which had been revised a couple of years ago. However, there was also a recognition that this needed to be completed without compromising the engagement of staff in the process.

The Quality Committee reported quarterly to the board and with an annual report. We reviewed the trust’s quality accounts and found the objectives were linked to the quality strategy with an annual report submitted to the Quality and Audit Committees.

Each division had a dedicated quality manager. They supported monthly divisional clinical governance meetings. The key governance meeting for each division was the performance board, which included a review of performance on quality, finance, operations, workforce, governance and current risks. The performance report was presented monthly to the executive team members. Divisional teams felt the meetings were positive, gave direction and engaged teams.

The deputy director of nursing role focused on clinical governance, quality and safety and the nursing strategy. They reported to the director of nursing, with the key reporting committee being the Quality Committee.

In addition, the medical director chaired a monthly clinical policy forum attended by divisional directors, heads of service and senior nurses from each department. The agenda included items regarding clinical policies, clinical strategy, and professional standards.

There was also a senior leadership forum, which had only met twice at the time of the inspection. The minutes of this meeting also went to the board.

There was a monthly overview of complaints, incidents and serious incidents for each division which identified themes and trends. These were triangulated together with any safeguarding incidents.

A ‘Learning from Incidents Review Committee’ reviewed and signed off serious incidents reports and investigations. All serious incident reports were approved by the director of nursing and/or the medical director and submitted to the relevant clinical commissioning group. Reports were sent to the appropriate division and learning was circulated by a newsletter. Grand rounds were used to disseminate learning to the medical staff.

A weekly safety panel was held. This panel, which included the director of nursing, medical director or their deputies, reviewed all incidents.

Following a regulation 28 report to prevent future deaths, the coroner had requested that all serious incidents were investigated independently outside their clinical area. There was now a cohort of independent investigators and a case manager who were all trained into incident
investigation; these included clinicians, quality managers and divisional managers. They reported to the divisional lead for serious incidents and the safety panel.

An external well-led governance review was undertaken by MIAA and AQuA and reported to the board in October 2016. The overall conclusion from the review was that the trust was well-led. The report authors stated that they encountered examples of good practice in terms of strategic grip, engagement and governance process. They also identified good examples of leadership behaviours and values were evident in a range of settings. Some issues were raised regarding whether the strategic aims remained achievable and relevant, the speed and impact on mortality performance and the aligned pathway compliance and there were some concerns about appropriate information being analysed and challenged. The trust had developed an action plan to address these areas; this was monitored at the board meetings.

Management of risk, issues and performance

Assurance systems were in place and performance issues were escalated appropriately.

Divisional board meetings were held monthly. Themes from divisional boards were reported as part of the divisional performance review meetings with the executive directors.

An integrated performance report was reviewed at board subcommittees, including the Quality Committee. Although we had some concerns about the process for reviewing the integrated performance report by the board, we were assured that all board members received a copy and it was discussed at board meetings as part of the chief executive's report. This was confirmed when we attended a board meeting. However, the board minutes did not reflect that it was consistently considered.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. There was a lead for corporate governance whose focus was the board assurance framework, the corporate risk register and legal. They reported to the CEO, with the key reporting committee being the Audit Committee. The Audit Committee reviewed the risk register and discussed new risks and risks that had been removed following the executive directors meeting. The assurance framework and the risk register were presented to the board at least quarterly.

There was a process for categorising risks using a risk matrix and framework based on the likelihood and consequence of the risk occurring. There was a clear process for escalation of risks to divisional and board level. All risks on the risk register had planned review dates. Risks were identified as those that should be treated, tolerated, transferred or terminated. The risk register contained risks that had been identified for a number of years, which remained despite mitigation. The trust were aware of the need to relook at risk appetite in the organisation; they had arranged a session with the non-executive directors to look at the risk register as part of a board development session.

The leadership team and staff across the organisation could articulate the key risks in the organisation. These matched the areas identified on inspection. These related to workforce, finance, demand and flow and mortality.

The trust leadership team recognised the significant challenge it had regarding recruitment, specifically to nursing and medical vacancies. There was a programme of improvement to address gaps and focus on long term sustainable workforce solutions. These included targeted recruitment campaigns to support hard to fill vacancies and support business cases for alternative roles or revised service delivery models where recruitment was not possible, management of the
temporary staffing service, overseas recruitment campaigns for medical and nursing staff and expansion of new roles such as nurse associates and wellbeing support workers.

During the last inspection in 2015, it was identified the systems for checking essential equipment were ineffective. The trust has since developed a subsidiary company to provide a fully managed estates service including the maintenance and servicing of medical equipment. There was a recovery plan in place, staff reviewed this at the client monitoring meetings chaired by the director of nursing. There was a focus on the high-risk devices. At the previous inspection, 22% of all equipment had been checked across the trust; at this inspection 68.5% (approximately 9,000 devices) of equipment had been checked. The plan was to achieve 90% by August 2018. This issue was recorded on the corporate risk register.

The trust summary hospital level mortality indicator had been raised for over five years and the trust was one of 14 trusts across the country that had been subject to a Keogh mortality review in 2013. The trust had appointed a mortality reduction lead who reported to the medical director and undertaken work to reduce the indicator.

The trust had reviewed nine clinical pathways for the major conditions with high mortality rates using guidance from the National Institute for Health and Care Excellence. The nine pathways were available on the front page of the trust intranet and the trust compliance to the pathways was monitored by the trust mortality lead. They had also looked at coding issues in patient records. The patient records had been redesigned to improve the quality of the record and there were education sessions for new doctors to improve record keeping.

There were weekly mortality reduction steering group meetings to review progress and to discuss mortality issues. There was a bimonthly mortality committee that reported to the quality committee. The clinical commissioning groups had representation at the mortality meetings.

We saw evidence that the strategy to reduce the mortality rates was having a positive effect. However, this was not yet to be reflected in national mortality data. We also noted the high levels of deprivation in Blackpool and the impact on life expectancy. We considered that, whilst the trust was taking action to improve mortality rates, some of the factors involved were multifactorial and it was likely that further work, involving partners across the geographical area, would be required to maximise benefits to the overall population.

The trust had implemented a ‘responding to deaths’ policy in September 2017. This embraced the principles outlined in the ‘Learning, candour and accountability’ report published in July 2017. This included undertaking ‘end to end’ retrospective case records review in conjunction with primary care to look at opportunities for action and learning to improve patient care.

The internal audit plan was linked to the Board Assurance Framework. The trust identified the audits areas required at a corporate level. There was additional flexibility to agree other areas for internal audit.

All staff undertaking audit or a service improvement had an identified lead link person to support them and ensure the member of staff completed the audit or service improvement with an action plan that was signed off centrally, particularly for junior doctors and nursing and allied health professional students. Staff with experience of quality improvement mentor other staff.

The trust was starting to use Model Hospital data in management meetings. The NHS England Medicines Optimisation Dashboard showed the trust uptake of biosimilars (a biosimilar is a medicine highly similar to another already approved biological medicine) was in the lower interquartile range. Increased use of biosimilars can result in significant savings without any
clinically meaningful differences in terms of quality, safety and efficacy. The dashboard also showed an increasing trajectory for National Reporting and Learning System reported medicines safety incidents [April 2014 to September 2016]. This is challenging to interpret as high reporting can be due to good reporting or associated with high levels actual problems. The trust had identified a concern with regard to the number of medicines omissions. A medicines error task and finish group was formed and a new process, ‘Yellow Omission Stickers’ was piloted and rolled out to try and bring about improvement in the recording and follow-up of medicines omissions. Audits were in place to look at short-term adoption and longer term embedding into practice.

Antimicrobial ward rounds had not been carried out since February 2017 due to a shortage of consultant microbiologists. Public Health England Guidance, Start Smart - Then Focus 2015 recommends that trusts have a ward-focused antimicrobial team to review prescriptions at ward level as part of multidisciplinary antimicrobial stewardship ward rounds. This position was being advertised. The Director of Pharmacy was also developing a business case for the recruitment of additional antimicrobial pharmacist support, measured against the Antimicrobial Self-Assessment Tool for the NHS. In the interim clinical ward pharmacists were advised where high risk antimicrobial prescribing was identified from the trusts dispensing records, in order to confirm microbiology approval and review.

Quarterly audits on the choice of antimicrobials and stop/review date were carried out to ensure compliance with the trust formulary and policy. The trust reported low (40% ) compliance with recording antimicrobial stop/review date overall. However, the trust achieved 100% in April to June 2017 and 95% in July to September 2017 for compliance with the CQUIN for empiric review of antibiotics within 24 to 72 hours in sepsis patients. In response to incidents, the trust was piloting a vancomycin monitoring form to provide staff with guidance on the appropriate prescription and therapeutic drug monitoring of vancomycin therapy. Similarly, a gentamicin dose calculator was in the final stages of development.

There was a process for considering cost improvements programmes and their impact on quality. An analysis was considered by the medical director and director of nursing and quality. The executive team were able to provide an example of when a cost improvement had been rejected due to the potential impact on quality.

The trust had contingency plans and a major incident plan in place. There was work to improve systems following the cyber-attack. We had some concerns regarding the plans in place to support the emergency department when it was busy so that all staff were aware of the processes. There was a trust-wide patient flow and escalation policy, however this was a draft document. This was to replace the bed management policy, which had not been updated since 2014.

**Information management**

The trust was continuing to improve access to appropriate and accurate information. However, the use of technology could be improved further and some plans were in place to address this. Available information was being effectively processed, challenged and acted on.

The trust had recently been identified as a ‘digital exemplar’ fast follower trust. This meant it was selected as a partner with another trust to accelerate their digital maturity.

The trust had introduced an electronic records system during 2016 and 2017 in the emergency department and some community areas, although the majority of clinical areas used paper
records. An information technology business plan had been agreed, although the financial aspects were yet to be agreed. The trust did not have currently have e-prescribing due the cost of implementation.

The trust leadership team recognised that the electronic records system recently introduced in the community services had resulted in a significant improvement in data quality, although there was further work to do.

The trust produced an integrated performance report, which sufficiently covered and integrated people’s views with information on quality and operations. This included information on trends to measure improvement. This was reviewed at divisional and executive level.

We found board members effectively challenged data and information. The chair spoke about corroborating the information by checking with staff, observing when doing regular walk arounds and occasionally attending divisional meetings. The non-executive directors challenged information; we observed this during a trust board meeting and staff also provided us with additional examples.

The trust had a data quality policy and were compliant with the latest Information Governance toolkit standards, last published in July 2017. The current Information Governance Toolkit assessment been completed as required by 31 March 2017.

The trust had introduced an executive-led transformation programme called ‘better care now.’ This was established to improve patient flow throughout the trust. There were three key work streams to address all aspects of the patient’s journey. These were admission avoidance and admission, treatment and inpatient care and return to home.

To support this work an in-house tracker system had been developed and was being rolled out across the trust. This supported daily ward board rounds and patient pathways. There was a real-time display screen on each ward displaying details and progress for each patient. The use of the tracker provided information from individual patient to trust-wide level. The use of the tracker system was in the process of being fully embedded, but once fully in use would allow the trust to have access to ‘live’ information across the trust. The executive team were fully aware of the benefits this would make to information management.

With patient consent, the pharmacy team had access to GP information through Medical Interoperability Gateway to support medicines reconciliation on admission to hospital. Trust data for medicines reconciliation showed performance was in line with the NHS England average for non-specialist acute trusts.

**Engagement**

The trust had systems in place to gather people’s views and experiences and used these to improve the services.

There were a range of meetings held to engage patient, carers, the public and external stakeholders. These included a quarterly patient carer and involvement meeting, which involved external stakeholder such as Healthwatch and visually impaired groups, as well as directorate team members. This reported to the Quality Committee. There was a quarterly equality, inclusion
and diversity meeting, which included Healthwatch, chaplaincy and the trust equality and diversity lead.

There was also a monthly influence panel. Plans for service developments are presented to the panel. The trust provided examples of when this had happened, such as the redesign of the outpatients department when the panel members also visited the site. It was felt that the panel worked well with the estates department; the involvement of a person who used a wheelchair to consider the external footpath around the hospital had led to recent changes.

The trust had developed a number of learning disability guides within the trust. These met monthly. The trust had initially introduced link nurses, but this had been modified to be multidisciplinary and include anyone in the trust with an interest. Patient stories were heard at the meeting and a patient with learning disabilities had attended the meeting. There was learning disability lead who was jointly appointed with the local authority.

There was also engagement with children through Victoria’s voice and a health ambassador role. Children and young people could join when they were 12 years of age. The trust had engaged with 10 high schools in the area and the ambassadors were engaged in awareness of health issues and disseminating this information to their peer groups.

The trust monitored friends and family data. In addition, they had ‘listeners’ who were volunteers. They asked patients and visitors a core set of questions based on national surveys or bespoke information. For example, they had recently asked questions about “John’s campaign” to help determine how this was to be progressed. A consultation event with staff and stakeholders was also held.

The trust were piloting a recognised programme to look at what should always happen for relatives of patients with cognitive impairment. They had identified a patient charter to allow greater freedom for supporting patients.

The patient engagement team, used user experience and staff experience to support development, such as dementia care. There was a memory corridor at the trust and staff from all areas were encouraged to take patients there; it was felt this engaged staff and reminded them why they were there.

There was evidence of engagement to support the wider population. For example, the trust had worked with an external organisation who aimed to reduce social isolation. In July 2017, they had created a ‘living room’ in a 45 foot tepee in the entrance to the acute hospital. Patients, staff and visitors were able to go and meet each other. This had a positive impact on individuals.

We saw that people who had made a complaint were responded to appropriately. However, we identified that there was limited involvement of patients and carers in the investigation process for serious incidents.

The trust pharmacy team made electronic referrals to the patients usual community pharmacy where they identified that the patient would benefit from further review or support in the community. Monitoring by the trust pharmacy showed there were approximately 100 referrals a month with an increasing trajectory. Work was beginning to determine measurables to evaluate the patient benefits and possible effect on hospital re-admissions.

The trust also has a service level agreement with Fylde and Wyre CCG for pharmacists in GP practices. The pharmacy team worked alongside GPs to support audit and ensure cost effective prescribing.
The trust reported good working relationships with its local commissioners. Over the last 2 to 3 years, the trust had been working with Blackpool CCG, Fylde and Wyre CCG, Blackpool Council and Lancashire County Council as part of the Fylde Coast vanguard within the National New Models of Care Programme. These organisations along with the trust are to develop into an accountable care system. There is a memorandum of understanding in development across all partners within the accountable care system and wherever possible, joint appointments were being made to support the effective transition to the accountable care system.

In the 2016 NHS staff survey the trust performed better than other trust in four questions, about the same as other trusts in 28 questions and worse than other trusts in two questions.

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</tr>
<tr>
<td>Percentage of staff suffering work related stress in last 12 months</td>
<td>●</td>
<td>36%</td>
<td>35%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>●</td>
<td>28%</td>
<td>31%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents in the last month</td>
<td>●</td>
<td>89%</td>
<td>90%</td>
<td>⬤</td>
</tr>
<tr>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>●</td>
<td>3.75</td>
<td>3.72</td>
<td>⬤</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>RAG</th>
<th>Trust</th>
<th>National</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective use of patient / service user feedback</td>
<td>○</td>
<td>3.68</td>
<td>3.7</td>
<td>N/A</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>○</td>
<td>3.65</td>
<td>3.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>●</td>
<td>55.34</td>
<td>50.51</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>●</td>
<td>45%</td>
<td>45%</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>●</td>
<td>73%</td>
<td>67%</td>
<td>N/A</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>●</td>
<td>3.69</td>
<td>3.66</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>●</td>
<td>12%</td>
<td>15%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>●</td>
<td>2%</td>
<td>2%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>●</td>
<td>26%</td>
<td>25%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell</td>
<td>●</td>
<td>57%</td>
<td>55%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff reporting good communication between senior management and staff</td>
<td>●</td>
<td>31%</td>
<td>33%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff able to contribute towards improvements at work</td>
<td>●</td>
<td>72%</td>
<td>70%</td>
<td>⬤</td>
</tr>
<tr>
<td>Staff recommendation of the trust as a place to work or receive treatment</td>
<td>○</td>
<td>3.66</td>
<td>3.77</td>
<td>⬤</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>□</td>
<td>3.97</td>
<td>3.93</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage believing that trust provides equal opportunities for career progression or promotion</td>
<td>○</td>
<td>85%</td>
<td>86%</td>
<td>⬤</td>
</tr>
<tr>
<td>Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>○</td>
<td>10%</td>
<td>12%</td>
<td>⬤</td>
</tr>
<tr>
<td>Overall Engagement Score</td>
<td>○</td>
<td>3.81</td>
<td>3.81</td>
<td>⬤</td>
</tr>
</tbody>
</table>

(SOURCE: NHS England - (01/09/2016 - 31/12/2016))

The trust had completed both the equality, diversity standards 2 and the workforce, race, equality standard (WRES) in 2017, both of which are requirements for NHS trusts. The aim of it is to assist
trusts to identify areas for improvement in relation to staff from black and minority ethnic groups or those who have a disability associated with the key characteristics by monitoring processes and procedures to ensure equality and limit discrimination.

Equality, diversity standards 2 was completed in 2016 and an action plan was developed. An annual review of how the organisation was progressing against the plan took place in March 2017. The annual review of outcomes was done by public consultation. A wide range of people were represented at the public forum including veterans from the armed forces. Following the consultation and workshops a report was produced. The report was presented to the equality, diversity and inclusion implementation group in March 2017. The action plan was updated and was being overseen the equality and diversity manager.

The 2017 workforce, race, equality standard was completed and a copy was published on the trust website in line with current recommendations. The latest workforce, race, equality standard presented a good picture in relation to the employment and integration of black, minority and ethnic staff and also reflected the local population. However, the results from 2017 were the same or worse than those key questions from the staff survey outlined below from 2016. An action plan had been developed in order to further improve workforce, race, and equality standard outcomes and suggested a strong focus on equality and diversity within the trust.

Although the trust is in line with workforce, race, equality standard requirements, it was proactive in managing those with the protected characteristic. For example, a member of staff who was unable to return to work in their current role was moved into another role, so that they could remain in work.

For the workforce race equality standard, the total response rate was lower than the England average but did not meet the minimum recommended response rate of 50%, the trust response rate was 37.7%. Average response from black minority ethnic staff was 4.7% compared to the England average of 16.2%.

The responses from black minority ethnic staff and white staff were significantly different for the following three questions:

- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months
- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

Key for % difference between BME and white staff

- Statistically significant
- Not statistically significant
- Statistical analysis of results was not undertaken due to the low number of BME respondents (<50)
Learning, continuous improvement and innovation

Systems and processes were in place to support learning and continuous improvement. There was some evidence of innovation, although it was recognised that this needed to be more widely developed and embedded across the trust.

An assistant director, who reported to the deputy director of nursing, led on quality improvement. Each division also had a quality manager. There was a strategy for quality improvement that linked with the trust strategy.

The trust used recognised improvement methodologies including ‘plan, do, study, act’ and ‘rapid spread.’ There was a stakeholder process, for example with universities, and a coaching approach. Support was provided centrally with a focus on improvements that helped to deliver the trust’s strategy.

There was a director of medical education who had been in post for three years; they worked with the foundation level one and two doctors. The trust offered a postgraduate leadership course at a local university for the foundation year level two doctors. This was not compulsory, but those doctors who completed the course said that it was beneficial. The doctors who undertook the course then had to complete a project and they presented this to the other foundation level two doctors and sustainability of the projects was addressed.

The executive-led ‘better care now’ initiative had been introduced to improve patient flow throughout the trust. This included a number of initiatives such as the introduction of primary care streaming within urgent and emergency care, piloting a geriatrician acute medical unit in-reach service (frailty), piloting a nurse led model for post-acute care on one ward, the implementation of the ward tracker, pilot of the post discharge telephone follow up and ongoing collaboration with partners to reduce admissions and readmissions.

The trust had aspirations to develop a quality improvement faculty working with the universities and the deanery.

The trust had an annual ‘celebrating success’ award ceremony. This recognised improvement an innovation. For example, the extensive care service was a multidisciplinary team supporting older people with long-term conditions in their own homes. The service aimed to reduce the number of appointments patients needed to attend and to reduce hospital attendance and admission. The

<table>
<thead>
<tr>
<th>NHS Staff Survey Indicator</th>
<th>Proportion of respondents answering “Yes”</th>
<th>% difference between BME and white staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME staff</td>
<td>White staff</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust 27.0%</td>
<td>Trust 26.0%</td>
</tr>
<tr>
<td></td>
<td>England 27.4%</td>
<td>England 26.5%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months</td>
<td>Trust 35.7%</td>
<td>Trust 24.8%</td>
</tr>
<tr>
<td></td>
<td>England 26.2%</td>
<td>England 24.1%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust 68.9%</td>
<td>Trust 85.4%</td>
</tr>
<tr>
<td></td>
<td>England 72.7%</td>
<td>England 88.0%</td>
</tr>
<tr>
<td>Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?</td>
<td>Trust 19.1%</td>
<td>Trust 7.0%</td>
</tr>
<tr>
<td></td>
<td>England 14.8%</td>
<td>England 6.1%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2016)
extensive care service had won the trust celebrating success “going for gold” award for “innovation and service improvement”. This was also nominated for a national award.

The trust had engaged with other trusts and external partners. For example, the chairperson was the deputy chair for a network of the neighbouring trusts and clinical commissioning groups. The trust was part of the vanguard programme and they were setting up a new care model working collaboratively with consultant paediatricians, GPs, social care and children’s community health services and mental health teams to develop a multi professional care plan to support identified young people and their families to manage at home with appropriate support.

The trust had worked in collaboration with colleagues from another trust to implement the regional service for people with cystic fibrosis which opened in March 2017. Clinicians from both trusts worked across both sites with the aim of transitioning patients who lived closer to Blackpool to the local service. The trust reported that this was the first service of its kind to be opened across England in the past 40 years.

The plan to move to an accountable care system was recognised as challenge and opportunity for improvement and innovation.
Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and emergency care services

- Blackpool Victoria Hospital

(Source: Trust Provider Information Request)

The emergency department provides care and treatment to approximately 250 people a day. Services are provided to both adults and children for medical / surgical emergencies and trauma. The majority of the department is in the old hospital. However, a modernised reception / waiting area and children’s department have recently been added to provide a more suitable environment for patients.

There is direct access to a mental health assessment unit as well as a minor injuries and general practitioner assessment unit; these services are managed by different providers and were not included as part of this inspection.

Activity and patient throughput

Total number of urgent and emergency care attendances at Blackpool Teaching Hospitals NHS Foundation Trust compared to all acute trusts in England.

There were 198,642 attendances from April 2016 to March 2017 at Blackpool Teaching Hospitals NHS Foundation Trust as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission
The percentage of A&E attendances at this trust that resulted in an admission increased from 2015/16 to 2016/17. In 2016/17, rates were lower than the England average.

(Source: NHS England)

Urgent and emergency care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>25,362</td>
<td>25,362</td>
</tr>
<tr>
<td>Discharged*</td>
<td>40,636</td>
<td>40,636</td>
</tr>
<tr>
<td>Referred*</td>
<td>9,234</td>
<td>9,234</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>2,743</td>
<td>2,743</td>
</tr>
<tr>
<td>Died in department</td>
<td>251</td>
<td>251</td>
</tr>
<tr>
<td>Left department#</td>
<td>5,513</td>
<td>5,513</td>
</tr>
<tr>
<td>Other</td>
<td>2,552</td>
<td>2,552</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

^ Includes: to A&E clinic, fracture clinic, other OP, other professional

(Source: Hospital Episode Statistics)

We visited all areas of the emergency department including the reception / waiting area, the triage area, majors and resuscitation areas, the paediatric area as well as the combined assessment and treatment unit.

The service was undergoing a redesign at the time of the inspection with building work ongoing throughout the department.

We spoke to staff of different grades, including nurses, doctors as well as members of the management team from both the department and the unscheduled care division. We also spoke to staff from other areas of the hospital that had regular contact with the emergency department. This included staff from the primary care centre which provided general practitioner and minor injuries services.
We reviewed 41 sets of patient records for adults and children, including 10 prescription charts. We also reviewed information that was provided by the trust before and after the inspection. We also spoke to 12 patients and relatives about their experience and observed care and treatment being delivered.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff, however not all staff had completed it, as required.

Compliance with mandatory training for all nursing staff was monitored by a senior nurse who had a split role between mandatory training and normal clinical duties. The matron also supported this process. They held a training matrix which provided an overview of what staff were up to date with.

Updates for individual modules varied. Some modules were completed once yearly, for example, basic life support. Staff received updates for other modules such as conflict resolution and consent every three years.

The management team informed us that compliance with mandatory training in the department was difficult due to the department being consistently busy.

The department had not managed to ensure that all new members of staff had completed all mandatory training modules before starting in their roles. This meant that there was a risk that they would not be fully compliant with trust policies and procedures. Staff that we spoke with confirmed that this had not always been facilitated.

Mandatory training was also monitored through the appraisal process. If staff were not compliant, they were required to submit an action plan on how this was going to be improved. We reviewed appraisal records which indicated that this had been discussed.

The trust set a target of 95% for completion of mandatory training. The trust report training completion rates on a rolling monthly basis.

A breakdown of compliance for mandatory courses as of June 2017 is shown below for (nursing staff only):

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>126</td>
<td>113</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>71</td>
<td>64</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>126</td>
<td>109</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>121</td>
<td>103</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>126</td>
<td>106</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>126</td>
<td>102</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>121</td>
<td>97</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>126</td>
<td>101</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support for adults)</td>
<td>121</td>
<td>95</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Immediate Life Support for adults)</td>
<td>83</td>
<td>27</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Advanced Life</td>
<td>36</td>
<td>30</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of eligible staff</td>
<td>Number of staff trained (YTD)</td>
<td>Completion (%)</td>
<td>Target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------</td>
<td>----------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>39</td>
<td>21</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>39</td>
<td>27</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>39</td>
<td>18</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>39</td>
<td>19</td>
<td>49%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>39</td>
<td>23</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>39</td>
<td>16</td>
<td>41%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>39</td>
<td>19</td>
<td>49%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support for adults)</td>
<td>37</td>
<td>31</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Immediate Life Support for adults)</td>
<td>23</td>
<td>12</td>
<td>52%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Advanced Life Support for Adults)</td>
<td>23</td>
<td>12</td>
<td>52%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>39</td>
<td>17</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>39</td>
<td>17</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>39</td>
<td>21</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>39</td>
<td>12</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>39</td>
<td>12</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>39</td>
<td>14</td>
<td>36%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>39</td>
<td>10</td>
<td>26%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion Process : Administration</td>
<td>26</td>
<td>4</td>
<td>26%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

A breakdown of compliance for mandatory courses as of November 2017 is shown below for (medical staff only):

Safeguarding
All staff completed training for safeguarding adults. In addition, all registered nurses were required to complete level 3 safeguarding training for children. This was in line with the intercollegiate document, 2014 (safeguarding children and young people) and meant that there was always a member of nursing staff on duty who was up to date with this training.

However, non-registered nursing staff were only requires to complete safeguarding level one training for children. Some medical staff had only received level one training. This was not in line with the intercollegiate document which states that all non-clinical and clinical staff who have any contact with children should receive a minimum of level two safeguarding training for children.

Following the inspection period, the trust informed us that level three safeguarding training for children had been made available to all healthcare assistants. However, we were not provided with any evidence that this had been completed.

The trust set a target of 95% for completion of safeguarding training. The trust report training completion rates on a rolling monthly basis.

A breakdown of compliance for safeguarding courses as of June 2017 is shown below (medical staff only):

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Number of eligible staff this year</th>
<th>Sum of Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>39</td>
<td>17</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>15</td>
<td>5</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>9</td>
<td>6</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>13</td>
<td>1</td>
<td>8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for safeguarding courses as of June 2017 is shown below (nursing staff only):

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Number of eligible staff this year</th>
<th>Sum of Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>126</td>
<td>105</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>30</td>
<td>23</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>12</td>
<td>11</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>84</td>
<td>58</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had an up to date safeguarding policy for adults and children which was available on the intranet. Staff were aware of this and knew how to locate it.

The trust had a designated safeguarding lead and there was a safeguarding team based in the hospital during normal working hours. Staff also had access to 24 hour services if a safeguarding referral was required out of hours.
The department used two separate electronic systems which flagged safeguarding concerns. The electronic system that was used in reception was integrated with the system that was used in the emergency department. This meant that safeguarding concerns were shared between the two areas.

In addition, a separate electronic system was used in the rest of the department. This was completed at triage and had a flagging system which highlighted any other safeguarding concerns that had been raised previously. Staff were able to demonstrate how to access and use this system.

Most staff that we spoke with gave us examples of what constituted as a safeguarding concern. Examples given included physical abuse, financial abuse and neglect. Staff also had an understanding of child sexual exploitation and Prevent (a government strategy to safeguard vulnerable individuals who are at risk of radicalisation). However, not all staff had an awareness of female genital mutilation (FGM). This was important as since October 2015 it is mandatory for regulated health and social care professionals to report all known cases of FGM in persons under the age of 18 to the police.

There were a number of screening questions to support staff in recognising safeguarding concerns for children. Examples of this included if there had been an inappropriate delay in presentation or if there were any inconsistent injuries. We reviewed two sets of records for children, finding that this had been completed on both occasions.

Staff informed us that a member of the trust-wide safeguarding team reviewed all records that were completed for children who attended the department, making sure that information was shared with a general practitioner as well as any relevant other health care professionals. However, a formal record of compliance with safeguarding reviews had not been kept.

**Cleanliness, infection control and hygiene**

Between April 2016 and March 2017, the department had not reported any incidents of patients developing methicillin-resistant Staphylococcus aureus, methicillin-sensitive Staphylococcus aureus or colostrum difficile.

Staff had regard to ‘bare below the elbow’ requirements in line with trust policy. We saw that all staff adhered to this on the days of the inspection.

There were hand gel dispensers at the entrance and exit points to all main areas and each cubicle had a sink. Hand gel dispensers were also available inside each cubicle. However, we observed six members of staff providing care and treatment to different patients without decontaminating their hands in between.

The most recent hand hygiene audit (July to September 2017) indicated that compliance with standards of hand hygiene was 92%. Records indicated that compliance with this had reduced since the last audit had been undertaken.

We observed staff cannulating patients (a cannula is a plastic tube used to administer medicines) on four occasions. On one occasion we found that best practice guidance was not followed. This was because the member of staff did not wear gloves while undertaking the procedure.

The department used an electronic system to record details of infectious patients. This information was available to staff if a patient re-attended in the department so that preventative measures
could be taken, reducing the risk of infections being spread. Personal protective equipment was available for staff to use including gloves and aprons.

Staff informed that they managed infectious patients in doored cubicles when possible, however, due to the demand that the department faced staff also informed us that they were not always able to facilitate this.

All areas of the department were visibly clean. Equipment and mattresses were visibly clean and free of damage. We observed staff cleaning mattresses following use and changing linen in between patient use.

Housekeepers were available during normal working hours. An out of hours service was also available 24 hours a day, seven days a week if required. However, housekeeping staff informed us that they did not complete checklists to document what had been cleaned. This meant that there was a risk of staff in the department not being aware if there were areas that still required cleaning.

Cleaning equipment was found to be accessible and stored appropriately.

**Environment and equipment**

The department was based in the original hospital which was a number of years old. A modernised reception and waiting area had been built and a new children’s area was opened during the inspection.

The department had easy access to services such as critical care and scanning facilities. The department had its own designated x-ray department which was open 24 hours a day, seven days a week.

The waiting room had two separate areas. One area was used for patients who were waiting to book in at reception, which provided privacy when they were giving information about an illness or injury. There was a separate waiting area for patients who had been booked in. We were informed that at times of peak activity, this area became overcrowded and there was sometimes insufficient seating for all patients and relatives.

Resuscitation areas in the department had unimpeded access which was in line with the Health Building Note HBN 15-01. The children’s department was separated from other areas of the department and was only accessible by using a swipe card or an intercom system.

Most areas in the department were well maintained. In addition, most equipment was stored in appropriate areas so that the department was clear from hazards.

There were systems in place to manage and dispose of clinical and non-clinical waste. Sharps boxes were also available. However, we observed one occasion when a sharps box was full and was left open. We also witnessed one member of staff carrying a bare needle across the department after administering medicines. This meant there was an increased risk of patient or staff injury.

An environment report was completed in September 2017 by the management team which indicated high levels of compliance with most areas in the department. For example, there was 96% compliance with the general environment, 95% compliance with the correct management of sharps and 100% compliance with maintenance of equipment.

Resuscitation trolleys were available in all areas of the department. Tamper evident seals were used to identify if any equipment had been used since it was last checked. However, we found that
Resuscitation equipment had not always been checked in line with trust policy. For example, between October 2017 and November 2017 there had been 17 occasions when this had not been recorded as checked daily in the majors area of the department. In addition, we found several items of equipment that had already been opened left out. These included airways, nasal tubes and equipment used for intubation (a flexible plastic tube inserted into the trachea to maintain an airway in an emergency situation).

Paediatric resuscitation trolleys were available in both the children’s area and the resuscitation area. These stored appropriate equipment for use in an emergency and we found that these had been checked regularly.

The trust contracted an external service to maintain all equipment in the department. We checked a sample of equipment, finding that they were compliant with electrical safety testing and had stickers which indicated that they had been serviced regularly. In addition, a central database was used to monitor all equipment and records indicated that the department were 87% compliant with the required standard. This demonstrated an improvement since the last inspection when we found there to be no effective system used to monitor compliance with safety testing and servicing of equipment.

Assessing and responding to patient risk

The environment did not always allow for patients to be treated in the most appropriate area. This was because the number of cubicles that were available in the resuscitation and majors areas were limited.

Patients were regularly cared for in areas that did not have sufficient equipment which meant that there was an increased risk to patient safety. Equipment that was unavailable included suction as well as call bells for patients to use. This included corridors which were used on a daily basis as well as the combined assessment and treatment unit which was used overnight.

We saw one patient who required a cubicle in the resuscitation area who was managed in the triage area as there was no space available. We also observed an example of treatment being delayed for over ten minutes for a patient who was short of breath. This was due to one member of staff was looking after eight patients.

The department had a number of cubicles that were out of sight from the nurse station. All of these cubicles had call bells available so that patients were able to request assistance if required, however, we observed three occasions when call bells had not been given to patients. This meant that there was a risk that patients would not always be able to request help if needed.

Staff informed us that they tried to make sure that higher risk patients were managed in visible cubicles. However, staff we spoke with told us that this was not always possible because of how busy the department was.

A suitable environment was not provided for the assessment of high risk patients with mental health illness. Inappropriate areas of the department were used to undertake initial assessments or manage patients who had been assessed as a high risk. This was important as these areas had ligature points as well as equipment that could be used to cause harm to the patient or other people.

The department had access to a designated room in the combined treatment and assessment unit which had been commissioned to assess patients with mental health illness. However, staff informed us that this area had not been used for its intended purpose for the last four months.
We noted that the department had reported a serious incident in October 2017 involving a patient with a mental illness who had taken a piece of equipment from a cubicle in the minor injuries area to harm themselves without members of staff being aware.

During a later part of our inspection, we saw that a room within the emergency department had been designated for the purpose of managing patients identified at high risk. However, further work was still required to ensure that the room was fit for purpose. This was because important requirements such as ligature points had not yet been actioned.

However, the emergency department worked closely with another provider and had recently opened a co-located mental health assessment unit to provide a safe environment for patients who had been assessed as a low risk.

Records that we reviewed showed that a patient with suspected mental health needs was admitted to a paediatric inpatient ward, staff from the trust’s child and adolescent support and enhanced response team produced detailed risk management plans to guide hospital staff on the measures they needed to take to keep patients safe.

However when children and young people were discharged back home or into the community, risk management plans were not always detailed or updated to guide parents or carers on the measures they needed to take to keep their child or young person safe. For example, staff were not specifically recording guidance given to parents on storage of medication to keep children and young people safe.

Staff recorded that a discharge plan was completed when patients were not admitted to hospital. However, we could not find the discharge plans. When we asked managers where we would find the completed discharge plan, they confirmed it was usually a verbal plan and not always recorded.

We did not identify any episodes of actual harm as result of shortfalls in written risk management plans. In addition, there have been no serious incidents relating to the trust’s child and adolescent support and enhanced response team in the two years the service has been running.

The management team had implemented a number of controls to reduce any potential risk to patients during busy periods. This included maintaining two supernumerary nurses (not included in the staffing numbers) and safety huddles which were held four times daily. We attended two of these huddles, finding that staff discussed the progress of treatment for different patients who were in the department.

The hospital had a trust wide escalation plan which members of the management team were aware of. However, it did not highlight many key actions for staff in the department to take in the event of the department reaching full capacity and there was no formal policy or standard operating procedure for this.

Although members of the department management team were able to tell us about some key actions that would be implemented during busy periods, we were unsure if all team members would be aware of appropriate actions to take due to the lack of formal processes and procedures around this.

The department had a triage process which included a traffic light system to prioritise patients. This was based on their clinical observations and the symptoms that they presented with. This system alerted staff to which patients’ required immediate assessment.
Receptionists that we spoke with were aware of actions to take if a patient self-presented and was unwell. We were given examples of conditions that were escalated to the triage nurse immediately.

In addition, the department used the national early warning score for adults and the paediatric early warning score for children to support staff in recognising and escalating patients who were deteriorating in a timely manner. Both of these systems were based on a number of observations including blood pressure, heart rate and temperature.

We checked 10 sets of patient records for adults and two for children, finding that national early warning scores and paediatric early warning scores had all been calculated correctly and patients had been escalated appropriately when required.

Patients were assessed for the risk of pressure ulcers and falls on admission to the department. However, staff used their own clinical judgement to assess the risk of pressure ulcers as the formal screening tool that was used in the rest of the hospital was not used in the emergency department. This meant that full risk assessments were not completed for patients who had been in the department for over 6 hours in line with trust policy.

The management team had introduced a skin and safety walk around record. This had been implemented to support staff in making sure that patients were reviewed on a regular basis and was particularly important for patients who were in the department for extended periods of time. This included skin inspection, nutritional requirements, if a patient had been incontinent and if mobility aids were close by if required. However, we checked 10 sets of patient records, finding that this had not been completed on three occasions.

The department used a pathway for the management of sepsis in adults (sepsis is a life threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs).

In addition, the department had started a trial for a consultant and a nurse to hold a bleep between 9am and 5pm from Monday to Friday. This had been implemented to provide treatment in a more timely way. Staff were aware of this system and we observed it being used on three separate occasions.

However, we noted that the department did not have a sepsis pathway for children. This was important as there was a risk that sepsis in children would not be recognised or treated in a timely way.

The trust informed us they used the guidelines for the management of sepsis and children from the north west transport and critical care networks. Following the first part of our inspection, the trust informed us that they had made guidance for the management of sepsis more visible in the department and they had planned for this to be supported by additional training.

**Median time from arrival to initial assessment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to being triaged (having an initial assessment undertaken) is no more than 15 minutes. This is important as it is a system that emergency departments use to make sure that the patients who may need immediate treatment are prioritised.

The department had consistently failed to meet this standard. Records indicated that between December 2016 and October 2017, monthly compliance varied between 52% and 69%. However, we noted that compliance in October and November 2017 had improved to 82%.
We observed a large number of patients experiencing delays in receiving an initial assessment during the inspection. This varied between 30 minutes and 2 hours.

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

The median time from arrival to initial assessment was worse than the overall England median for the 12 month period from September 2016 to August 2017.

In the most recent month, August 2017, the median time to initial assessment was 20 minutes compared to the England average of seven minutes.

**Ambulance – Time to initial assessment from September 2016 to August 2017 at Blackpool Teaching Hospitals NHS Foundation Trust**

![Graph showing time to initial assessment](source)

(Source: NHS DIGITAL: A&E quality indicators)

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

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for six months over the 12 month period from September 2016 to August 2017.

Performance against this standard showed a trend of decline.

In the most recent month, August 2017, the median time to treatment was 75 minutes compared to the England average of 53 minutes.

**Median Time to treatment from September 2016 to August 2017 at Blackpool Teaching Hospitals NHS Foundation Trust**

![Graph showing time to treatment](source)

(Source: NHS DIGITAL: A&E quality indicators)

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

**Blackpool Victoria Hospital**
From October 2016 to September 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Blackpool Victoria Hospital. In the most recent month, September 2017, 51% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Blackpool Victoria Hospital**

![Bar chart showing ambulance journeys with turnaround times over 30 minutes at Blackpool Victoria Hospital from October 2016 to September 2017.](chart)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Blackpool Victoria Hospital**

![Line chart showing percentage of ambulance journeys with turnaround times over 30 minutes at Blackpool Victoria Hospital from October 2016 to September 2017.](chart)

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From July 2016 to June 2017 the trust reported 948 “black breaches”, with an increase in instances over the winter period.

**Number of black breaches during week**

![Line graph showing the number of black breaches over a week from October 2016 to September 2017.](chart)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)
Emergency Department Survey 2016

The trust’s scored “worse than” other trusts for one of the five emergency department survey questions relevant to safety and “about the same” as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

Nurse staffing

The planned number of registered nurses in the department had not always been achieved. In addition, Royal College of Emergency Medicine guidance was not always met as the staff to patient ratio in the resuscitation area exceeded the recommended 1:2 between 2am and 10am on a daily basis.

The departmental management team planned to have a minimum of eight registered nurses, 24 hours a day as well as two additional registered nurses between 10am and 2am. Two of the planned nurses were supernumerary, one was the co-ordinator and the other was the nurse in charge. We reviewed rotas for November 2017, finding that there had been a total of 12 shifts when the planned establishment had not been achieved.

The management team had planned to have eight emergency department assistants in the day and seven at night. This was important as emergency department assistants had extended skills to support registered nurses. Their extended skills included being able to take observations such as a blood pressure and a pulse rate as well as being able to undertake blood tests. Rotas for the same period indicated the planned number of emergency department assistants had been achieved on all but three occasions.

A minimum of one trained children’s nurse was available at all times, which was in line with national guidance. We reviewed rotas for November 2017, finding that this had been achieved on all occasions.

However, the management team had not adjusted the planned number of children’s nurses available at night time when the new children’s area opened, meaning that there was a risk that Royal College of Nursing guidance would not been met. This was because there was potential for the minimum staff to patient ratio of 1:4 to be exceeded.
The area for children was geographically isolated and had an increased number of beds. This was important as at night there was only one registered nurse available to triage and look after a maximum of five patients. Following the inspection, the trust provided assurance that this had been reviewed and that they now included a health care assistant as part of the night time establishment.

The emergency department were responsible for providing nursing staff for the combined treatment and assessment unit. We reviewed rotas for November 2017 and found this had been staffed appropriately on all occasions.

Records indicated that there had been 59 red flag staffing incidents for all areas of the department between May and October 2017. Red flag staffing incidents are reported when staff feel that patients are unsafe due to staffing shortfalls.

The department also employed emergency and advanced nurse practitioners. These are registered nurses who have extended skills enabling them to see and treat patients without them seeing a doctor. However, rotas for November 2017 indicated that the planned number of emergency and advanced nurse practitioners had only been achieved on 52% of occasions.

The management team had completed a full review of their nursing establishment in July 2016 following an external review. Due to recruitment challenges the role of the emergency department assistant was developed to support nursing staff. The trust was reviewing the nursing staff establishment in line with the National Quality Board ‘safe sustainable and productive staffing; an improvement resource for urgent and emergency care’ that was still in draft format. A model was being developed for consideration by the executive board early in 2018.

Senior leaders informed us that their view was that the current nurse staffing levels in the department were adequate.

All nursing staff attended a safety huddle at the start of each shift. This meeting was used to discuss topics including concerns that had been raised in the department or any changes in practice. We also observed a full nursing handover, finding that although patient information was handed over, it did not follow a set structure. This meant that there was a risk that important information would be missed as part of this process.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a vacancy rate of -13% in Urgent and emergency care which indicates they are over establishment in some areas.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From July 2016 to June 2017, the trust reported an average turnover rate of 0.3% in Urgent and emergency care

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From July 2016 to June 2017, the trust reported an average sickness rate of 6.7% in Urgent and emergency care which is higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

The department had access to a pool of bank staff to fill vacant shifts. This included both registered nurses and healthcare assistants. Bank staff were employed directly by the trust which meant that they had access to a full induction and were required to complete mandatory training.

Between November 2016 and October 2017 had been consistently high. Monthly averages had ranged between 17% and 32%.

The management team informed us that agency staff received a local induction on their first shift in the department. However, the management team were unable to provide any evidence that this had been completed. This meant that there was an increased risk that agency staff would not be supported to adhere to trust policies and procedures while undertaking their role.

Between November 2016 and October 2017, the monthly usage of agency staff in the department had varied between 3% and 8%.

Medical staffing

The trust reported their staffing numbers below for the period July 2016 and June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>9.03</td>
<td>7.02</td>
</tr>
<tr>
<td>Junior medical</td>
<td>28</td>
<td>30.47</td>
</tr>
<tr>
<td>Middle grade medical</td>
<td>33.71</td>
<td>20.27</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

In July 2017, the proportion of consultant staff reported to be working at the trust were lower the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 38 whole time equivalent staff working in Urgent and emergency care at Blackpool Teaching Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>47%</td>
<td>31%</td>
</tr>
<tr>
<td>Junior</td>
<td>29%</td>
<td>25%</td>
</tr>
</tbody>
</table>
The department was funded for consultants to be available on site between 9am to 10pm, five days a week. At weekends, the department had planned to have a consultant on site between 9am and 5pm. An on call consultant was also available out of hours.

We reviewed the rota for November 2017, which indicated that the planned number of consultants had not always been achieved. This was because there was no on site consultant cover during the daytime on five weekend shifts during this period. This did not meet guidance from the Royal College of Emergency Medicine which states that there should be 16 hours of consultant cover on site seven days a week.

The department had also planned for middle grade doctors of different seniority to be present in the department 24 hours a day, seven days a week. However, rotas for November 2017 indicated that a doctor of sufficient seniority was not available in the department on five occasions between the hours of 5pm and 9pm.

In addition, planned shifts for other medical staff, including junior doctors had not been achieved on 12 occasions during the same period.

The department employed a consultant who had sub speciality training in paediatrics. However, they were currently on extended leave. A different consultant within the department was undertaking the role as the paediatric lead, although they had not completed speciality training for paediatrics.

We attended a medical handover, finding that this was thorough and informative. Members of medical staff were also involved in staffing huddles that were held throughout the day. This was an opportunity to review patients who were currently in the department.

All medical staff were required to attend a trust induction as well as completing all mandatory training modules. However, one new member of medical staff informed us that they had not received an induction and we observed that they were struggling to use the various electronic systems in the department.

The trust did not submit any information about turnover rates for medical staff within urgent and emergency care.

From July 2016 to June 2017 the trust reported an average sickness rate of 2.5% in Urgent and emergency care which is lower than the trust target of 4%.

Records indicated that the average monthly use of medical agency staff between November 2016 and November 2017 had varied across different staff groups.

The use of locum consultants had reduced from 10% to 0% between December 2016 and April 2017. There had been no locum consultants used after this time.

The monthly average use of locum middle grade doctors had varied between 12% and 36% and the average use of junior doctors had been between 2% and 11%.

The management team informed us that all locum doctors received a full trust induction and a local induction. We were told that these records were unavailable in the department as they were kept centrally.
Records were mostly stored by nursing stations so that patient confidentiality was maintained. However, records for patients who were receiving care on the corridor were stored in an open filing system that was sometimes left unattended. This meant that there was a risk that patient confidentiality may be breached.

The emergency department used a combined electronic and paper based system for all patient records. Paper based records included observation charts, prescription charts and risk assessments. The electronic records contained patient information such as safeguarding alerts or infection control risks.

We found that all records had been dated and signed. Also, the time of triage and when treatment was started was clearly documented. However, two out of 12 records were illegible which was not in line with professional standards set by the Royal College of Physicians and Nursing and Midwifery Council.

The trust completed a monthly records audit which measured all elements of compliance against these standards. However, records indicated that results from the emergency department were unavailable. This meant that there was potential for missed opportunities to make improvements when needed.

Records were scanned into the electronic system when a patient was discharged. This meant that this information was easily accessible if a patient re-attended.

Medicines

The trust had an up to date medicines management policy which was available to all staff on the intranet.

The management team informed us that pharmacists visited the department on a regular basis and were responsible for replenishing drugs.

Medicines including controlled drugs were stored in an omnicell system in the majors and resuscitation areas of the department. This system was introduced to improve safety and the system recorded the details of staff who had accessed it and what they had withdrawn.

However, there was no formal guidance for staff to follow when using this system. Staff informed us that they regularly used an override code rather than their own pin number which meant that identifiable information was not recorded correctly.

Clinical rooms were available to store and prepare medicines in areas where the omnicell system was not used. This included the children’s area and the observation ward.

Controlled drugs were stored securely in line with legislation. However, daily checks had not always been completed in line with trust policy. We sampled controlled drugs registers, finding that although the number available tallied against the number recorded, checks had not been completed on 11 occasions between October 2017 and November 2017.

We sampled a number of controlled drugs, finding that the numbers tallied against the amounts that had been recorded. However, we noted that medicines that had expired were kept in the same areas as all other medicines. Expired medicines had ‘expired’ written on the boxes, although there was a risk that expired drugs would be administered in error.

The trust wide pharmacy team completed a controlled drugs audit twice a year which indicated that compliance in the emergency department had varied between 80% and 96%. The main
reasons for compliance not being achieved was either poor documentation or daily checks not being completed in line with trust policy.

The management team informed us that patients’ own controlled drugs were not reconciled and stored securely in line with trust policy. This meant that there was a risk that these could be used without staff being aware, or more importantly there was a risk that they could be stolen.

Medicines requiring storage at low temperatures were kept in fridges. Fridge temperatures across the department were found to be in correct range and checked regularly.

Medical gasses were stored correctly on most occasions. However, on two occasions we observed that oxygen cylinders had been left in the corridor after being used to provide treatment to patients.

Staff had access to guidance for prescribing antibiotics when required and there was a form available on the intranet for staff to complete when antibiotics had been administered. However, there was no allocated pharmacist to provide support and to monitor compliance with best practice guidance.

The emergency department used paper based medicines charts to record medicines that had been prescribed and administered. We sampled seven prescription charts, finding that they had all been completed correctly and patient allergies were clearly documented.

Nursing staff were able to administer a small number of medicines by following a patient group direction. These allow nursing staff to administer medicines without the need for a prescription. The management team had recently introduced a patient group direction that allowed nursing staff to administer antibiotics in cases of suspected sepsis. This had been implemented to improve compliance with treatment being started in a timely way when needed.

In the event of patients being discharged, any medicines prescribed were added to the electronic discharge form that was completed.

Incidents

The trust had an up to date incident reporting policy that was available on the intranet.

The department used an electronic reporting system. Staff that we spoke with knew how to use the system. Agency staff did not have access to the incident reporting system but were encouraged to let the nurse in charge know about incidents so that they were able to report them.

The type of incidents that staff had reported included staffing issues and incidents that had resulted in patient harm. However, the management team informed us that not all incidents were reported using the electronic system in line with trust policy. For example, pressure ulcers that had been acquired outside of the department had not always been recorded.

The management team had identified this as requiring improvement and evidence was provided which suggested that some improvements had been made during October and November 2017.

Most staff informed us that when they had reported incidents, they had received feedback.

Learning from incidents was shared with all staff through a governance newsletter that had been introduced. The management team also informed us that incidents were discussed in weekly team meetings and information was cascaded to all team members. However, we reviewed the minutes for these meetings, and found that there was no documented evidence that this had happened. In addition, incidents had not been discussed at all monthly governance meetings that we reviewed minutes for.
Staff in the department had reported a total of 500 incidents between June 2017 and November 2017. Of these, 88 had been reported as near misses, 154 had resulted in no patient harm, 166 in low harm, and two in moderate harm. However, there had been 90 incidents reported where the level of patient harm had not been determined. This meant that there was a risk that incidents requiring more senior review would not always be escalated appropriately.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2016 to August 2017.

The incidents were categorised as;

- Adverse media coverage or public concern about the organisation or the wider NHS with 1 (50% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with 1 (50% of total incidents).

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

Root cause analysis investigations were undertaken when a serious incident had been identified. A root cause analysis tool is used to support staff in completing a thorough investigation and implementing actions to reduce the risk of a similar incident happening again.

However, we found one occasion when a serious incident had not been identified in line with NHS England guidance. This was an incident that had been recorded in October 2017 involving a patient suffering a fractured hip as a result of having a fall in the department. This injury was missed as an x ray had not been undertaken following the incident. The incident had been graded as low harm and there was no evidence of any further investigation being completed.

The management team in the department had responded to a regulation 28 report that had been issued in January 2017 (a regulation 28 report is sent from the coroner following an investigation into incidents to prevent future deaths). A diabetic screening tool was being used in triage and information highlighting diabetic patients was used at the main nursing station. This included blood sugar measurements and information about the administration of insulin.

A trust wide pathway for diabetic ketoacidosis (this is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones) had been introduced. However, we did not see any evidence of this being available in the emergency department.

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

From September 2016 to August 2017, the trust reported no incidents classified as never events for Urgent and emergency care.

(Source: NHS Improvement - STEIS)

Mortality reviews are important as they facilitate learning from deaths that have happened in the department, particularly in cases when a death may have been avoidable. However, there was no documented evidence that mortality reviews had been undertaken and there was no evidence of mortality being discussed in minutes of governance meetings.

The management team had identified this as being an area that required improvement. Following the inspection period evidence was provided which indicated that some improvements had been
made. This included a mortality review newsletter which had been designed to share learning from reviews that had been undertaken.

The management team understood the duty of candour and we saw evidence that it had been applied when required. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, 10 falls with harm and 11 new catheter urinary tract infections from September 2016 to September 2017 within urgent and emergency care.

The department had clearly displayed information about the number of patient harms for staff and patients to see.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Blackpool Teaching Hospitals NHS Foundation Trust

(Source: Safety thermometer - Safety Thermometer)
In addition, the department had reported two hospital acquired pressure ulcers during the same period.

### Is the service effective?

#### Evidence based care and treatment

Staff had access to up to date evidence based guidance from organisations such as the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine. However, not all staff were aware of best practice guidance, particularly regarding Royal College of Emergency Medicine standards. For example, the majority of medical staff that we spoke with did not have an understanding of conditions that had to be reviewed by a consultant before patients were discharged.

A small number of clinical pathways were used to support staff in complying with all aspects of best practice guidance when treating adults. This included pathways for acute kidney injury, pneumonia and chest pain of cardiac origin.

For children, only three pathways were available. These included a pathway for the treatment of asthma which had been introduced as a result of poor compliance that had been highlighted in a recent audit. Importantly, the treatment of sepsis was not included in these. However, following the first part of our inspection, the trust informed us that they had made guidance for the management of sepsis more visible in the department to support staff in recognising and managing sepsis in children.

In addition to pathways, staff had access to best practice guidance on the intranet. This included protocols for a large number of other conditions and disorders. We sampled a number of these, finding them to be current and up to date.

The emergency department submitted data to the Royal College of Emergency Medicine on a regular basis so that patient outcomes could be compared nationally. However, the management team did not complete any other audits that monitored compliance with other protocols that were not included in the Royal College of Emergency Medicine standards. This was confirmed on review of audit plans for 2016/2017 and 2017/2018. This meant that there was a risk that the management team would not identify all areas that required improvement.

The integrated care pathway that was used by the mental health liaison team was based on up to date evidence based practice. This included performance reporting and clinical management that are defined in the ‘care programme’ approach. The mental health liaison team had planned a full review of the pathway in February 2018 to measure overall compliance and effectiveness.

#### Nutrition and hydration

Staff were required to complete a mini nutritional risk assessment for all patients. This supported staff to consider whether patients were at risk of malnutrition.

The department did not use a formal nutritional assessment tool that was used in the rest of the hospital. This type of assessment identifies patients who might be at risk of malnutrition and allow for a referral to appropriate professionals for ongoing support.

Dietitians were available during normal working hours, five days a week if a patient referral was required.
We observed food and drink being provided for patients during their stay. This was important as there were a number of patients who spent 12 hours or more in the department.

In the CQC Emergency Department Survey, the trust scored 6.5 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as than other trusts.

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

**Pain relief**

The department had access to a variety of medications used for pain management. Pain scoring tools were used for both adults and children. However, we noted that the children’s department did not use a modified pain scoring tool that could be used for younger children. This was important as there was a risk that younger children would not be able to fully communicate how much pain they were in.

In addition, the trust had introduced the abbey pain scale. This was used to assess the pain score for patients who were not able to communicate, such as patients with cognitive impairment. However, minutes of management meetings suggested that this was not being consistently used and we did not see evidence of this being used in the department.

There had been a small number of occasions when pain relief had not been given in a timely manner. We reviewed five sets of records for adults who had required pain relief. We found that on one occasion, documentation stated that pain relief had not been administered for up to two hours despite the patient having a high pain score. In addition, between June 2017 and October 2017 four incidents had been reported when the administration of pain relief had been delayed due to low numbers of staff.

We reviewed two sets of records for children and found the pain scores had not been documented correctly on either occasion.

In the CQC Emergency Department Survey, the trust scored 5.4 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

**Patient outcomes**

In the Royal College of Emergency Medicine Audit: Moderate and Acute Severe Asthma (2016/17) Moderate and Acute Severe Asthma report, the trust failed to meet any of the eight
fundamental standards (which were all set at 100%).

The trust’s results for three standards placed it in the lower UK quartile:

- The proportion of patients had vital signs measured and recorded on arrival at the ED (5.5% compared to the national median of 26%).
- The proportion of patients who had added nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. (58.2% compared to the national median of 77%)
- The proportion of relevant patients prescribed oral prednisolone on discharge. (23.1%, compared to the national median of 52%).

The trust’s results for the other four fundamental standards were all between the upper and lower UK quartiles.

The trust submitted 73 patient records to the audit.

In the Royal College of Emergency Medicine Audit: Vital Signs in Children (2015/16) audit for vital signs in children, Blackpool Victoria Hospital was in the lower quartile compared to other trusts for five of the six measures and was between the upper and lower quartile for one of the six measures.

The measures that performed in the lower quartile were:

- All children attending the emergency department with a medical illness should have a set of vital signs consisting of temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score
- All children attending the emergency department with a medical illness should have a set of vital signs consisting of capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.
- Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set.
- There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present).
- There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases.

In the Royal College of Emergency Medicine Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast (2015/16) audit for Lower Limb Immobilisation in Plaster Cast, Blackpool Victoria Hospital performed:

- In the lower quartile for the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, with a score of 0% in one case.
- In the middle for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 1.9% in 53 cases.

(Source: Royal College of Emergency Medicine)

In the Royal College of Emergency Medicine Audit: Procedural Sedation in Adults (2015/16) Procedural Sedation in Adults audit, Blackpool Victoria Hospital was in the lower quartile for
three of the seven measures and the middle quartiles for the remaining four measures.

The measures that performed in the lower quartile were:

- Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse

- Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area.

- Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  - 7a Return to baseline level of consciousness
  - 7b Vital signs within normal limits for the patient
  - 7c Absence of respiratory compromise
  - 7d Absence of significant pain and discomfort
  - 7e Written advice on discharge for all patients

(Source: Royal College of Emergency Medicine)

The Royal College of Emergency Medicine Audit: Consultant Sign Off (2016/17) Consultant Sign Off audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

Of all patients aged over 30 admitted for acute chest pain in the 2016/17 audit, 0% were seen by a consultant and 44.4% were seen by an ST4 or above. This failed to meet the standard of 100%.

For the metric measuring whether all children under 1 year of age admitted with a fever were seen by a consultant and an ST4 or above, the trust indicated they were eligible for this metric however did not submit any data on performance for it.

Of all patients making an unscheduled return to the emergency department in 2016/17 with the same condition within 72 hours of discharge, 11.1% were seen by a consultant and 37.8% were seen by an ST4 or above. This failed to meet the standard of 100%.

Of all audited patients over 70 years of age who were admitted with abdominal pain, 100% were seen by a consultant and 100% were seen by an ST4 or above. This met the standard of 100%.

From September 2016 to August 2017, the trust’s unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% but generally better than the England average of 7.8%.

Unplanned re-attendance rate within 7 days - Blackpool Teaching Hospitals NHS Foundation Trust
Education for nursing staff in the department was facilitated by a senior nurse who had a split role between training and normal clinical duties. The matron also supported this process.

The trust had an induction and preceptorship plan for staff. Staff who had recently qualified were required to complete competencies that were specific to the emergency department over a 12 month period. This included topics such as administering medicines and gaining intravenous access. We saw evidence of these having been completed.

Other members of staff such as the emergency department assistants were also required to complete role specific competencies. This was important as emergency department assistants were able to undertake extended skills such as undertaking observations and diagnostics such as blood tests. We saw evidence of these competencies having been completed.

However, the management team were unable to provide evidence of competencies for nursing staff who had been in the department for over 12 months. This meant that we were unsure if these members of staff had been formally assessed for the roles that they undertook.

All nursing and medical staff were required to have an annual appraisal which gave them an opportunity to discuss their achievements and areas for improvement. Members of the band 7 senior nursing team were responsible for appraising all nursing staff and were each allocated a team of nurses of different grades. However, records indicated only 55% of nursing staff had completed an annual appraisal.

A small number of consultants had been identified to supervise and appraise other medical staff in the department. However, records indicated that only 41% of medical staff had completed this.

The trust only provided appraisal data for medicine staff in Urgent and emergency care. From April 2016 to March 2017, 57.1% of medical staff within Urgent and emergency care at the trust had received an appraisal compared to a trust target of 100%. From April 2017 to June 2017 there had been no complete appraisals.

In addition, emergency and advanced nurse practitioners informed us that they had not been assigned a named mentor and that they had limited opportunities for training and development. In addition, they were unclear whether they were managed under the nursing or medical teams.
A number of education days had been facilitated for nursing staff in addition to mandatory training. This included topics such as oncology and electrocardiograph recognition (a tracing of a patient’s heart).

Consultants informed us that they received regular programmed activities for learning and education. However, middle grade and junior doctors informed us that education opportunities were sometimes limited due to operational demand.

Trauma training had also been delivered to nursing and medical staff in the department. This was important as the hospital was a trauma unit. This meant that there was a potential for the department to receive patients who had suffered major trauma, although most patients would be taken to a local hospital which had been designated as a trauma centre.

The trust had a central team who monitored clinical revalidation for all staff. Senior nurses in the department were confirmers for the nursing and midwifery council, meaning that they were able to confirm revalidation when needed.

**Multidisciplinary working**

Staff informed us that they had positive working relationships with other staff groups within the hospital. This included staff from medical and surgical specialities as well as the children’s and young people’s team. Members of the physiotherapy and occupational therapy teams also visited the department, particularly if patients who were ready for discharge required assessment.

Members of the management team worked closely with a local ambulance trust. Monthly meetings were held to discuss access and flow and other operational issues. There was an ambulance liaison officer based in the department who regularly attended bed meetings. This meant that they were able to inform the management team of the demand that the service currently faced, and were able to consider directing patients to a neighbouring hospital if needed during periods of peak activity.

We observed two occasions when members of staff from the department worked closely with members of the stroke team. Patient records indicated that referrals had been made in a timely manner and we were informed that this service was very responsive when it was needed.

Staff in the department worked alongside members of the adult, adolescent and child mental health teams to make sure that patients received assessment in a timely manner when needed. We were informed that working relationships between the two teams were positive.

The adult mental health liaison team would contact relevant services for patients referred to their service to ensure they received the most informed treatment. We saw evidence of liaison with alcohol and drug teams in order to gain the most appropriate treatment for patients.

We spoke with members of the security team who were located in close proximity to the department. They informed us that they had a good relationship with members of staff in the emergency department.

The department had also developed a positive relationship with local police services. There was a clear process in place for staff to follow in the event of a patient absconding from the department prior to assessment and there was a designated number for staff to contact to report this.

**Seven-day services**
The emergency department was open 24 hours a day, seven days a week. The management team had planned for the department to be covered 24 hours a day by a minimum of a senior middle grade doctor.

Consultant cover was planned between 9am and 5pm, seven days a week. In addition, there was an on call consultant who was on site between 1pm and 10pm, seven days a week and remained on call through the out of hours period.

The department had access to a 24 hour, seven days a week primary percutaneous coronary intervention service (this is a procedure used to treat narrowed coronary arteries and can be used as an emergency intervention for patients who have had a heart attack).

There was also access to a stroke team who were available between 9am and 5pm, seven days a week. An on call service was provided outside of these hours so that patients requiring emergency treatment received this in a timely manner.

The hospital had access to a 24 hour, seven days a week radiology service which was available within the department. This included the provision of x-ray and computerised tomography scanning facilities.

Magnetic resonance imaging was available between 9am and 5pm from Monday to Friday. However, patients who required an emergency scan outside of these hours had to be transported to a local NHS trust.

The trust reported some gaps in pathology and ultrasound. These were readily available between 9am and 5pm from Monday to Friday, but were not always accessible outside of these hours.

**Health promotion**

Staff that we spoke with informed us that they were aware of how to access support for patients around promoting patients health if needed.

All staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients.

Advice leaflets about a variety of conditions and disorders were available at different points in the department such as the waiting room.

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

There was a trust wide policy for consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet.

Most staff had an understanding of and were able to describe the process for best interest decisions and mental capacity assessments. However, some staff that we spoke with were unclear about the difference of the mental capacity act and the mental health act.

Medical staff were responsible for completing mental capacity assessments. This was in line with trust policy.

The mental health liaison team were available to provide advice and support for staff in the department in relation to mental capacity and mental health assessments. There was also access to an on call psychiatrist for further advice if required.
We reviewed 29 sets of records for patients who had required a mental health assessment, and found that approved mental health professionals had completed patient assessments on all occasions. We also found on occasions when patients had required detaining, this had been completed using the correct procedures which were in line with trust policy.

The trust reported that as of June 2017 Mental Capacity Act (MCA) and Deprivation of Liberty (DOLS) training has been completed by 80% of nursing staff in urgent and emergency care. This was below the trust target of 95%.

(Source: Trust Provider Information Return P14/P49)

In addition, only 41% of medical staff were up to date with this training.

**Is the service caring?**

**Compassionate care**

All patients and relatives that we spoke with were complimentary of the staff that they had encountered. Comments by patients and relatives included ‘they work so hard and do their best’, ‘they are very caring despite it always being busy’ and ‘staff have made me feel relaxed during my stay in the department’.

We spoke with two patients who had attended on a number of occasions due to the nature of their conditions. They informed us that staff had been ‘fabulous’ on each occasion that they had visited.

We observed examples of staff treating patients in a kind and compassionate way despite the department being very busy during the inspection.

We also observed staff responding quickly to patients on most occasions if they were uncomfortable or were distressed. However, there were two occasions when patients had to wait longer than expected for attention. This was because staff were busy looking after other patients.

Patients were treated with dignity and had their privacy maintained on most occasions. The department had designed a designated area for patients to be transferred from ambulance trolleys to hospital beds so that their privacy was maintained during this process. In addition, the resuscitation area was accessed directly by the main entrance so that patients did not have to pass other patients and relatives who were waiting on the corridor.

However, we saw some examples when privacy and dignity was not maintained. This included a patient being left exposed in the corridor for a long period of time, a patient being left exposed in a cubicle without attention as well as a staff member taking a patient history in an area of the corridor that allowed members of the public to hear the conversation in full.

The trust’s Urgent and emergency care Friends and Family Test performance (% recommended) was generally better than the England average from September 2016 to August 2017.

In August 2017 the trust’s performance was 88.1% compared to the England average performance of 88%.

**A&E Friends and Family Test Performance - Blackpool Teaching Hospitals NHS Foundation Trust**
Emotional support

Patients and relatives informed us that staff were approachable, friendly and were easy to talk to. They felt that they were able to express any concerns or anxieties that they had.

We saw examples of staff taking time to reassure patients and relatives if needed. We observed staff being sensitive in their approach towards patients when addressing concerns that had been raised.

The department had access to the palliative care team and chaplaincy services if needed. Staff informed us that these services were responsive and were able to support patients and families when required.

Understanding and involvement of patients and those close to them

Patients and relatives that we spoke with informed us that staff had taken time to explain about the care and treatment that they were receiving. However, this had not always been documented clearly in patient records. We found that this had not been documented in five out of 12 patient records that we sampled.

We observed occasions when members of staff spent time with patients and relatives to explain different aspects of their care. We also saw occasions when staff spent time with families of patients who required immediate intervention, particularly if they had been taken into the resuscitation area of the department.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts in 12 of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>2.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>7.8</td>
<td>Worse than other trusts</td>
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<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and</td>
<td>7.3</td>
<td>Worse than other trusts</td>
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<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
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<tr>
<td>treatment in a way you could understand?</td>
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<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>examining and treating you?</td>
<td></td>
<td></td>
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<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you</td>
<td>8.7</td>
<td>About the same as other trusts</td>
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<tr>
<td>weren't there?</td>
<td></td>
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<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a</td>
<td>6.8</td>
<td>Worse than other trusts</td>
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<tr>
<td>doctor, did they have enough opportunity to do so?</td>
<td></td>
<td></td>
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<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>7.9</td>
<td>Worse than other trusts</td>
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<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
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<tr>
<td>Q21. If you needed attention, were you able to get a member of medical</td>
<td>7.1</td>
<td>Worse than other trusts</td>
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<tr>
<td>or nursing staff to help you?</td>
<td></td>
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<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and</td>
<td>8.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td></td>
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<tr>
<td>the emergency department?</td>
<td></td>
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<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>6.9</td>
<td>Worse than other trusts</td>
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<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>while you were in the emergency department?</td>
<td></td>
<td></td>
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<tr>
<td>Q15. If you had any anxieties or fears about your condition or</td>
<td>6.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>treatment, did a doctor or nurse discuss them with you?</td>
<td></td>
<td></td>
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<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td></td>
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<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
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<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>7.5</td>
<td>About the same as other trusts</td>
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<tr>
<td>of your tests?</td>
<td></td>
<td></td>
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<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way</td>
<td>8.5</td>
<td>About the same as other trusts</td>
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<tr>
<td>you could understand?</td>
<td></td>
<td></td>
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<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
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<tr>
<td>Q39. Did a member of staff tell you about medication side effects to</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>watch out for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into</td>
<td>4.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>account when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding</td>
<td>5.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your illness or treatment to</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Question | Trust 2016 | 2016 RAG
--- | --- | ---
watch for after you went home? | other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.0 | About the same as other trusts
Q45. Overall... (please circle a number) | 7.6 | About the same as other trusts

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

Is the service responsive?

Service delivery to meet the needs of local people

The emergency department was based at the front of the hospital with easy, well signed access from main roads.

Managers were aware that the department presented challenges to make sure that the environment matched the needs of the patients using the service. This was mainly because there were limited amounts of space in the majors and resuscitation areas of the department which were not always sufficient to match the increased demand that the department consistently faced.

However, the trust had commissioned the modernisation of both the waiting area and the children’s assessment area. The waiting area was split into two main parts. The reception area was separate to the waiting area to maintain privacy for patients. However, the seated waiting area did not always have sufficient seating for patients, particularly when the department became busy.

The department had opened an area that had been designed to meet the needs of children requiring treatment. This area was secure, bright and child friendly. Toys were available for children to play with while waiting and the walls had been designed with child friendly pictures.

The trust had worked with an external provider who had commissioned an assessment facility for low risk mental health patients. This had been implemented to provide a more suitable environment for the assessment of patients.

A room had been designated to use as a waiting area for relatives. This provided a private environment for relatives to wait or for staff to have sensitive conversations with them when needed. However, the department did not have access to overnight accommodation for relatives to use if required.

There was an appropriate area that was used to allow relatives to spend time with their loved ones if they had passed away.

Patients and relatives had access to vending machines while in the department. Coffee shops and canteens were within easy access in the main hospital if needed.

Meeting people’s individual needs

The department had an electronic system that was used to alert staff of any individual needs that a patient may have. Examples of this were if a patient had learning difficulties or if a safeguarding concern had been raised during a previous attendance at the hospital.
Staff had an awareness of a symbol that was used to identify patients who were living with dementia. We were informed that patients who were living with dementia were managed in high visibility cubicles wherever possible. The trust had implemented a ‘paint me a picture’ scheme which was used in the department. This was important as these books highlighted individual needs such as communication, memory and a full medical history.

A trust wide learning disabilities team were available to support staff when providing care and treatment to patients with learning disabilities. They were available between 9am and 5pm from Monday to Friday.

The department had access to a drugs and alcohol liaison service who were available during normal working hours. Staff had knowledge of this service and knew how to make referrals when required.

A bereavement support worker was available in the department between Monday and Friday during normal working hours. There was also access to a specialist palliative care team when required.

The department had access to a 24 hour telephone based translation service. Interpretation services for different languages were also provided by a number of approved staff who worked within the trust. In addition, staff informed us if a translator was required to attend the department that this could also be facilitated.

Patient advice leaflets were available in the department providing information about a number of illnesses and injuries. These were not readily available in different languages, although we were informed that this could be supplied if requested.

The department was accessible for patients using wheelchairs.

Patients who presented in the department with mental health needs were redirected to appropriate services. Records indicated that in September 2017, 82% of patients had been assessed by an appropriate member of staff within four hours. This did not meet the national standard of 95%. However, there had been an improvement in the responsiveness of this service since the last inspection.

The mental health liaison team were available to provide advice and support to staff in the emergency department. There was also access to an on call psychiatrist if required.

The trust scored “worse than” other trusts for one of the three Emergency Department Survey 2016 questions relevant to the responsive domain. The trust scored “about the same” as other trusts for the remaining two questions. The question the trust scored worse than other trusts on was relating to patient privacy.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.5</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

Access and flow
The department had a limited bed capacity which meant that access and flow through the emergency department was restricted.

The management team informed us that patients had to wait in the department for longer than 12 hours on a daily basis. We observed this on a number of occasions during the inspection. More importantly, patients had to wait overnight, sometimes in inappropriate areas of the department such as the corridor.

Extended waits in the emergency department were mainly as a result of there being limited access to the medical and surgical assessment units as well as inpatient wards.

In addition, we found that the combined treatment and assessment unit was primarily used as an extended area of the medical assessment unit as well as being an area that was used to manage patients with mental health conditions who had been assessed as a low risk.

Members of the management team attended daily bed management meetings to discuss patients who were waiting for inpatient admission. We attended a bed management meeting, finding them to be structured and informative. We observed that the management team worked well with staff from other areas. However, we found that clear actions to resolve flow issues were not always made. This resulted in limited flow in the emergency department.

The trust had responded to the challenges that were currently faced by working with an external provider who had commissioned a primary care centre. This area was located next to the emergency department and was staffed by emergency and advanced nurse practitioners as well as general practitioners. The primary care centre had been open for two months and had already seen a large number of patients who had presented with minor injuries or illnesses.

In addition, a designated area for the management of low risk mental health patients had been opened. The aim of this was not only to provide a safer environment for patients using the area, but to also relieve the pressure on the observation ward, promoting patient flow through the department.

There was a child and adolescent support and enhanced response team which worked out-of-hours. This had led to patients being assessed for admission or discharge without having to wait for a mental health assessment by the child and adolescent mental health which only worked during office hours.

This had also helped reduce the numbers of children and young people presenting with self harm or mental health needs waiting four hour and above and also reduced the numbers of patients being admitted into a paediatric bed until they could be seen by a mental health professional.

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 did not meet the standard at any time from October 2016 to September 2017.

From October 2016 to September 2017 performance against this metric showed a trend of decline.

**Four hour target performance - Blackpool Teaching Hospitals NHS Foundation Trust**
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From October 2016 to September 2017, Blackpool Teaching Hospitals NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Performance against this metric has been consistent except for the winter period where it declined.

The department followed NHS guidelines when reporting the number of patients waiting more than 12 hours from the decision to admit until being admitted. This guidance states that ‘the time of
decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in the accident and emergency department before admission is complete – whichever is the later’.

Over the 12 months from October 2016 and September 2017, 39 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2016 (13) and March 2017 (10).

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>796</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>753</td>
<td>1</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1093</td>
<td>13</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1207</td>
<td>6</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1216</td>
<td>3</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1019</td>
<td>10</td>
</tr>
<tr>
<td>Apr-17</td>
<td>773</td>
<td>5</td>
</tr>
<tr>
<td>May-17</td>
<td>902</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>720</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>910</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>831</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>857</td>
<td>1</td>
</tr>
</tbody>
</table>

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

From October 2016 to September 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

From October 2016 to September 2017 performance against this metric showed a trend of decline.

In the most recent month, August 2017, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 8%, compared to the England average which was 3%.

Performance has been declining since March 2017 and is now at the highest point over the last 12 months.

**Percentage of patient that left the trust without being seen - Blackpool Teaching Hospitals NHS Foundation Trust**

![Graph showing percentage of patients that left the trust without being seen](image-url)
From October 2016 to September 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a trend of decline.

In August 2017 the trust’s monthly median total time in A&E for all patients was 231 minutes compared to the England average which was 144 minutes.

Learning from complaints and concerns

The trust had a complaints policy which was located on the intranet for staff to access if needed. Staff that we spoke with informed us that if patients or relatives raised a complaint or concern they would highlight it to the most senior person in charge. Members of the management team were aware of the complaints process and had access to information about how to make a formal complaint if needed.

From July 2016 to June 2017 there were 46 complaints about urgent and emergency care services. The trust took an average of 143 days to investigate and close complaints. This is not with their complaints policy, which states complaints should be completed within 25 days or 45 days for complex cases.

The top three subjects of complaints were:

- Treatment issues – 28
- Waiting times – 11
- Staff attitude - 3

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
We reviewed seven complaints that had been received between June and November 2017. We found that the response to each complaint provided an apology when needed and stated the outcome of the investigation that had been undertaken.

However, we were unclear if there had been lessons learnt from this process. This was because there was limited documented evidence of improvements being made both in the complaints response and in minutes of departmental and divisional meetings.

Advice was also provided for patients and relatives who were dissatisfied with the outcome of the complaints process. Patients and relatives were provided with information of how to contact the parliamentary health service ombudsman. The ombudsman is an independent adjudicator who considers complaints when departments within the national health service have not acted properly, fairly or have provided a poor service.

Is the service well-led?

Leadership

The emergency department had a clear leadership structure within the division of unscheduled care. The leadership team for the emergency department was made up of a matron and a lead consultant. However, we noted that the department had been without a business manager for a number of months.

The division of unscheduled care was led by a clinical director, an associate director of operations and an associate director of nursing. Members of the departmental and divisional management teams informed us that they had clear roles and responsibilities and they were clear what these were. However, the departmental leads informed us that it had been difficult to undertake the business manager role as well as undertaking daily responsibilities and clinical duties.

The management team informed us that they felt they had the knowledge and skills to undertake their roles and had access to training so that they were able to make improvements to their own service.

The department had recognised the need for a consultant with speciality training for paediatrics. However, the substantive member of staff who held this qualification was taking a long term break from employment with the service. The management team had identified a lead consultant for paediatrics in their absence, although they did not have speciality training in paediatrics.

Staff in the department informed us that the leadership team were visible and approachable. We observed positive interactions between members of the management team and other staff members in the department.

The management team were supported by a team of senior nurses who were responsible for managing the department on a daily basis. The department had developed a system that allowed there to be two supernumerary members of nursing staff available at all times to co-ordinate patient and flow and to monitor the delivery of care.

In addition there was a designated lead consultant between 9am and 5pm whose job was to coordinate the delivery of medical care in the department.

Vision and strategy
The trust had an overall vision and strategy that the management team were able to identify with. However, not all staff in the department had an understanding of this.

The division of unscheduled care and the emergency department had a vision which was to provide the best possible service and ‘to strive for excellence’. Within this, a number of key objectives had been developed.

However, we found that there was limited evidence of a strategy to achieve this. An example of this at departmental level was to increase the number of nurse practitioners and nurse specialists and at divisional level to improve patient pathways. These had been included in the appropriate ‘strategy bubbles’ but there was no clear action plan detailing how this was to be delivered and when it was due to be delivered by.

In addition to this, the trust had developed an overall improvement strategy for the emergency department which was focussed on access and flow, particularly about access to other areas such as minor injuries, the combined treatment and assessment unit, mental health services as well as better use of the discharge lounge.

Some progress had been made against the improvement plan. This included opening a designated room for the assessment of low risk mental health patients, streaming minor injuries to a primary care centre with nurse practitioner and general practitioner resources as well as opening a dedicated children’s area.

Progress with the improvement plan was monitored by the divisional board as well as the board of directors. However, we found examples of when actions implemented had not always been followed by the divisional and departmental team. An example of this was the department not using a room that had been designated for the assessment of low risk mental health patients. This meant that assessments of patients with mental illness were being undertaken in inappropriate areas of the department.

**Culture**

There was a positive culture across most staffing groups in the department despite the challenges that were faced with increased demand.

Most staff that we spoke with told us that they felt respected and valued by members of the management team. They felt that concerns were listened to and they felt supported. In addition, staff had access to a freedom to speak up guardian if needed. This was important as it provided staff a forum to raise concerns that they had confidentially.

We saw examples when the departmental team had supported staff with challenging personal issues and had been responsive in making sure that their needs were met.

The management team promoted a ‘no blame’ culture and staff were encouraged to be open and honest, particularly when reporting incidents. The management team informed us that the number of incidents reported in the past had been low, but there had been significant improvement in this area over the last 12 months.

Staff we spoke with were proud to work in the department and there were members of staff who had worked in the department for a number of years.

The positive culture was reflected in the low turnover rates. Between June 2016 and July 2017 the turnover of nursing staff had been 0.3%.
Governance

The trust had a governance structure which allowed information to be shared from ward to board level.

Departmental managers held a weekly meeting with the senior nursing team to discuss issues within the department. However, meetings for all other staff in the department were not facilitated.

Governance newsletters were produced on a quarterly basis to cascade information to all staff in the department. We found that these were thorough and informative.

The department held monthly governance meetings which were attended by members of the management team, senior nurses and members of medical staff. We reviewed minutes for three of these meetings, and noted that there was no set agenda for the meetings.

Any actions from these meetings were tracked by the use of an action log. We saw that an update was provided on outstanding issues but no date had been set for the actions to be completed by. As a result, some actions had continued for a number of months without being resolved.

Members of the management team attended monthly divisional governance meetings. We found that there was a set agenda for these meetings which provided an overview of topics such as performance, staffing and training. In addition, clinical governance was also discussed. This included topics such as updates about policies and clinical pathways. However, there were no documented actions for these meetings. This meant that it was unclear as to what actions would be taken to improve areas of concern that had been highlighted.

We found that most of these meetings were well attended. However, minutes from the paediatric governance meetings in June 2017, August 2017 and October 2017 indicated that the lead consultant for paediatrics had not attended any of these meetings.

Members of staff also attended a weekly divisional meeting of harm which allowed lessons to be shared across different areas.

Incidents that were scored as moderate or above were reviewed by the trust wide governance team. A regular safety panel was held to discuss serious incidents and follow up actions resulting from these.

Management of risk, issues and performance

The departmental management team had recognised the need to increase the number of registered nurses available. However, on reviewing a trust wide staffing report that had been completed in November 2017, there was no evidence that the overall number of registered nurses was to be increased. Senior leaders informed us that their view was that the current nurse staffing levels in the department were adequate.

We found that the management team did not always have oversight of poor areas of performance. This was because they only undertook a small number of audits to measure compliance with key areas. In areas were audits had been completed, such as nursing documentation audits, areas of poor compliance had been identified. We identified a continuation of the similar issues that had been highlighted during the inspection.

In addition, they were not aware of outcomes of audits completed by other departments within the trust. This meant that actions to make improvements had not always been implemented
appropriately. An example of this was continual poor performance with the management of controlled drugs over an 18 month period.

We were unclear about how information from quarterly records audits had been used to improve areas of poor compliance. This was because there were no results relating to the emergency department which meant that the management team were unable to implement actions so that improvements could be made if needed.

Audits to measure compliance with pathways, protocols and best practice guidance had not been undertaken in addition to submissions required by the Royal College of Emergency Medicine. This meant that there was a lack of assurance that staff had provided care and treatment in line with best practice guidance.

In addition, the departmental management team were required to implement a local policy for the use of the omnicell system to support staff in its use. We found that this had not been completed at the time of inspection.

However, we noted that actions had been taken to make improvements in other areas. For example, a pathway had been introduced for the management of asthma in children and a strategy was being trialled to improve compliance when treating sepsis. In addition, there had been some learning from a recent regulation 28 that had been issued by the coroner.

The trust had an overall escalation plan that what was used during periods of increased capacity. However, there were no clear actions documented for members of the management team to take in the event of the department facing increased pressure. This was because there was no local policy or standard operating procedure for staff to follow. This meant that we were unsure if members of the management team would know what actions to take at times of increased demand.

The department did not have a clear inclusion or exclusion criteria for certain areas of the department. This included areas such as the corridor or the minor injuries unit. This meant that there was an increased risk that patients would be managed in inappropriate areas of the department.

Standard operating procedures were in place for other services such as the mental health liaison team. This highlighted the key performance indicators that the service were required to meet.

The trust had a risk management policy which was available for staff on the intranet. Members of the management team knew about this.

Managers in the department completed organisational risk assessments to assess risks that the department currently faced. We reviewed a sample of risk assessments which covered areas of concern including staffing issues and medication errors. We found that these had recently been reviewed and had a number of controls in place to reduce the level of risk posed.

Risks that had scored highly were added to appropriate risk registers. Higher scoring risks were held at departmental, divisional and corporate level. Risks that had been added to the risk registers had controls in place to reduce the level of risk and there were clear dates for these to be reviewed.

A performance dashboard was used to measure key indicators in the department. This system monitored compliance with areas such as the compliance with the 15 minute Royal College of Emergency standard for initial assessment and the four hour standard to admit, transfer or discharge patients. Compliance with the performance dashboard was monitored at both divisional and trust level.
Information Management

Staff informed us that they had access to information that was needed for them to undertake their roles effectively. This included access to the trust intranet where policies, procedures and protocols could be accessed. Staff also had access to information about the treatment of injuries and conditions which reflected best practice guidance.

Electronic systems had been introduced triage patients, record were treatment plans were up to and to alert staff of any concerns that had been raised during previous visits, including safeguarding concerns.

An electronic discharge pathway was used for all patients who were discharged from the department. This system allowed staff to share important information to other services such as general practitioners or local authorities.

Electronic systems were used effectively to manage diagnostic results, making it easy for staff to access results when needed.

Important information such as safety alerts and changes to policies and procedures were cascaded to departmental managers by email so that appropriate adjustments to the service could be made.

Engagement

Patients and relatives who attended the department were encouraged to complete the friends and family test. This provided an opportunity for them to give feedback about their experience of visiting the department.

The trust had introduced a ‘tell us’ campaign which was another initiative to seek feedback from patients and relatives. The trust also used social media to communicate messages and receive feedback from members of the public.

Staff were able to take part in a ‘what are you proud of scheme’. This gave staff an opportunity to celebrate successes within different departments throughout the hospital.

All staff were asked to complete an annual staff survey. This was used to measure how staff felt about the culture, their role within the trust and whether they would recommend the hospital as a place to work and a place to receive care and treatment.

Senior staff nurses attended a weekly departmental meeting where key messages were cascaded. Information from these meetings was disseminated to all staff in the department through safety huddles and emails.

The clinical lead had developed a quarterly newsletter which was used to let all staff in the department know of any clinical or non-clinical updates.

Learning, continuous improvement and innovation

The department made regular data submissions to the Royal College of Emergency Medicine which allowed patient outcomes to be benchmarked nationally. We saw evidence of action plans having been implemented as a result of areas of poor performance.

The department had provided a suitable environment for the assessment of treatment and children who attended the department. The trust had also worked with an external provider who had commissioned a suitable assessment room for low risk mental health patients.
The department had worked closely with an external provider so that they were able to stream patients with minor illnesses and injuries to more appropriate services. The aim of this was to relieve some of the pressure that the department currently faced. Records indicated that since October 2017, a large number of patients had been seen and treated in this area.

Members of the management team worked closely with external providers such as a local ambulance service to manage daily pressures that the department faced. In addition, collaborative working had also been facilitated with the local accident and emergency delivery board.

The trust’s child and adolescent support and enhanced response team which provided out-of-office mental health assessment and support in the emergency department had been shortlisted for a recent Nursing Times award.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment for general medicine, care of the older person, diabetes & endocrinology, infectious diseases, gastroenterology, stroke, respiratory, rheumatology, dermatology and tertiary haematology.

A site breakdown can be found below:

- Blackpool Victoria Hospital: 430 beds are located within 20 wards

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 56,526 medical admissions between July 2016 and June 2017. Emergency admissions accounted for 21,806 (39%), 2,347 (4%) were elective, and the remaining 32,586 (57%) were day case.

Admissions for the top three medical specialties were:

- gastroenterology (12,676)
- general medicine (10,740)
- clinical haematology (7,291)

(Source: HES)

The medical services are managed by the unscheduled care division at Blackpool Teaching Hospitals NHS Trust. The division includes three directorates of long term conditions, specialist medicine and emergency services. The division includes the medical wards, cardiology and the acute medical unit.

The Care Quality Commission carried out an inspection between 29 November and 1 December 2017. During this inspection we visited the acute medical unit, general medical wards C and 6, ward 25 (Care of older person), ward 2 (short stay), stroke unit, ward 11 (diabetes and endocrinology), critical care outreach team, ward 37 cardiology ward, adult cystic fibrosis service, surgical assessment unit to visit medical outliers, and the discharge lounge.

We spoke to 42 patients and relatives. We also spoke with 53 members of staff, including senior managers, specialist nurses, registered nurses, student nurses, health care assistants, consultants, middle grade doctors, junior doctors, medical students, allied health professionals (including physiotherapists, occupational therapists, speech and language assistant, and dietitians), pharmacists, domestics, ward clerks, housekeepers, technical instructors and nursing agency staff.

We observed care and treatment and looked at 28 patient care records. We reviewed comments from staff focus groups and we looked at the service performance data.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. At the time of our inspection not all staff had completed their mandatory training, but plans were in place to address this.
Mandatory training is those elements of training that the organisation deemed are necessary in order for staff to undertake their duties effectively and safely. This is usually training such as basic life support and infection control, but can be different depending on the role of the member of staff.

The trust set a target of 95% for completion of mandatory training. The trust report training completion rates on a rolling monthly basis. A breakdown of compliance for mandatory courses as at June 2017 in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion Process : Administration</td>
<td>117</td>
<td>151</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion Process : Collection</td>
<td>87</td>
<td>108</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>315</td>
<td>421</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>358</td>
<td>410</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>452</td>
<td>497</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>376</td>
<td>497</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>467</td>
<td>497</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>355</td>
<td>437</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>392</td>
<td>497</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>404</td>
<td>497</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>143</td>
<td>180</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>372</td>
<td>416</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>367</td>
<td>450</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>333</td>
<td>405</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>418</td>
<td>497</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Recognise &amp; Act</td>
<td>65</td>
<td>115</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>354</td>
<td>437</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>365</td>
<td>497</td>
<td>73%</td>
<td>95%</td>
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<tr>
<td>Safeguarding Children Level 1</td>
<td>284</td>
<td>307</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>136</td>
<td>179</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>5</td>
<td>11</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>457</td>
<td>497</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>147</td>
<td>159</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff within medicine had not met the 95% training completion for any mandatory training modules as of June 2017 the lowest training completion rate was for recognise and act at 57%.

Blackpool Victoria Hospital had an 83% mandatory training completion rate.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff had access to a mandatory training policy. Records reflected that new starters were included in mandatory training figures and this could reduce the percentage of completion rates whilst their training was arranged and completed.

Staff spoken with stated that overall they were given opportunities to attend mandatory training and were confident that on an individual basis they were able to maintain appropriate training levels. During the registered nurse staff focus group, staff told us their training was monitored at the time of their appraisal. If they had not completed their mandatory training they were required to submit a plan to address this.
Managers from the division reported to us that although mandatory training levels were below trust targets, plans were in place to improve these rates. Compliance with mandatory training for all nursing staff was monitored by a senior nurse and the matrons.

The time frame for completing training modules varied. Some modules were completed once yearly, for example, basic life support, other modules such as conflict resolution and consent every three years. Ways to improve training figures was for staff to complete training at home via the internet or in workbooks. The managers told us there was a one month delay in updating results.

In addition to mandatory training, the divisional practice development sisters undertook a rolling programme of face-to-fact training.

A policy was accessible for staff on the wards in sepsis management. Staff were aware of this and were aware this policy was due to be reviewed to make it easier for staff to follow. Training in the recognition, assessment and management of sepsis had been included as mandatory for all nursing and medical staff.

Safeguarding

Staff understood safeguarding, which means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It refers to the processes in place to identify and protect a patient who is vulnerable or at risk. The service worked well with other agencies to protect patients from abuse, they knew how to recognise, report abuse.

The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for safeguarding courses as at June 2017 for all staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Safeguarding training completion by Module</th>
<th>Completion (%)</th>
<th>Target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>92.5%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

Mandatory training was reported on a rolling month on month basis and as at June 2017 the medicine division was below the trust target for all four safeguarding modules with the lowest score in safeguarding children level three which was required to be completed by a total of 11 staff. Managers in the division told us they were working on improving the staff training figures.

Blackpool Victoria Hospital had an 88.7% safeguarding training completion rate. The trust had not achieved its target of 95% in any of the safeguarding training modules in medicine.

The trust wide safeguarding team comprised of the director of nursing and quality who was the executive lead for safeguarding and the head of safeguarding. There were designated lead doctors and named safeguarding nurses for both children and adults. In addition there were designated contacts in the team for looked after children, youth offenders, child sex exploitation, domestic abuse, mental capacity act and deprivation of liberty safeguards, domestic abuse amongst others.
The trust had an up-to-date safeguarding policy for adults and children, which was accessible to staff on the intranet. Staff we spoke with during the inspection knew how to locate the policy and understood their responsibilities and followed procedures to protect vulnerable adults or children. The designated safeguarding lead and the safeguarding team were based in the hospital during normal working hours. Staff had access to 24 hour services if a safeguarding referral was required out of hours. Staff told us they had strong links with the Safeguarding team and with Mental Capacity Act lead.

Each ward had a safeguarding ‘champion’ who could support staff with any concerns.

Safeguarding vulnerable adults and children was included in the hospital mandatory training programme.

Staff across the medical division had received Prevent training in recognising individuals who may be vulnerable and therefore more susceptible to radicalisation by extremists or terrorists. Staff we spoke with had an understanding of child sexual exploitation and an awareness of female genital mutilation (FGM) which is mandatory for professionals to report all known cases of persons under the age of 18 to the police.

Cleanliness, infection control and hygiene

The service controlled infection risk well. There was an infection prevention and control team in the hospital with leads on each ward. Staff kept themselves, equipment and the premises clean. We saw that staff adhered to trust uniform standards and followed ‘bare below the elbows’ guidance. The wards we saw were visibly clean, tidy and free from odour. Each ward had an assigned housekeeper who was responsible for the cleaning of the ward. The housekeepers we spoke with were aware of the importance of infection control and their responsibilities in following the trusts infection control policy and procedures.

The medical wards displayed the outcomes of their infection control audits at the entrance to the wards. There were hand washing facilities and hand gel dispensers available in the wards which we observed medical, nursing and allied health professionals using appropriately. We observed staff following the infection control policy in their use of personal protective equipment. Staff were seen wearing aprons and gloves when delivering personal care and they reported there was always enough available.

We looked at the cleanliness of a number of areas on the wards and found sluices, treatment rooms, staff areas to be visibly clean and orderly. Chemicals for cleaning were appropriately stored in line with the Control of Substances Hazardous to Health guidelines.

On ward six, we saw commodes were checked every two hours and this was clearly documented. The commodes were new and could be completely dismantled for cleaning. “I am clean” stickers were then put on the commodes.

On ward six, the hand hygiene audit score had fallen to 85%. In response to this, action had been taken by the ward manager for hand hygiene training for all staff on the ward. The scores for the commode audit were at 100%. We saw that mattresses were cleaned when patients were discharged from the wards. Staff told us that where the audit showed less than 100% compliance, issues were discussed at the safety huddles.

The nursing assessment document incorporated a section on infection prevention; it had questions on MRSA, Clostridium difficile history and multidrug resistant coliforms. This enabled staff to make a decision on whether the patient required barrier nursing. Side rooms were then used to isolate these patients who were at risk of increased infection. We saw side rooms had signs to show staff and visitors they must take infection prevention precautions when they enter
and leave these rooms.

We saw the storage and disposal of sharps, including contaminated needles were in line with good practice guidelines. Containers were signed and dated.

At our inspection in 2014, we found some inappropriate storage of equipment which represented a risk regarding the prevention and control of infection. We saw this had been resolved as we did not find inappropriately stored equipment during this inspection.

Audits were carried out on the wards by ward managers, link champions and staff who had been trained to carry out audits. Examples of these audits were the use of protective equipment, waste disposal, commodes and sharps management. Outcomes for the medical division showed that for the period October 2016 to September 2017, compliance improved over the last four quarters.

Environment and equipment

The ward areas we visited were mostly well maintained and clinical areas were kept locked for safety. On ward six, there were new point of care blood glucose machines. The ward manager was waiting until all staff had been trained in their use before starting to use them.

The ward manager said that they had a number of agency staff on the ward, so equipment was clearly labelled with full instructions on how to use it next to each piece of equipment.

Systems were in place to service and maintain equipment.

Since our last inspection we found the monitoring of emergency equipment had improved. The equipment included a defibrillator, oxygen, portable suction and other emergency items. In addition emergency drugs and fluids were stored on the trolley. We saw that equipment was maintained, serviced and checked as required. At the last inspection, it was unclear if resuscitation equipment was always being checked, which meant that emergency equipment might not be available when needed. At this inspection, resuscitation equipment was available on all the wards we visited. We checked five resuscitation trolleys and a sample of items on the trolleys. We found them to be in date and in a useable condition. Daily equipment checks were in place in line with trust policy and tamper safe seals were intact. Tamper seals were used to identify if the equipment had been used since it was last checked. Systems were in place to check that equipment was checked on a daily basis.

The resuscitation trolleys on ward six were checked daily by the ward manager. The battery for the defibrillator was checked weekly and all checks were recorded. There was a medical devices folder, which included guidance for staff on single use items of equipment. Staff training records and competencies for medical devices used on the ward were kept in this folder.

Patients who were identified at risk of developing pressure ulcers were provided with pressure relieving equipment which was available on site and staff reported they did not have a problem requesting this. On the discharge lounge, we found patients may have to wait longer than four hours prior to their transport arriving. We found two patients who were subject to lengthy delays did not have access to pressure relieving equipment. This was shared with the nurse in charge.

Assessing and responding to patient risk

The service did not consistently manage risk well.

Pressures created by an increase to the number of medical admissions into the division were responded to in part by the use of escalation within the core clinical area of the acute medical unit. We observed patients being managed on a corridor area. The corridor area was within the acute medical unit but was not the main access to the wider unit as a whole. The corridor escalation
area was used to manage patients in the short term whilst the actual bed space was created within the acute medical unit / medical bed base.

Patients were risk assessed for suitability by the AMU coordinator in conjunction with the emergency department coordinator, and supported by the patient flow manager in hours and the duty team out of hours. Staffing to support the escalated area was provided by the corporate team.

When in escalation, there was also an organisational response. Checks were made on the acute medical unit undertaken by the matron of the day, associate director of nursing and duty matrons to ensure staff and patients were supported with patient flow.

The division was working on improving flow throughout medicine to prevent congestion within the acute medical unit. This had included the introduction of the safer bundle, board rounds, electronic white boards, a discharge lounge, a frailty service and discharge to assess.

However, the escalation environment did not always allow for patients to be treated in the most appropriate area. During this inspection we made a number of visits to the unit to observe and monitor the risk to patients of being attended to on the corridor. We observed up to six patients being cared for by one registered nurse on the corridor within the Acute Medical Assessment Unit. Staff reported that guidelines had recently been introduced for only low risk patients to be assigned to the corridor following there being an incident whereby patient safety was put at risk.

The corridor was inappropriate for equipment to be available in the event of an emergency which meant there was a potential risk to patient safety. During periods of peak activity we were told the corridor had been used to manage the flow of patients. We were shown how patients were risk assessed for ‘the corridor’. Although staff conducted a risk assessment, there was a risk that patients could deteriorate rapidly. Staff reported they did not feel satisfied with the arrangements of ‘nursing’ patients on this corridor.

We observed the following examples where the arrangements for the management of these patients had the potential to put them at risk. Two patients who were on trolleys, appeared uncomfortable whilst awaiting transfer to a bed. We saw one patient who required an intravenous infusion. The patient’s equipment was managed in the corridor, as there was no space on the ward. Staff were observed climbing over the flex of the intravenous infusion pump where this was plugged in to the one available socket. We observed the registered nurse dealing with patients basic needs as the health care assistant had been moved to cover another area at short notice. Staff told us how caring for patients on this corridor affected their morale as they could not deliver quality care.

Call bells were not in patients reach, however, the nurse did position herself close by whilst maintaining and writing up the records. This meant that there was a risk that patients were not able to request help if needed.

The senior management team had introduced some measures to minimise the risks to patients during the peak times when the corridor was used. This included the introduction of criteria for patients who were assessed as suitable for the corridor, as it concerned them that patients were potentially at risk. In line with trust escalation response, a registered nurse and health care assistant, in addition to the acute medical unit planned establishment, was assigned to care for the patients in the escalation area.

During the inspection, our concerns were reported to the trust management team who took some immediate action to address the number of patients on the corridor and told us further action would be taken to address these concerns.
Following the concerns that we raised, the management of the acute medical unit was re-organised and when we returned to the unit staff told us that there had been no patients managed on the corridor since we had left after the inspection. Consultants were working more closely with urgent and emergency care colleagues and managing patients in the urgent and emergency care department and to try to avoid admission to the acute medical unit by sending patients to areas of the hospital which best met their needs. Staff, including consultants and nurses said that this was working well and we saw that the unit was much calmer.

Staff followed a procedure to monitor patients who were acutely unwell. On admission to the wards, nursing staff completed a comprehensive nursing assessment document. This included sections on risk assessments including; falls, moving and handling, bone health, skin integrity and hygiene needs, the malnutrition screening tool, and a continence assessment. Patients over 75 years of age, admitted to medical wards were screened for dementia using the national dementia screening tool. Patients highlighted by this tool were assessed for mental capacity and appropriate care plans were introduced.

In addition, the wards used the national early warning system (NEWS) for adults for staff to recognise and escalate patients in a timely way if their condition was deteriorating and the triggers to flag for sepsis. This required carrying out some basic observations including the patient’s blood pressure, heart rate and temperature. We looked in 18 patient’s notes where we looked specifically to see that this tool was used appropriately. We saw these were completed and staff were aware of the procedures to follow when a patient was deteriorating. Records showed that where necessary, the medical staff had been called and staff continued to monitor the patients vital signs.

The medical division had a pathway for the management of sepsis in adults (sepsis is a life threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs). We saw records had been completed where there was a suspicion a patient may have sepsis and that appropriate interventions were taken. Staff we spoke with demonstrated knowledge of the sepsis pathway and explained what they would do if patients observations showed signs of sepsis.

The trust had a sepsis team to drive improvement and knowledge around sepsis. Various audits of sepsis performance had been conducted including a monthly sepsis pathway compliance audit. This looked at various standards in relation to the sepsis pathway and detailed whether the hospital was achieving these standards. The hospital participated in the ‘National Confidential Enquiry into Patient Outcome and Death’ (NCEPOD) Sepsis study. The sepsis team had implemented various initiatives to understand how they might improve. These included visiting another local NHS trust to discuss and learn from them; launching sepsis educational materials and leaflets and additional training for staff. The team had produced action plans many items of which had been implemented and completed; there was also evidence of ongoing audits to ensure continuing compliance.

Guidelines were available for staff on the management of a patient with acute kidney injury. The medical staff had developed a proforma for all new cases to attach inside patients notes.

Patients were assessed for the risk of pressure ulcers and falls on admission to the different wards. Patients with pressure ulcers and moisture lesions were referred for medical photography as part of the assessment for skin integrity. In addition photographs were taken before the patient was discharged. We looked at 10 patient records, finding that the initial assessments had been completed on all occasions. Staff we spoke with could tell us the action they would take if a patient’s condition deteriorated.

We observed and attended board rounds and handovers. On the acute medical unit we
observed the morning handover from the senior nurse on night duty. This was well attended by all the day staff. The staff teams then split into smaller groups for each bay. This was then followed by a detailed handover from the lead nurse for each patient. There was a set template, which held patient information for the meeting and which was completed by the senior nurse from the night shift. In addition we attended daily safety huddles which were attended by all ward staff. The huddles included information about the patient’s risk of deterioration, any patients where a do not resuscitation order was in place, any safeguarding issues or risk of the patient absconding from the ward and any risks including diabetes, pressure areas and falls. The huddles were documented by the staff.

Staff responded to patients on ward six, who were most at risk. Their beds were moved so they could be viewed from the nurses’ station. We saw that patient risk was discussed at the multidisciplinary team meeting and patients were moved accordingly. Patient risk for falls and the Waterlow scoring for pressure areas was reassessed every seven days or sooner if necessary. Four patient records confirmed this. Patients had routine tests completed on admission to the ward, for example urine testing. This helped the staff to identify and treat any potential problems, including urinary tract infections. The ward manager had designed a form for the patient records for the recording of the results of the urine tests. Testing was repeated as appropriate.

We attended a multi-disciplinary team meeting on the stroke unit where each patient was reviewed and risk factors were discussed including falls risk, safeguarding issues and infection control issues. On the stroke unit, risk assessments were completed as the patient was admitted to the ward and then updated twice a week. Patients on the stroke unit were never outliers in the hospital, however the ward took medical outliers and we saw that they were reviewed by the stroke physicians as part of the review of the stroke patients.

There was an on call telestroke scheme, where consultants could give advice on thrombolysis at night. The scheme was for hospitals across Cumbria and Lancashire and had been running for about ten years. The medical director who was part of the scheme said that it was well used and was a good service.

The department had put actions in place to reduce the risk of falls, for example: falls risk assessments, better lighting and flooring, falls alarms and bay tagging.

**Nurse staffing**

The service had a high number of staff vacancies and the data showed that not all shifts were filled by agency or bank staff. The planned number of registered nurses and health care assistants on the medical wards was not always achieved. Senior management assessed and reviewed the staffing establishment annually in line with national guidance using patient acuity tool, professional judgement, local knowledge and through the use of quality indicators. The safe staffing exception report of November 2017 showed there were 78.3 whole time equivalent qualified staff short and 23.7 unqualified staff. The hospital relied heavily on the use of bank and agency staff due to a high number of vacancies and acknowledged recruitment was a challenge. Nurse staffing levels was on the risk register.

Matrons met with the ward managers to discuss and monitor staffing levels. All wards were risk assessed daily against actual patient need and acuity, and staffing allocated appropriately by a
divisional matron to ensure the areas remained safe. A daily safety huddle was led by nominated matron of the day to review skill mix, staffing numbers and patient risk and acuity. This senior nurse then allocated staff. There was also a dedicated bleep holder who visited each area once staffing has been allocated to undertake safety and assurance checks throughout the 24 hour period. At least daily, there was a corporate nurse staffing meeting led by the Deputy Director of Nursing or nominated lead to review risks across the whole organisation and the allocation of staff.

The stroke ward was divided into four areas that were overseen by a trained nurse. There was also a supernumerary nurse who was the point of contact for staff on other wards. Staff told us that the ward ran well if they had the four nurses, but if one of them had to cover another ward due to staff shortages, this was difficult for the three nurses left on the ward. There were three band three nursing vacancies on the ward, but each shift was covered. The unit used the agency, staff but these were usually the same staff and had experience of working on the ward.

On ward six, they were fully staffed with health care assistants, although there were six vacancies in the qualified nursing staffing. The ward manager could offer overtime to the nursing staff and they could use staff from the nursing agency provided by the trust.

On ward C, there were 14 qualified nurse vacancies, which meant a high reliance on bank staff, staff who were provided by the trust and agency as necessary. In the early shift, the establishment should be five qualified staff and seven healthcare assistants. The duty rotas showed us that they met this requirement by one of the ward managers stepping in to be one of the qualified staff. One of the ward managers usually stayed clinical. Ward C had two ward managers; it was expected and planned into the establishment that 50% of their time was spent in the clinical numbers supporting the ward team in action and the other 50% of their time was non clinical supernumerary management time.

Staff confirmed it could be challenging to the team when the ward manager was the lead nurse in a bay and managing the ward overall too.

Staff we spoke with expressed concerns of pressures they felt due to short staffing and the movement of staff. Staff told us this was due to various reasons; the actual staff on duty being lower than the planned staffing levels, staff required to ‘special’ patients on a one on one basis, or staff being moved to another area.

There were vacancies in the allied health professional teams in medicine. This included occupational therapists and physiotherapists. Staff said that they were busy but they managed to see patients in a timely manner and they used appropriate skill mix. The trust was out to advert for a number of therapy posts.

The trust has reported their staffing numbers below for the period July 2016 to June 2017 for medicine.

There were 17.14 fewer WTE staff in medicine than the trust planned for to provide safe care.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing, midwifery &amp; health visiting</td>
<td>581.63</td>
<td>564.49</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a vacancy rate of 7.4%
• Blackpool Victoria Hospital: 7.5%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The safer staffing figures published on the hospital website dated 29 October 2017, acknowledged that the medical division had a high vacancy factor for both registered and unregistered nurses across the division. In light of this the managers had started a review, looking at skill mix, patients groups, and had started a nurse led discharge ward.

In addition, in response to the national nurses shortage, the divisional recruitment strategy had focused on national, European and international recruitment over the past three years, The division had recruited 64 overseas nurses following a recruitment drive and nine had taken up their posts at the time of inspection. The review has recognised there needs to be different ways of working and new roles, such as the band 3 ‘clinical escorts’ that support the acute medical unit with transfers and tasks such as cannulation and taking bloods and the assistant practitioner roles.

Between July 2016 and June 2017, the trust reported a turnover rate of 6% in medicine;
  • Blackpool Victoria Hospital: 11%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Between July 2016 and June 2017, the trust reported a sickness rate of 5% in medicine;
  • Blackpool Victoria Hospital: 8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 16.5% in medicine;
  • For the trust total of 84,225 shifts over the 12 month period, qualified nurses were used as bank staff to cover 14.4% of shifts.
  • In addition agency staff were used to cover 2.1% of shifts.
  • Overall there was a total 14% (11,532) of shifts not covered by nursing staff.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The division did use significant numbers of ‘bench’ staff. Bench was the hospitals own staff bank where staff could work additional hours for payment.

**Medical staffing**

The trust considered the medical staffing as their biggest challenge and risk. The stroke service had advertised for medical staff and were using long term agency staff to cover the stroke service. Consultant ward rounds were not undertaken taken daily, however, there was an on call system to provide consultant cover throughout the 24 hours period.

During our inspection, we found medical staffing was sufficient to meet the needs of patients. Doctors we spoke with told us their workloads were manageable. Junior doctors stated there was always access to advice and support from senior staff and consultants and they could access that support at all times. Doctors told us that there were opportunities for development and learning and that the training programme was excellent.
The medical division used a high number of locums and therefore considered this a risk.
The division held a weekly medical meeting specifically around deployment and recruitment.
There was seven day consultant cover for all wards including ward 6; all wards have designated
cover Monday to Friday. Weekend consultant cover was shared between six and eight consultants
dependent on need. The consultant was a locum but had been on the ward for three months so
there was continuity of care. There was also a registrar and a senior house officer. At weekend
there was consultant cover on Saturday mornings and then the ward used the hospital on call
arrangements.
The consultant cover on the medical assessment unit involved four consultants. They rotated each
week to cover ward two, a short stay ward. The consultants told us this worked well because they
already knew the patients due to the rotation. Medical staff on the Unit reported that the nurse
practitioner team worked well with the medical staff on ward rounds to support their roles.
The trust has reported their staffing numbers below for the period July 2016 to June 2017 for
medicine.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>63.21</td>
<td>38.58</td>
</tr>
<tr>
<td>Dental</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Junior medical</td>
<td>115.9</td>
<td>100.04</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>179.11</strong></td>
<td><strong>138.62</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a vacancy rate of 16.3%
- Blackpool Victoria Hospital: 16.4%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between July 2016 and June 2017, the trust reported a turnover rate of 6% in medicine;
- Blackpool Victoria Hospital: 15%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Between July 2016 and June 2017, the trust reported a sickness rate of 5% in medicine;
- Blackpool Victoria Hospital: 2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Between July 2016 and June 2017, the trust reported a bank and locum usage rate of
percentage in medicine;
- For the trusts total of 12,025 shifts over the 12 month period, for which medical staff were
  used, as bank staff to cover 19.9% of shifts.
- In addition locum staff were used to cover 63.8% of shifts.
- Overall there was a total 4% (410) of shifts not covered by any medical staff.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Between 1 June 2017 and 30 June 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was the same.

**Staffing skill mix for the 135 whole time equivalent staff working in medicine at Blackpool Teaching Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>24%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017)

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Patients notes were stored by nursing stations in lockable trolleys so that patient confidentiality was maintained. Some patient documentation, such as observation and food charts, were held and used at the bed side in accordance with governance guidelines.

The nursing assessment included a consent form for this to be completed upon admission. We looked at 10 consent forms on the acute medical unit and all these had been completed.

The wards used both electronic and a paper system for all patient records. Paper based records included assessments, observation charts, prescription charts and risk assessments. The electronic records contained patient information, such as safeguarding alerts or infection control risks. All patients were required to have a skin assessment and safety check as part of their records. This included documentation for staff to complete when they had checked patients as part of intentional rounding (this is when staff are required to check patients at regular intervals to reassess their needs).

Of the 28 patient records we reviewed, we found the majority were records were completed to an acceptable standard, these included a detailed care plan for the patient, risk assessments that were reviewed in a timely way. Records had been dated, signed and were mostly legible.

On ward six, records for the current patient admission were kept on the ward adjacent to the nurses’ station, while the previous notes were kept in the doctors’ office on the ward. This meant that the most up-to-date information was available for appropriate staff to view. All records were stored in lockable trolleys.
We looked at 11 records on this ward, including doctors, nurses and allied health professional records. All were completed appropriately, they were legible and signed and doctors’ records included their General Medical Council number where appropriate.

On the acute medical unit the senior nursing staff were piloting an ‘acute admission nursing assessment document’ where they carry out an initial assessment. Due to the length of stay of some patients having increased, the assessment staff have identified a need to develop care plans. One patient was on their fifth day on the unit as it was deemed inappropriate to move this patient to another ward.

**Medicines**

A dedicated pharmacist technician team and clinical pharmacists provided support to the medical wards on weekdays. There was a reduced weekend service with a single pharmacist and technician team providing support across the hospital. With patient consent, the pharmacy team had access to GP information through Medical Interoperability Gateway (MIG) to support medicines reconciliation on admission to hospital. The trust audited medicines reconciliation each month achieving an average of 74% compliance. This places the trust in the interquartile range when compared with other acute non-specialist trusts [NHS England Medicines Optimisation Dashboard].

<table>
<thead>
<tr>
<th>Medicines Reconciliation Audit Criteria</th>
<th>Annual Target</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of pts receiving drug review within 24 hrs of admission (12:30 Sunday - 12:30 Friday) Pharmacist covered wards</td>
<td>R &lt;80% A 80-85% G &gt; 85%</td>
<td>74%</td>
<td>74%</td>
<td>78%</td>
<td>74%</td>
</tr>
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Pharmacist Led discharge was used on weekdays on medical wards to try and reduce discharge prescription and medicine processing time. Additionally, there was some provision for the ward-based dispensing of take home medicines on the medical assessment unit. The trust did not supply monitored dosage systems on discharge, but worked with patients’ families and their usual community pharmacy to ensure that appropriate medicines arrangements were in place on discharge.

The trust completed quarterly antimicrobial audits. Compliance with regard to choice of antimicrobials was 90%. The review of antibiotics within 24-72 hours in sepsis patients was 100% in Q1 and 95% in Q2 2017-18 [Trust data]. However, the trust’s quarterly antimicrobial audits (2017/18) were showing only 40% compliance with ‘stop/review’ date. The trust had identified that ‘more work was needed’ to ensure documentation of the stop/review date. On reviewing prescription charts, we similarly found that that the review date was not consistently documented. Additionally, it was not always clear who the prescriber was as their General Medical Council number or name in capitals was not completed. Prescriber identify has been added to the trusts antimicrobial audit from Q2 2017/18 to facilitate prescriber feedback.

The trust had a medicines self-administration policy that allowed patients to keep and self-administer a limited range of medicines. However, we found that this was not adhered to in practice. For example, on the medical assessment unit one patient was self-administering all of their own medicines. We also saw examples where prescription charts were not annotated to indicate that a patient was self-administering their own medicine.
Medicines and equipment for emergency use were readily available and stored appropriately. Staff carried out checks to ensure these were in place and fit for use in accordance with trust policy.

We found medicines requiring refrigeration were stored securely. The trust’s annual medicines storage audit (February 2017) had highlighted concern regarding storage area room temperatures being monitored and recorded. New paperwork for recording refrigerator cleaning, thermometer checking and both room and fridge temperature recording had been rolled out to support improvements in temperature monitoring. Nurses completed daily checks of controlled drugs handing. However, on ward 11 we found that controlled drugs transit forms were not completed in accordance with trust policy additionally, the lock did not meet with current standards. We raised this with the ward clinical pharmacist in order that this could be addressed.

Matrons and ward managers told us that they received feedback regarding medicines related audits or incidents. For example, ward six commented positively about the additional support provided by the pharmacy team regarding controlled drugs. In addition the professional development nurses’ provided audits and staff training to support the ward team. Learning from incidents was also shared electronically via the trust’s Medicines Management Bulletin.

On ward six, we saw that medicines were stored appropriately in locked cabinets that were in locked rooms. There were separate cupboards for controlled drugs and records of controlled drugs were up to date. If patients brought in their own controlled drugs to the ward, these were stored and recorded in a separate locked cupboard. We saw that fridge temperatures and room temperatures were recorded daily and all the readings we saw were in the correct range for safe storage. We looked at medicines from the fridge and from the cupboards and all of the medicines we looked at were within their expiry dates. Fridges were cleaned at regular intervals and this was recorded.

The ordering of medicines was done every week by the pharmacy department and a stock check was carried out at the same time. Any medicines that were not being used were returned to the pharmacy. The trust’s medicines policy was available to staff in the room where the medicines were stored and relevant parts of the policy were highlighted for staff. There were completed risk assessments for each of the intravenous medicines.

Staff undertaking medicine rounds wore red aprons with “do not disturb” on them. This was to minimise the risk of them being distracted while dispensing medicines to patients. We observed this worked effectively.

Nursing assessment document included allergies to medicines. Out of 10 records we looked at we saw these had been completed appropriately.

**Incidents**

At the 2014 inspection, we found that the systems and processes in place to maintain the safety and effectiveness of the service required improvement. Some staff relied on others to report incidents and others rarely reported ‘near misses’, believing it was not necessary to report an incident unless a patient came to harm or an incident actually occurred. During this inspection we found the service managed patient safety incidents well. The medical division had an electronic system in place for reporting actual and near miss incidents. Staff recognised incidents, were familiar with the reporting process and understood their responsibilities. Managers investigated incidents and shared lessons learned with the whole team and the wider service. The person
reporting an incident had the option to be notified of the outcome of their incident. A governance newsletter had been introduced where learning from incidents was shared with staff.

Staff were familiar with the types of incidents that should be reported. Types of incidents reported included patient safety incidents, including medication, falls, staffing and equipment issues.

Staff told us senior staff encouraged them to report incidents and they spoke confidently about incidents they had reported. Staff gave us examples of incidents that had occurred and the changes to practice put in place after this. For example, following staff not carrying out all the elements of the sepsis pathway for a patient due to time constraints, a history sheet had been introduced to go into a patient’s record folder and activities recorded in ‘real time’ rather than at the end of the day, to improve their record keeping. Staff reported to us that learning had been provided around earlier recognition of sepsis and documenting all steps taken. We looked at the minutes following a team meeting on one of the wards and found evidence of incidents having been discussed.

On each ward the number of incidents per month was displayed. Ward managers noted themes in the incidents reported and discussed these with staff and actions to be taken. On ward two, staff shared that the falls incidents had been a problem due to only three beds being easily visible from the nurses’ station. The staff recognised the importance of falls alarms and one to one staffing requests for high risk patients.

The medical division reported incidences of using the duty of candour processes. We reviewed a sample and found that it had been applied correctly, in line with trust policy and an apology given.

Incidents and risks were discussed during weekly meetings and information was escalated to senior management as necessary. Managers attending these ‘harm’ meetings had the opportunity to review incidents, discuss issues and ensure learning was circulated and actioned. This meeting enabled staff to look at ways to reduce the chance of reoccurrence in a timely way.

A hospital bulletin was available to staff where lessons learned were shared with staff. We saw a copy of this bulletin where a case study of a patient sent to emergency care was used. Lessons learned were highlighted and action identified to support the lesson.

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

Between September 2016 and August 2017, the trust reported one incident classified as a never event for medicine.

A patient had a Nasogastric (NG) tube inserted as part of ongoing management for feeding and medication. The NG tube had to be re-inserted and a chest x-ray was requested to ensure the tube was in the correct position prior to commencing feeding. The previous x-ray was reviewed by the on call doctor by mistake which showed the tube was correctly positioned. The staff realised their mistake and addressed the issue, the patient did not suffer from any long term effects and was discharged.

The trust had a policy on the duty of candour. Staff we spoke with had an understanding of the principles of duty of candour and gave us appropriate examples of when this had been used. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.
In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common type of incident reported was:

- Pressure ulcer meeting SI criteria with five (42% of total incidents).
- Slips/trips/falls meeting SI criteria with three (25% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (17% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (8% of total incidents).
- Treatment delay meeting SI criteria with one (8% of total incidents).

Site specific information can be found below:

- Blackpool Victoria Hospital: nine incidents

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The trust used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

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

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

Data from the Patient Safety Thermometer showed that the trust reported 54 new pressure ulcers, 21 falls with harm and eight new catheter urinary tract infections between August 2016 and August 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Blackpool Teaching Hospitals NHS Foundation Trust

![Graph of Pressure Ulcers](image)

Total Pressure ulcers (54)

![Graph of Falls](image)

Total Falls (21)

![Graph of CUTIs](image)

Total CUTIs (8)

Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17

The number of pressures ulcers reported over the 12 month period have been steadily rising until July 2017, the trend of falls also increases from April 2017 onwards.

Source: Safety thermometer - Safety Thermometer

As a whole the trust recorded a slightly better level of harm free care 95.2% compared to the England average of 94.3% from October 2016 to October 2017.

During the inspection, we observed that safety thermometer information was prominently displayed on the wards we visited. The information was updated regularly to keep patients and visitors informed about the ward performance. We saw evidence that the information was being used to identify areas for improvement and actions implemented as appropriate.

Risk assessments for pressure ulcers and falls were completed for each patient upon admission and reviewed as appropriate throughout their stay. Documentation we looked at confirmed risk assessments were done appropriately and actions taken where risks were identified such as using a pressure relieving mattress or implementing a falls care plan.

On the stroke unit the lead nurse for incidents told us they had between 20 -30 incidents every month. Many of these were falls and medicine errors where staff had not signed medicine
paperwork following administration to the patients. There were plans in place to try to improve this and monitor this going forward. Staff said that they were comfortable to report incidents and said that they were followed up appropriately.

The critical care outreach team carried out a root cause analysis for all cardiac arrests that happened in the hospital to look for any trends in the treatment and care of these patients. In addition all cardiac arrests were reported as incidents.

Is the service effective?

Evidence-based care and treatment

Staff provided care and treatment based on national guidance and the trust’s policies reflected this.

Patient pathways were available on the trust intranet system and information was readily available about the different stages of the pathway. Adherence to the pathways was also available to staff.

There were electronic trackers on the acute medical unit and staff could identify very quickly which part of a pathway that patients were on and what was needed next in their treatment. Staff said that this was a really useful tool that had evolved and improved over time, it was helpful and saved time.

Use of the tracker had identified that the acute kidney injury pathway was not always being followed. This had been addressed through a quality improvement meeting and actions had been put in place on all the medical wards to improve adherence to the acute kidney injury pathway.

The unscheduled division took part in local clinical and nursing care audits to assess their compliance against evidence based care and treatment. These audit results were discussed during clinical quality groups and where required we saw actions had been put in place to improve standards.

Patients were assessed if they were at risk of venous thromboembolism (blood clot) and treatment in accordance with National Institute for Health and Care Excellence guidance was provided. Staff were aware their nursing documentation was audited, including if they had completed venous thromboembolism checks.

A comprehensive clinical audit plan was in place for the medical division. This was in line with best practice and evidence based guidance. The audit plan detailed the frequency of audit, who was responsible and demonstrated compliance.

The trust used guidance and guidelines from the National Institute of Health and Care Excellence and the Royal College of Physicians for its stroke services. There was an acute stroke integrated pathway and each patient had a checklist so that staff were aware when each action had been completed.

There was a critical care outreach team who followed the guidance from the National Institute of Health and Care Excellence, so that they could manage patients with high acuity or dependency when they were discharged from the critical care unit onto the medical wards. Staff said that this service was good as it supported their care of very poorly patients and they could use it for advice.

The cystic fibrosis service was using the European cystic fibrosis society standards of care: best practice guidelines for their service. The service was a hub and spoke arrangement with another trust with Blackpool being the spoke service. The guidelines and evidence based care and treatment were shared with the established hub service.
There was a non-invasive ventilation flow chart for patients who were admitted to the hospital. The service was developing and there was a dedicated team to support these patients.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Patient’s records included nutritional assessments on admission and were referred to a dietitian where necessary. Nutritional assessments were reviewed regularly. Fluid balance charts and food charts were completed.

Staff knew how to access the dietitians and speech and language therapists during core hours across the trust. These staff provided advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. Records we reviewed showed patients were referred to and reviewed by a dietitian appropriately.

Patients who needed assistance or encouragement with eating and drinking were highlighted by use of the red tray system. This system provides staff with prompts for patients who are at risk. We observed that patients were assisted at meal times by staff.

Patients told us they were happy with the quality and choice of food and that was provided. Protected meal times were in place on the wards to enable patients to be supported in a calmer environment and eat their meals without interruptions.

On ward 6 we saw the kitchen that was used for the benefit of patients. Staff could make hot drinks and light snacks for patients and their relatives throughout the day and night. There were food record charts for all patients, so that staff knew how much patients had eaten and we saw that staff supported patients with eating and drinking. Staff completed the malnutrition screening tool as part of the nursing assessment document. Staff said that if they needed a dietitian that they would come to the ward the following day.

The ward manager said that fluid balance charts were not completed properly and had organised training for all staff, including the health care assistants, from the clinical skills team. This was part of the work around the acute kidney injury pathway and the target was to have all fluid balance charts completed by all staff by the end of February 2018. Three charts we looked at had been completed with input and output of fluids recorded.

On the stroke unit patients’ weight was checked on admission and then twice weekly. There was a speech and language therapist for the unit who was supported by a nutrition and speech and language assistant. They undertook swallowing assessments and used the swallow assessment pathway for newly admitted patients. They used thickeners for patients’ food and worked with patients so that they could tolerate liquids of syrup consistency. This helped patients so they could eat more solid food and this reduced the number of patients who were nil by mouth.

**Pain relief**

We saw that patients’ pain was assessed and managed individually. Pain scoring tools were in place. Pain was scored and recorded as part of the national early warning system in patients’ records and the trust had introduced the abbey pain scale, which is appropriate for patients with cognitive disorders including dementia.

On the stroke ward we saw that pain was assessed and scored at every medicines round and patients were given appropriate analgesia.
We looked at six medication and nursing records for patients who had required medication for pain relief. We found these records showed pain relief had been administered in a timely way. Patients told us that staff responded to their requests for pain relief in a timely way, was assessed and managed appropriately.

**Patient outcomes**

The trust summary hospital level mortality indicator had been raised for over five years. The trust had appointed a mortality reduction lead who reported to the medical director and had undertaken work to reduce the indicator.

The trust had reviewed nine clinical pathways for the major conditions with high mortality rates using guidance from the National Institute for Health and Care Excellence. The nine pathways were available on the front page of the trust intranet and the trust compliance to the pathways was monitored by the trust mortality lead. They had also looked at coding issues in patient records. The patient records had been redesigned to improve the quality of the record and there were education sessions for new doctors to improve record keeping.

There were weekly mortality reduction steering group meetings to review progress and to discuss mortality issues. There was a bimonthly mortality committee that reported to the quality committee. The clinical commissioning groups had representation at the mortality meetings.

We saw evidence that the strategy to reduce the mortality rates was having a positive effect. However, this was not yet to be reflected in national mortality data.

**Relative risk of readmission at Trust level**

Between June 2016 and May 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions

- Patients in medical oncology, gastroenterology, clinical haematology had a lower than expected risk of readmission for elective admissions

Non-Elective admissions

- Patients in general medicine had a slightly higher than expected risk of readmission for non-elective admissions

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

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

**Blackpool Victoria Hospital**

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- Patients in medical oncology, gastroenterology, clinical haematology had a lower than expected risk of readmission for elective admissions

- Patients in general medicine had a slightly higher than expected risk of readmission for non-elective admissions

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

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))
readmission for non-elective admissions

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

Blackpool Victoria Hospital takes part in the quarterly Sentinel Stroke National Audit programme. This is on a scale of A-E, where A is best. The trust had achieved grade E in Sentinel Stroke National Audit level audit for December 2016 to March 2017.

Data for April to July 2017 showed the trust had achieved grade E in Sentinel Stroke National Audit level audit, however the combined total key indicator level had improved to a grade D.

Subsequent to the inspection, the trust provided information which showed further improvement. At the time of the inspection, this data had not yet been published.

**Blackpool Victoria Hospital**

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Patient-centred Total Key Indicator Level

- **Oct-Dec 15**: E
- **Jan-Mar 16**: E
- **Apr-Jul 16**: E
- **Aug-Nov 16**: D↑
- **Dec 16 - Mar 17**: E↓

(Source: Royal College of Physicians London, SSNAP audit)

**Team centred Performance**

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On the stroke unit there was a weekly meeting about the sentinel stroke national audit data. The meeting was attended by all team members, including nurses, allied health professionals and medical staff. The team discussed any failures in performance that affected the data and any lessons learned and any training needs. There was a stroke service newsletter that was produced every month that contained lessons learned and other relevant information. There was dedicated administration support for data input.

There was an early supported discharge team for stroke patients and therapists said that this worked well. Staff said that they were confident to discharge patients back into the community with the support of the discharge team and then they would be handed over to community therapy teams for longer term care and treatment.

**National Diabetes Inpatient Audit**

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

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

The 2016 National Diabetes Inpatient Audit identified 128 inpatients with diabetes at Blackpool Victoria Hospital, 81% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 2.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

Between April 2014 and March 2015, 26.1 of nSTEMI patients were admitted to a cardiac unit or
ward at Blackpool Victoria Hospital and 92.7% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%.

The proportion of nSTEMI patients who were referred for or had angiography at Blackpool Victoria Hospital was 68.2% compared to an England average of 79%.

<table>
<thead>
<tr>
<th>2014/15</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
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<tr>
<td>Blackpool Victoria Hospital</td>
<td>522</td>
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<td>92.7%</td>
<td>26.1%</td>
<td>68.2% (No data)</td>
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<td>England: overall</td>
<td>45500</td>
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<td>38099 (38099)</td>
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<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
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(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 58.4%, which was worse the audit minimum standard of 90%. The 2016 figure was 77%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 21.2%; this is similar to the national level. The 2016 figure was 26.1%.

The proportion of fit patients with advanced NSCLC receiving chemotherapy was 73.6%; this is similar to the national level. The 2016 figure was 63%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 81.1%; this is similar to the national level. The 2016 figure was 59.6%.

The one year relative survival rate for the trust in 2017 is 37.1%. This is similar to the national level.

(Source: National Lung Cancer Audit)

**National Audit of Inpatient Falls**

The trust does not submit to this audit.

(Source: Royal College of Physicians)

The allied health professionals started to work with the patients as soon as they were well enough following admission. There was goal setting on the initial contact with the patient and a discussion about what their anticipated discharge destination would be. The physiotherapists worked with the patients to support them with their goals.

The allied health professionals had received cross prescribing training for community equipment. Both physiotherapists and occupational therapists could prescribe equipment that would normally be out of scope of their professional practice. This could include chair raises for physiotherapists which would normally be prescribed by occupational therapists. This meant that
patients could be discharged after an assessment by one allied health professional and did not have to wait for another assessment. Staff said that this worked well and improved the discharge processes. The allied health professionals worked well with teams in the community, including the rapid response team to facilitate early discharge where appropriate.

The stroke unit used the early warning scores to monitor the degree of illness of their patients. Four hourly observations were undertaken and more frequently following thrombolysis. This was part of the standard operating procedures on the unit. On the stroke unit, band six nurses had additional roles, including complaints, training leads, risk assessments and incidents.

A team had audited 50 sets of patient records of the deteriorating patient; this was according to guidance from the National Institute for Health and Care Excellence. The audit had identified that the recording of fluid balance was an issue and training had started to address the reporting of the fluid balance. This linked into the work on the acute kidney injury pathway.

The non-invasive ventilation team had completed a number of audits and a pilot to support the business case for a dedicated unit. Audits showed there was non-compliance with the National Confidential Enquiry into Patient Outcome and Death for non-invasive ventilation. The audit looked at non-invasive ventilation in acute respiratory failure focusing on the use of non-invasive ventilation in acute respiratory failure secondary to chronic obstructive airways disease. During the pilot, each patient on non-invasive ventilation had their treatment changed by the team, the outcome was that patients were moved through the service more quickly and spent less time in hospital than they would have done without the support.

Medical services carried out local and national audits to review the effectiveness of care and treatment. Information provided in the six monthly audit report provided by the trust in July 2017 showed the unscheduled care services were registered to participate in 53 audits and were 98% on track of their commenced audits. Examples of audits with action being monitored by unscheduled division included: endoscopy referral audit, gastro intestinal bleed re-audit, appropriate EEG referrals and an enquiry into the care of hospital patients receiving parenteral nutrition. We saw evidence of an action plan in place where audits in the division had fallen behind timescale in order to progress to complete.

The trust had made improvements for patients with fluid and electrolyte disorders. A review of 32 sets of case notes found that none of the patient deaths were considered to have been avoidable. They found some areas where improvements with care were identified and have developed an action plan to address this with staff.

The sepsis pathway was highlighted on the tracker on the wards. This was in place and was monitored. We saw evidence of monthly reporting on this pathway.

**Competent staff**

New staff undertook an induction programme that detailed the expectations and requirements of their role. Their mandatory training then followed the induction. Staff received annual training updates, which included resuscitation, infection control, moving and handling and safeguarding. Bespoke training was available and recent examples included tissue viability and a dementia course at the University of Cumbria.
We saw that there was staff development across the division. There were examples of health care assistants being supported and funded to attend university courses and become qualified staff. The division has 18 trainee advanced practitioners to supplement the four qualified advanced practitioners already in post. The trust has funded a total of 33 advanced practitioner trainees in 2017/18.

This was part of a long term plan to support the use of new roles to undertake traditional medical roles, thus supporting non-medical clinical progression and areas where medical staff are difficult to recruit such as stroke, acute medicine and frailty.

On ward C, the practice development sisters were developing a specific training programme for the staff team. As part of this programme, training was being provided by the diabetic, respiratory and endocrine specialist nurses.

Management staff reported there was a strong culture of ‘growing your own’. Examples of courses offered were: management and leadership development courses, an aspiring director’s programme and a talent development programme.

Staff told us that they felt they received good and thorough training to meet patients’ needs.

Despite staff telling us they were encouraged to develop and progress, during the staff focus groups and from speaking with staff on the wards, staff reported that due to staffing levels on the wards; attending training was the ‘first thing they cancelled’. They reported they often completed their ‘E booklet’ in their own time.

Staff had opportunities to attend specific skills training courses or refresher training. Resources and training was provided to assist staff with the Nursing and Midwifery Councils revalidation process. An annual revalidation day for nursing and allied health professional staff was held by the trust to support staff with this process.

Existing staff, new starters and students told us there was access to a buddy system, learning and development opportunities to further their knowledge and consolidate their training. They told us mentorship and preceptorship schemes were effective and they received support from practice development managers.

Staff told us they had attended specific development programmes as band 5 or 6 nurses. The programme had covered human resource policies, managing sickness, managing difficult situations and complaints, which was valuable in their roles.

Junior doctors we spoke with told us they felt well supported by senior colleagues and consultants who provided them with advice and training.

Staff were positive about the trainee assistant practitioner role stating they have had the opportunity to develop in a supportive environment.

We saw evidence of staff competency records on the wards, these showed evidence of competencies to undertake certain tasks, such as medication competencies, blood glucose monitoring and basic swallow assessments and were available for recently qualified staff or staff new to the specific area.

The critical care outreach team were responsible for the delivery of training, including advanced, intermediate and basic life support training. They also delivered “Recognise and Act”, which was the recognition of the deteriorating patient. This was a half day course for qualified staff and the trust was rolling this out for health care assistants. This was because health care assistants often did patient observations and the training would help them to recognise a deteriorating patient and bring this to the attention of the qualified staff. There was also scenario training for doctors who
were new to working at the trust. Staff reported positive feedback about this training. The team were starting to roll out training for acute kidney injury around fluid balance.

On the stroke ward, the allied health professionals had undertaken some training with the nursing staff about the positioning of stroke patients; the nurses said that the training had been really useful.

The division were addressing staff performance problems for a number of staff by providing additional support from the ward manager on one ward. The ward manager said that the staffs’ performance had improved and two of the staff confirmed they were well supported by the team.

Following appropriate training and a competency assessment, the advanced nurse practitioners would be able to order computerised tomography (CT) scans for patients, which would help them to achieve the target for patient thrombolysis.

Blackpool Victoria Hospital had 100% appraisal completion rate for relevant staff between April 2016 and September 2016.

Data was not provided broken down to staff group level.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with including junior staff and senior staff told us their appraisal helped them to identify any training and development needs they had. On medical wards, a number of the staff we spoke with, including a ward sister and two ward managers, told us how they had been supported by the trust to develop their careers.

**Multidisciplinary working**

Staff described effective professional working relationships to deliver effective care and treatment for patients. Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care. Staff worked closely with specialist teams, including speech and language, dietitians, tissue viability, pain and diabetes specialist staff. We observed good multidisciplinary team working amongst the allied health professionals on the medical wards we visited. We attended board round meetings on the medical wards and heard how complex patients were in receipt of joint assessments with therapists and social workers. We attended a bed management meeting, where we noted the presence of an ambulance liaison officer who attended these meetings to share with the management team the demand the service was dealing with at the given time. Due to the demand of their services, physiotherapists would prioritise new patients and occupational therapists would prioritise patients about to be discharged. There were links into the community teams and to the rapid response teams and staff said they were confident to discharge patients to these teams.

Staff told us there were strong relationships between medical, nursing and the allied health professional staff. From observations during multi-disciplinary team meetings, nurses and allied health professionals challenged doctors appropriately.

On the stroke unit, nurses and allied health professionals and medical staff worked well together to get the best outcomes for the patients. There were daily meetings to discuss patients’ progress and possible dates for discharge. There was an early supported discharge team of physiotherapists, occupational therapists and speech and language therapists, who worked with the staff on the stroke unit to facilitate early discharge for patients. There were weekly multi-
disciplined team meetings with the diagnostic imaging department to interpret information and review patient progress.

The cystic fibrosis service, which opened in May 2017, had started to develop links with other services. There was support for patients with other co-morbidities and links with services, such as gastroenterology, midwifery and obstetric services.

Staff on wards 18 and 25 said they had good support from the discharge team, despite the key challenge being to meet patients’ social care needs. They worked well to provide patients with a ‘safe, timely discharge’ where possible. Examples included: ‘complex discharges’ which included a lot of services and one where a patient was discharged within 4 hours and was provided with hospice at home care.

We saw examples in patients’ notes where records showed the involvement of input from multidisciplinary team.

Seven-day services

Not all services were providing seven day services. The allied health professionals had vacancies in the team. They provided a seven day service, but this was a diluted service due to the vacancies. Patients were not always seen in a timely manner but the physiotherapists always saw new patients and occupational therapists always saw patients who were about to be discharged. The service was advertising for additional staff.

On the acute medical unit, the integrated assessment team provided a seven day service for patients who were medically fit for discharge, providing holistic assessments and transfers prior to discharge. The team included physiotherapists, a clinical lead and rehabilitation coordinators. They were carrying one vacancy.

The transient ischaemic attack clinics were currently operating five days a week, but when the advanced nurse practitioners had completed their training, the service would be operated for six days a week and if the service could recruit another consultant, then it would become a seven day service. Transient ischaemic attack patients had to wait for the next available clinic to be seen.

The critical care outreach team told us they were currently unable to provide a seven day service. They have put a case to management to increase staffing levels. This team ensure the safe transition of patients from Intensive care or high dependency unit and ensure an effective handover is carried out prior to their surgical or medical management. This may impact on patients who are discharged on a Friday.

There was a chaplaincy service available 24 hours a day, seven days a week for patients, relatives and staff.

Health promotion

Health promotion information leaflets were displayed around the medical wards and corridors and other areas in the hospital, such as canteen and entrance areas.

The medicine service had access to health promotion advice and smoking cessation advice.

Promotion leaflets were available to encourage staff to have a flu vaccination to reduce the risk of the spread of flu between staff and patients.

The nursing assessment document included a section on patients’ alcohol consumption. Referrals could be made to specialist alcohol nurses if necessary.
We saw on the stroke unit that there was health information for patients, including prevention of a blood clot, information on medicines, reducing the risk of pressure ulcers and reducing the risk of falls. During the multi-disciplinary team meeting, the doctor said that they had advised a patient to give up smoking and had prescribed medicines to help them to achieve this. Alcohol specialist nurses were visiting a patient during the inspection.

In the cystic fibrosis service, staff worked with patients in the secondary prevention of disease. In some patients this was by using anti-microbial treatment to prevent infection and the service used the multi-disciplinary team to alleviate symptoms of the disease.

A staff team on pressure ulcer prevention had reviewed their current patient information leaflet in line with a 'how to keep yourself safe in hospital' leaflet.

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

The trust reported that as at June 2017 Mental Capacity Act and DOLS training had been completed by 89% of staff within medicine. This was below the trust target of 95%.

*(Source: Trust Routine Provider Information Return P39)*

The trust’s policy for consent, capacity and deprivation of liberty safeguards was accessible to staff on the intranet.

We saw in 20 patient records that consent forms had been completed appropriately and that the consent form for patients without capacity had been used.

Staff had an understanding of and could describe the process for best interest decisions and mental capacity assessments. On ward C, refresher training had been arranged for all staff on the mental capacity act via the trust mental capacity act lead. A link lead sister had been identified to offer additional training and help staff keep up to date with their knowledge on mental capacity.

On the stroke unit, doctors assessed capacity and gave some examples of where they had given capacity assessments. We saw in three patient records on the stroke unit where capacity had been recorded. Assessing capacity is part of the sentinel stroke national audit programme.

We did not see any patients who were currently subject to a Deprivation of Liberty Safeguards order. Staff told us that the trust lead for Deprivation of Liberty Safeguards was very helpful and would support them with patients who were subject to a Deprivation of Liberty Safeguards. We saw that there was documentation of consent on the admission checklist for the stroke unit both written and verbal in three patient records.

**Is the service caring?**

**Compassionate care**

At the previous inspection in January 2014, we rated caring as good, we have maintained this rating following this inspection, because we found the service involved and treated patients with compassion, kindness, dignity and respect. Feedback from patients confirmed that staff treated them well and with kindness.

Patients and relatives we spoke with were positive about the staff who cared for them and told us they were treated with dignity and respect. From discussion with staff, they took the necessary time to engage with patients. They communicated in a respectful and caring way, taking into account the wishes of the patient at all times.
Apart from the corridor on the acute medical unit patients had access to call bells and staff responded promptly or were heard explaining they would be with them as soon as they possibly could be, as they were occupied caring for other patients. Comments from patients and relatives included mentioning that staff were 'kind and caring, despite always being busy'. Examples of comments included: “I have been treated very well, the staff are 1st class” and “care in here has been excellent as are the staff”. We observed a porter making sure a patient was covered up with a blanket before they took them for diagnostic imaging.

On the acute medical unit we observed examples of staff treating patients in a kind and compassionate way, despite the unit being very busy during the inspection. We observed two staff members making a relative feel supported and involved in their loved one’s care with compassion at the end of their life. We observed the use of mobile privacy screens in use for patients to maintain their dignity.

However, on the corridor on this unit, we saw some examples when patients’ privacy and dignity needs were not being maintained. This included a patient having their medical history taken in the corridor that allowed members of the public being able to hear the conversation. On ward C we observed a patient whose preferred name was not above their bed, their dignity was not maintained in the night wear they were wearing and their assigned nurse was not fully aware of their care needs. This was shared with the nurse in charge and acted upon immediately.

Staff demonstrated an understanding and a non-judgemental attitude towards patients living with dementia, a learning disability or with mental health needs.

Staff were passionate about their roles and were dedicated in providing excellent care to patients. On the acute medical unit staff told us how they always did their best for palliative or end of life patients. They told us they had accessed the support of the palliative care nurses to sit with a patient who was nearing the end of their life.

A patient told us how the ward sister was ‘so compassionate and understanding as she talked with me about going into a care home.’

On the medical wards we saw where cubicle curtains were drawn and side room doors were closed to protect the privacy and dignity of patients. Staff were observed knocking on doors prior to entering. Some wards had a ‘relaxation room’, where patients and relatives could spend time together away from the ward.

In August 2017 nurses, midwives and allied health professionals celebrated an annual ‘compassionate care day’.

The Friends and Family Test response rate for medicine at the trust was 34% which was better than the England average of 25% between September 2016 and August 2017.

(Source: NHS England Friends and Family Test)

The percentage of friends and family who would recommend the service averaged 95% across the medical wards between December 2016 and November 2017.

There were set times for visiting the stroke unit to allow patients to undertake their rehabilitation and to rest. The matron told us these times were flexible to enable carers and relatives who were working to visit too.
On the falls risk assessment, there was a section with “is call bell within reach and does the patient know how to use it”. In the three records we reviewed this had been completed. This was so that patients could summon assistance if necessary.

**Emotional support**

Staff provided emotional support to patients, to minimise their distress.

Visiting times were flexible to meet the needs of patients and relatives, with evidence of open visiting for patients who required this level of support.

A chaplaincy service was available to support the spiritual, religious or pastoral support needs of patients, relatives and staff which included an onsite chapel. On one of the wards we went to, the staff had just attended the funeral of a patient who had died on the ward. They had been on the ward on a number of occasions and staff said that they wanted to pay their respects.

The nursing assessment form included the spiritual needs of the patient and referrals could be made to chaplaincy if appropriate at this stage.

Bereavement advice and support was available to relatives and staff through the bereavement service.

A psychology service was available to support stroke patients. All wards had access to the palliative care team. Staff reported these services provided emotional support and information to support patients and their relatives to cope emotionally with their care, treatment or condition.

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

Staff involved patients and those close to them in decisions about their care and treatment.

We saw evidence in patients’ records that confirmed meetings and conversations about involvement of relatives.

The nursing assessment form included social information about the patient, whether they lived alone, the name of any carers and whether they had a care package in place. We saw that these had been completed in the seven records that we looked at. At the multidisciplinary meetings, relatives and carers were included in discussions about the patients and their continuing care.

On ward six, patients and their relatives, including children, were encouraged to draw pictures and these were displayed on the walls of the ward. Staff said that patients liked seeing the pictures and that they brightened up the ward. We spoke with four relatives who said that the staff were ‘brilliant’ and they had confidence in their decisions and that the ward manager had been very helpful. They said that the staff had listened to them and worked with them to achieve the best outcome for their relative.

On the stroke unit, there were events for patients and their relatives, including a Christmas party. We observed the staff speaking with the relative of a patient who had died on the ward with compassion and sympathy.

The cystic fibrosis service provided a holistic service for their patients with a focus on quality of life. There was negotiation with patients about their care and their social needs and many of the patients were at the transition stage between children’s and adult services. These negotiations were complex and needed to be adapted to the requirements of the patients to achieve their short, medium and long term goals. A psychological support service was available for these patients.
The trust participated in ‘The John’s Campaign’, a project whose aim was to investigate people’s views and experiences of new visiting arrangements. The Campaign is to help NHS staff recognise the importance of working with family carers as equal partners in the care and support of people with dementia who are in hospital. The key focus behind John’s Campaign is to have an open visiting culture; supporting carers to access the hospital outside of normal visiting hours, and to enable the carer to be with the person living with dementia.

**Is the service responsive?**

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

The service planned and provided services in a way that met the needs of local people. The medicine division recognised the needs of the local population and used public engagement and local data and statistics to design and plan the services provided.

Escalation beds were opened in response to high levels of bed occupancy. Staff were generally moved from other wards to cover these beds.

The stroke unit had 42 beds and was divided into male and female areas. There was a mixture of single rooms and bays for patients. One room was always kept free in case a patient from urgent and emergency care required thrombolysis. There was a gym for rehabilitation, which was sometimes used as a day room when not in use. There was a bleep holder who was an advanced nurse practitioner, who would go to urgent and emergency care if the staff suspected that a patient had suffered a stroke. Patients could be given thrombolysis if appropriate. This treatment needs to be administered within four and a half hours of the patient having the stroke to be most effective to improve the neurological outcomes for patients. We saw that the senior staff member received a call during the inspection and gave advice to a doctor in the urgent and emergency care department. The medical director said that consultants provided an effective service.

There was a daily transient ischaemic attack clinic every afternoon, Monday to Friday. There were three stroke consultants who rotated between the stroke unit and the outpatient department. Patients had a computerised tomography scan, X rays and carotid Doppler scans. If necessary, patients could then be referred directly to the stroke unit. Patients could be referred to the service by their G.P., however, the medical director told us that patients delayed attending their G.P., which led to a delay before they were referred to the clinic. This affected the response times of the trust for the management of transient ischaemic attacks.

Investment from the trust for the stroke unit included advanced nurse practitioner posts, nursing posts and additional therapy posts in physiotherapy, occupational therapy and speech and language therapy. There was also funding for technical instructors and band 3 support workers and for psychology services. The medical director said that they hoped there would eventually be four consultants for the unit. Length of stay on the stroke unit was longer than average, as the discharge of patients was from the combined stroke and rehabilitation unit. Some patients accessed rehabilitation at a nearby community hospital.

There was a critical care outreach team, who followed up patients discharged from the critical care unit onto the medical wards and supported the transition to the new medical team. If a patient was ready for step down to the medical wards on a Friday, the critical care unit would keep them until Monday. The team comprised three nurses with a range of experience, including urgent and emergency care and critical care. They worked 7.30am to 4.30 pm, Monday to Friday. There was also an out of hour’s team. The team would also review deteriorating patients and support the junior doctors. They attended all cardiac arrests and major haemorrhages in the hospital and could
engage with the doctors and consultants from critical care if necessary. Staff we spoke with said that the critical care outreach team was a really good resource and were responsive if they rang them in supporting poorly patients.

A unit for adults with cystic fibrosis officially opened in May 2017, but had been taking patients since February 2017. This was part of a hub and spoke model, with the hub being a hospital in a trust in Manchester. The Manchester hub was above capacity and expressions of interest were put out across the wider health economy and Blackpool was selected as the spoke unit. This meant that patients did not have to travel to Manchester for treatment if they wanted to transfer their care to Blackpool.

Staff recruitment for the cystic fibrosis service had started in February 2017 and there was a skilled multidisciplinary team for the service, consisting of a dedicated pharmacist, physiotherapists, a dietitian, a social worker, nurses and a psychologist. The unit would take direct admissions from patients with cystic fibrosis onto the unit, which had eight beds in single rooms. Most of the patients were currently patients in the transition between children’s and adult services and whose symptoms were not as severe as some patients in adult services.

There was a non-invasive ventilation service for the hospital, but no dedicated non-invasive ventilation ward. A pilot was in place to evaluate the effectiveness of the service. A senior member of staff identified patients on the acute medical unit, respiratory wards and any outlying patients who might be suitable candidates for non-invasive ventilation and to commence the treatment. Following the two month trial, the service had ceased, however, the staff member was to be reinstated and the vision was for a staff member to be able to support patients over 24 hours. In addition, funding and training was available for an extended scope nurse practitioner, who would be able to support the non-invasive ventilation team and run out-patient clinics to review patients in a timely manner. There was not enough capacity in the current team for the timely review of patients.

Patients could be referred to the mental health team for assessment if their needs were appropriate.

On ward six , there was a display board in the entrance to the ward called “together we make a family”. On the board were photographs of all the staff who worked on the ward, including agency staff, the pharmacist for the ward, occupational therapists, physiotherapists, doctors, nurses, health care assistants and the housekeeper. Patients and relatives told us they liked the board, as they could identify who the ward staff were.

A pharmacist on ward six worked afternoons to assist with patients awaiting discharge. The staff said this was a positive service and they had good support from the pharmacist.

The trust had commissioned a new discharge lounge with a completion date of January 2018. The lounge would accommodate up to 24 patients at any one time, including patients still in a bed. On average the discharge lounge supported 20-30 patients each day.

Between July 2016 and June 2017 the average length of stay for medical elective patients at the trust was 2.3 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 8.6 days, which is higher than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Cardiology is lower than the England average.
- Average length of stay for elective patients in Clinical Haematology is higher than the England average.

- Average length of stay for elective patients in Gastroenterology is similar to the England average.

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in General Medicine is higher than the England average.
- Average length of stay for non-elective patients in Respiratory Medicine is higher than the England average.
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average.

**Elective Average Length of Stay – Trust Level**

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<th>Specialty</th>
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<th>England Average</th>
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<tbody>
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<tr>
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**Non-Elective Average Length of Stay – Trust Level**

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<th>Specialty</th>
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</thead>
<tbody>
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<tr>
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<tr>
<td>Geriatric Medicine</td>
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<td>9.6</td>
</tr>
</tbody>
</table>

**Blackpool Victoria Hospital**

Between July 2016 and June 2017 the average length of stay for medical elective patients at Blackpool Victoria Hospital was 2.3 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.3 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:
- Average length of stay for elective patients in Cardiology is lower than the England average.
- Average length of stay for elective patients in Clinical Haematology is higher than the England average.
- Average length of stay for elective patients in Gastroenterology is similar to the England average.
average.

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in General Medicine is higher than the England average.
- Average length of stay for non-elective patients in Respiratory Medicine is higher than the England average.
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average.

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Patients’ care plans were individualised and paper in form.

In the nursing assessments, there were trigger systems to screen for patients with cognitive impairments or learning difficulties. The wards were dementia friendly, with coloured doors and appropriate lighting and flooring. The hospital had a ‘dementia corridor’, which had memory triggering scenes and smells.

During the inspection we were told of ‘comfort or activity boxes’ on some of the wards, which staff said relaxed people who lived with dementia. This included items for drawing and colouring; games and books for patients to use. However, during our inspection we did not see any of these in use.

Patients with cystic fibrosis did not have to go to urgent and emergency care to be admitted to the hospital, they would go directly to the unit and this would ensure that they were treated in a timely manner.

The medical division had staff who were trained as dementia champions and the wards used the ‘Butterfly Scheme’ to indicate patients who were identified as living with dementia, so there was increased awareness for staff.

In the nursing assessments there were trigger systems to screen for patients with cognitive impairments or learning difficulties.

On ward six, there was a small day room so that staff could have private conversations with patients and their relatives and carers.

We saw there were beds and equipment that were appropriate for bariatric patients who were receiving treatment. There were also low beds for patients at risk of falls. Equipment could be ordered when the patients were admitted to the ward and staff said that they were delivered promptly.

We found wards were suitable for patients using wheelchairs with wheelchair accessible toilets available.

A system was in place for people who needed translation and interpretation services; this included British Sign Language and a wide range of languages. This was primarily a telephone interpreting service; however, face to face interpreters could be arranged. In addition, the hospital had approved staff who were authorised to provide interpretation services for certain languages. Staff told us they had no problems accessing interpreters.

Patients’ relatives were provided with meals and drinks when necessary.

**Access and flow**
Managers were constantly reviewing the access and flow of patients within the division and across the trust. During our inspection, there were 40 medical outliers out of 465 medical beds. Managers told us that this has been as high as 70 patients.

The trust were updating their patient flow and escalation policy to replace their bed management policy. We reviewed the draft document which identified which staff had authority to open escalation beds. This policy stated that patients would only be placed in clinical accommodation that was appropriately equipped and staffed. We found occasions during the inspection when the clinical accommodation was not appropriate on the acute medical unit.

There were electronic trackers on the wards and staff updated the trackers every day. The trackers were used to identify patients who were outliers on the wards to ensure they were followed up by the correct speciality doctors. Trackers were also used to identify the bed capacity of each department and ward. Managers could identify where there were blockages in the system and we saw that doctors from the acute medical unit would go to urgent and emergency care if necessary.

We saw that all specialities and grades of staff attended the daily tracker meetings. Actions, such as diagnostic testing, blood tests and therapy interventions were recorded in the trackers and if these had not been carried out, the patient status stayed on red, if the actions had been completed, the status went to green. This meant that staff were aware of outstanding actions and could follow them up as necessary. The trackers were used to identify patients who were outliers on the wards and doctors were allocated to the outlying patients.

The hospital was working towards a medical team for outliers. We saw on the stroke unit that the medical outliers were reviewed with the other patients on the stroke unit during the ward meetings.

We spoke with a patient who had been admitted the previous day with a stroke. They had been scanned and received thrombolysis (treatment to dissolve dangerous blood clots) in two and a half hours of arriving in urgent and emergency care.

The hospital had regular bed meetings to address the access and flow through the medical division. This proved difficult at times due to the number of medical outliers occupying surgical beds. Medical outliers are patients with medical conditions who are not waiting for surgical treatment, but who are occupying beds designated for patients who are waiting for surgery.

The discharge lounge, was used to assist in the flow of patients who were waiting to be discharged from the wards that day and may have been waiting for medication to take home or transport to arrive.

Between July 2016 and June 2017, 10% of individuals did not move wards during their admission, and 90% moved once or more.

(Source: Trust Routine Provider Information Return P50)

Medical patients were routinely admitted to the medical admissions unit before being transferred to a suitable ward, if they were not able to be discharged home within a set time period.

We reviewed the number of out of hours (between 10pm and 8am) ward moves that patients experienced. We looked at data for the period July 2016 to June 2017 which showed an average of 32 patients had been moved out of hours per month across the medical care beds.

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

Trust’s referral to treatment time (RTT) for admitted pathways for medicine has been similar to the England average for the whole time period between August 2016 and July 2017.
Most recently the trust’s referral to treatment time (RTT) for admitted pathways for medicine for July 2017, showed 89% of this group of patients were treated within 18 weeks versus the England average of 90%.

(Source: NHS England)

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

Two specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>93.8%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons were shared with all staff. The staff we spoke with understood the complaints process, were aware of the complaints policy and could advise patients and relatives on how to raise a complaint. Senior managers told us that the complaints were discussed every week and a decision was made if the complaint needed to be escalated for further investigation.

During our inspection, we observed posters and leaflets displayed on the medical wards, which provided information for patients, relatives and professionals on how to make a complaint. Information was provided on how to contact the Patient Relations Team, whose role it was to support patients and relatives to raise concerns. In addition, detailed information was provided on the hospital website.

Complaints were managed by a divisional complaints manager and team. Input from ward managers and relevant staff was sought during the investigation stages to assist with fact finding around issues and events. We reviewed a sample of complaints and found that all complaints were acknowledged and responded to in the agreed timeframes and dealt with in an appropriate manner.

We saw November 2017 governance minutes for the division, which showed a summary of complaints. 14 complaints had been received during the previous month, which was comparative
with 2016/17. The minutes highlighted the main complaints related to treatment and communication.

Staff on the stroke unit said that if they had a complaint that they would invite the patient and their relatives into the stroke unit to try to resolve the complaint. They described a complaint which was about a patient fall and met with the relatives of the patient. There was acknowledgement from the team about how things could have been done better and changes were made and these were fed back to the staff team.

Patients and relatives we spoke with during the inspection told us they were satisfied overall with the care and treatment they received. Staff said that complaints were discussed at team meetings and if appropriate at the safety huddles.

Patients and relatives were advised whom they should contact if they were dissatisfied with the outcome of their complaint. Patients and relatives were provided with information of how to contact the parliamentary health service ombudsman. The ombudsman is an independent adjudicator who reviews complaints when departments within the NHS have not acted properly, fairly or have provided a poor service.

Between July 2016 and June 2017 there were 75 complaints about medical care. Most related to the care provided by staff as well as their communication to patients. The trust took an average of 32 days to investigate and close complaints. This does not meet the trust’s target in their complaints policy, which states complaints should be completed within 25 days or 45 days for complex cases.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The service had managers at all levels, with the right skills and abilities to run a service providing sustainable care. The governance structure for medicine consisted of the medical director, deputy medical director, divisional director and the assistant director of nursing. In addition, there are speciality matrons. The managers we spoke with were skilled and knowledgeable and showed leadership skills. We met with the senior management team for medicine, who spoke positively and with enthusiasm to strive to improve the quality of the service delivered. They were very aware of their challenges and looking at ways to drive improvement forward.

The leaders were clear on the challenges facing medicine. We spoke with the divisional manager for outliers, who allocated consultant teams to outliers. They confirmed that within medicine not every patient will see a consultant every day of their hospital stay, as patients may be awaiting tests and investigations. The manager could run a tracker on all medical outliers to oversee patient moves between wards and to monitor these patients.

Staff on the wards and department told us they saw the senior divisional and trust managers regularly and that they were approachable. Nursing and medical staff spoke highly of the matrons and ward managers. Managers reported they felt supported with issues they raised.

Medical staff told us that senior medical staff were responsive and provided them with good support and training.
Vision and strategy

The service had a vision for what it wanted to achieve and plans to turn it into action, developed with involvement from staff, patients, and key groups representing the local community.

Staff said that there was a vision for the stroke service and that they were moving towards that with the service investment and additional staffing.

The division of unscheduled care, in which medical care resided, had a vision. This was to provide the best possible service and ‘to strive for excellence’. Within this, a number of key objectives had been developed.

The trust had identified four core values: excellence, people centred, compassion and positive. Staff we spoke with were aware of the trust strap line ‘together we care’. These themes were evident on literature and communications from the trust.

The trust had a strategic vision for 2020, which was: ‘As a high performing trust, operating as part of an integrated care system, we will provide high quality, safe and effective care. This will be achieved in a financially sustainable way, through our skilled and motivated workforce’. The strategy had been developed to align with those of external partners.

Culture

Managers across the service promoted a positive culture that made staff feel supported and valued. During focus groups and when we visited the wards, staff told us that they felt respected and valued by members of the management team. They felt their concerns were listened to and issues were escalated. Staff had access to a freedom to speak up guardian, with whom they could raise concerns confidentially.

Staff told us they were proud of the hospital and the care they delivered. They felt there was an open and honest culture. Staff’s strong patient focus was evident. Some staff expressed frustration due to the impact of having patients on the acute medical assessment unit’s corridor and the constant high demand of the service. They felt the staffing levels affected their morale, but they did feel valued.

Staff shared some concerns; the practice of having to move patients off their wards to create a different single sex bay and moving staff around wards particularly mid-shift. However, they did appreciate this was to meet the needs of patients in a safe way.

The staff we spoke with stated their managers and leaders and colleagues were supportive of them and each other and this made for a positive working environment.

Nursing staff we spoke with said that they liked working at the trust, even though it could be very busy. They said that they all worked as a team and helped each other out. The allied health professionals said that they liked working at the trust and that some had left and come back. The main reason that they left was career opportunities at larger trusts.

On the stroke unit, staff told us that there had recently been a number of deaths and some of these had been young people. They said that they had supported each other and staff also used a closed page on a social media site as a way to thank staff on the wards after a particularly hard shift.

Governance

The service had clinical governance procedures, risk management and quality measurement
processes to improve the outcomes for patients. These ensured risks were identified and escalated through different committees and steering groups.

We saw there was a clear reporting structure within the service. We reviewed minutes of the clinical governance report for November 2017 which included incident reporting, complaints and risks.

In the cystic fibrosis unit, governance structures were in development. Managers had hoped to have policies and procedures in place when the service started, but have found that they needed to be more flexible and to be able to change to meet the needs of the service and the patients. The two services were working closely together. The consultant was undertaking outpatient clinics at the hub in Manchester to improve their skills and to receive support advice from the established team.

Staff told us they had regular team meetings in their wards and areas; a sample of minutes showed these were well attended. Minutes showed that issues discussed included: patient safety issues, incidents, complaints, quality indicators and key messages were delivered. Actions were identified and had follow up dates.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The management team had clear knowledge of the risks within medicine. We discussed their main challenges of patient flow, medical and nurse staffing and their plans in place to address these issues.

The medical division had a risk register, which highlighted areas of risk to the effective management of the service. Medical division risks were also captured on the trust wide risk register. This included the use of escalation beds.

Managers in the service completed risk assessments to assess risks that the department currently faced. We looked at some of the risk assessments, which covered areas of concern, including falls, staffing issues and medication errors. We saw these had been reviewed and actions were in place to minimise the risks.

High scoring risks added to departmental, divisional and corporate level risk registers. We saw risks had dates for these to be reviewed.

We saw where improvements had been made in the stroke service. A peer review of the stroke service by the stroke clinical network had been carried out and an action plan developed to address the shortfalls in care. A stroke improvement board was set up to oversee the action plan, which was a standing agenda item. Significant improvements had been made and there was recognition from the trust board that there needed to be investment in the stroke service to improve the quality of the service. The trust board had approved the investment in the service.

There had been a review of deaths in stroke as part of end to end care starting with primary care services. The report concluded that in 50% of cases that care could have been improved in primary care. This included the management of blood pressure, type 2 diabetes, and anticoagulant therapy. The report also concluded that the effects of deprivation had an impact on the mortality and morbidity of strokes.

The lack of a dedicated unit for non-invasive ventilation was on the risk register.

Staff had access to a major incident and business continuity policy and a strategy for dealing with major incidents and emergencies, such as terrorist threats, flood, and fire or process management failures.
Information management

The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards. Ward staff and managers confirmed they had secure log in systems before they could access any confidential patient information. Staff told us they had completed online training in information governance.

Matrons and senior managers told us about the information available in the medical division around quality indicators from audits, performance dashboards, staffing figures, complaints and patient feedback and used this information to understand and respond to issues within medicine.

Information, such as safety alerts, changes to guidance, actions from incidents and minutes of meetings were shared with staff through meetings and via emails. We observed on wards where messages were displayed in staff areas to ensure these were received and acted upon.

Staff had access to policies and procedures via the trust’s intranet facility. Staff told us they had sufficient access to terminals in the medical wards and departments.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and worked with partner organisations effectively.

Information about how members of the public could provide feedback to the medical division was displayed on the wards, hospital corridors and in public areas. Leaflets and posters were displayed, providing options on how to feedback experience to the hospital.

Patients and relatives were encouraged to complete the friends and family test. This provided an opportunity for them to give feedback about their experience of using the medical services.

The hospital’s Patient Experience Department engaged with the public and fed this back to the hospital. They promoted a ‘Tell Us’ campaign to seek feedback from patients and their relatives. Social media was encouraged to engage with the public, partners and the local community. This provided information about all services, but included messages from the medical and unscheduled care division regarding latest developments in the division and useful information for patients.

People who had been patients on the stroke unit came back to volunteer and help other patients. There was also input from the stroke association, which staff said was invaluable to patients and staff. Staff were involved in fund raising for additional facilities on the unit.

Staff were working with pupils from a local sixth form college who were interested in a career in the NHS and the pupils spent time observing in their area of interest.

The trust celebrated the achievements of staff at annual ‘Celebrating success awards’ event.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
The division had six model wards at the time of inspection and have plans to progress across the whole division. The ‘model ward’ was a ward based on best practice taken from across the NHS in an attempt to reduce inconsistency in the delivery of patient care. The wards had introduced the model ward concept, whereby a 24 hour plan of ward activity was created to ensure patient safety, staff safety, flow, discharge, care for example were provided consistently across all wards. The model wards were part of the divisional test and learn collaborative.

Senior staff spoke positively about the ‘Better Care Now’ leadership plan for 2017-18, which was in place with leadership from the medical director to review acute admissions, care and treatment in hospital, including mental health patient flow and patient discharge. On ward 23, care of the elderly ward, the team had introduced a tracker to help with ‘Better Care Now’. Patients had an estimated discharge date on admission, a daily board round had been introduced and patients were assigned ‘red days’ of which they were allowed only two for investigations to be carried out.

Plans were in place for the next phase of this. The ‘Health Atlas’ will address patients with delays and medical outliers. This will include an electronic discharge so the tracker can link with GP’s.

In the cystic fibrosis service, one of the challenges that was faced by the patients and the staff was that the patients had developed a type of diabetes that was not type 1 diabetes, but required insulin for treatment and was known as cystic fibrosis related diabetes. The staff and the community diabetes team were upskilling themselves in the diagnosis and treatment of the condition. There were links to a local university to further develop learning.

There had been learning and development around the care of patients with a tracheostomy (an opening in the windpipe), to assist in discharge arrangements into the community. This was in response to local nursing homes not having the skills and knowledge to manage these patients. Hospital staff went to a nursing home to develop the staff to deliver tracheostomy care and staff from the home in-reached into hospital to develop their skills. A patient was successfully discharged to the home following a five month stay at the hospital and the hospital staff continued to monitor the patient in the home for four weeks to assure themselves of the competence of the staff and the safety of the patient.

Work was being done to address service improvement. Examples included: improving patient flow by working with commissioners and social services to improve discharge arrangements. Providing an effective ambulatory care service, upgrading the discharge lounge, safety board rounds are other examples where improvement work was being addressed.
Facts and data about this service

The trust has nine surgical wards and two day case areas;
- Ward 14 - Ear nose and throat surgery, ophthalmology, surgical high care
- Ward 15A - Urology and general surgery
- Ward 15B - General surgery
- Ward 16 - Elective orthopaedics
- Ward 34 - Trauma and orthopaedics
- Ward 35 - Trauma and orthopaedics
- Ward 38 – cardiothoracic surgical ward
- Ward 39 - Cardiothoracic surgery
- Surgical admissions unit
- Day surgery unit
- Surgical assessment unit

The trust has approximately 195 surgical inpatient beds.
(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

The trust had 30,369 surgical admissions from June 2016 to May 2017. Emergency admissions accounted for 7,465 (25%), 18,605 (61%) were day case, and the remaining 4,299 (14%) were elective. (Source: HES)

The surgical services are managed by the Scheduled Care Division’ at Blackpool hospital. These are divided into three smaller directorates; general surgical, cardiac and specialist surgical. The division includes the operating theatres, the surgical wards, the surgical admissions unit and the pre-operative assessment unit.

The Care Quality Commission (CQC) carried out an inspection between 29 November and 1 December 2017. During this inspection we visited general surgical wards 14, 15A, 15B, 16, orthopaedic wards 34 and 35, cardiothoracic surgical ward 38, day surgery unit, surgical assessment unit, pre-operative assessment unit and the surgical admissions unit.

We spoke to 27 patients and relatives. We also spoke with 40 members of staff including senior managers, specialist nurses, registered nurses, student nurses, health care assistants, consultants, middle grade doctors, junior doctors, medical students, allied health professionals including physiotherapists, occupational therapists, dietitians, pharmacists, domestics, ward clerks, housekeepers and nursing agency staff.

We observed care and treatment and looked at 23 patient care records. We reviewed comments from staff focus groups and we looked at the service performance data.

Is the service safe?

Mandatory training

Mandatory training is those elements of training that the organisation deemed are necessary in order for staff to undertake their duties effectively and safely. This is usually training such as basic life support and infection control, but can be different depending on the role of the member of staff.
The trust set a target of 95% for completion of mandatory training. The trust report training completion rates on a rolling monthly basis.

A breakdown of compliance for mandatory courses as of June 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Staff trained</th>
<th>Completion (%)</th>
<th>Met Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>1285</td>
<td>1152</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>1285</td>
<td>1147</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>1046</td>
<td>926</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>1064</td>
<td>910</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1285</td>
<td>1102</td>
<td>86%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>1062</td>
<td>904</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>557</td>
<td>475</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>630</td>
<td>529</td>
<td>84%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>1285</td>
<td>1061</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion Process : Collection</td>
<td>243</td>
<td>195</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>1285</td>
<td>1026</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>959</td>
<td>709</td>
<td>74%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>989</td>
<td>723</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>1285</td>
<td>934</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>931</td>
<td>684</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>1285</td>
<td>924</td>
<td>72%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>1047</td>
<td>715</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Blood Transfusion Process : Administration</td>
<td>409</td>
<td>258</td>
<td>63%</td>
<td>No</td>
</tr>
<tr>
<td>Recognise &amp; Act</td>
<td>309</td>
<td>191</td>
<td>62%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust is not achieving its target in any of the mandatory training modules in the surgery core service.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The division had a mandatory training policy. This was based on a training needs analysis which determined which training staff had to undertake based on their roles and responsibilities. They were required to undertake a range of general and role specific mandatory training modules in line with the policy and the mandatory training schedule. This also set out the frequency that each module was to be repeated. The majority of these were online training.

Although mandatory training levels were below trust targets, managers from the division told us plans were in place to improve these rates. These included the opportunity to complete training at home via an internet link and or the production of workbooks for those who preferred to work on hard copies or who did not have internet access; time would be given back for this work. The managers also stated there was a one month delay in updating results and there was also some recording inaccuracies. They stated that appraisals would not be signed off without all mandatory training being up to date.
Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It refers to the processes in place to identify and protect a patient who is vulnerable or at risk.

The trust set a target of 95% for completion of safeguarding training. The trust report training completion rates on a rolling monthly basis.

A breakdown of compliance for safeguarding courses as of June 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Eligible staff</th>
<th>Staff trained</th>
<th>Completion (%)</th>
<th>Met Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>1050</td>
<td>949</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>1285</td>
<td>1143</td>
<td>89%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>235</td>
<td>174</td>
<td>74%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust is not achieving its target in any of the safeguarding training modules in the surgery core service.

(Source: Trust Provider Information Request P40)

Managers in the division stated they were working on improving the figures and measures included those stated above.

The trust wide safeguarding team comprised of the director of nursing and quality who was the executive lead for safeguarding and a head of safeguarding. There were designated lead doctors and named safeguarding nurses for children and adults. There were also designated contacts in the team for looked after children, youth offenders, child sexual abuse, domestic abuse, children who were looked after, mental capacity act and deprivation of liberty safeguards, domestic abuse amongst others.

The trust safeguarding team was available during core hours for staff to contact should they have any safeguarding queries or concerns. Outside of these hours staff could contact on call managers for guidance on safeguarding matters.

There was a safeguarding policy in place which was accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a patient or their family member and they could describe the correct process to follow.

Safeguarding vulnerable adults and children was included in the hospital mandatory training programme. Each ward had a safeguarding ‘champion’ who could support staff with any concerns. Young patients aged 16 and 17 were cared for on the adolescent ward were staff were trained to level three in safeguarding children. All child surgical patients were cared for on the children's ward in the hospital. If staff required any guidance with child safeguarding they could seek advice from the children’s ward at any time. The paediatric staff caring for children in the operating theatres were training to level three in safeguarding children in keeping with intercollegiate guidance.

Cleanliness, infection control and hygiene

During our inspection, we observed that wards appeared visibly clean and tidy and free from
clutter. We saw evidence that cleaning regimes were in place and that these were audited regularly.

Cleaning audits were performed by the external contractor and were supplied in percentage form for each ward or area to the managers of that area. Where audit outcomes fell short of 100% compliance, the issue was highlighted to ensure the areas of non-compliance were revisited and made clean. For example, if it was noted that a toilet was not clean, arrangements were made for it to be cleaned straight away.

Operating theatres compliance with cleaning standards from September 2017 to November 2017 are shown below.

<table>
<thead>
<tr>
<th>Theatres</th>
<th>Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>99.7%</td>
</tr>
<tr>
<td>October 2017</td>
<td>99.8%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
</tr>
</tbody>
</table>

Infection prevention was classed as a component of mandatory training for clinical staff. The compliance rate for surgical staff was 80%, which was lower that their target of 95%.

An infection prevention in the acute setting policy was in place and in date and staff we spoke with were aware of this policy. There was an infection prevention and control team in the hospital with leads on each ward. A range of infection prevention and control audits were conducted which covered the saving lives areas, such as peripheral line insertion and care, mattress condition and hand hygiene. The hospital also undertook ‘saving lives’ audits which looked at compliance with 10 care bundles around reducing health care related infections. These included peripheral line insertion, wound care, intra-operative actions and catheter care. In the October 2017 audit, the results for the scheduled care division were the best in the hospital as they achieved 99.4% compliance. The results of all infection control audits were published and sent to ward managers to produce action plans. Ward managers shared the results with their teams and, where appropriate, additional training was undertaken.

Ward based infection control audits were undertaken by ward managers, link champions and department staff who have been trained to complete the audits using an audit tool designed by the infection prevention team. These looked at environmental standards, use of protective equipment, waste disposal and sharps management. Outcomes for the surgical division showed that for the period October 2016 to September 2017, compliance improved over the last four quarters. However, the report identified that the recovery areas within the division as falling below the accepted standards. This had been highlighted to managers and an action plan was in place.

<table>
<thead>
<tr>
<th>Period</th>
<th>Compliance percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016 to December 2016</td>
<td>94.4%</td>
</tr>
<tr>
<td>January 2017 to March 2017</td>
<td>93%</td>
</tr>
<tr>
<td>April 2017 to June 2017</td>
<td>96.1%</td>
</tr>
<tr>
<td>July 2017 to September 2017</td>
<td>96.6%</td>
</tr>
</tbody>
</table>

This team also conducted covert hand hygiene audits. Outcomes for the surgical division showed that for the period October 2016 to September 2017, compliance was consistently over 95%, but showed a slight decline in the last quarter. The report identified that doctors compliance fell short of the accepted standards, but that this had improved since the year before.
<table>
<thead>
<tr>
<th>Period</th>
<th>Compliance percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016 to December 2016</td>
<td>95.2%</td>
</tr>
<tr>
<td>January 2017 to March 2017</td>
<td>95.7%</td>
</tr>
<tr>
<td>April 2017 to June 2017</td>
<td>97.1%</td>
</tr>
<tr>
<td>July 2017 to September 2017</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

During our inspection, we saw that staff appeared to comply with best practice in relation to uniform standards, ‘bare below elbows’ guidance, used appropriate personal protective equipment and washed their hands in between contact with patients. However, in the surgical assessment unit we saw that a patient who was under isolation precautions had no sign depicting this and the door to their room was left open. This was contrary to best practice and to the hospital's own policy. We raised this with staff during our visit.

We saw good access to hand washing sinks and hand gels on the wards, in theatres and also at the point of care. We observed good compliance with hand hygiene by staff. Hand washing plays an important part in helping to prevent the spread of infection.

Trust wide the hospital recorded 29 cases of *Clostridium difficile* infection in the year from April 2016 to March 2017; the trust deemed four of these cases as avoidable cases of *Clostridium difficile* and 25 cases as unavoidable. This followed a general downward trend over the last four years.

During the period April 2017 to October 2017, the surgical division had three cases of *Clostridium difficile* infection, no cases of Methicillin resistant *Staphylococcus aureus* and two cases of Methicillin sensitive *Staphylococcus aureus*.

The trust reported some orthopaedic surgical site infection rates to Public Health England. The table below shows that during the year July 2016 to June 2107, the surgical division reported higher that the England average rates of infection for this period. However, for hip replacement and for knee replacement the division reported a general downward trend. That is their rates of infection were improving. For neck of femur repairs, the improvement was not sustained.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number of infections</th>
<th>Infection rate percentage</th>
<th>England Infection rate percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck of femur repair</td>
<td>7</td>
<td>1.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>16</td>
<td>4.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>32</td>
<td>9.2%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

The division had implemented an extensive action plan to reduce the risks of infection. This included measures such as restructuring services to ensure elective orthopaedic patients were not nursed with general surgical patients to reduce the chance of infections. They have also improved processes involving Methicillin resistant *Staphylococcus aureus* and Methicillin sensitive *Staphylococcus aureus* decolonisation treatment prior to surgery and improved cleanliness and hygiene processes. This action plan has been reviewed and updated regularly since its implementation.

The decontamination of reusable medical devices was completed in line with national guidance. Sterilisation, where required, was undertaken by the in house sterile services department through a service level agreement. The agreement was documented and signed by both parties and reviewed regularly. Sterile services provided decontamination certificates as on clean equipment.
Environment and equipment

We found that the wards and clinical areas were generally in good order and provided a suitable environment to care for patients. The day surgery unit was a suitable, pleasant and well-equipped purpose built area for the quick turnaround of surgical patients. It was easily accessible within the hospital and complied with many of the recommendations made by the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery guidance.

Theatres were compliant with the Royal College of Surgeons and Association and the Association of Surgeons of Great Britain and Ireland (ASGBI) recommendations around emergency surgery and the department of health best practice concerning the environment and facilities.

Waste and clinical specimens were handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

The operating theatres and wards used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with external provider which was in date.

Emergency and resuscitation equipment was accessible in the ward and theatre areas. Records showed that during November 2017 equipment and consumables were checked daily in line with hospital policy. We checked a sample of consumables and these were in good order and in date. The emergency trolleys were equipped with a defibrillator, oxygen, portable suction and a selection of emergency items. Emergency drugs and fluids were kept within the trolley and tamper evident seals with unique reference numbers were recorded. We checked sample of items on the trolleys and found them to be in date in and useable condition.

Staff stated they had access to the equipment they needed to care for patients and maintained and used it in a way that helped keep people safe. Standard operating procedures were in place to help staff check and use equipment. Staff told us these were readily available on the staff intranet.

Machines were serviced and maintained by the medical engineering department. They held a database of annual servicing dates and arranged for these to be completed. There had been a lapse in equipment maintenance in the past and the trust had adopted a new process. They reported that they were currently 78% up to date with the servicing schedule. We were advised that the division had prioritised the servicing of machinery depending on risk and that they expected to have completed the backlog by March 2018. There was a process in place to request repairs and replacements of faulty or broken equipment.

In the operating theatres, we found that machine, equipment and air circulation and ventilation systems had been serviced, calibrated and maintained according to guidelines. Deposit thickness tests were conducted in October 2017 and conformed to minimum standards. Vital equipment such as anaesthetic machines were checked as per guidance each day and records were kept.

During our inspection, we found items subject to the 'control of substances hazardous to health' were securely stored.

Assessing and responding to patient risk

The service complied with all aspects of the World Health Organization safer surgery checklists. They undertook comprehensive audits both observational and documentary to assure themselves of their compliance. These audits showed 100% compliance with the range of elements under analysis. During our inspection, we observed several safer surgery phases such as team brief, sign in, time out, sign out and found they were undertaken to a good standard.

Theatres had implemented a ‘prosthetic pause’ that is, they undertook an additional safety precaution to prevent mistakes by pausing the operation before an implant was used to ensure
everything was correct. An audit of this process undertaken in October 2017 showed 100% compliance.

The surgical division implemented Local Safety Standards for Invasive Procedures based on National Safety Standards for Invasive Procedures. These were ratified by the Quality and Safety committees and were audited as per the audit programme. Results were fed into the divisional governance committee.

Surgical services had a sepsis identification and care record in place. We saw evidence that these had been completed where there was a suspicion a patient may have sepsis and that appropriate interventions were taken. Staff we spoke with demonstrated knowledge of the sepsis protocols and explained what they would do if observations scores were elevated and if they showed signs of sepsis.

The hospital had a sepsis team to drive improvement and knowledge around sepsis. Various audits of sepsis performance had been conducted including a monthly sepsis pathway compliance audit. This looked at various standards in relation to the sepsis pathway and detailed whether the hospital was achieving these. The hospital also participated in the 'National Confidential Enquiry into Patient Outcome and Death' (NCEPOD) Sepsis study. The sepsis team had implemented various initiatives to understand how they might improve. These included visiting another local NHS trust to discuss and learn from them; launching sepsis educational materials and leaflets and additional training for staff. The team had produced action plans many items of which had been implemented and completed; there was also evidence of ongoing audits to ensure continuing compliance.

The risk of patient deterioration was identified through a process of monitoring observations and vital signs. These were formulated into a scoring system called a ‘national early warning score’. An early warning score is a recognised and widely used system to quickly determine how poorly a patient may be and this is matched against an appropriate clinical response depending on the score. The national early warning score entries we checked had been completed and calculated appropriately, with the exception of one record, which related to pain scores for one patient and this was highlighted to the relevant ward manager.

The hospital had a ‘Recording of Vital Signs Observations on Adult Patients’ policy in place. This was in date and was readily accessible to staff. Staff were able to explain how the process worked and what action to take when scores indicated a patient’s condition was deteriorating.

Early warning score documentation and completion were audited as part of the nursing care indicators programme. Any non-compliance, omissions or errors were noted these were highlighted as areas for improvement.

The trust had an emergency resuscitation team, which operated within core hours. This team responded to emergencies on the surgical wards and those who were identified through the national early warning score process as being at risk of deterioration. Outside of these hours, this role was undertaken by the acute response team nurse practitioners.

Upon admission to the wards and departments, staff undertook a series of risk assessments within their admission document. These included nutrition and malnutrition screening, risk for pressure ulcers, falls risks and risk of venous thromboembolism. Completion of these assessments was audited through nursing care indicator audits.

Patient risk was assessed during the pre-operative assessment. These were undertaken by experienced and capable nurse practitioners. The assessment was comprehensive and thorough and ensured that any patient risk was identified. The pre-operative nurses had access to advice from an anaesthetist and could refer the patient for an anaesthetist review if necessary. They could also secure input from a range of other specialists and request further tests if necessary. The assessment ensured up to date blood tests and laboratory tests were held and screening and treatment for methicillin resistant Staphylococcus aureus was completed.

Allergies were discussed with patients at the pre-operative assessment visit and upon admission to the wards and departments and we saw that these were noted in their records.
All patients over 75 years of age who were admitted to the surgical wards were screened for dementia using the national dementia screening tool. Those highlighted by this tool were assessed for mental capacity and care plans implemented as appropriate.

There was access to a mental health liaison team through a service level agreement with a local NHS mental health trust. Staff on the surgical wards could refer patients in their care for assessments and additional support.

An audit of nursing care indicators was conducted monthly for all wards and areas. The nursing care indicators audit was an audit covering a wide range of aspects such as documentation standards, consideration of risk, appropriate assessments, infection control procedures, vital signs completion and early warning score calculations. The results were sent to matrons and ward managers for them to formulate action plans to improve where necessary. Themes were analysed which became ‘theme of the month’ where attention extra training and focus was placed, involving practice development sisters to drive improvement. Areas who were achieving good results became buddies to those who were performing less well in order to share practices.

We saw that these reports were highlighted and discussed with staff during ward and directorate team meetings and were discussed at the divisional performance board with the executive team.

Patients deemed at risk of falls were highlighted and measures put in place to reduce the risk following risk assessment. This included the use of slipper socks, one to one supervision and the use of falls alarms. The hospital also operated a slipper exchange scheme. The surgical division had access to a falls prevention team. Referrals could be made to the team who could assist by providing input into plans to help reduce the risk of falls in susceptible patients.

Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. Call bells were available on wards and we saw that these were placed within reach of patients’ hands to help make sure they could access help should it be required.

Nurse staffing

Staffing establishment levels were assessed and reviewed twice per year using patient acuity tool, professional judgement, local knowledge and through the use of quality indicators and reference to national guidance. The last review was undertaken in October 2017. On inspection, we found that staffing levels were sufficient to meet the needs of the patients. However, we were told by staff they were often moved of their own wards to staff wards with lower staff levels. Some staff felt this was not always ideal as they had no knowledge of the competency and ability of staff they had never worked with before. Registered nurses felt this was an issue on occasion as duties such as taking observations were delegated to health care assistants. However, some staff enjoyed the variety and found it beneficial to work in a range of areas.

We were advised that on one occasion a health care assistant was left on their own for several hours during a night shift as there were no registered nurses available to cover. We were told this involved five patients identified as low risk based on their early warning scores. An incident report had been completed and was being investigated.

The staffing of the operating theatres were compliant with association for perioperative practice minimum standards.

The safer staffing figures published by the trust reported that the staffing fill rates on surgical wards; that is the percentage of staff who were actually on duty compared to the planned levels from May 2017 to October 2017 was on average above 90% for registered nurses and above 93.4% for care staff.

<table>
<thead>
<tr>
<th>Average Fill Rates - Surgical wards</th>
<th>Registered Nurses</th>
<th>Care Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
<td>90%</td>
<td>93.4%</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
For ward 35 alone, fill rates were 71.5% for registered nurses during the day and 68.4% for registered nurses during the night. This was due to high vacancy and sickness rates. Care staff levels were increased to 103% during the day and 167% during the night to compensate for this in order to maintain safety.

The surgical division used very few agency staff; they reported that they used only six agency staff in the year 29 November 2016 to 29 November 2017. The division did use significant numbers of ‘bench’ staff. Bench was the hospitals own staff bank where staff could work additional hours for payment.

Surgical wards, most notably the surgical assessment unit, ward 16 surgical high care, ward 35 orthopaedic and ward 38 cardiothoracic surgery used over 1000 bench shifts in the year 29 November 2016 to 29 November 2017. This equated to at least three staff per day. These were largely to cover vacancies and sickness.

Theatres, including recovery and the operating theatres used 28 staff for the year 29 November 2016 to 29 November 2017

The trust reported their staffing numbers below for the period up to June 2017

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing, midwifery &amp; health visitors</td>
<td>340.47</td>
<td>336.51</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From July 2016 to June 2017, the trust reported a vacancy rate of -8.6% in surgical care which indicates that they are above the expected WTE.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Safer staffing figures published on the hospital website dated 29 November 2017, reported that the surgical division had a deficit of 31 registered nurse vacancies across the division. We were advised that some of these had been recruited to from overseas and they were yet to take up their posts.

From July 2016 to June 2017, the trust reported an average turnover rate of 0.9% in surgery.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Between July 2016 and June 2017, the trust reported an average sickness rate of 4.9% in surgery which is higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Detailed information was not received.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Surgical staffing

Consultant ward rounds were undertaken daily with ward rounds being undertaken at weekends by the consultant of the week. Orthopaedic ward rounds take place twice per day. There was an on call system to provide consultant cover throughout the 24 hours period. There were anaesthetists on call throughout the night if called upon by wards or theatres.

During our inspection, we found surgical staffing was sufficient to meet the needs of patients. Doctors we spoke with stated their workloads were manageable. Junior doctors stated there was always access to advice and support from senior surgical staff and consultants and they could access that support at all times. Doctors told us that there were opportunities for development and learning and that the training programme was excellent.

The surgical division used 270 locum and agency surgical doctors during the period November 2016 to October 2017. These were predominantly senior house officers or specialist registrars, but there were some consultant grade agency staff.

The trust has reported their staffing numbers below for June 2017

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>79.34</td>
<td>72.57</td>
</tr>
<tr>
<td>Dental</td>
<td>0</td>
<td>0.09</td>
</tr>
<tr>
<td>Junior medical</td>
<td>115.56</td>
<td>101.29</td>
</tr>
<tr>
<td>Total</td>
<td>194.9</td>
<td>173.95</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From July 2016 to June 2017, the trust reported a vacancy rate of -4.8% in surgical care which indicates that they are above the expected WTE.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between July 2016 and June 2017, the trust reported an average sickness rate of 4.9% in surgery which is higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Information on bank and locum staff usage is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. Detailed information was not received.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In July 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the whole time equivalent staff working at Blackpool Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>47%</td>
</tr>
<tr>
<td>Middle career</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>10%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Records

The surgical division used paper patient records, they comprised of a medical file and a nursing file. All members of the multidisciplinary team updated the medical file which contained the patient’s medical history, clinical pathways and plans, admission records, consultation and follow up notes. The nursing file contained risk assessments, nursing documentation, observation charts and prescription charts.

Staff told us records were always available and confirmed there would be no occasion in which patients would receive treatment without relevant records being available.

The records we checked showed that the results of diagnostic tests were responded to and actioned appropriately and in a timely way.

We reviewed a random sample of 23 records across the wards we visited. We found these were generally of a good standard, were comprehensive and complete. We saw some good admission and nursing documentation which assisted nursing staff to care for patients in a safe way.

Documentation audits undertaken monthly as part of the nursing care indicators audits and reported to ward and area managers in to highlight learning and improvement.

Medicines

During our inspection we found that medicines, including controlled drugs and intravenous fluids were stored safely and in line with best practice guidance and trust policy.

We observed records that confirmed that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection, we also checked a selection of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs. We saw correct recording of ‘wasting’ of controlled drugs, where the full contents of a vial was not prescribed.

We found that medicines requiring cool storage were stored appropriately and records showed that refrigerators were being checked daily to ensure they were maintained at the correct temperature. We also found that room temperatures where medicines were stored were being checked appropriately. Staff we spoke with knew what to do if temperatures were found to be out of range.
Incidents

The division used an electronic incident reporting and management system. Reports were submitted by completing sections of an electronic form. The person reporting had the option to be notified of the outcome of their incident. Staff stated they understood the system, it was easy to use and they would report incidents.

The staff we spoke with were familiar with the types of incidents that should be reported, these included patient safety incidents, staffing issues and equipment failures. Staff said they were encouraged to report incidents and could give examples of when they had reported. These included staffing incidents and medicines incidents. They also said they received feedback from the incidents they had reported. They were able to give examples of incidents that had occurred and changes made as a result. For example, following a choking incident staff received additional training with scenario to increase their knowledge and confidence.

Staff were aware of the duty of candour and what this meant. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

The surgical division reported 53 incidences of using the duty of candour processes. We reviewed a sample and found that it had been applied correctly, in line with trust policy and an apology given.

Incidents and risks within the surgical division were escalated through a series of committees and governance structures to senior managers and so that information regarding patient safety was shared across services.

The division held weekly meetings of harm; these gave managers the opportunity to review incidents, discuss issues and ensure learning was circulated and actioned in a timely way. This meeting enabled a quick response and consider ways to reduce the chance of reoccurrence in the surgical division and other areas of the hospital.

We reviewed a sample of investigations relating to serious incidents over the last 3 months and found they were investigated in an open and candid way and that key issues were identified and shared in a timely way.

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

From October 2016 to September 2017, the trust reported two incidents classified as never events for surgery. All were surgical/invasive procedure incidents.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2016 to September 2017.

Of these, the most common type of incident reported was

- Surgical/invasive procedure incident meeting SI criteria with seven (70% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (10% of total incidents).
- Treatment delay meeting SI criteria with one (10% of total incidents).
- Venous thromboembolism meeting SI criteria with one (10% of total incidents).
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

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

Data from the Patient Safety Thermometer showed that the trust reported seven new pressure ulcers, seven falls with harm and four new catheter urinary tract infections from September 2016 to September 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Blackpool Teaching Hospitals NHS Foundation Trust
Total
CUTIs
(4)

(Source: NHS Digital)

The trust as a whole recorded a slightly better level of harm free care 95.2% compared to the England average of 94.3% from October 2016 to October 2017.

During the inspection, we observed that safety thermometer information was being displayed in a prominent place on the wards we visited. The information was updated regularly to keep patients and visitors informed about the ward performance. There was evidence that the information was being used to identify areas for improvement and actions implemented as appropriate.

Risk assessments for pressure ulcers and falls were completed for each patient upon admission and reviewed as appropriate throughout their stay. Documentation that we checked confirmed this was done appropriately and actions taken where risks were identified such as using a pressure relieving mattress or implementing a falls care plan.

Is the service effective?

Evidence-based care and treatment

National Institute for Health and Care Excellence, evidence based practice guidance, alerts and updates were reviewed for changes by clinical leads and matrons to ascertain if these impacted on their scope of practice. They assessed if there were changes in the care and treatment processes to be implemented. Any deviation or planned departure from the guidance was risk assessed, agreed through the governance structures and documented accordingly.

Care pathways such as fractured neck of femur, knee replacement and cardiac surgery reflected National Institute for Health and Care Excellence guidance and this was followed by surgical teams. We found the service adhered to guidance and recommendations in relation to operating theatres and recovery issued by the Association of Anaesthetists of Great Britain and Ireland and the British Anaesthetic and Recovery Nurses Association such as ‘Immediate Post-anaesthesia Recovery’ and ‘Recommendations for standards of monitoring during anaesthesia and recovery’.

Patients assessed to be at risk of venous thromboembolism were offered venous thromboembolism prophylaxis in accordance with National Institute for Health and Care Excellence guidance.

The division undertook a programme of local clinical and nursing care audits to assess compliance against evidence based care and treatment. Results of such audits were discussed and cascaded through a range of clinical quality groups and actions had been put in place to improve standards where required.

A comprehensive clinical audit plan was in place for the surgical division; this was aligned to best practice and evidence based guidance. The plan detailed the frequency of audit, who was responsible and was rated for compliance.

The division participated in the NHS improvement agency ‘Getting it right first time’ audit. This was a network, which sought to improve performance and reduce inefficiencies by identifying variance and inefficiencies in the service.

Nutrition and hydration

The patient’s records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition. We saw that these were reviewed at appropriate intervals. We found patients on food charts and fluid balance charts had these completed and
updated appropriately.

Wards had access to a dietitian during core hours who provided advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. We saw evidence that those at risk were referred to and reviewed by a dietitian appropriately.

Surgical wards had access to a diabetes specialist nurse who was available for advice for patients and staff. We saw evidence that blood glucose monitoring was undertaken at regular intervals and that those patients whose readings were out of range were escalated appropriately.

Patients who needed assistance or encouragement with eating and drinking were highlighted by use of the red tray system. We saw evidence that patients were assisted at meal times by staff.

Patients told us they were happy with the quality and choice of food and that was provided. They stated the food was warm and palatable.

**Pain relief**

Wards and recovery areas assessed pain as part of the national early warning system. The measurement of pain levels was integral to the scoring system and we saw that these were mostly recorded and added into the national early warning system score. Surgical services also had an additional pain recording documentation; this dictated the level of pain medication that was appropriate to the pain score reported. There was a system in place to assess pain in those who were unable to verbalise their pain.

The surgical wards had access to a dedicated pain team with specialist pain control nurses within core working hours. Out of hours and weekends, pain advice could be sought from the on-call anaesthetist. We saw that when a pain team review was requested this was provided in a timely way and was reviewed periodically.

A patient told us that their pain had not been well controlled during their stay and that staff did not always ask about pain during every set of observations. When we reviewed the records, we saw the recording on the pain chart and the national early warning score record did not correspond with each other and with what the patient reported to us. This was raised with the ward manager for that ward who stated they would arrange a review by the pain team.

Pain including existing chronic and ongoing pain and anticipated pain levels from surgery were discussed as part of the pre-operative assessment process. Any anticipated issues were discussed with the anaesthetist prior to surgery. Advice from the pain team could be sought and a plan implemented where necessary.

The majority (21 out of 23) of patients we spoke with were satisfied that their pain was assessed and treated appropriately.

The trust introduced rectus sheath catheter analgesia pumps for abdominal surgical patients, for which a trust consultant was awarded the National Acute Pain Symposium Acute Pain Consultant of the Year 2017 award.

**Patient outcomes**

Out of five of the national audits within surgery, the trust scored similar to other trusts for two audits. These were the oesophageo-gastric cancer national audit and the national emergency laparotomy audit.

However, it scored worse than other trusts in the hip fracture and bowel cancer audits. In the hip fracture audit, the hospital was in the bottom 25% of all trusts for four of the five measures which were comparable. The trust was taking action to address this. There was a fractured neck of femur steering group that had an orthopaedic action plan. We saw from the plan that some actions had been completed and that all the other actions were amber and were work in progress. On the 13
November the summary standardised hospital level mortality for fractured neck of femur had reduced to 88; the target was 100.

In the bowel cancer audit, the hospital was found to be worse than other trusts for three of the five measures which were comparable.

The trust did not participate in the 2016 national vascular registry audit.

The relative risk of admission was lower than expected for elective and non-elective admissions when compared to the England average with the exception of elective admissions for general surgery.

From June 2016 to May 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

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

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

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

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

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

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

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

**Elective Admissions – Trust Level**

![Elective Admissions Graph]

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Graph]
Blackpool Victoria Hospital

From June 2016 to May 2017, all patients at Blackpool Victoria Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Urology patients at Blackpool Victoria Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at Blackpool Victoria Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

Ophthalmology patients at Blackpool Victoria Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at Blackpool Victoria Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General surgery patients at Blackpool Victoria Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at Blackpool Victoria Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at Blackpool Victoria Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - Blackpool Victoria Hospital**

![Elective Admissions Chart](image)

**Non-Elective Admissions - Blackpool Victoria Hospital**

![Non-Elective Admissions Chart](image)
100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics)

**Hip Fracture Audit**

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10.7% which was worse than expected. The 2015 figure was 8.9%.

The proportion of patients having surgery on the day of or day after admission was 57.5%, which was worse than the national standard of 85%. The 2015 figure was 59.3%.

The perioperative medical assessment rate was 26.5%, which failed to meet the national standard of 100%. The 2015 figure was 25.5%.

The proportion of patients not developing pressure ulcers was 95.1%, which falls in the middle 50% of trusts. The 2015 figure was 98.5%.

The length of stay was 27.9, which falls in the bottom 25% of trusts. The 2015 figure was 26.5 days.

The hospital was in the bottom 25% of all trusts for four of the five measures which were comparable.

(Source: National Hip Fracture Database 2016)

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 73.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 77.9%.

The risk-adjusted 90-day post-operative mortality rate was 4% which was within the expected range. The 2015 figure was 5.3%.

The risk-adjusted 2-year post-operative mortality rate was 29.8% which worse than expected. The 2015 figure was 27%.

The risk-adjusted 30-day unplanned readmission rate was 12.2% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 65.2% which worse than expected. The 2015 figure was 70.7%.

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

In the 2016 National Vascular Registry (NVR) audit, the trust did not submit any data.

(Source: National Vascular Registry)

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 14.7%. This placed the trust within the middle 50% of all trusts for this measure.

The 90-day post-operative mortality rate was not applicable
The proportion of patients treated with curative intent in the Strategic Clinical Network was 2,104, similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2016 National Emergency Laparotomy Audit (NELA), Blackpool Victoria Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 189 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 151 cases.

The hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 112 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 75 cases.

The risk-adjusted 30-day mortality for the hospital was higher than expected, based on 382 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 performance on groin hernias was worse than the England average. For hip replacements, performance was about the same as the England average. For Knee replacements was about the same as the England average. (Source: NHS Digital)

The surgical division participated in various ‘getting it right first time’ audits and initiatives. They had received positive feedback and citations of success in various publications and based on reports by external partners and peers. These included; high percentages of patients experiencing improved outcomes following video-assisted thoracoscopic surgery lobectomy techniques rather than traditional techniques and the implementation of increased same day admissions for certain cardiac surgery.

The division reports positive outcomes in National Institute for Cardiovascular Outcomes Research benchmarking data for cardiothoracic surgery and report improved survival rates compared with other providers.

**Competent staff**

Staff we spoke with told us they were encouraged and supported to develop; registered nurses said there were opportunities for further development and progression. There were opportunities to attend additional skills training courses such as electrocardiography interpretation and tissue viability courses. Health care assistants had the opportunity to extend their scope of practice to enable them to undertake skills such as cannulation, catheterisation, taking blood and other procedures. Some health care assistants were being sponsored by the trust on the nursing assistant programme. The trust were supporting return to practice nurses and student nurses to achieve their placement hours and we saw students training on the surgical wards and departments.

New staff and students said there was good access to learning and development opportunities to further their knowledge and consolidate their training. They stated the mentorship and preceptorship schemes were effective and they received support from practice education facilitators and mentors.

Staff were positive about the practice development nurse’s role stating they have had the opportunity to improve their practice and learn from mistakes in a positive and supportive environment. They stated the practice development nurse had arranged additional training and scenario practice for a range of skills and competencies and staff found these sessions very enjoyable and useful.

Revalidation of nursing staff and allied health professionals was supported by the trust; resources and training was provided to assist staff with this process.
The junior doctors we spoke with told us they felt well supported by senior colleagues and that they had no problem obtaining advice and support from senior surgeons and consultants. Junior doctors said this hospital and surgical services provided an excellent training environment and provided opportunities to learn a range of skills. They stated they would recommend it as a place to work for fellow doctors and surgeons.

Ward staff had competency files, which recorded evidence of competencies to undertake certain tasks such as removing surgical drains and central lines. Competency booklets with skills sign offs were provided for newly qualified staff or staff new to the speciality area.

From April 2016 to March 2017, 85% of staff within surgery at the trust had received an appraisal compared to a trust target of 100%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

The surgical division encompassed a range of disciplines. Staff told us these disciplines worked together and each had an input into the care planning and delivery for patients. Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care. Staff reported that the multidisciplinary team relationship was good and the team worked well together. Staff we spoke with from a range of specialisms and grades said they felt part of a team and were involved in patients’ care and treatment.

There was access to a wide range of specialist staff such as colorectal, cardiac, diabetes, stoma care, palliative care and tissue viability specialists, which could be requested for advice and input. A range of specialists and multidisciplinary staff were available should the pre-operative assessment nurse feel the patient might benefit. We saw evidence that this was done on a regular basis.

Occupational and physiotherapists worked with patients to assist in their recovery and rehabilitation particularly on the orthopaedic and cardiothoracic surgery wards. Patients undergoing elective orthopaedic procedures could be referred to the physiotherapists for optimisation and exercises prior to their procedures and were given information packs on self-help exercises.

Occupational therapists worked collaboratively with social services and local authority staff to organise ongoing and community care for patients being discharged. Occupational therapists undertook environmental visits to patients homes to ensure it was safe and appropriate for patients to return there following their surgery.

Patients who had received cardiac surgery were referred to the cardiac rehabilitation specialist nurses both in the hospital and in the community where appropriate.

Seven-day services

There were consultant led ward rounds every day including weekends. A consultant of the week undertook these ward rounds at the weekend and was available for advice.

Diagnostic procedures and laboratory tests including included blood tests, ultrasound scans, echocardiograms, X-rays and computed tomography were available at weekends. A magnetic resonance imaging scan was available through an arrangement with an external provider. Processes were in place that urgent requests were undertaken and reported on in a timely way.

Specialist services such as dietitians, occupational therapy, access to specialist nurses, were not available at weekends. However, physiotherapy services were seven days per week on orthopaedic and cardiothoracic wards.

Pharmacists were available on a daily basis and operated out of hours cover during the weekend.
and evenings.

**Health promotion**

The surgical division had access to smoking cessation and health promotion advice through a referral to the appropriate department.

Staff in the division were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients.

A range of leaflets were available on health promotion such as weight loss, healthy eating and smoking cessation and 'living well with…. .' condition specific advice was provided in leaflets and posters which were in place at various points around the surgical wards and departments, corridors and other areas in the hospital such as canteen and entrance areas.

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

The trust had a ‘Mental Capacity Act ’ policy in place, which had been reviewed and updated as appropriate; this was compliant with the Mental Capacity Act (2005) legislation and associated guidance.

A deprivation of liberty means taking someone's freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both 'under continuous supervision and control and not free to leave'. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts it impacts on their freedom. This may be done following a decision which confirms the care provided is in the best interests of the patient and that actions taken are the least restrictive. This is then authorised if appropriate by the local authority.

The trust had a ‘Deprivation of Liberty’ policy in place, this had been reviewed in 2017; the policy appeared robust and compatible with the ‘Mental Capacity Act Deprivation of Liberty Safeguards’ principles.

The trust had a ‘Consent’ policy in place which was ratified on 12 July 2012 and which was due for review on 1 June 2015. This policy had not been reviewed since then. This was the policy available to staff on the trust intranet.

Consent, mental capacity act and the deprivation of liberty safeguards training was part of the mandatory training package. During our inspection, we found that staff had a good understanding of consent, mental capacity act and the deprivation of liberty safeguards. We saw example of these being implemented appropriately and staff were knowledgeable about the processes.

The consent forms we checked showed that consent was obtained correctly and in line with trust policy and national guidance. The mental capacity assessment and deprivation of liberty documentation we checked was completed appropriately and in line with trust policy.

The trust reported that as of June 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training has been completed by 89% of staff in within surgery. The target is 95%.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

**Is the service caring?**

**Compassionate care**

During our inspection we found that staff were kind and caring towards patients and their
families. We overhead several exchanges and observed positive and supportive interactions between patients and staff. Cubicle curtains were drawn around the bedsides and single room doors were closed whilst patient care was taking place in order to protect the privacy and dignity of patients. Staff sought permission from patients before entering rooms and closed curtains.

Patients we spoke with were positive about the way staff treat them and stated they were treated with dignity and respect. They said that the care provided by staff was delivered with kindness and compassion and they were supported throughout their stay in surgical wards and areas. They said staff “always had a kind word” and were patient and understanding with their needs.

The Friends and Family Test response rate for surgery at Blackpool Teaching Hospitals NHS Foundation Trust was 26% which was lower than the England average of 29% from September 2016 to August 2017.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg Response Rate</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
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</tbody>
</table>

Highest score to Lowest score

Key: 100% 50% 0%

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

Note: sorted by total response

(Source: NHS England Friends and Family Test)

**Emotional support**

During our inspection we observed that staff considered the emotional needs of patients in their care. This was supported by what patients and relatives told us when we spoke with them. Patients stated that although staff were very busy they always had time for them and demonstrated a supportive attitude.

We saw that staff provided emotional support for anxious and nervous patient who were scheduled to have surgery. They provided reassurance and spoke kindly to patients, explaining the processes and procedures to put their minds at rest. Pre-operative nurses assessed if additional help was required for extremely anxious or nervous patients, those with phobias or those living with mental health issues. They could arrange quiet rooms, tours of theatres, support from specialist nurses if they felt this appropriate.

The chaplaincy service was available for spiritual, religious or pastoral support to those of all faiths and beliefs. There was a chapel in the hospital and they offered confidential support to patients and relatives. They also provided bereavement advice and support to patients and relatives.

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

The patients and relatives we spoke with told us they found members of staff approachable,
accommodating and considerate. Most reported that staff of all levels gave them time to express themselves and have their concerns listened to.

Patients told us they felt involved in their care and were given choices about decisions and options for treatment. They also said they felt they had opportunities for discussion with staff and sufficient time to have their questions answered. They stated they received clear and comprehensive information verbally and in leaflets provided to them in way they understood. They felt they were able to make informed choices and that they had a voice that was listened to. This was supported by what we saw during our visit.

Is the service responsive?

Service delivery to meet the needs of local people

The surgical division used available sources of local data and statistics to understand the needs of the local population and used these to design and review service provision.

The facilities and premises within the surgical division were designed and implemented with the needs of service users in mind. The division was involved in a rolling programme of environmental and service improvements to improve the services provided. The day surgery unit was utilised so that patients could return home the same day as their surgery wherever possible. This enabled other resources to be redirected to those who were required to recover in hospital.

Patients could access the surgical services through various means based on their need. Emergencies could gain access through the accident and emergency department. There was also a GP direct referral service to the surgical assessment unit. Other patients were referred for a consultation through the outpatients department who deemed if surgery was appropriate, the patient would then go on a waiting list for their treatment.

The cardiac service implemented various initiatives to meet the needs of their patients. They established some same day admission and enhanced recovery pathways for certain types of cardiac surgery. Blackpool reports high numbers of same day admission cases for such procedures, which leads to reduced length of stays and fewer complications for patients. They also provided electrophysiology services which offered several methods of minimally invasive cardiac ablation treatments as an alternative to surgical interventions and carried out minimally invasive mitral valve surgery, which reduced length of stay and complications for these patients.

Minimally invasive thoracic surgery was offered at Blackpool, this provision had received recognition from external partners as it delivered positive outcomes for patients.

From July 2016 to June 2017, the average length of stay for all elective patients at the trust was 3.9 days, which is higher than the England average of 3.3 days.

For Trauma & Orthopaedics, the average length of stay for elective patients at the trust was 4.2 days, which is higher than the England average of 3.4 days.

For Urology elective patients at the trust, it was 1.9 days, which is similar to the England average of 2.0 days.

For Cardiothoracic surgery elective patients at the trust, it was 6.0 days, which is lower than the England average of 7.3 days.

Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th></th>
<th>This Site</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td>6.0 days</td>
<td>7.3 days</td>
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<tr>
<td>Cardiac</td>
<td>2.0 days</td>
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</tr>
<tr>
<td>Elective Urology</td>
<td>1.9 days</td>
<td>2.0 days</td>
</tr>
<tr>
<td>Elective Trauma</td>
<td>4.2 days</td>
<td>3.4 days</td>
</tr>
<tr>
<td>Elective Orthopaedics</td>
<td>3.9 days</td>
<td>3.3 days</td>
</tr>
</tbody>
</table>

This Site

England Avg.
Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 6.5 days, which is higher than the England average of 5.1 days.

The average length of stay for General surgery non-elective patients at the trust was 4.4 days, which is higher than the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 12.6 days, which is higher than the England average of 8.9 days.

The average length of stay for Urology non-elective patients at the trust was 3.1 days, which is similar to the England average of 3.0 days.

Meeting people’s individual needs

Patients’ care plans were completed to a good standard and were individualised to them.

We found that patients living with dementia, sensory and cognitive impairments or learning difficulties were screened and identified appropriately using a trigger system. This brought about further actions to determine if additional support was needed and if it was necessary to consider issues such as mental capacity and consent.

The surgical division had dementia champions in place and used the ‘Butterfly Scheme’ to indicate those patients who were identified as living with dementia. The division participated in ‘John’s campaign’ to enable carers to be involved in care and they offered extended visiting options. The hospital had a ‘dementia corridor’ which was 72 metres of corridor with memory triggering scenes and smells. However, we did not see any patients being taken to this area during our visit and when we visited the corridor, no patients were using the corridor. We were also advised that the hospital used dementia ‘comfort boxes’ on the wards and used reminiscence pods within the clinical environment. However, we did not see any of these in use during our inspection.

The environment on some wards, particularly ward 19 (surgical assessment unit) was not in keeping with best practice with regards to caring for patients living with dementia, sensory or
cognitive impairments. The ward appeared cluttered with trolleys and equipment stored in the corridors and they did not have dementia friendly signage or clocks. Rooms and bays were labelled room one or room seven rather than being given a colour and name to make it easier for patients to return to the correct bays or rooms. There was a patient living with dementia on the ward at the time of our visit.

Most areas were suitable for patients using wheelchairs. There were some wheelchair accessible toilets available around the hospital.

There were processes in place for people who needed translation and interpretation services; this included British Sign Language (BSL) and a wide range of languages. This was primarily a telephone interpreting service, however in person interpreters could be arranged in advance. The hospital also had a list of approved staff who had been authorised to provide interpretation services for certain languages.

We saw that advice and information leaflets were available and a telephone number was written on the front leaflets stating to telephone if you wanted the leaflet in accessible form or in another language. However, this was written in English. We did not see any stock copies of leaflets in any of the more common language spoken by members of the local community.

**Access and flow**

The surgical division had electronic trackers on all of the wards, these were used to facilitate the progress of a patients treatment. Staff updated the trackers daily and this enabled actions such as diagnostic tests, procedures and therapy interventions to be followed up. Progress meetings were held to ensure there were no delays in treatment due to missed events; if they had not been carried out the patient status stayed on red, if the actions had been completed the tracker status went to green. This meant that staff were aware of outstanding actions and could follow them up as necessary. The trackers were used to identify patients who were outliers on the wards to ensure they were followed up by the correct speciality doctors. At the daily bed meetings outliers were discussed and reviewed so that outstanding tests and interventions were followed up.

There was a discharge lounge, which was used for patients who were waiting to be discharged from hospital that day and may have been waiting for medication to take home or transport to arrive. Surgical wards also sometimes used the day surgery unit for this purpose.

The hospital had regular bed meeting to facilitate the access and flow through the surgical division although this proved difficult at times due to the number of medical outliers occupying surgical beds. Medical outliers are patients with medical conditions who are not waiting for surgical treatment, but who are occupying beds designated for patient who are waiting for or who are recovering from surgery. This is relevant as this can mean that there may not enough beds for surgical patients who need a bed after their surgery. This may result in cancellations of surgical procedures if there is nowhere to look after them after their surgery.

At the time of our inspection, there were 40 medical outliers from a bed base of approximately 195 surgical beds. Managers admitted that this has been as high as 70. This led to operations being cancelled as there were no bed available post-surgery. This also impacted on the ‘referral to treatment’ times with the percentage of patient admitted within 18 weeks of referral declining in the previous year.

The hospital had higher bed occupancy rates than the England average. For the period July 2017 to September 2017, on average 95.8% of the inpatients beds were occupied compared to the England average of 88.9%. Occupancy figures for this period were amongst the highest 15 of 200 hospital trusts that provided this data. This meant that beds were nearly always occupied, which made it more difficult to find beds for new patients being admitted and for patients following their surgery. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.

Operating theatres utilisation was 91% on average from November 2016 to October 2017. There had been a gradual improvement in utilisation over this period. However, the number of late starts
to procedures also appeared to increase over that time and this coincided with a gradual increase in the number of cancelled operations.

The theatres productivity working group was working hard to improve theatres efficiency, prevent overruns of procedures, accommodate more procedures, reduce cancellations, inefficiencies and delays. The group had undertaken comprehensive analysis of various contributing factors and produced a detailed improvement and efficiency plan to facilitate changes within the processes. Work was being done on improving the scheduling of operations to further improve efficiency. This had in the last month showed some signs of improvement.

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

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery has declined. In September 2016 85% of patients were treated within 18 weeks versus the England average of 71% however in August 2017, this is down to 69% versus the England average of 70%.

(Source: NHS England)

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

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, two specialties were above the England average and two specialties were below the England average.

<table>
<thead>
<tr>
<th>Speciality grouping</th>
<th>Result</th>
<th>England average</th>
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</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>84.4%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>82.2%</td>
<td>62.2%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>78.9%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>73.0%</td>
<td>74.3%</td>
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</table>

The hospital also supplied a breakdown of referral to treatment times as seen in the table below. This showed that over the period from November 2016 to October 2016 there was a decline in referral to treatment times. That is patients waited longer for treatment as the year passed.

The table shows that in the green boxes the surgical division met the NHS operational standard; that is; at least 92% of patients wait no longer than 18 weeks for their surgery. The red boxes show that the standard of 92% of patients waiting less than 18 weeks for their surgery was not achieved. Despite not achieving the NHS operational standard overall, on average half of patients waited 7 weeks for their treatment and they achieved the 92% figure in 21 weeks. This was similar to the England average rates.

The surgical division had considered different options to deal with the referral to treatment times performance and an action plan was in place to improve these figures. They stated the plan implemented will see them achieve the NHS operational standard by March 2018. The work being done by the theatres productivity working group also played an important role in achieving improvements in this area.
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

During the year July 2016 to June 2017, the trust treated all patients, who had their operation
cancelled, within 28 days of the cancellation.

<table>
<thead>
<tr>
<th>Quarter - Period</th>
<th>Number of last minute cancellations</th>
<th>Number not treated within 28 days of cancellation</th>
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</thead>
<tbody>
<tr>
<td>July 2016 – September 2016</td>
<td>115</td>
<td>0</td>
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<tr>
<td>October 2016 – December 2016</td>
<td>187</td>
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<tr>
<td>January 2017 – March 2017</td>
<td>233</td>
<td>0</td>
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<tr>
<td>April 2017 – June 2017</td>
<td>201</td>
<td>0</td>
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However, in the latest quarter from July 2017 to September 2017, the surgical division had 172 last minute cancellation for non-clinical reasons and of those four patients were not treated within the 28 days. The trust explained that this dip in performance was due to the rise in unplanned admissions in medical care at that time which they managed by using surgical beds and by cancelling elective surgery.

The surgical division provided a breakdown of the reasons why surgeries were cancelled during the period 1 November 2016 and 31 October 2017. 573 were cancelled for clinical reasons, those included patients being unfit for surgery, or surgery was not appropriate. 788 procedures were cancelled for non-clinical reasons. Those included no beds available, running out of time (operating lists overrunning), lack of appropriate staffing and emergency surgeries. The division reported that 532 patients ’did not attend’ for their operations with a further 627 cancelling on the day for other reasons.

There were ongoing projects and initiatives to look at why operations were cancelled with work being done to improve the issues. Ensuring patients have confirmed their attendance and reminder calls were introduced and the division had implemented various strategies to try to reduce the cancellations and non-attendances by taking steps to improve efficiency. The latest data provided by the surgical division showed there has been some improvement in the number of cancelled operations.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Blackpool Teaching Hospitals NHS Foundation Trust

![Graph showing percentage of cancelled operations]

Cancelled Operations as a percentage of elective admissions - Blackpool Teaching Hospitals NHS Foundation Trust
Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

A complaints policy was in place and was accessible to staff, this was due for review in December 2016, but it had not been reviewed. The staff we spoke with understood the process and could advise patients and relatives on how to complain. During our inspection, we observed posters and leaflets in prominent areas around the surgical wards and areas which provided information on how to make a complaint. Details were also provided on the hospital website. Information was also provided on the Patient Relations Team whose role it was to support patients and relatives to raise concerns.

Complaints were managed by a divisional complaints manager and team. Input from ward managers and relevant staff was sought during the investigation stages to assist with fact finding around issues and events. We reviewed a sample of complaints and found that all complaints were acknowledged and responded to in the agreed timeframes and dealt with in an appropriate manner.

When complaints remained unresolved, complainants were advised about the opportunity to take their complaints to the Parliamentary and Health Service Ombudsman (PHSO) for review.

We saw evidence that complaints were shared with staff and learning opportunities were considered. We saw that there had been changes made following learning from complaints. For example where patients’ procedures were cancelled previously, attempts were made for patients to occupy earlier positions within the next theatre list to reduce the chances of further cancellation due to overruns. We saw that information about complaints was discussed at team and divisional meetings and that learning was shared.

From July 2016 to June 2017 there were 144 complaints about Surgical Care. The trust took an average of 33 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 25 days or 45 days for complex cases.

The top three subjects of complaints were:
- Treatment issues (73)
- Waiting times (21)
- Communication (16)

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)
Leadership

Managers we spoke with were skilled and knowledgeable and appeared very capable of leading the surgical division effectively. The senior management team in the division were very enthusiastic and keen to improve the quality and service provided. They told us that although they were relatively new as a group of managers, they had come together well to form a good team with excellent working relationships and dynamics. They felt empowered to take forward initiatives and had started implementing strategies to improve performance and effectiveness in the division.

On reviewing quality strategy improvement documents and speaking to managers it appeared that leaders were sighted on the challenges facing the surgical division. In particular, the managers in theatres had undertaken a lot of work in understanding the issues and had implemented an improvement strategy.

Staff on the wards and department told us they saw the senior divisional and trust managers regularly and that they were approachable. They told us that senior managers undertake walk arounds and spoke with staff on a regular basis. Staff also spoke highly of their ward and theatre managers stating they were supportive, effective and led by example.

Vision and strategy

The trust had a five year strategy in place entitled “2020 Vision; ‘Together We Can...’’. This echoed the trust strap line ‘together we care’. The trust had core values in place, those being excellence, people centred, compassion and positive. These themes were evident on literature and communications from the trust.

They also had a quality improvement strategy for the 2016-2020 period. This was entitled ‘leading change, adding value’. The vision was that care was ‘informed, timely and safe’. It was planned that this would be achieved through four quality and safety domains and through the adoption of 10 aspirational commitments. The aspirations and values of the trust were broadly understood by staff within the surgical division and on the whole staff had bought into the strategy and were positive about it.

The division had its own strategy which reflected the trust’s strategy. In the short term this mainly involved improving referral to treatment times, reducing cancelled operations, improving operating theatres efficiency, reducing medical outliers on surgical wards and recruiting satisfactory numbers of medical and nursing staff to the division. They also had plans to improve safety and quality and reduce patient harm.

Culture

In most areas we found there was a positive and supportive culture embedded within the surgical division. The majority of staff felt proud of the hospital and the care they delivered. Staff worked very hard to provide the best care they could deliver. Some staff felt frustrated at times due to the cancellations of operations, which they felt impacted heavily on patients.

Some staff did not like the practice of moving staff around wards and areas to even out staffing and cover. However they understood why this was the case.

The staff we spoke with stated their managers and leaders and colleagues were supportive of them and each other and this made for a better working environment.

Staff we spoke with stated they felt supported and encouraged to raise concerns and were confident that these would be listened to.

Governance
There was evidence of clinical governance procedures and quality measurement processes. These ensured risks were identified and escalated through different committees and steering groups.

Monthly surgical division governance, quality and safety meetings were held. At the meetings the group discussed items for inclusion on the divisional risk register, clinical audits, clinical effectiveness, serious incidents, patient experience and morbidity and mortality. There was evidence that there was sharing of information with and from other committees and groups and into the trust wide risk meetings. There were also divisional weekly meetings of harm to share information and learning in a timely way.

Staff told us they had regular team meetings in their wards and areas and that they were relatively well attended. We saw from minutes that they discussed issues such as safety issues, incidents, complaints, quality indicators and key messages were delivered. We saw that actions were identified and followed up appropriately.

Management of risk, issues and performance

The surgical division had a ‘risk register’ which highlighted areas of risk to the effective management of the service. Surgical division risks were also captured on the trust wide risk register. Surgical division risks included staffing on wards, the reduction in surgical beds, issues with older equipment and the risk of delays in treatment. Each item on the register was allocated to a department and responsible director stated. However, there were no follow up dates and dates for completion. We also found there were risks on the register that had been on there for long periods of time and it was not clear what actions had been implemented and how the risk levels had changed as a result. For example, there had been an item recorded on the register regarding the monitoring system in cardiac theatres; this had been on the register with a rating score of 20 since March 2015, but recorded when and what actions had been taken and what measures had been put in place to mitigate this risk.

Managers worked hard to understand the issues facing the division by undertaking intelligence gathering to ensure they could comprehend the factors influencing performance in order to better tackle the issues. Managers were effectively sighted on the issues within their division and were attempting to implement measures to deal with risks, issues and performance. They had recruited interim managers from external sources to theatres for them to implement a review and restructure of the department with a view to improving performance, quality and the experience of both staff and patients. A theatres quality and safety committee was established and regular meetings took place to oversee clinical performance, share patient experiences and ensure learning and improvement from incidents.

The division used performance indicators to measure performance. This included areas which required improvement as well as areas that were good. For example, number of falls and the number of infections. These were reviewed, examined and discussed at quality and safety meeting within the division and through the wider trust structures.

There was a documented major incident and business continuity policy in place and a strategy for dealing with major incidents and emergencies such as terrorist threats, flood, and fire or process management failures.

Information management

Managers told us that they had access to the information they needed to monitor performance. They said this provided assurance where things were going well and enabled them to focus their attention on areas for improvement. Information included performance in relation to quality as well as finance.
The division had in place a range of information around quality indicators from audits, performance dashboards, staffing figures, complaints and patient feedback and used this information to understand and respond to issues in the division.

Time critical and important information such as safety alerts, changes to guidance, actions from incidents and minutes of meetings were shared with staff through various means and key messages were displayed in staff areas to ensure messages were received and acted upon.

Theatres has introduced use of white board to assist with the safer surgery processes. This provided a focal point for staff to ensure the process was followed thoroughly and that all staff participated.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible via the trusts intranet facility. There were sufficient access to terminal in the surgical wards and departments.

Staff had access to patients’ records and diagnostic tests results to ensure they acted on them in a timely and appropriate way.

**Engagement**

Information on how the public could provide feedback to the surgical division was displayed in the surgical wards and corridors and in public areas. Leaflets and posters were displayed providing options on how to feedback experience to the hospital.

The hospital’s Patient Experience Department engaged with the public and fed this back to the hospital. They also promoted a ‘Tell Us’ campaign to seek feedback from patients and their relatives. There was a focus on using social media sources to engage with the public, partners and the local community. This system provided information about all services, but included messages from the surgical and scheduled care division regarding latest developments in the division and useful information for patients.

A wide range of information including policies and procedures, surgical and condition specific information was available via the trust website. ‘Admission to day surgery’, ‘Recovering from surgery’ and ‘What to expect from surgery’ publications were available on the website.

The surgery senior managers had informal sessions in the main foyer of the hospital where staff would approach them to raise issues, make suggestions or just have a chat.

The hospital had a ‘what are you proud of’ scheme where staff would state what they were proud of so this could be celebrated. Wards and theatres celebrated achievements on their wards such as staff successes and accomplishments.

Theatres had engaged staff in task and finish groups to ensure their voices and experiences were captured within new work streams and initiatives.

Surgical wards, theatres and departments had their own social media groups to facilitate the exchange of information within their own teams. Staff said this helped them to keep abreast of events, news and developments within their teams.

**Learning, continuous improvement and innovation**

The practice development nurses played a constructive role within the surgical wards, theatres and departments. Staff were very positive about their role and the supportive learning opportunities they provided. Staff on the cardiac surgery wards had developed practical scenario training to reinforce learning on certain topics such as choking and emergency responses.

Operating theatres managers described efforts to learn, improve and innovate. These included undertaking workforce and operational redesigns to help ensure that processes were effective and staffing models continued to meet patient needs.
The perfusionist team demonstrated innovation in developing a new bypass machine and working in collaboration with manufacturers to produce a clinician focussed state of the art piece of equipment.

Blackpool was one of the first units in the country to adopt a new safer spinal needle connector, in response to a safety alert. They published a report of their experience of this product to enable shared learning with other units.
Community health services

Community health services for adults

Facts and data about this service

Integrated care communities have been created to bring together local health and care organisations in Morecambe Bay.

Fylde and Wyre clinical commissioning group: District Nursing Services are being aligned into new enhanced primary care teams.

There is also a nurse led IV (intravenous) team providing a range of intravenous therapies to patients in a non-hospital setting across the Fylde coast Nursing and therapy services are aligned to neighbourhoods

The community brain injury rehabilitation service, podiatry and musculoskeletal services are commissioned by Morecambe Bay, Fylde & Wyre and Blackpool clinical commissioning groups. In the north locality the physiotherapy team are commissioned to provide triage clinics in GP practices.

Information about the sites, which offer services for adults at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location/site name</th>
<th>Team/ward/satellite name</th>
<th>Patient group</th>
<th>Number of clinics per month</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>162 sites</td>
<td>multiple</td>
<td>All locations mixed</td>
<td>Out of 30 applicable an average of 32 clinics per month</td>
<td>Morecambe Bay CCG and Blackpool, Fylde and Wyre CCG.</td>
</tr>
</tbody>
</table>

A summary of the different services and number of locations for each is shown below:

<table>
<thead>
<tr>
<th>Services</th>
<th>Number of locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>18</td>
</tr>
<tr>
<td>District Nursing Team</td>
<td>17</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>14</td>
</tr>
<tr>
<td>MSK</td>
<td>12</td>
</tr>
<tr>
<td>Community Nursing</td>
<td>12</td>
</tr>
<tr>
<td>District Nursing</td>
<td>11</td>
</tr>
<tr>
<td>Community Brain Injury Rehabilitation Service</td>
<td>10</td>
</tr>
<tr>
<td>Pulmonary Rehab and Heart Failure</td>
<td>9</td>
</tr>
<tr>
<td>Adult Continence</td>
<td>9</td>
</tr>
<tr>
<td>Care Home Support Team</td>
<td>8</td>
</tr>
<tr>
<td>Community Nutrition and Dietetics</td>
<td>6</td>
</tr>
<tr>
<td>Extensive Care</td>
<td>6</td>
</tr>
<tr>
<td>Early Supported Discharge</td>
<td>6</td>
</tr>
<tr>
<td>Heart Failure &amp; Arrhythmia</td>
<td>5</td>
</tr>
</tbody>
</table>
Diabetes Nursing 4
Rapid Response + 4
Community Matrons 2
REACT 2
Community Heart Failure/Arrythmia 2
End of Life Team 2
ESD Stroke Team 2
Parkinson’s Disease Nurse Specialist 1

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to staff. The trust set a target of 95% for completion of mandatory training and their overall training compliance was improving and was reported as 85% for the division in October 2017.

A breakdown of compliance for mandatory courses as of June 2017 for medical/dental and nursing staff in community services for adults is shown below:

Staff in North Lancashire told us at focus groups that it was not always easy to access mandatory training and that for some training they had to travel to Blackpool Victoria hospital; they also said that online training could sometimes be difficult to access due to slow computer systems. On inspection, the staff told us that following the focus groups, trainers had been brought in to deliver training, including mandatory training in the locality.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Number of eligible staff this year</th>
<th>Sum of Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>1078</td>
<td>827</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>1022</td>
<td>884</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>1228</td>
<td>1081</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>1228</td>
<td>936</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>1228</td>
<td>1117</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>990</td>
<td>932</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>1228</td>
<td>1068</td>
<td>97%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1228</td>
<td>1063</td>
<td>97%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>568</td>
<td>456</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and OCLS</td>
<td>1022</td>
<td>988</td>
<td>97%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>1060</td>
<td>971</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>932</td>
<td>771</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>1228</td>
<td>1093</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Recognise &amp; Act</td>
<td>48</td>
<td>22</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>1022</td>
<td>753</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>1228</td>
<td>942</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>1174</td>
<td>1080</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>54</td>
<td>40</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>0</td>
<td>0</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>1228</td>
<td>1104</td>
<td>95%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>439</td>
<td>371</td>
<td>96%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Safeguarding

Safeguarding referrals¹

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.

¹ (Provider Information Return; CHS v Final; Referrals)
Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community health services for adults made 1417 safeguarding referrals between July 2016 and June 2017 of which 838 concerned adults and 579 children.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff we spoke with were aware of the safeguarding policies and procedures and demonstrated an awareness of what to raise as a safeguarding concern.

Some teams, such as the rapid response and REACT and rapid plus teams, were also able to access systems within the local authority to identify if there were ongoing safeguarding concerns. This aided communication and working in partnership with other organisations to ensure patients were protected from abuse.

We saw that in a number of daily huddles, safeguarding incidents and issues were raised and discussed amongst the team. These discussions led to decisions being made about safeguarding for patients which were documented. Staff said that these processes were useful and were part of the supervision process.

<table>
<thead>
<tr>
<th>Referrals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>838</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>579</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total referrals</td>
<td>1417</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was no information on monthly or ward trends.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well.

Staff had access to infection prevention and control policies and we saw evidence these were implemented.

Staff washed their hands before and after removing dressings in patient’s homes and clinics. They disposed of clinical waste appropriately. Staff also used hand gel in patient’s homes.

We saw that staff used personal protection equipment in the clinics and on visits. Staff said that this was plentiful. Sharps boxes were available in patient’s homes and there were arrangements to collect clinical waste if necessary.

Staff told us that they completed environmental checks every three months on all the treatment rooms in their area and these were fed into the infection control team.
We saw that equipment in clinical areas was labelled with “I am clean” stickers. In patients homes equipment was cleaned with wipes after use.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

At the last inspection, the trust were in breach of regulation 10 (1) (b) Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (part 3) - the assessing and monitoring the quality of service provision. People were not protected against the risks associated with defective equipment because the systems for checking essential equipment were ineffective. The trust had put systems and processes in place to address this breach in the regulations.

We saw that equipment was being tested as required; staff were aware of the programme of checks which included the engineers attending community locations to test the equipment on site. Some staff spoke of delays in getting equipment repaired, although the engineering team explained this was sometimes due to the service contracts for specific equipment.

The rapid response team in North Lancashire said that there was a medical devices register and we saw that all equipment had been serviced and maintained in November 2017. They said that this was done every year and that there was an action plan for medical devices including the availability of devices and any training requirements for the devices.

There was a link member of staff for medical devices and community equipment who was a therapist.

Clinic environments were often shared with other services. They were maintained and fit for purpose.

**Assessing and responding to patient risk**

The service had effective systems and processes in place to assess and respond to patient risk.

Serious untoward incidents were discussed at most daily huddles we observed across all the community services; these were usually about pressure ulcers. The learning from these was fed back to the teams.

In the extensive care service, there was a daily huddle for patients at risk including those recently discharged from the hospital. There was also a review of any patients admitted to the hospital every morning. Patients had an emergency plan for support if their condition deteriorated, this included rescue packs for people with chronic obstructive airways disease which contained antibiotics and steroids. There was information at the patient’s home for any emergency services attending the patient that provided a baseline of clinical information for the patient which allowed emergency services to make an informed diagnosis about further treatment.

The community teams used patient clinical handover guidance and forms when they transferred care between teams for continuity of care.

We observed a telephone handover of nursing services from night staff to day staff, this included staff from hospice at home. Each locality operated the telephone handover twice a day at 7.30am and at 9.30pm. The teams from all the localities exchanged information about patients while prioritising those patients most at risk. This included information about all patients at end of life.
In the tier two physiotherapy service in North Lancashire, the staff responded to urgent referrals for patients with symptoms of cauda equina syndrome, a serious medical condition that requires urgent treatment.

There was an emergency phone so that GP’s could ring the diabetes specialist nurses for advice. The nurses said that it was well used.

The community matrons had access to the REACT team who coordinated services, such as the rapid response team, with the aim of avoiding hospital admission. There were also escalation plans and pathways in place for patients with chronic obstructive pulmonary disease.

We reviewed patients records and found risk assessments were completed which included pressure ulcer risk assessments and malnutrition universal screening tool (MUST) assessments.

**Staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Caseloads for the community teams had been calculated using methodologies that were consistent with best practice. There was one community specialist practitioner for every 10,000 population, a benchmark of a band five nurse undertaking an average of 10 visits per day, triangulation with nursing care indicators such as pressure ulcers and medication errors and clinical judgement. The nursing care indicator results were above 95%. There was an annual staffing report and a six monthly review. On a monthly basis, there was a divisional staffing report that was reviewed at the divisional board meeting that identified sickness levels, vacancies and other factors. Managers and staff were able to provide examples of where action plans had been put in place and staff had been moved to other areas to support safe staffing.

The Heads of Service across the service led a telephone dial in meeting with the locality teams every week which included a review of staffing across the localities.

The management team confirmed that there had been community matron vacancies, but these had been filled at the time of inspection.

Staff confirmed and we reviewed records that demonstrated that the caseloads were consistent with those planned.

We observed the handover arrangements in teams across the localities visited. The handovers were well attended and involved the wider multidisciplinary team, where they were working in neighbourhood teams. The quality of the handover varied with some demonstrating an understanding of the patient’s holistic needs. A record of decisions made at the handover was not always evident.

**Safer Staffing levels**

**Total numbers – Planned vs Actual**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Trust wide for adult community services, we were told by the trust that there were a total of 64.1 whole time equivalent staff less in place at the trust in March 2017 than the planned establishment of staff.
### Table: Staff Group Comparison

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Month (specify Date)</th>
<th>Planned Staff WTE</th>
<th>Actual Staff</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSULTANTS</td>
<td>Mar-17</td>
<td>8.75</td>
<td>5.32</td>
<td>60.8</td>
</tr>
<tr>
<td>DENTAL</td>
<td>Mar-17</td>
<td>17.41</td>
<td>14.68</td>
<td>84.3</td>
</tr>
<tr>
<td>JUNIOR MEDICAL</td>
<td>Mar-17</td>
<td>8.14</td>
<td>9.12</td>
<td>112.0</td>
</tr>
<tr>
<td>NON CLINICAL STAFF</td>
<td>Mar-17</td>
<td>219.64</td>
<td>223.81</td>
<td>101.8</td>
</tr>
<tr>
<td>NURSING &amp; MIDWIFERY</td>
<td>Mar-17</td>
<td>598.41</td>
<td>573.73</td>
<td>95.8</td>
</tr>
<tr>
<td>OTHER CLINICAL STAFF</td>
<td>Mar-17</td>
<td>31.58</td>
<td>42.82</td>
<td>135.5</td>
</tr>
<tr>
<td>SCIENTIFIC, THERAPEUTIC &amp; TECHNICAL</td>
<td>Mar-17</td>
<td>434.7</td>
<td>381.58</td>
<td>87.7</td>
</tr>
</tbody>
</table>

**Core service total**

|                      |          | 1309.88           | 1245.74      | 95.1       |

There were a total of 76.9 whole time equivalent staff less than the planned staffing establishment in place at the trust in June 2017. Five agency staffing groups had been used in June 2017.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Month (specify Date)</th>
<th>Planned Staff WTE</th>
<th>Actual Staff</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGENCY CONSULTANTS</td>
<td>Jun-17</td>
<td>0</td>
<td>0.96</td>
<td>0.96</td>
</tr>
<tr>
<td>AGENCY JUNIOR MEDICAL</td>
<td>Jun-17</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>AGENCY NON CLINICAL STAFF</td>
<td>Jun-17</td>
<td>0</td>
<td>2.42</td>
<td>2.42</td>
</tr>
<tr>
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<tr>
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<tr>
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**Core service total**

|                      |          | 1365.7            | 1288.8       | 76.9       |
Vacancies

- Between July 2016 and June 2017, the trust reported an overall vacancy rate of -7% in community services for adults. The trust had used agency staff to fill gaps left by vacancies. The trust had a vacancy target of 5.17%.

![Monthly Adult Community Service vacancy rates over the 12 month period](image)

Turnover

- Between July 2016 and June 2017, the trust reported an overall average turnover rate of 8.4% in community services for adults which did not exceed the trust's turnover target of 9%.

Sickness

- Between July 2017 and June 2016, the trust reported an overall average sickness rate of 4.8% in community services for adults which exceeded their internal sickness target of 4%.

Nursing – Bank and Agency Qualified nurses

The community services used an acuity tool for caseload planning. Managers used skill mix to address some of the gaps in staffing and they were developing the role of the band four nurses.

Managers in the enhanced primary care teams told us that in Blackpool they tried to use the trust bank staff at least once a week to maintain their competencies.

The trust was looking at different approaches to developing their own staff and had introduced nursing apprenticeships and a nursing associate's programme.

In Blackpool and Fylde and Wyre, there was acknowledgement that Friday afternoons were particularly busy with hospital discharges. Managers tried to put on extra staff to meet the demand and there was a dial in for all the teams to discuss workload, staff sickness and absence and the number of patients at end of life. Staff could be moved to different teams to meet the demands of the service.

- Between July 2016 and June 2017, the trust reported an overall bank and agency usage rate of 28.6% for qualified nursing staff.
### Nursing - Bank and Agency Healthcare Assistants

- Between July 2016 and June 2017 the trust reported an overall bank and agency usage rate of 15.2% for healthcare assistant staff.

#### Quality of records

Staff kept appropriate records of patients’ care and treatment.

There was a standard operating procedure for standardising clinical records and the documenting and recording of patient information. Staff used an electronic system for record keeping. In addition, there were patient held paper records that were kept in patient homes that were records of clinical observations. Staff completed electronic records when they returned from a visit as there were no appropriate mobile devices to access medical records in the community.

There was a holistic assessment form used by all groups of staff and specialist assessments for different teams and staff groups. This was completed for every patient. There was also a risk bundle and a malnutrition universal screening tool nutritional risk assessment, which was available electronically. The risk bundle contained a falls risk assessment, a bone health and osteoporosis risk assessment, a Waterlow score for risk of pressure ulcer and the nutritional needs of the patient. There was also an initial assessment for patients with wounds. The trust had worked with staff to refine the documentation and there had been a number of versions of the documentation before agreement on the final version. We saw that staff completed both electronic and paper records appropriately in most cases. We saw discrepancies between the written records and those held electronically in a couple of cases we viewed.

In the community, there were documentation audits for pressure ulcers that were completed monthly by the clinical governance teams and the information was displayed on a safety wall.
within the community nurse localities. Information on the walls was discussed at team meetings and cascaded to staff. Staff said the results of the documentation audits have improved since the implementation of the documentation standard operating procedure.

**Medicines**

The service prescribed, gave, recorded and stored medicines well.

There was a non-medical prescribing lead at the trust and the divisional lead provided training and annual refreshers. A prescribing formula was available for district nursing and there was a process in place to review anything that needed to be prescribed by exception.

We saw at south shore primary care centre that medicines were stored appropriately. Fridges were checked daily and fridge temperatures and room temperatures were recorded and were in range. All storage cupboards were locked as was the medicines storage room. There were cool bags available for the transport of vaccines of site.

In the intravenous team, we saw that there was good practice in the checking, recording, and storage of medicines for treatment. We saw that there were good facilities and space for the staff to work to prepare medicines for infusion.

The care home team included a part-time pharmacist who supported the team and reviewed individual patients.

**Safety performance**

**Safety Thermometer**

Staff collected safety information and used information to improve the service.

The community teams monitored nursing care indicators, which were consistent with the safety thermometer indicators. These were reported in the divisional governance report. The teams were achieving 95% against these indicators.

The tissue viability team were an organisation wide resource which supported adult community services. They were involved in the safety thermometer initiative. The tissue viability team investigated high areas of incident reporting for pressure ulcers for follow up with targeted training. The tissue viability team did not however complete a prevalence audit of pressure ulceration.

**Incident reporting, learning and improvement**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There was an electronic incident reporting system. Staff we spoke with said that they were confident and able to use the system. Staff said that they received individual feedback if they raised an incident and there was feedback about incidents at safety huddles and at staff meetings. Managers described incidents where lessons were learned from incidents and practices had changed. The health and wellbeing staff were being trained in incident reporting as they were sometimes the first contact for patients.
Incidents were investigated appropriately. A weekly incident report was shared at team level to enable lessons to be learned. A monthly divisional review of performance included information about incidents. This included near misses and those linked to a care or nursing homes. This report enabled themes and trends to be identified. All serious incident reports were also considered at the trust’s divisional governance and quality committee. The monthly divisional review of performance also included information about any national safety alerts.

Pressure ulcers were the most reported incident within the community. Grade one pressure ulcers were reported on the incident reporting system and then investigated locally. Grade three and four pressure ulcers were investigated by root cause analysis (RCA), with the RCA tool added to the incident as a mandatory element before closure of the incident. Grade two pressure ulcers in the community will, from January 2018 follow the same process as the grade three and four.

In the community some pressure ulcer grades were validated by a review of photographs by the tissue viability nurses (TVN). We were told that sometimes the grading of pressure ulcers was left to staff in the community. Clinical supervision sessions with high reporting teams occurred to ensure the validation of grade of pressure ulcers was correct.

As pressure ulcers were reported on the incident reporting system, the TV team checked the incident reporting system each morning (Monday to Friday) to learn about new pressure ulcers. All grade three and four pressure ulcer incident reports were accompanied by a tissue viability referral. The TV team were then able to see patient. The incident grade was then confirmed and a decision was made if the ulceration was attributable to a clinical area and the assistant director of nursing was then informed of the new pressure ulcer. The TV team then requested a timeline of events leading up to the new pressure ulcer occurring and following this, the incident was investigated and the root cause analysis (RCA) was completed. The RCA’s were discussed at a panel every two weeks.

**Serious Incidents - STEIS**

- Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

- In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in community services (this may include other community services however further information is available within the analysis) which met the reporting criteria, set by NHS England between April 2016 and June 2017. Of these, the most common type of incident reported was pressure ulcer meeting SI criteria with 90% of all incidents.

**Serious Incidents (SIRI) – Trust data**

- Between July 2016 and June 2017 trust staff in this core service reported two serious incidents.

- Of these, none involved the unexpected death of a patient.

- The two types of incident were treatment/delay meeting SI criteria and apparent/actual/suspected self-inflicted harm meeting SI criteria.
• The number of the most severe incidents recorded by the trust incident reporting system not comparable with that reported to Strategic Executive Information System (STEIS). This gives us less confidence in the validity of the data.

Prevention of Future Death Reports

• The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Patient’s had their needs holistically assessed using a number of evidence-based assessment tools. For example, teams used the patient activation measure (PAM) which is a validated, commercially licenced tool, promoted by NHS England, to help measure the spectrum of skills, knowledge and confidence in patients and the extent to which people feel engaged and confident in taking care of their condition.

The divisional governance team were responsible for the dissemination of National Institute for Health and Care Excellence (NICE) guidance. A template was disseminated and completed by appropriate services when guidance had been implemented. There was a timeframe for implementation of guidance into clinical practice. The relevant NICE guidance was recorded at the divisional monthly governance health safety and risk committee.

Pathways of care were in use; these were based on guidance from NICE and other appropriate organisations. There were also escalation plans in place so patients with, for example, chronic obstructive pulmonary disease (COPD), knew when to seek further help.

The trust had a formulary for dressings from which they expected nurses to select an appropriate dressing for their patient. The tissue viability team reviewed prescription data and where there were any dressings prescribed outside of the standard formulary the tissue viability team approached the prescribers and requested further information.

Nutrition and hydration

Patients had their nutritional needs assessed appropriately.

We saw that as part of the assessment, the extensive care team and community nursing teams completed the malnutrition universal screening tool. Diet was discussed with patients and, if necessary, patients were referred to a dietitian. Patients were given a malnutrition sheet that gave advice on how to increase calorie intake, where this was appropriate. There were link nurses for nutrition and hydration.

During a visit to a patient, we saw that the nurse discussed appetite with a patient as their partner said that they had lost their appetite since their stay in hospital.
Pain relief

Patient's pain was assessed and managed appropriately.

We saw that patient's pain was assessed and recorded and the services used the Abbey pain scale; this is suitable for patients who have poor cognitive function and dementia.

On a visit to a patient’s home, we saw that the nurse checked the patient’s pain levels and discussed analgesia with the patient.

Some of the patients referred to the tier two physiotherapy service were for assessment and management of non-resolving lower back pain. Patients were triaged and assessed and a treatment plan was developed for patients which could sometimes involve a referral to secondary care services. The service could also give steroid injections to help to address patient’s pain. We saw that staff had worked with patients at end of life to relieve their pain to enable them to perform everyday tasks.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

There was a programme of clinical audits, which were monitored at the monthly divisional performance meeting. At the October 2017 meeting, there were 17 clinical audits recorded across the division which included those relevant to community adults’ services. These included preventing falls in older people, medical device audit, medicines management audit of adults with long term conditions at community health centres and clinics, therapy indicators, a notes audit of a musculoskeletal physiotherapy service against NICE guidelines, a MUST audit and a records audit of podiatry against NICE guidelines.

The report included progress against the action plans following the audits. Most relevant audits were on target, with the exception of the audit of pressure ulcer management in adults with long term conditions; there was no recorded action on how this was being addressed.

The service monitored key nursing care indicators, such as falls, nutrition and pressure ulcer assessments. These were reported and reviewed on a monthly basis at divisional board and the divisional performance review with the organisations executive team. Trends over the previous months were considered: district nursing had achieved 97% compliance between April and September 2017.

The extensive care team demonstrated a 20% reduction in unplanned urgent care attendances for patients who were part of their cohort. For patients with five or more unscheduled admissions, the numbers of admissions had reduced, but for patients with five or less admissions, the numbers had stayed the same.

The team used the validated patient activation measure (PAM) to monitor the outcomes for patients regarding their skills, knowledge and confidence and the extent to which people felt engaged and confident in taking care of their condition. The team said that they had seen positive changes in patient activation scores meaning that patients understood their long term conditions better and changes they could make to positively affect their long term conditions. There was also better awareness for patients about why they were taking medicines and better compliance with medicines.
Patients in the extensive care team had a comprehensive medical review every three months and, by the advanced practitioner, every six weeks. Staff monitored patient’s ongoing condition and, if their condition had improved, patients were stepped down to the enhanced primary care team or their treatment was reviewed if they had deteriorated.

Some patients in the extensive care team had been selected for a research programme with a nearby university. This was aimed at patients with heart failure and chronic obstructive airways disease (COPD). The patients were given tele health equipment, so they could monitor their condition and they were also given a computer so that they could feed their results in for a review by a doctor. If their condition deteriorated actions were put in place to try to prevent further deterioration. The patients also had their activation scores taken so that they understood how they could make changes to positively affect the management of their long term condition. Staff said that there were positive outcomes from the project which was still underway. Patients were offered training in digital technology to support them with the project.

Patients had detailed personal care plans that were regularly updated. These were stored electronically as part of the patient record.

**Audits – changes to working practices**

- The trust has participated in one clinical audit in relation to this core service as part of their Clinical Audit Programme.

<table>
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<th>Objective</th>
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<td>Preventing falls in older people CO1604</td>
<td>All patients have a full falls risk bundle completed. Falling leaves to be placed at high risk patients bedsides. Ensure all staff have completed falls workbook to be knowledgeable in clinical practice</td>
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**Competent staff**

The service made sure staff were competent for their roles.

The organisation had supported on occasion the use of budget underspends for specific training programmes. This had supplemented the training funding already available within the organisation. A range of training was available for nursing and therapy staff.

The trust had introduced a trainee nursing associate role to support the qualified nursing staff. Staff were multi skilled and there was a crossover of roles. Staff were trained in the cross prescribing of equipment. The technical instructors could also take blood if necessary which saved health professionals making duplicate visits to patients homes.

There was a leg ulcer link support group for the nurses who had done the leg ulcer training. One of the nurses had developed a range of practical information and best practice guidance to share with colleagues and with student nurses.

In the intravenous team across the Fylde coast there were clear pathways for the different grades of staff in the team with appropriate completed competency assessments. Most of the staff were non –medical prescribers and the band five staff were about to undertake their training. The team were also working with the clinical improvement team to develop a training package for district nurses.
There was a divisional clinical improvement team who supported staff across the whole division that could support training including mandatory training. There was a programme of training for staff at band five to seven that was delivered locally. Training included intravenous therapy, and training for chronic obstructive airways disease. There was also one to one training if staff had competency issues. External training courses that had been completed by staff included nurse prescribing and assessment and diagnosis of patients.

Staff in the rapid response team (RRT) in North Lancashire said that there were link nurses who covered a number of areas including tissue viability, palliative care and some were disease specific covering Parkinson’s disease and dementia. They attended meetings and fed information back to their teams. In the RRT in Blackpool, Fylde and Wyre staff had received training on clinical skills and assessment and standard observations. There were also staff available in musculoskeletal assessment, abdominal assessment, respiratory assessment end of life assessment diabetes and mental health assessment.

There was a student information board in the rapid response team office in North Lancashire for all students. At the time of the inspection, there were two student nurses and an occupational therapy student with the team. All the qualified staff were trained as mentors to support the students and other staff.

Following a regulation 28 report from the coroner (this is a prevention of future death report issued by the coroner) following the death of a patient the trust had implemented a number of measures to reduce the risk of a similar incident happening again.

Training in tissue viability was introduced and the tissue viability (TVN) nurses said that there were half day training sessions on a rolling programme. A dedicated skills lab for training was available, although training programmes could be also run in all clinical locations. The current training programme included pressure ulcer prevention, wound assessment and dressing selection. The training was tailored to meet the needs of the staff and skill mix of staff attending.

Some of the training the TVNs delivered was accredited by the University of Central Lancashire. This course was entitled principles and practice of tissue viability. This course was accessed by registered nurses and associate practitioners. The course was bespoke and delivered to the requirements of the trust. Since the start of the course, around 80 participants had attended the course from both acute and community services. Following completion of the course attendees were then encouraged to be tissue viability link workers in their clinical areas. The course lasted for six days over a three month time period. Participants were assessed by an exam and an assignment.

The clinical improvement team also delivered targeted clinical training to staff in tissue viability and delivered competency based training in application of compression bandages to preceptorship nurses starting in the community.

A tissue viability nurse told us that a lot of their training was ad-hoc and that they delivered it when and where they could, but that they also learned from clinical incidents. Training had recently been rolled out to non-nursing health care professionals as there was an identified gap in some staff’s skills in tissue viability. The occupational therapy teams were now being trained in tissue viability.

A tissue viability nurse said that hospital and community initiatives were shared and that there was a shared link nurse forum. They said that they ran four shared link nurse forums per year.

**Clinical Supervision**
Staff felt supported, although it was recognised there was more work to do to fully embed the trust’s clinical supervision policy.

The trust’s clinical supervision policy specified a commitment to professional staff receiving a minimum of one hour of recorded supervision per year. Staff accessed one hour recorded face to face clinical supervision per year. The divisional team had set the standard of two recorded face to face clinical supervision sessions per year, but recognised a lack of recorded evidence. Work had been undertaken to improve this, with the development of a monitoring matrix for the division, staff booklets and a plan to audit progress in January to March 2018.

Staff felt they received supervision through various routes, for example, matrons attended a monthly matrons meeting and staff, particularly new starters, had one to one sessions with their managers.

In the extensive care team, there was group supervision and any incidents were reviewed and discussed by the team. The diabetes team members said that they received clinical supervision every week and that they spoke with the other team members every day. They said that they kept up to date with new treatment regimens and treatment innovations.

Appraisals for permanent medical and non-medical staff

Appraisals were completed by October each year. Staff we spoke with confirmed the appraisals process. Compliance at 9 October 2017 showed 84.7% appraisals were completed across the division, 6.52% were in progress and 8.7% were not started. Managers were being sent a list of those not started and in progress to review for accuracy.

- Between April 2017 and July 2017 10% of all staff within the community services for adults core service had received an appraisal. The trust did not provide an internal target.

- Between April 2016 and September 2016 78% of all staff within the community services for adults core service had received an appraisal. The trust did not provide an internal target.

*There is no staff group split for appraisals so the total includes sexual health for adults.

Multidisciplinary working and coordinated care pathways

Staff worked together as a team to benefit patients.

In the extensive care teams, staff said that there was excellent multidisciplinary team working with all services in the trust including mental health. Both of the rapid response teams had multidisciplinary working in place with nurses, therapists, technical instructors and social workers. Staff described truly integrated working with patients receiving the right care from the most appropriate member of the team.

There were social workers in the Blackpool neighbourhood teams. Where the neighbourhood teams in Fylde and Wyre were not fully in place, we saw good coordination and communication between different professionals.
In the tier two physiotherapy service, staff described excellent multidisciplinary working with primary care, secondary care and radiologists in the triage, assessment, care and treatment of patients referred to the service.

In North Lancashire, there was effective multi-disciplinary team working between the therapists in the REACT team in the hospital, the RRT and the community therapy teams, so that patients were followed up for two weeks following discharge from RRT and REACT.

**Health promotion**

Patients were supported to live healthier lives. The service was aware of the health of the population and working to improve this.

There were health and wellbeing workers who worked across community services to help people to manage their long-term conditions and to act as an advocate for patients. They could signpost patients to a range of community activities including smoking cessation and weight management. Patients could also access pulmonary rehabilitation services, if appropriate for the stage of their condition.

Patients with long-term conditions, such as chronic obstructive pulmonary disease, were supported by matrons to maximise independence and manage their own health and well-being.

We saw that all teams had been active in administering the flu vaccination and the pneumonia vaccination to appropriate patients including patients in care homes and in their own homes.

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

Staff demonstrated they understood and applied the relevant consent and decision-making guidance including the Mental Capacity Act 2015.

Assessment records included prompts regarding mental capacity and verbal consent was recorded at each visit.

Staff were able to give examples of when mental capacity had been considered and acted upon appropriately. This included best interests meetings and situations where capacity fluctuated. Staff could access and received support from the mental capacity act lead at the trust.

Staff told us that they attended best interests meetings for patients in the community. Staff in Blackpool said that at the time of the inspection they had nobody on their caseload with a Deprivation of Liberty Safeguards.

In North Lancashire, staff said that they would risk assess all patients for mental capacity and any issues could be escalated to the community safeguarding team. There was a social worker in the REACT team to support staff in their decision making. They said that they would work with friends and relatives of patients to look at the best interests of patients and they described processes for gaining consent for individual tasks which were part of the patient’s care.

We saw that during patient visits staff obtained consent for treatment and for taking photographs of wounds.

**Deprivation of Liberty Safeguards**
• The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority July 2016 and June 2017 of which were pertinent to community health services for adults.

Is the service caring?

Compassionate care

We saw that staff treated patients with compassion and respected their privacy and dignity. Staff were kind to patients and demonstrated they knew patients individually, particularly those who regularly used the services. We observed staff put patients at their ease and enquired about patient’s mental well-being.

We saw in the intravenous service in Blackpool that patients were treated with compassion. One of the patients we spoke with who received intravenous medicines twice a day told us how good the service was and described it as a lovely team. They had wished to attend a family occasion and staff had arranged treatment in another area of the country so that they could attend.

The rapid response team in Blackpool and Fylde and Wyre told us how they had looked after patient’s pets when they had gone into hospital as the patients would not go into hospital otherwise. They also gave examples of how they had supported patients with cognitive impairment in crisis situations until relatives could be with them.

We heard examples of staff going the extra mile for their patients. For example, when a patient had not attended a routine clinic as expected, the nurse had contacted them, identified there were unexpected care needs that the patient was unable to address themselves and had actively liaised with other agencies to ensure that the patient was seen appropriately. The care needs were entirely unrelated to the reason they were attending the clinic.

The division recorded and reported compliments. In September 2017, there were 254 compliments received although the managers felt this was an under-representation. We looked at thank you cards displayed in community clinics. These contained positive comments such as “especially grateful for the friendly way phone calls were received – never a suggestion that we were a nuisance” and “thank each and every one of you so much for the way you have cared for me and listened to my problems and helped me so much.”

Emotional support

There were effective systems in place to provide emotional support for patients.

Health and wellbeing workers were employed to support older people who were lonely. This was seen to have wider health benefits for these patients.

Patients spoke positively about the emotional support provided. A patient attending for treatment said that staff were supportive as their needs were now palliative.

Some of the staff in the rapid response team in Blackpool, Fylde and Wyre were trained in cognitive behavioural therapy. This is a talking therapy that can help patients to manage their problems by changing the way they think and behave. It is used to treat anxiety and depression and staff said that they used it as many of their patients with long term conditions suffered from symptoms of anxiety and depression.
Patients in the extensive care team could be referred for counselling and a mental health nurse sometimes joined the multi-disciplinary team meeting to support the staff in their decision-making.

We saw that in other community nursing teams, a mental health nurse and the health and well-being workers attended handover meeting and the community nurses referred patients to these staff in a timely manner to ensure the emotional needs of the patients were being supported.

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

Staff involved patients and those close to them in decisions about their care and treatment.

We saw examples of patient’s understanding being checked and them being offered options of treatment or additional support.

At a handover of care meeting, we saw staff were concerned about the health and wellbeing of one of their patients who was not looking after themselves and was raising some safeguarding issues. They agreed a plan to speak with the patient and their relative about their concerns and possible options. A referral was also made to a voluntary sector agency for support for the patient.

Carers of patients with long term conditions had plans that showed how they were managing and there was support for carers from the health and wellbeing staff and the voluntary sector.

During a visit to a patient’s house, we saw that the nurse spoke with the carer to ask about their health and well-being.

The health and wellbeing workers had received training in advanced communication skills.

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**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The trust planned and provided services in a way that met the needs of local people. There were a number of different initiatives across the service. Variations in the localities were due to different commissioning arrangements.

There was a Vanguard site, which was a multi-speciality community model, that provided acute and community services. This was the extensive care service and it provided co-ordinated and integrated care for patients with at least two or more complex conditions across the community. Patients were referred into the service by their GP’s and once they had been accepted into the service were lifted from primary care. A consultant geriatrician was the medical lead for the service and was supported by additional medical staff some of which had a general practice background. Other members of the team included nurses with advanced clinical investigation skills, advanced practitioners, pharmacists and health and wellbeing workers. Patients had a comprehensive holistic medical assessment including medicines usage and hospital attendances; there was also a wellbeing assessment. Following a multi-disciplinary meeting, patients were given a care plan to follow in their own homes.

A significant amount of work was carried out with National Health Service Improvement (NHSI) using the workforce and productivity tool. This looked at the skills of the community matrons and how the skills could be used to best advantage and not to duplicate with the extensive care team.

Patients completed a patient activation measure and the scoring from the patient activation measure describes the knowledge, skills and confidence a person has in managing their own
health and care. Evidence from NHS England shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. The score allowed health professionals to target services and resources appropriately.

There was an enhanced primary care service to provide co-ordinated and integrated care for patients with one complex condition across 10 neighbourhoods in the Blackpool and Fylde and Wyre clinical commissioning group areas. This service was provided by an integrated team including the GP and practice nurses, community matrons, district nurses, rehabilitation therapists, health and wellbeing support workers, care co-ordinators and mental health and social care staff. Many of the patients referred into the service did not engage with their long term condition, were socially isolated and had frequent attendances at their doctors or hospital admissions. Many were supported by a carer. The roll out of this service was staggered and not all teams were delivering the complete service model. Managers said that they had consulted and worked with teams around the transition to this new model of care.

There was joint multi-disciplinary team working between the extensive care team and the enhanced primary care teams to look at the needs of the patients and how they could step up or down between the services.

In the enhanced primary care service, the initial patient assessment was carried out by a nurse or a therapist most appropriate to meet the patient’s needs. Occupational therapists and physiotherapists worked closely together and the health care assistants had training in therapy skills. There was cross prescribing of equipment between different therapists so that there were reduced numbers of hand offs between staff and patients. All staff were trained to order basic equipment for patients.

There was an intravenous service across the Fylde coast that ran 8am to 8pm every day. The service had been set up by the rapid response team led by a microbiologist, but had evolved into a nurse led service. Some of the nurses were non–medical prescribers and they said that this had enabled them to treat more patients. The team was supported by a dedicated pharmacist to support the administration of antibiotics and patients also received a range of medicines and blood products as appropriate. There was also provision to visit patients at home and the service could undertake ten domiciliary visits every day. There were plans to expand the service to include treatment for pregnant women for hyperemesis. Patients told us that they liked the service as it meant they did not have to go into hospital for treatment. Referrals to the team were from both primary and secondary care.

Patients attending the intravenous service complained that there were no refreshments available on site. They said that nurses would make them a drink, but that they would like to be able to purchase food as sometimes they were there for several hours.

Staff told us that they had developed a shared care model of care for the leg ulcer service; this had positive results with improvements seen in healing rates.

In North Lancashire, integrated care communities were in place. They were based on a similar model to the enhanced primary care teams. Referrals to services were through a single point of access. This meant that referrals could be triaged to the most appropriate service to meet the needs of the patients.

In North Lancashire the rapid response team (RRT) worked to support patients in the community to try to prevent admission to hospital and to support discharge. They worked with the REACT team who were based in the local hospital. This service was developed to assess people to prevent avoidable admission to hospital and to help people to leave hospital within 48 hours.
following admission if appropriate. The teams worked closely together and there was a single point of access to both services through the REACT team. The skill mix was similar on both teams though there was no occupational therapist (OT) on the RRT; staff on the RRT said that the OT’s would support them if necessary. There was a social worker on the REACT team to support discharge for patients. The teams could assess health, social care and therapy needs for patients. They had a stock of equipment at the clinic including walking frames and pressure relieving mattresses and they could supply complex equipment for patients to support them at home.

The RRT could deliver intravenous therapy if necessary for patients. This could be done in a patient’s home or in a clinic on the same day as the referral if necessary. This prevented patients’ admission to hospital.

There was an RRT for Blackpool and Fylde and Wyre. There were 38 staff including nurses, physiotherapists, occupational therapists, technical instructors and social workers. The service ran from 8am to 8pm seven days a week. The purpose of the service was to avoid hospital admittance and to facilitate early discharge. Staff were cross referrers for equipment so that all members of the team could prescribe certain items of equipment and they could have appropriate equipment to support carers and family into a patient’s home within the day. They could have a hoist in a patient’s home in four hours if necessary. The service could put carers in a patient’s home to support a patient for 14 days in Blackpool and Fylde and Wyre and three days in North Lancashire. This provided personal care, meal preparation and respite if necessary. The service would pick up referrals for end of life care at weekend before they were transferred to the hospice at home service.

In Blackpool and Fylde and Wyre, there was a care home team that supported a number of residential care homes. There was also a care home team in North Lancashire. There was a focus on long term condition management and the team worked with district nurses, GP’s and allied health professionals to support people in homes. The team reviewed all residents of the homes and worked with staff from the homes and relatives of the residents to educate them in the management of the long term condition of the residents.

In North Lancashire, a nurse led intermediate care unit had recently opened eight beds. The opening of beds was being staggered as a number of staff from the rapid response team and the community nursing team were applying for posts at the unit and the manager said that they needed to assure staffing in all services before they could open all of the 24 beds.

There was a tier two physiotherapy service for musculoskeletal patients in North Lancashire, which provided a service closer to home for patients. Patients had their needs assessed by an extended scope practitioner and a treatment plan was developed for the patient. The service could access scanning and other diagnostic testing including nerve conduction studies and had been commissioned to reduce referrals to hospitals. Patients were offered a range of treatments and sometimes were referred into secondary care for further treatment. Some patients needed services at a specialist centre and staff worked with the surgeons at the specialist centre to work up patients in preparation for treatment at the centre which was some distance away. Patients did not have to travel to the specialist centre until their treatment date.

There was a community diabetes service for the trust. The service worked alongside acute physicians from the hospital and GP’s in community with clinics, domiciliary care and out-patient appointments. There were three diabetes specialist nurses who supported the service. This included an ante-natal service. There was a dose adjustment for normal eating group (DAFNE) for patients which met weekly. This is a way of managing type one diabetes for adults and provides the skills necessary to manage insulin and carbohydrate intake. This empowered patients to take
control of their diabetes. We saw that a patient was receiving treatment for a new device, the nurse went through the information pack and that the patient was given information leaflets and contact numbers. Staff said that the key focus of the service was education for all stakeholders including staff and patients, patient choice and patients being empowered to take responsibility for their own care.

In the tissue viability service, we were told that the tissue viability team took one to two weeks to get to routine referrals though they could see patients quicker depending on the urgency of the referral. The community nursing teams were in the process of implementing a wound care passport to allow further integration of wound care across differing healthcare settings.

Patients with long term conditions could be referred to improving access to psychological therapies (IAPT). This service provided psychological therapies to people with anxiety disorders and depression.

There was a pulmonary rehabilitation programme for patients with chronic obstructive airways disease (COPD). This was run by a nurse, a physiotherapist and an occupational therapist. The course covered inhaler technique, diet, exercise. It was run at local venues, once a week for 12 weeks and patients we spoke with said that it had been helpful. They were also supplied with a book called “my breathing book”.

Following issues with discharge of patients from ward 11 at Blackpool Victoria Hospital, one of the nurses from community had gone to the ward to work with staff on the quality of the referrals.

Staff had access to translation services and demonstrated they used these appropriately.

**Meeting the needs of people in vulnerable circumstances**

The service took account of patients’ individual needs.

Patients had an “about me” plan that was completed by the patients supported by a health and wellbeing worker. It was a comprehensive document with some medical detail, but mainly focused on the patient. There were sections about religion and what was important to the patient and also “my story” the patient’s history, jobs, music, family etc. There were sections about patient’s friends and relatives and about their routines and things that worried them. There was also a section on power of attorney and if appropriate, the patient’s choices about end of life care. At the end of the plan was a progress chart, so that patients could work to develop goals in their lives and to record their progress in the achievement of these goals.

There was an integrated learning disability team which was a partnership between health and the local council to support patients in the Blackpool locality. The organisations worked collaboratively and the trust patient experience and involvement lead and the team manager of the Fylde and Wyre learning disability team had developed guidelines for the trust staff about how to support people with a learning disability in hospital and in the community.

Staff said that they used advocacy services and carers to support patients.

The patient experience and involvement lead, the lead learning disability nurse and representatives from a local mental health trust had developed learning disability guidelines for patients who accessed services. They had developed a learning disability internal webpage and an e-learning package to support staff training and development.

Patients were given files to keep at home which contained information about their long term condition including their medicines. There was advice on how to use medicines and information relevant to their long term condition. We saw that there was information about breathing control exercises for a patient with COPD.
Staff described how they had accessed translation services for a patient. The trust had collated a database of members of staff who could speak different languages and these staff could be used as interpreters for patients.

**Access to the right care at the right time**

Patients had timely access to services. There were no waiting lists for district nursing service. The teams prioritised their work every day and responded to the patients according to clinical need or a specified date or instruction detailed on a discharge form. The district nursing teams revisited their work and reprioritised at least three times a day at shift change. The nurses carried mobile phones so that changes to patient’s needs were communicated in a timely way to enable staff out on visits to respond to any changes.

There were different arrangement to access care across the geographical areas with a hub staffed by a matron operating in some areas and an electronic referral process in other areas. This did not appear to affect the responsiveness of the service.

Referrals to the extensive care service and enhanced primary care services were received by telephone and electronically at the hub and triaged by qualified staff allocated patients to the most appropriate service for their care needs.

A daily multidisciplinary discussion was held to agree response times for the community nursing service and identify who was best placed to respond to urgent issues. The management team stated there had been no reported incidents or complaints; there was no commissioning requirement to monitor response times. Referral to treatment times were monitored for services including physiotherapy, dietetics, foot and ankle services, and access to mental health services. There were high numbers of patients waiting longer than the 18 week standard in some areas, most notably foot and ankle services in Fylde and Wyre where 143 patients were waiting longer than 18 weeks. These patients had received an initial assessment for treatment but the service received high numbers of referrals and theatre sessions were limited.

Patients who accessed the tier two physiotherapy service could be seen in one to two days if urgent and one to two weeks if not urgent with a maximum wait of two to three weeks. Patients could be assessed and treated on their first visit to the service and staff gave examples of this.

**Accessibility**

- The 2011 Census showed that white British people were the majority of the population in the area covered by the trust. According to the Census 93.6% of the population of Blackpool Unitary Authority (UA), and 89.7% of the population of Lancashire (excluding UAs) identified as white English, Welsh, Scottish, Northern Irish or British.

- According to the Census the largest ethnic minority groups in these two local authorities were as follows:

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White – other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Mixed/multiple ethnic group - White</td>
</tr>
</tbody>
</table>
and Black Caribbean

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian/Asian British - Pakistani 3.1%</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – other 1.9%</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British - Indian 1.6%</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>White - Irish 0.6%</td>
</tr>
</tbody>
</table>

Lancashire (excluding UAs)

<table>
<thead>
<tr>
<th>Service type</th>
<th>Median Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>438</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>191.5</td>
</tr>
<tr>
<td>Therapies</td>
<td>186</td>
</tr>
<tr>
<td>Mental Health</td>
<td>23</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>0</td>
</tr>
</tbody>
</table>

Referrals

- This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
- The information the trust provided us with covering the period July 2016 to June 2017 indicates that there is no target or national target for days from referral to initial assessment, and the trust have a referral wait time of 838.5 days across 55 services.
- Below is a table of the various service types and the total number of days from referral to initial assessment.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

There were low numbers of complaints regarding the community adults service. There had been seven complaints between April and September 2017. These related to different services. Data regarding complaints was discussed at the monthly divisional board, divisional governance, quality and risk committee, and divisional performance review with the trusts executive team.

This enabled the sharing of lessons learnt and any action plans arising from complaints.

Patients were aware of how to make a complaint. Staff in North Lancashire described a complaint from a patient and how it had been resolved. Staff had apologised to the patient and the issue had been resolved.
Managers in Blackpool and Fylde and Wyre told us about a number of complaints that they had received and lessons learned from the complaints. They also told us about a verbal complaint and additional training that had been put in place for staff following the complaint.

Staff said that they always submitted verbal compliments to the governance team. The trust received 1369 compliments between July 2016 and June 2017 which related to community services for adults.

**Is the service well-led?**

**Leadership**

The services had managers with the right skills and abilities to run a service providing high-quality sustainable care.

The division was led by a triumvirate of a divisional director, clinical director and associate director of nursing. They were supported by a quality manager.

The leadership team demonstrated an understanding of the challenges to quality and sustainability and had taken action to address these.

Managers said that senior managers at divisional level were very supportive. Staff, including those working remotely, felt connected to other teams, and to the organisations as a whole. They were aware of their local and divisional leadership as well as senior directors in the organisation.

In North Lancashire, senior managers said that it was sometimes difficult to work for one organisation, but provide services for another organisation. They said that there was sometimes duplication.

Staff in North Lancashire told us that local leadership was visible and that they received good support.

A tissue viability nurse told us that they had good management support and that their manager trusted them and was interested in the service. They said that skin care was everyone’s business.

**Vision and strategy**

There was no documented strategy for adult community services; however they were part of the adults and long term conditions division across the trust. There was a strategy for adult long term conditions and the division’s objectives, vision and values were aligned to the organisational strategy and other local strategies.

The leadership team stated that the trust’s overall strategy was followed. The management team could articulate a clear sense of direction for the services provided, including the move to neighbourhood care teams. The division responded to different commissioners to meet the needs of the local population.

The trust were working within the local economy to become an accountable care organisation.

The trust had a clear set of values; these were people-centred, positive, compassion and excellence. Staff confirmed these were integral to their work and used as part of the appraisal process.
Staff we spoke with described how there were a number of additional nursing teams, such as the rapid response team, care home team, extensive support teams. Although these teams were viewed positively, some staff in the community nursing teams felt there was a lack of clarity about roles, functions, pathways and referral criteria. They were keen to ensure that opportunities for their patients were not lost.

Staff within the community adult services had contributed to the trusts nursing and midwifery strategy.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff at focus groups told us that there was good team working and that they had been doing some team building. They said that there had been an influx of new and younger staff that had made a positive difference to teams.

Staff across the services reported they felt supported, respected and valued. For example, the diabetes team said that they were enthusiastic and proud of the service that the team offered across the trust. Staff in the intravenous team in Blackpool said that there was a positive, supportive culture in the team. Administration staff in the division said that they were well supported and that the team was a good team to work in.

Staff in North Lancashire described a culture of continuous improvement. They said that staff survey had showed that there was a lack of communication between managers and staff, but this had been resolved and there was better communication with the teams. Staff in the tier two physiotherapy service said that the administration staff in the department could not do enough for patients and ‘bent over backwards’ to accommodate them. They said that the staff were excellent.

There was a focus on helping patients to continue in their own homes, where possible. For example, one team said that their vision was to keep people safe and support patients to stay at home.

Measures were taken to protect the safety of staff. The lone working policy was implemented. Staff had mobile phones for personal safety. Some staff also had lone worker devices so that conversations could be monitored via the device and assistance provided if necessary. Staff were required to ring in following evening visits. Managers said that the system worked as a member of staff had forgotten to ring in and the manager on call had been notified.

**Governance**

There was a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

The services were part of the adults and long-term conditions division. There were senior leadership team meetings every two weeks and these alternated with the divisional board meetings. There was a set agenda and the meetings had increased in frequency to allow full discussion of all agenda items. The divisional board meetings informed the divisional report that went to the trust’s executive team.

There were community divisional meetings which involved the heads of the localities, their deputies and the improvement leads. Managers said that there was a consistency of approach
across localities. Following the divisional meetings there were team leader meetings which included feedback from the community divisional meetings and operational issues including new guidance and a patient story.

The extensive care team had monthly team meetings to cascade information to their own teams and to other teams in the trust.

Managers told us that the clinical improvement team were very supportive and helpful. They identified areas of concern and then supported managers and staff to address these areas. An example of this was if a patient was about to exceed the 18 week wait for treatment, analysts in the team could identify these patients so that care and treatment could be initiated.

In the North Lancashire locality there were monthly meetings between the integrated care teams and the local GPs. Staff said that the meetings were useful and that the GP’s were proactive.

In Fylde and Wyre, there were monthly meetings between managers and band five staff. This followed feedback from this staff group that managers only came to see them when something went wrong.

To provide assurance around the Duty of Candour process, the divisional governance team completed a weekly check of all incidents reported within the division to identify those that may require the Duty of Candour process to be followed. Teams were contacted and provided with advice and support to complete this.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a divisional risk register, which was reviewed at the monthly divisional performance review meeting, divisional board and the governance committee. The risks on the risk register matched those identified as part of the inspection process. Senior managers and staff demonstrated a knowledge of the key risks.

One of the issues of concern for managers was the maintenance of medical devices and equipment, but this had improved to 76% compliance and there was a consistent approach to monitoring and maintenance of equipment. One of the advantages of the improved service was that everybody used the same equipment which made staff training easier.

Managers across community services said that staffing of services was a risk. Retention of staff rather than recruitment was more of an issue. Nurses left to take up practice nurse posts or posts in the extensive care team or in the new intermediate care service. These senior posts did not require the district nurse qualification and so were attractive for development for staff who did not want to or who were unable to undertake the district nurse qualification.

There was a systematic approach to clinical audit with the audits, including the progress of action plans, being monitored on the performance report.

Key indicators were regularly monitored and triangulated to identify any risks to services.

**Information management**

The service collected, analysed, managed and used information well to support all its activities.

There was a comprehensive monthly performance report that was integrated patient’s views with information on quality, operations and finances.
We saw evidence that data quality was questioned and tested, for example, in relation to referral to treatment times.

There was good access to patient records and staff could access records from the G.P,s, with some services having access to social care and urgent care records as well as the community services. This supported patients to access timely care. The extensive care service could access patient records in urgent care and so could track patients through the service. Staff told us that the ability to view records from different services was invaluable in the delivery of care and prevented duplication of services.

There was limited access to information technology systems in the community. This resulted in community staff documenting records in patient’s homes and then returning to their base to update electronic records. There were also issues with connectivity in the rural areas.

The staff in the rapid response team in North Lancashire described an incident that was a breach of information governance. Following the incident senior staff applied the duty of candour and changed practice so that records were more secure. All staff also attended information governance training.

We saw that staff locked their computers when they moved away from them and that records were stored securely in lockable cabinets where appropriate.

Engagement

The division engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations.

The divisional staff engagement score was reported in October 2017 as being slightly improved and was the highest divisional score across the trust.

The divisional performance report included information and trends for friends and family tests, complaints and compliments alongside other indicators. There was evidence this information was reviewed and acted upon.

The leadership team described how there had been engagement with the public with, for example, the extensive care team. They also described the trusts influence panels, where patients and the public advice on particular issues or themes.

The community services were working with voluntary sector organisations to look at assets in the community that could be accessed by patients with support from the health and wellbeing workers. In North Lancashire, a voluntary sector agency for older people collected referrals from community services three times a week. There was also support for carers through the voluntary sector.

There had been staff consultation about the transition to neighbourhood working and the workforce redesign that supported this.

The management team undertook quality assurance visits and, for the last two years, managers with clinical qualifications had undertaken a clinical visit every six weeks. Patient stories and their experiences were feedback at the divisional board meetings.

Staff spoke positively about the seven minute briefing document circulated within the trust. This was designed to keep staff briefed on key issues.

Learning, continuous improvement and innovation
The division was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The division was supported by a quality manager; this post was well-respected in the division. This meant that quality improvement was driven across the services.

Some patients under the care of the extensive care team had been selected for a research programme with a nearby university.

We saw evidence of improvement made to services as the result of complaints and incidents.
Community health services for children, young people and families

Facts and data about this service

The 0-19 years community health service consists of health visiting and school nursing teams who are working together to promote the health and well-being of families, children and young people.

The Fylde coast is pivotal in developing the neighbourhood model which has incorporated new models of working across the local health economy to deliver high quality care affordably. The increased development of integrated working and feedback from families is supporting improvements in patient care.

All children, young people and their families receive the healthy child programme universally proportionate to need.

The service encourages healthy lifestyles, addressing concerns about physical and mental wellbeing, as well as readdressing health inequalities. The priority for the service is delivering key public health measures around the six high impact areas.

The service aims to work in partnership with families and with other local providers of services for families in collaboration with schools, GPs, youth services and many other community services and is delivered in the family home, school or a community venue.

In Blackpool, close working relationships have been developed with Better start and Head start partners.

The service is offered on four levels, according to need; the universal core offer for every child and family, universal plus which is time limited interventions to support a specific need within the family, universal partnership plus where the identified need requires support from other agencies and safeguarding where a child or family is identified at risk of harm which necessitates multi agency working with social care and other agencies.

(Source – Community RPIR – Context CHS tab)

Blackpool Teaching Hospitals NHS Foundation trust has 291 recorded locations which offer a number of different services for children, young people and families.

A summary of the different services and number of locations for each is shown below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>School nursing &amp; immunisation</td>
<td>198</td>
</tr>
<tr>
<td>Health visiting</td>
<td>33</td>
</tr>
<tr>
<td>Children's speech &amp; language therapy</td>
<td>24</td>
</tr>
<tr>
<td>Special needs nursing/specialist health visiting and child development</td>
<td>8</td>
</tr>
<tr>
<td>Children's hearing &amp; audiology</td>
<td>7</td>
</tr>
<tr>
<td>Children's OT and physio</td>
<td>7</td>
</tr>
<tr>
<td>Children's continence</td>
<td>5</td>
</tr>
<tr>
<td>TB services</td>
<td>1</td>
</tr>
<tr>
<td>Family nurse partnership</td>
<td>1</td>
</tr>
<tr>
<td>Paediatric outreach</td>
<td>1</td>
</tr>
</tbody>
</table>
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. We found approximately 84-85% compliance against an internal trust target of 95%.

Staff have failed to meet the trust target year to date for all of the mandatory training modules.

A breakdown of compliance for mandatory courses as of June 2017 for all staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff this year</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>310</td>
<td>259</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>306</td>
<td>270</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>362</td>
<td>308</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>362</td>
<td>269</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>362</td>
<td>306</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>346</td>
<td>294</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>362</td>
<td>294</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>362</td>
<td>326</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>181</td>
<td>147</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>301</td>
<td>254</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>308</td>
<td>271</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>274</td>
<td>243</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>362</td>
<td>319</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>326</td>
<td>224</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>362</td>
<td>275</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>50</td>
<td>43</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>30</td>
<td>27</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>282</td>
<td>257</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>362</td>
<td>315</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>169</td>
<td>140</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Figures provided by the service following inspection showed some variation in the completions rates, but the overall compliance rate was similar at 85%. The more recent figures showed that compliance with resuscitation training had increased to 81%.

New starters at the trust completed a one day induction course which consisted of generic training such as fire safety. A local induction followed this, where staff were shown the service specific protocols. This was coordinated with a two week plan to attend clinics; this was partly supernumerary dependent on the individual’s experience.
There was a policy for sepsis management, however staff we spoke with were not aware of it and had not undertaken sepsis training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There was a large, central multidisciplinary safeguarding team in place at the hospital trust and safeguarding policies which outlined roles and responsibilities at all levels.

Safeguarding training was mandatory for all staff at the level set out in the intercollegiate document, safeguarding children and young people: roles and competences for health care staff. Most staff in the service had completed safeguarding children level three training. Female genital mutilation training had been recently introduced and was to be mandatory in future.

Standalone training about child sexual exploitation was targeted at relevant teams including school nurses. Other staff received training about child sexual exploitation as part of the level 3 safeguarding children training.

The trust had dedicated co-located child sexual exploitation teams for each area, which staff could contact directly for advice and guidance. Audits were in place and showed high levels of attendance by health professionals at safeguarding conferences and core group meetings. Staff had regular safeguarding supervision, usually three monthly.

Staff we spoke with were aware of the Lancashire Risk Sensible Framework For Multi Agency partners which was designed to support staff in understanding how underlying and high risk factors may be identified, and support practitioners to target referrals appropriately. Staff gave examples of safeguarding cases they had raised, and were aware of particular safeguarding issues in the local area.

There were partnerships with Blackpool Safeguarding Children Board and Lancashire Safeguarding Children Board, both of which had strategies in place to promote Working Together to Safeguard Children (2015).

Where there was a safeguarding concern a pop-up box opened an alert on the electronic patient record so that all professionals accessing those notes were aware.

There was an alert on the electronic patient records system for looked after children. Looked after children were seen more frequently by health visitors and underwent a comprehensive assessment every six months up to the age of five and then yearly up to the age of 18. An alert automatically flagged on the records system when the assessment was due. The assessments had to reflect the voice of the child, as well as the professional. They included a history of the child’s health, vaccinations, presentation, referrals to other services and dental appointments.

If the child was with their parents they would meet with health visitors every four to six weeks. If the child was with foster parents, meetings would be arranged in line with the child’s needs and the experience of the foster family.
Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children’s services, adult services or the police should take place.

The trust was unable to provide the appropriate data and this will need to be requested during the inspection as part of standardised requests.

Cleanliness, infection control and hygiene

Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The clinics we visited were visibly clean and tidy, and we observed staff displaying good hand hygiene practice between contacts with babies. Equipment, including weighing scales, was cleaned after use and between patients.

A health visitor explained they took precautions to prevent the spread of infection, for example staff made separate appointments for babies known to have a potentially infectious condition.

Health visitors carried personal infection control packs with them when conducting home visits and they cleaned equipment, for example a portable baby-weighing machine, before using it. We saw staff using personal protective equipment such as gloves and aprons where appropriate.

In some areas there were up to date cleaning checklists in place for toys, scales and height charts. We saw completed cleaning checklists in place for soft mats and equipment in a sensory room. Clinical equipment was cleaned after every clinic and in between each use. We observed this taking place.

However, cleaning logs were not in use in all areas. In one clinic room where toys were being used, staff told us they were cleaned on an ad hoc basis, but this was not recorded. Toys were sometimes shared between teams, but staff did not consistently record which items had been moved or whether they had been cleaned before being returned. This meant that there was an increase in the risk of spreading infections.

The service provided us with information from hand hygiene audits for the families division for the last 12 months. However, these were primarily children, young people and family services within the hospital. The community children’s hearing service was included within the adult and long term conditions data once in 2017 and once in 2016. On both occasions they were 100% compliant with hand hygiene audit standards.

The universal children’s service had developed an action plan in November 2017, to increase the level of auditing for hand hygiene. This included an action for annual hand hygiene audits of all staff to be undertaken by the hand hygiene champions.

Whilst children’s services had an up to date Infection Prevention and Control Policy, they had not met their target for completion of mandatory training in this area.

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2 Universal RPIR – Safeguarding referrals tab
Public toilets were clean and contained signs reminding parents and children about hand hygiene and good infection control practice.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

We found the premises we visited were equipped to be safe and appropriate for purpose, with child friendly furnishings and decorations. The child development centre at Whitegate Centre had a well-equipped sensory room. Waiting areas had toys available for children and there were slam guards on door hinges. We observed staff explaining to visitors that hot drinks were not allowed in areas with children and babies.

Documentation showed that equipment was maintained and ready for use; weighing scales had been calibrated and safety tested, medicine fridges had been serviced and calibrated data loggers continually tracked fridge temperatures. There were clear guidelines about the action staff should take if a fridge temperature went outside of the target range.

We saw completed and up to date weekly checklists, for example battery replacement, for equipment such as ophthalmoscopes and auroscopes. Blood pressure machines and oxygen saturation monitors were charged weekly.

**Assessing and responding to patient risk**

The service had systems in place to respond to patient risk. There was a health records policy which detailed how to request a new alert or attention warning marker description to be added onto the electronic health record and we saw these in place.

There were different processes in different locations for accessing medical attention for a child who was unwell. Staff were aware of the protocol for managing medical emergencies at Whitegate Centre, and showed us the emergency flow charts that were clearly visible in clinic areas. These set out the process for requesting urgent medical assistance from the GP services on another floor of the building where oxygen and defibrillators were available.

The paediatric integrated community service team worked with children with long term, complex health needs with a focus on preventing admission to hospital. As part of the Empowering Families programme they also worked with ‘frequent attenders’ who visited their GP or open access frequently, but with conditions that were not necessarily complex. These families stayed on the caseload for around six months.

There was a policy for sepsis management, however staff we spoke with were not aware of it.

**Staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There was a ‘cross patch’ paediatric integrated community service team which covered Blackpool, Lancaster, Fylde and Wyre. This included four specialist health visitors, one based in Lancaster and three in Blackpool.
The Lancaster area paediatric integrated community service team also included three whole time equivalent community children’s nurses and a nurse from the local hospital working one day a week in the community team. There were 4.5 whole time equivalent nurses in the special schools.

In Blackpool the paediatric integrated community service team also included two lead nurses for continuing care, an outreach clinical lead, two outreach nurses (one band five and one band six) and four special schools' nurses. There was also a rotational nurse who worked two days in the community and one day in the hospital.

The family nurse partnership consisted of five nurses (4.8 whole time equivalent) plus a supervisor and an administrator.

Health visitors held fortnightly and ad hoc team meetings where they discussed their caseloads. In Morecambe, the health visitors each had caseloads of approximately 200, with around five looked after children. This was in line with the Community Practitioners and Health Visitors Association (CPHVA) recommendation in The Best Start: The Future of Children’s Health (Royal College of Nursing, 2017) report that an optimum average caseload for safe and effective practice is 250.

Another health visiting team we met in the Blackpool area reported similar caseload numbers.

The health visitors had a weighting tool which calculated acuity and complexity, with consideration for factors such as whether or not the case was: a child in need (as defined under the Children Act 1989); in need of child protection; a looked after child; subject to a common assessment framework or team around the family; or a child subject to a Section 47 (Children Act, 1989) assessment by social workers.

The tool allowed the team to allocate new cases, including antenatal appointments, births, and transfers in, equitably.

School nurses caseloads varied from area to area. One team were allocated one secondary school and three primary schools to oversee. Another team had one high school and six primary schools each on their caseload.

A physiotherapy team we spoke with reported caseloads of between 60 and 70. They used a weighting tool to facilitate a balanced caseload between the team and said their caseloads felt manageable.

There were informal arrangements in place for staff to cover each other in different areas, or provide support from acute areas if significant staffing problems arose, for example due to sickness or adverse weather causing more absence than usual.

**Total numbers – Planned vs Actual**

Information provided by the service showed that staffing levels were 103% compared with establishment figures, when numbers for child and adolescent mental health services, which are reported on separately, were removed.

**Vacancies**

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3 Universal RPIR – Total staffing tab
4 Universal RPIR – Vacancy tab
Between July 2016 and June 2017 the trust reported an average vacancy rate of 1.9% in community services for children, young people and families. This was better than the trust’s overall target vacancy rate of 5.17%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Average annual vacancies (%) (Jul 16 - Jun 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; midwifery registered</td>
<td>6.1%</td>
</tr>
<tr>
<td>Healthcare assistant</td>
<td>2.6%</td>
</tr>
<tr>
<td>Other</td>
<td>0.8%</td>
</tr>
<tr>
<td>Allied health professional</td>
<td>7.1%</td>
</tr>
<tr>
<td>Core service total</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

There had been three serious case reviews in the past twelve months. There was an action plan detailing recommendations and direct actions related to the families division. Key themes from all other learning points will be shared in safeguarding supervision and mandatory training in 2018.

**Serious Incidents - STEIS⁵**

Trusts are required to report serious incidents to Strategic Executive Information System. These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in community services for children, young people and families, which met the reporting criteria, set by NHS England between, April 2016 and May 2017.

**Serious Incidents (SIRI) – Trust data⁶**

Between July 2016 and June 2017, trust staff in community services for children, young people and families reported no serious incidents.

The families division were working to adopt the new trust serious incident processes to facilitate better learning across the trust and close the knowledge gap across the divisions. There was a new process in place to appoint an investigating officer and case manager from outside the division to lead the serious incident process, where appropriate. Where there were concerns that an external review would not capture all of the relevant information, this was discussed at the monthly divisional risk governance group. We saw evidence of this in the meeting minutes from October 2017.

**Is the service effective?**

**Evidence-based care and treatment**

The health visiting teams monitored and recorded their performance for delivering the Healthy Child Programme effectively. The universal programme included five mandated contacts with families starting when a woman was at least 28 weeks pregnant. The four further visits were when the child was aged one day to two weeks, six to eight weeks, nine to 15 months and 24 to 30 months. In Blackpool, the universal model also included a three to four month development visit (to include mood assessment).

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⁵ STEIS
⁶ Universal RPIR – incidents tab
Performance figures provided by the service for three of the quarters (ie nine months) in 2016-2017 showed that new birth visits were completed within 14 days for 85% (86% in one quarter) of cases. Most of the rest were completed after 14 days and reasons were recorded for these; for example the mother or baby was in hospital, parent choice or availability and cancellations. The remaining three percent were mostly either completed out of area or not recorded correctly.

There was similar analysis for all the mandated visits with the majority of visits having taken place, and reasons provided when they had not. However, none met the key performance indicator threshold of 95%.

Once a child had started school, the health visiting service transferred care to the school nursing teams. These teams provided health promotion and advice within school to all school aged children and continued to work with families who required additional support in times of difficulties.

The school nurses Healthy Child Programme included a health needs assessment at ages four to five, ages 10 to 11, 12 to 13 and after 16 years for school leavers. There would also be a health needs assessment for those transitioning to adult services. School nurses also worked with the continence service and delivered the vaccination and immunisation programmes.

These services were monitored and recorded on the performance dashboards.

Audit results from October 2017 for the baby friendly initiative standards (UNICEF, UK) showed all of the new birth visit standards for breastfeeding had exceeded the target of 80%, with several scoring 100%.

Antenatal visit standards for breastfeeding were below the target and there were actions in place to address this, for example, information for discussion with parents was to be sent to staff and scheduled for discussion at the next infant feeding meeting. Similarly, actions were in place to address the standards that did not meet the 80% target in the follow-up questions.

For bottle feeding standards, several areas missed the target. At the new birth visit there were gaps in knowledge around formula milk and this was to be discussed at the next infant feeding meeting with possible solutions such as prompts on the electronic care records.

We reviewed an action tracker from the North Lancashire health visitor team infant feeding meeting. There were actions to try and improve compliance with the baby friendly initiative standards, for example the infant feeding team were to start attending well baby clinics to support engagement with hard to reach groups.

Nutrition and hydration

We reviewed 11 patient records and saw evidence of assessment of nutritional status in ten of them. In the eleventh set of notes it was documented there were no concerns around nutritional status.

Pain relief

Of the 11 patient records we reviewed most did not require pain assessments however there was a pain assessment and management plan documented in one set of notes where it was applicable.
Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them.

The service recorded their key performance indicators and these were submitted to the local clinical commissioning group for performance monitoring. Outcomes were discussed at the monthly families management team meetings and comparisons to national benchmarking data were reviewed. Improvement options were considered and recorded in the minutes.

We saw action plans in place where remedial work was underway to improve outcomes. For example, there were actions in place to address a low uptake of year 10 vaccinations in one area. Plans were being implemented to deliver bespoke training to the immunisation and vaccination clinical team on Fraser guidelines competence in order to increase staff confidence in taking informed self-consent from young people for their vaccinations.

In Blackpool 64.5% of young mums initiated breastfeeding after their babies were born. This figure was higher than the average family nurse partnership rate across England of 57.4% and slightly higher than the total Blackpool population initiation rate of 61.6% (Blackpool Child Health profile, 2016). However, breastfeeding continuation rates fell sharply soon after delivery to just 10.9% at six weeks.

There were plans in place to address this, including a focus on breastfeeding for the Accelerated Design and Rapid Programme Testing, detailed below in the Responsive section of the report.

Therapists completed therapy outcome measures for specific conditions which were recorded on the electronic patient record system. These enabled staff to monitor the outcomes of the services they provided.

The therapy outcome measures fed into the special educational needs and school reviews so that therapy could be worked into a child’s educational daily routine where possible. We saw therapy outcome measures for paediatric speech and language therapy, physiotherapy and occupational therapy in the north and south localities.

There were 247 therapy outcome measures completed in the north locality and 1851 completed in the south locality for speech and language therapy between May and October, 2017. The outcomes measured changes in impairment, activity, participation and child distress and wellbeing. They showed that overall the speech and language had a positive impact on the children reviewed during the time period, with most of the children either improving or maintaining in all areas. There were minimal areas of decline and these were attributed to the nature of the children’s conditions.

There were 165 therapy outcome measures completed in the north locality and 179 completed in the south locality for physiotherapy between May and October, 2017. For occupational therapy there were 258 therapy outcome measures completed in the north locality and 70 completed in the south locality during the same period. All showed largely positive outcomes.

The Empowering Families pilot was a multi-organisational initiative whereby professionals worked with a particular group of children identified by their GPs to reduce hospital admissions and GP attendances. There was multidisciplinary input from health and social care and data was collected to monitor the impact of the interventions.
Results showed that the families involved in the pilot had 31% less hospital admissions per month following working with the programme. There was a 10% reduction in overall admissions following the pilot.

**Audits – changes to working practices**

The service undertook a number of audits including safeguarding and record keeping (paper records). They also audited waiting lists and monitored other performance targets.

The trust have recorded no clinical audits in relation to community services for children, young people and families which they have participated in as part of their Clinical Audit Programme.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Information provided by the service showed that 93% of eligible staff within the community children, young people and families division had completed their appraisals. The remainder were either in progress or had not yet started.

Appraisals were generally carried out between April and August each year. Staff could access their appraisal and mandatory training system online.

There were competency frameworks in place, for example a non-medical prescribing framework including evidence logs, reflection and appraisal by a supervisor.

Health visitors told us they had competency training annually, as a minimum, aligned with their appraisals. Most of the health visitors were non-medical prescribers.

Staff in the paediatric integrated community service told us that all their specialist and community nurses had completed paediatric intermediate life support training.

Staff in all areas reported good supervision systems in place. These varied across the different teams. One school nursing team had clinical supervision every four to six weeks and described it as very supportive. They also had group supervision for additional support, and safeguarding supervision every three months. Other teams had similar arrangements in place.

After two years in post the school nurses completed a child protection supervision course which enabled them to become clinical supervisors.

**Appraisals for permanent non-medical staff**

This information is routinely requested within the provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for this core service and this will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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7 Universal RPIR – Audits tab
8 Universal RPIR – Appraisals tab
Appraisals for permanent medical staff

This information is routinely requested within the provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for this core service and this will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Nurses, doctors, health visitors and allied healthcare professionals supported each other to provide good care.

Community services for children, young people and families were integrated with acute services and facilitated clinics in the community led by consultants from the hospital. Referrals to the consultants could be made by a GP, school nurse or health visitor. The majority of community referrals were for behavioural issues for which the service would treat the child and family as a whole where possible.

Referrals to therapy services were made on the electronic patient record system by a doctor, paediatrician or allied health professional.

There were pathways in place however these varied across the different geographical areas as services were commissioned by different clinical commissioning groups and different local authorities. For example, in the Blackpool continence service the initial level one assessments could be undertaken by school nurses and health visitors, with a referral to level two to the continence team if the problem remained unresolved. However, in Wyre and Fylde the service was commissioned differently and some of the level two interventions could be undertaken before referring to the continence team.

In Morecambe and Lancaster, there was no commissioned continence service in the community so children in those areas were seen by their GPs or a paediatrician at the hospital.

Several teams gave examples of their multidisciplinary working, for example the continence team coordinated with drop-ins facilitated by the school nurses so that a child did not have to be absent from school for an appointment. This also meant their privacy and dignity was maintained as the drop-in was run by the school nurse and was not obviously a continence appointment.

The continence service liaised with and received support from the child and adolescent mental health services team around social issues and emotional health linked to continence.

The targeted children’s services, which included the paediatric integrated community service team and some therapy teams, were integrated with the acute service which benefitted both areas in a number of ways. It facilitated close working between the paediatric integrated community service team and the therapy teams. It helped with the skill mix, for example the smaller community teams were able to get support from nurses from the ward if necessary when someone was off sick.

The integration enabled ward staff to be involved in the medical devices and resuscitation training in the residential special schools where the children had complex requirements. Likewise,
specialist health visitors were able to in-reach into the acute setting and provide training and development for the ward staff to support the complex children.

However, services were again structured differently in the different geographical areas, for example in Blackpool the speech and language therapy team was part of the universal service, however in Lancaster it was part of the targeted services.

There was close working between the therapy teams, school nurses and community nurses. Therapy teams worked into the special schools when appropriate and dealt with issues regarding specialist equipment during the school holidays. During term time pupils at the special schools were seen by the school nurses, but their care was handed over to community nurses during school holidays.

The service used a tool based on the Ready Steady Go programme developed in reference to the NICE guidance NG43, ‘Transition from children’s to adults’ services for young people using health or social care services’. This was first introduced when a child was 14, in order to get them used to the idea of moving up to adult services.

In therapy services, they had worked with the adult teams to develop a therapy transition document for each individual patient due to transition to an adult therapist and they underwent a three step process. A year before transition was due a meeting was held to assess which adult service would meet the person’s needs. Four months beforehand the therapy transition document was completed and at the age of 18 the patient was discharged ready for transition to adult services.

The therapy transition document provided a summary of the person’s condition and treatment to facilitate information sharing and prevent delays or information being lost if the young person had no adult service identified at the point of discharge or was moving to another area.

Health promotion

The community children’s nurses and specialist health visitors were part of a paediatric integrated community service working with children and young people to support their additional health needs in home or at school. They had bases in the community across Blackpool, Fylde, Wyre, Lancaster and Morecambe. There was no single point of access.

The paediatric integrated community service team took referrals for palliative care, frequent attenders at hospital or the GP, from tertiary centres (children’s hospitals out of area), surgery follow-ups, oncology and from the wards, for example for intravenous antibiotics. Staff told us they had loosened their referral criteria to try and stop anyone from ‘falling through the gap’ if they did not meet the criteria.

The team also offered an informal ‘second on call’ service with the local hospice for paediatric end of life care patients. The team linked in with the Rainbow Trust, an organisation providing emotional and practical support to families who have a child with a life threatening or terminal illness.

There were four specialist health visitors who worked across two child development centres. They provided assessment and ongoing monitoring through episodes of care for families of pre-school children, as well as episodes of support for the multidisciplinary team. They also provided episodes of development, for example research projects and sitting on panels as specialist advisors.
The specialist health visitors provided an additional service to the universal service, but did not hold their own caseloads. There were clear criteria for their referral process and they provided in-reach support to the hospital as well as going into nurseries or clinics where appropriate.

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

Consent for treatment was obtained for children and young people who were under 16 with their involvement and was documented in the records we reviewed.

We observed staff talking with children attending the clinic and explaining to them in appropriate language what is happening and asking their views. Consent to be seen by health visitors was gained at the first ante-natal appointment and then presumed to be current unless withdrawn. We saw consent documented in the electronic patient records.

There was close working with the community adolescent mental health service (CAMHS) team which was based in the same building as some of the community services for children, young people and families teams. There was joint working between both services in the child and adolescent support and help enhanced response team.

Bespoke training was being developed for the vaccination and immunisation clinical team on Fraser guidelines and Gillick competence in order to increase staff confidence in taking informed self-consent from young people for their vaccinations.

**Deprivation of Liberty Safeguards**¹⁰

The trust reported that no deprivation of liberty safeguard applications were made to the local authority between July 2016 and June 2017 that were pertinent to community services for children, young people and families.

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**Is the service caring?**

**Compassionate care**

Staff treated children of all ages with dignity, respect and compassion. The friends and family test results from 2016-2017 were not disaggregated for this service specifically, however the children’s services and community services both achieved high scores (96% and 98% respectively) from respondents who would recommend the service.

Baby clinics were held in a variety of locations, some with waiting areas in the same room. Private areas were available if parents needed a private discussion.

We saw health visitors treating mothers with kindness and compassion. During one community visit we observed a health visitor helping a mother complete forms; the health visitor showed awareness of the mother’s health conditions and provided guidance.
Health visitors and school nurses were sensitive to the needs of families from different backgrounds and cultures, including travelling families. Staff explained how they were holding more clinics within the school environment to access the more hard to reach children.

**Emotional support**

Staff provided emotional support to children and their families depending on their need. The child and adolescent support and help enhanced response team provided emotional support for young people in the area. This was a service delivered jointly with child and adolescent mental health services and provided a drop-in facility.

The parents we spoke with were very happy with the support given to them by health visiting staff. The parents explained that they didn’t feel rushed during appointments and staff were approachable and gave good advice, including about sleeping.

There were various leaflets displayed in the baby clinics providing advice and support, for example mother and baby groups, breast and bottle feeding, and swimming lessons. One parent spoke about how they had had three health visitors in the three months since the birth of their child which meant that information had to be repeated. However, she had found the health visitors very supportive.

The service completed a school vaccination survey in June 2017 which showed that children thought staff administering vaccinations were friendly and reassuring. Children who required additional support were given stress balls during the injections to try and distract them and make the experience easier.

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

There was a focus on involving children in service development via several different processes. The service had agreed to a charter of promises which staff worked towards to improve the patient experience. The promises were written by a group of young people who were part of Victoria’s Voice, the trust’s youth forum and included statements such as, ‘we will talk to you in a way that you understand’ and ‘we will reassure you and make sure you know what is happening and why’. Interactions we observed between staff and children were caring and appropriate and met the promises set out in the charter.

There was a paediatric patient experience officer for child health in post who helped organise some of the Victoria’s Voice initiatives. The day prior to inspection had been ‘Takeover Day’ when children were invited to take over a role in children’s services and feedback their views. The Takeover Challenge was launched in 2007 by the Children’s Commissioner’s Office.

We saw some of the comments made by the children who attended a session delivered by the community children’s speech and language therapy team. The children were very positive and had learned about how people living with communication disabilities are supported by the team and the specialist equipment. Staff used the feedback from these sessions to help shape services.

There were other initiatives in place such as the Leapfrog project which looks at how the service can better use the children’s input.
Friends and family questionnaires in children’s areas used pictures of happy and sad faces instead of words or numbers for responses so that younger children could participate in providing feedback.

Is the service responsive?

Planning and delivering services which meet people’s needs

In March 2015, the Fylde coast was selected by NHS England as a vanguard site to test new ways of organising and delivering healthcare for local people. This meant that health and care organisations on the Fylde coast, including clinical commissioning groups, NHS hospitals and local councils, were looking at new ways to organise local services by introducing ‘new models of care’. These new models of care referred to the way in which healthcare services were arranged, provided and accessed.

School nursing and health visiting were contracted to Blackpool Teaching Hospitals NHS Foundation Trust by two local authorities. An agreement had been reached with one local authority, however the contract with the other local authority was under review with a decision due in December, 2017. This meant it was an anxious time for staff in Fylde and Wyre, and Lancaster, as they waited to find out whether proposed financial cuts would impact on their jobs.

The community health services for children, young people and families were part of the wider Families Division which incorporated acute and community services in one division.

The service had a 0-19 years pathway, so their involvement with a young person began in the antenatal period and usually lasted up to 19 years of age. It could last until the age of 25 years where appropriate, for example where the patient had a special educational need or disability.

Health visitors provided a universal health visiting service, which carried out the five mandated contacts with families starting when a woman was at least 28 weeks pregnant. The four further visits were when the child was aged one day to two weeks, six to eight weeks, nine to 15 months and 24 to 30 months. In Blackpool, the universal model also included a three to four month development visit (to include mood assessment).

There was a universal plus service for children with additional needs, such as safeguarding or mental health problems within the family and these families had more contacts with health visitors. These were set out in the enhanced health visiting model 2017-18 report for the Blackpool Health and Wellbeing Board.

The integration of services meant that transition from maternity to health visiting to school nursing was designed to be seamless because all of the teams were sitting in a hub. Medical support was provided by consultants who crossed over between the acute and community services.

We saw evidence of multi-disciplinary and multi-agency working with clinics and appointments being organised to best accommodate families’ needs. For example, there was a well-baby clinic every weekday at different locations across the Fylde coast. At Great Eccleston Health Centre the well-baby clinic was held weekly as a drop-in but babies’ eight week checks and vaccination appointments were scheduled at the same time which allowed a ‘one stop shop’ for parents.

Interpreters were available to staff when required via a small group of trust staff trained in interpreting or through a contracted telephone interpreting service, if a patient or carer’s first language was not English. Where patients required sign language interpreters, face to face sign
language interpreters could be booked to assist communication for patients or carers who were deaf or who had British Sign Language as their first or main language.

**Meeting the needs of people who are vulnerable as a result of their circumstances**

There was a family nurse partnership programme in place, commissioned jointly by Blackpool council and Blackpool Better Start. This was a structured programme of intensive home visits delivered by trained family nurses to young expectant women, under the age of 20, who were pregnant with their first baby. The programme continued through to the baby’s second birthday.

Mothers and nurses decided together what to cover in the visits; this could include self-care and care of the baby in pregnancy, childcare, education, housing or finances. Partners or family members were welcome to attend the appointments.

The programme was a three stage pathway. There were 14 visits in stage one (pregnancy), weekly, then fortnightly. In stage two (infancy, up to one year old) and stage three (toddler, one to two years) there were a total of 64 visits over two and a half years.

The aim of the programme was to support parents so that at the end of the interventions the mother could manage independently.

The family nurse partnership maximum team caseload was 125, which was 25 per full time post, with an additional five cases allocated to the team lead. An annual report for 2016-2017 showed the family nurse partnership team had worked with 184 families over the last year.

The programme was evolving over time and the Accelerated Design and Rapid Programme Testing was part of the new phase being rolled out with a focus on breastfeeding. New initiatives included plans to introduce two new facilitators in pregnancy to help families and partners and build a peer support network of breastfeeding mothers which had been identified as an important part of the adaption.

There was an emphasis on recognising and addressing the mental and emotional wellbeing of the children in the service. Staff told us that by offering support and intervention at an early stage where appropriate they hoped to prevent escalation to tier four in child and adolescent mental health services. Tier four services are aimed at children and adolescents with severe and/or complex mental health problems.

As part of this agenda there was an emotional health and wellbeing integrated care manager in post who managed the child and adolescent mental health services team. Since December 2015 the community health services for children, young people and families had been working with the mental health team in the provision of the child and adolescent support and help enhanced response team. This team included staff from different disciplines, including mental health workers, school nurses and social workers.

The child and adolescent support and help enhanced response team facilitated multi-agency drop in clinics providing children and young people (up to the age of 25) with enhanced outreach and support for emotional distress and mental health. In line with development of the accountable care system the team had started working into the local neighbourhoods and integrated clinical communities in Morecambe Bay. As well as linking in with the schools they were liaising with and referring on to third sector providers, for example local youth teams.
The drop in sessions were held weekly at alternate venues in Fleetwood and Blackpool Central, including youth and family centres. They were advertised in schools and GP clinics and were well attended. The child and adolescent support and help enhanced response team offered crisis management and follow up support with the aim of preventing unnecessary hospital attendance, or facilitating early support upon discharge to those who have attended the emergency department at the hospital.

Figures provided by the trust showed a small reduction in mental health/ self-harm admissions to the children’s ward, and a 33% reduction in length of stay/ bed days for children or young people with a mental health or self-harm diagnosis.

We saw a sensory room at one child development centre with lights, bubble lamps, soft mats and mirror balls. This room was used regularly by the therapists with their patients, for example for assessment purposes, or if there was a delay and a child needed to be calmed down.

An initial assessment was completed by a paediatrician, then six monthly assessments were completed by health visitors for looked after children aged up to five years. After the age of five, yearly assessments were completed up to the age of 18. The assessments were submitted to the safeguarding team for quality assurance and were sent back to the author if deemed further or different information was required. Further training was then offered in how to complete the assessments.

These assessments contained personal, as well as professional information. We reviewed one of the assessments which documented details such as a coloured hair clip in the child’s hair, their favourite toys, their routine and so on.

This meant that if the child had multiple foster carers or no way of asking about their history when they were older, they had a record with some of their childhood details on. At the age of 18 the young person could receive a ‘life story’ if they chose to.

**Access to the right care at the right time**

Attendances, referrals, cancellations and ‘did not attend’ rates were recorded on community information dataset performance sheets for each service, which were submitted to the relevant clinical commissioning groups. These performance records included summaries of the monthly activities and indicators to show whether or not the services had met their targets for face to face attendances.

No children were waiting over 18 weeks from referral to treatment for occupational therapy services, physiotherapy, speech and language services or hearing services in Morecambe Bay area between April and October 2017.

However, in Fylde and Wyre, in October 2017, 10 children were waiting over 18 weeks from referral to treatment for occupational therapy services and 53 were waiting over 18 weeks from referral to treatment for speech and language therapy.

We saw in October 2017 in Blackpool, 19 patients were waiting over 18 weeks from referral to treatment for occupational therapy services and 108 were waiting over 18 weeks from referral to treatment for speech and language therapy. The percentage of children waiting over 18 weeks from referral to treatment for speech and language therapy was deteriorating. However the maximum waiting time to be seen from referral was improving and was 33 weeks in October 2017 for both Fylde and Wyre and Blackpool.
Actions were being taken to address the backlog of appointments. The service had implemented new ways of working which included implementing a mainstream school service and drop in clinics. This followed a pilot study that showed that the school service was a good use of therapists time and minimised wasted time and the drop in sessions reduced inappropriate referrals to the service. The new service became operational in October 2017 and an audit of all patients waiting over 18 weeks for treatment was undertaken. This showed patients had mainly waited between 19 and 24 weeks for an appointment and those who had waited longer had usually missed or cancelled an appointment. All the children on the list had been given an appointment at the time of the audit.

There were other recovery plans in progress. These included streamlining the booking system, so that current issues such as duplication in the systems will stop, making better use of the electronic patient records, and new templated clinics that automatically become available for booking 10 weeks in advance.

A monthly drop-in clinic service commenced in four locations across the area in October 2017. These were based in neighbourhood hub centres with the aim of developing services held in the community for families at a central community location and supporting integrated working with wider health and social care professionals.

Therapy ‘did not attend’ rates had increased and this was attributed to the change in practice of not automatically discharging a child when they first failed to attend. A range of actions had been put in place to actively manage this. These included sending appointment reminders, using the time created by children failing to attend to contact families and re-arrange the appointment and offering more convenient appointment times, for example after school.

Standard operating procedures had been introduced across the service to support the changes, and increased performance monitoring was in place to track the activities. We saw detailed change management plans to support the rollout of the above service improvements.

Discussion was ongoing with commissioners to identify funding to try and resolve blocks to development which remained. These included lack of IT access in the community which meant that therapy staff had no access to records in the community and had to return to base at the end of each day to write up records.

There was a monthly families management team meeting where activities and performance were discussed. This included the presentation of a performance dashboard and discussion around indicators such as waiting times and contract performance exceptions.

Referrals for Blenheim House, child development and family support centre in Blackpool for pre-school children up to the age of five, were discussed at a weekly meeting. Staff told us children were mostly being seen within eight weeks of referral but there were not enough occupational therapists to provide a full service.

Physiotherapists we spoke with said they worked four extended days, between 8am and 6.30pm with no regular weekend working. However there was some flexibility and they gave an example of when weekend working had been agreed to accommodate the needs of a particular patient.

Similarly, nursing staff were allowed some flexibility to support patients who were coming to the end of their life.

There was an open access system at the hospital for children with recurrent health problems, for example chest infections, which enabled them to by-pass the emergency department when they needed medical intervention but were not inpatients. This was originally put in place for urgent intervention to be available for serious medical conditions such as problems with a nasogastric
tube or oxygen supply, but was now being accessed for more minor conditions such as a rash. Staff told us that 40% of children going into the Royal Lancaster Infirmary were there for only four hours and therefore did not need to be there.

Accessibility

The 2011 Census showed that white British people were the majority of the population in the area covered by the trust. According to the Census 93.6% of the population of Blackpool Unitary Authority (UA), and 89.7% of the population of Lancashire (excluding UAs) identified as white English, Welsh, Scottish, Northern Irish or British.

According to the Census the largest ethnic minority groups in these two local authorities were as follows:

<table>
<thead>
<tr>
<th>Blackpool UA</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White – other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Mixed/multiple ethnic group - White and Black Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian/Asian British – Indian</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lancashire (excluding UAs)</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian/Asian British - Pakistani</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – other</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British - Indian</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>White - Irish</td>
</tr>
</tbody>
</table>

Learning from complaints and concerns

Complaints

Community services for children, young people and families received four complaints between July 2016 and June 2017. One complaint related to health visiting and one school nursing. The main theme of complaints was communication.

Compliments

The trust received 105 compliments during the last 12 months from July 2016 to June 2017 which related to community services for children, young people and families. Children’s therapy team north received 25 which accounted for 24% of all the compliments received for the core service.

Is the service well-led?

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11 Universal RPIR – Accessibility tab; 2011 Census
12 Universal RPIR - complaints
13 Universal RPIR - Compliments
Leadership

The leadership triumvirate consisted of the head of service/ deputy director of operations, the head of department/ divisional director and the associate director of nursing/ head of midwifery. They worked closely with the clinical governance and quality manager and the heads of service.

There was a head of service for universal children’s services, targeted children’s services and an emotional health and well-being integrated care manager who was primarily responsible for CAMHS but did some crossover work with community services for children, young people and families, for example the child and adolescent support and help enhanced response team which comprised staff from both areas.

Leaders were visible and approachable and staff we spoke with felt well supported. There were different meeting structures in different localities, but all the staff we spoke with attended regular team meetings, clinical and management supervision. Caseload equity was discussed regularly and was a standing agenda item for the team meetings. Line managers provided monthly one to one appointments.

Team members told us they had been included in some of the transformational project work and had provided input to the service tenders via focus groups and team meetings.

Vision and strategy

The Fylde Coast, including community services for children, young people and families, was designing and implementing various new models of care to operate as an accountable care system.

In 2015, the Fylde Coast was selected as one of the first ‘vanguard’ sites in England with the aim of supporting selected multispecialty community providers to move specialist care out of hospitals and into the community. The vanguard partners included the hospital trust, two local clinical commissioning groups, another local NHS provider and two local councils. These organisations have been developing the plans, called ‘new models of care’, to better coordinate services by taking into account the health, social and emotional needs of residents. The vision for the Fylde Coast was to develop healthcare that ‘wraps around’ the patient, delivering more support closer to people’s home and less in hospital.

Fylde Coast GP practices were grouped into 10 neighbourhoods, six in Blackpool and four in Fylde and Wyre, representing the two clinical commissioning group footprints. Enhanced Primary Care is an enhanced level of clinical support provided in a community setting delivering the health component of each integrated neighbourhood care team involving a range of primary, community, acute, social, third sector and other services.

There was a Pan Lancashire Transformational Plan which promoted resilience, prevention and early intervention for families and young people’s emotional health and wellbeing. This followed the launch of the government’s Future in mind initiative (2015).

There was an emphasis on improving access to effective support, described as a system without tiers. We saw evidence of current practice, which was targeted to meet some of the aims of this plan, for example, plans to improve the provision for children and young people with autism spectrum disorder and provision for children and young people in crisis.

The service had set up a collaboration board with another local NHS care provider, which they had submitted a joint tender with to the local authority, to provide school nursing and health visiting services. This board met weekly until the submission of the tender in November, 2017 and was
continuing to meet fortnightly. The board was working on a mobilisation plan for the new service and if necessary, a de-mobilisation plan if the tender was unsuccessful. They were aiming to work together within the service model.

There was an emphasis on delivering ‘parity of esteem’ between physical and mental health. Parity of esteem means equal access to effective care and treatment; equal efforts to improve the quality of care; equal status within health care education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes (Royal College of Psychiatrists 2013).

**Culture**

Staff we spoke with felt positive and were proud to work for this service. They were keen to tell us about service improvement and innovation, including joint working with other services. There was good communication between staff at different levels when changes to the service were taking place, for example staff had been regularly briefed when contracts were out to tender.

We observed a culture of openness and honesty at different levels within the organisation, including with people who use services, in response to incidents, however formal incident reporting was infrequent. This meant there was limited evidence of appropriate learning and action being taken as a result of concerns.

There were safety processes and lone working arrangements in place, but these differed across the service.

We saw a system in one health visiting team where whiteboards and electronic diaries were kept up to date with details of where staff members were. The team had mobile telephones supplied by the trust and a buddy system in place where they would check in with each other at agreed times. If there were any doubts about the location being visited, then two people would visit together.

Some teams had smart card lone worker devices worn with identification badges which had an alarm button on the back. The device had a button to push to leave regular and current information such as name, activity being carried out, whereabouts and information about any apparent risk. This information was available to the alarm receiving centre to be accessed in the event of a subsequent ‘red alert’. When this was pressed it activated an audio link so that the external alarm receiving service could hear what was happening and escalate the situation, for example call emergency services, if they felt the staff member was at risk of harm.

However, the therapy teams we met with had neither mobile telephones or lone worker devices provided by the service. They had a buddy system in place but had to rely on their personal mobile telephones to contact each other while out on visits.

**Governance**

A families division risk governance group meeting was held monthly, where incidents which scored a level three or above for harm were discussed. We were unable to review this as none had been reported.

Matters that required escalating further were reported to the trust learning from incidents and risks committee and/or the divisional board as appropriate.
There was a monthly families management team meeting where activities and performance were discussed. This included the presentation of the performance dashboard and discussion around indicators such as waiting times and contract performance exceptions.

There were clear lines of accountability for arrangements for safeguarding children and support for children who are looked after.

**Management of risk, issues and performance**

There was a risk register for the families division which included risks for the community health services for children, young people and families. This included the potential reduction in local contract values for the 0-19 years healthy child programme pathway (health visiting, school nursing and family nurse partnership).

This reflected the risks and concerns that staff identified when we spoke with them on inspection.

Risks were discussed at the monthly families division risk governance group meeting which reported to the families divisional board. We reviewed six sets of minutes from these meetings and saw evidence of discussion around these risks.

There was also discussion around complaints, patient experience, incidents and duty of candour across the whole division. In community health services for children, young people and families there were no complaints and no incidents which scored level three or above in recent months.

The divisional board reported monthly to the divisional performance review and when required, risks were escalated to the trust board.

There were monthly activity position dashboards which were monitored by the clinical commissioning groups. These included activity levels, variance from target and percentage of variance for activities such as referral numbers, waiting times, did not attends, and attendances. We saw evidence of good reporting for activities across the different teams and geographical areas.

Where targets were not met, action plans were in place as detailed in ‘patient outcomes’, above.

There were current major incident and business continuity plans in place. These were available on the trust intranet. Staff we spoke with were aware of the policies and were able to provide examples of actions taken when computer systems had been affected by an outage, and when services were compromised following flooding last year.

**Information management**

Staff had good access to patient information as the electronic patient records system could be accessed by different disciplines and agencies when at their bases. However, whilst on community visits staff relied on paper records which were then used to update the electronic records on return to base.

Service performance measures were monitored by the service and the clinical commissioning groups. There was a clear reporting structure which identified how the different committees and groups reported to the trust board via the families division risk governance group.

Quality and risk information was discussed at the families division risk governance group. Matters such as ‘did not attend’ rate benchmarking and patient experience were also discussed at this monthly meeting.
Unresolved matters were carried over to the next meeting and actions were documented where decisions had been made to address concerns.

**Engagement**

There was a focus on involving children, young people and their families in service development via several different processes as described earlier in this report.

Children aged between 11 and 18 years who had received care at Blackpool Teaching Hospitals could join the young patient’s forum, Victoria’s Voice. The group was involved in numerous different projects to give children and young people the opportunity to have their say in how services worked for them and others like them.

Victoria’s Voice met every month after school and sometimes got together for special events in between. Some of the things the group did regularly included involvement in the recruitment process for new staff in the children’s service, leading a session for student doctors and different projects such as creating the charter of promises.

We saw evidence of the involvement of Victoria’s Voice, and also observed staff attitudes which were positive around the involvement of the service users in all aspects of service development and delivery.

**Learning, continuous improvement and innovation**

The service was involved with the lottery funded Better Start and Head Start Blackpool programmes. Better Start was a programme for young children up to the age of five years which had begun rolling out a schedule of evidence based interventions targeting the most vulnerable families to improve diet and nutrition, social and emotional development, and language and communication.

Head Start Blackpool was designed to support the building of resilience in young people aged 10-16 across Blackpool, for example at the transition stages of primary school to secondary school and child to adult services. Services were looking at bidding for some new innovative additions, for example texting services and live chat and were consulting with the Victoria’s Voice young people’s forum for their opinions.

A positive parenting programme was identified by the service as an effective intervention to support parents of children up to 12 years diagnosed with a serious physical or learning developmental disability. By engaging with the research element of this programme the children’s services had acquired two trained staff, without substantial financial cost. These staff were able to share their knowledge with the teams, and research and monitor the effectiveness of the programme.

Staff told us there was a culture of innovation and the heads of service encouraged staff to develop.
Community dental services

Facts and data about this service

The community dental service offers a range of dental services for patients who, due to personal circumstances are not able to access services from General Dental Practices. The services provided include the day time dental access service, the out-of-hours emergency dental service, special needs dentistry, paediatric dentistry and dental treatment under sedation and general anaesthetic.

The service also has a role in improving the dental health of the local population by delivering dental health education, oral health improvement programmes and conducting epidemiological surveys.

The service provides education and training to dental students, trainee dental therapists and dental nurse cadets.

(Source – RPIR – Sites CHS tab)

Information about the sites, which offer community dental services at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Site name</th>
<th>Team/ward/satellite name</th>
<th>Patient group</th>
<th>Number of clinics per month</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashton Road Dental Clinic (RLI)</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>30</td>
<td>Morecambe Bay CCG</td>
<td></td>
</tr>
<tr>
<td>Blackpool Victoria Hospital</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>5</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
<tr>
<td>Fleetwood Hospital</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>N/A</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
<tr>
<td>Moor Park Health and Leisure Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>70</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
<tr>
<td>Queen Victoria Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>150</td>
<td>Morecambe Bay CCG</td>
<td></td>
</tr>
<tr>
<td>Queen Victoria Centre Dental Education Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>50</td>
<td>Morecambe Bay CCG</td>
<td></td>
</tr>
<tr>
<td>South Shore Primary Care Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>80</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
<tr>
<td>St Annes Primary Care Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>30</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
<tr>
<td>Whitegate Health Centre</td>
<td>Dental Services</td>
<td>Mixed</td>
<td>170</td>
<td>Blackpool, Fylde and Wyre CCG</td>
<td></td>
</tr>
</tbody>
</table>

Is the service safe?

Mandatory training

- The trust set a target of 95% for completion of mandatory training. Their overall training compliance for staff in community dental services as of June 2017 was 87% against this target.
- A breakdown of compliance for mandatory courses as of June 2017 for all staff in community dental services is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff this year</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>73</td>
<td>58</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>73</td>
<td>65</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>79</td>
<td>69</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>79</td>
<td>64</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>79</td>
<td>71</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>77</td>
<td>68</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>79</td>
<td>69</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>79</td>
<td>67</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>64</td>
<td>56</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>75</td>
<td>69</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>78</td>
<td>66</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>63</td>
<td>53</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>79</td>
<td>72</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>77</td>
<td>61</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>79</td>
<td>69</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>78</td>
<td>73</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>79</td>
<td>73</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff across the service told us there was good access to mandatory training through study days or online training through the trust’s intranet. The trust set a target of 95% for completion of mandatory training. Updated records dated November 2017 showed that mandatory training for the service was at 86%.

A central log for mandatory training was maintained which helped the dental services manager proactively monitor staff training. The dental services manager was diligent in ensuring staff completed mandatory training. If there were any staff who had not completed mandatory training, the dental team leader was informed in order to prompt the individual to complete the relevant training.

Mandatory training for staff included infection prevention and control, safeguarding of vulnerable adults and children, information governance and the management of emergencies in the dental chair. We noted the mandatory training for safeguarding children was level 1 for all staff. The intercollegiate document, safeguarding children and young people states that all dentists and dental care professionals should be at least trained to level two for safeguarding children.

### Safeguarding

**Safeguarding referrals**

- A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

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14 Universal RPIR – Safeguarding referrals tab
• Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust had a dedicated safeguarding team for adults and children. Dental staff were aware of the safeguarding policy and were aware of the process for making a safeguarding alert.

The mandatory training records we saw demonstrated that 89% and 88% of staff working within the service had received level one safeguarding children and adult training respectively. We noted the mandatory training for safeguarding children was level 1 for all staff. The intercollegiate document, safeguarding children and young people states that all dentists and dental care professionals should be at least trained to level two for safeguarding children.

Staff we spoke with were knowledgeable about safeguarding issues in relation to the community they served. We spoke with staff about how safeguarding concerns could affect the delivery of dental care. This included children who presented with high levels of dental decay that could indicate that a child could be suffering from neglect and patients who did not attend for treatment. Staff we spoke with were aware of how to make a safeguarding referral.

We saw that the service had a system in place where they alerted and shared information with other professionals such as social workers, health visitors and school nurses. For example children that were subject to a children protection plan would be alerted by these professionals on referral into the service. This information would then be recorded on the services computerised dental record system.

**Cleanliness, infection control and hygiene**

The service used a system of local decontamination at Whitegate Health Centre, Queen Victoria Centre Dental Access Service and Queen Victoria Centre Dental Education Centre for the reprocessing of contaminated dental instruments and equipment. The clinics were meeting best practice Health Technical Memorandum (HTM) 01 05 (guidelines for decontamination and infection control in primary dental care) for infection control. Best practice HTM 01 05 was met because the decontamination units at each site we inspected had a separate room for processing contaminated dental instruments, an automated washer disinfector for pre-sterilisation cleaning and separate room for storing the processed instruments.

Staff demonstrated the arrangements for infection control and decontamination procedures. They demonstrated and explained in detail the procedures for the cleaning of dental equipment. Staff described the process for the transfer and processing of dirty instruments through designated on-site decontamination rooms. We saw safe storage of clean instruments and that equipment was used within the timescales stipulated in HTM 01 05. We observed that the dental nurses maintained the daily, weekly and quarterly test sheets for the equipment used in decontamination of dental equipment. This included sterilisers and the washer disinfector. We saw records of the maintenance schedules for this equipment which was kept on the electronic based governance system operated by the service.

We saw instrument identification tape and bands were routinely used on dental instruments. These bands and tape prevent effective cleaning of the instruments. We advised the head of service about this and we were told their use would be reviewed.
We observed good infection prevention and control practices across the service. Hand washing facilities and alcohol hand gel were available throughout the clinic areas.

We observed staff following hand hygiene and ‘arms bare below the elbow’ guidance. Staff wore personal protective equipment (PPE), such as gloves and aprons, whilst delivering care and treatment. We observed appropriate disposal of PPE.

We saw that there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use was in accordance with the European Directive for the safer use of sharps.

We found that cleaning schedules were in place and displayed for each individual treatment room and clinic. The responsible dental nurse at each clinic had signed off each schedule.

Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment were in place at each location.

The trusts infection prevention and control team carried out annual audit of cross infection and decontamination at each location. We saw the latest audit carried out between July and September 2017 demonstrated a high level of compliance. Where an issue had been identified, these had been addressed by the service in the action plans we saw. For example at Whitegate Health Centre the audit carried out between July and September 2017 identified a damaged chair in one treatment room and records showed that dental chair had been recovered.

We saw that the dental nurses also carried out monthly audits of the clinical environment. The senior dental nurses also carried out hand hygiene audits on a quarterly basis.

Records at Whitegate Health Centre, Queen Victoria Centre, Ashton Road Dental Clinic and Queen Victoria Centre Dental Education Centre showed that the testing of water temperatures was being carried out to minimise the risk of Legionella (Legionella is term for bacteria which can contaminate water systems in buildings).

**Environment and equipment**

We observed that dental equipment was clean and well maintained. We saw records that showed electrical equipment had been safety tested and decontamination equipment had been maintained on an annual basis.

There was sufficient equipment to maintain safe and effective care. This included equipment such as sterilisers and automated washer disinfectors used in the cleaning and sterilisation of dental instruments. There were processes in place to ensure that the equipment was maintained and staff knew how to use it.

We found that at each site we inspected equipment was present for dealing with medical emergencies. This included an automated external defibrillator, emergency medicines and oxygen. This was in line with the Resuscitation UK and British National Formulary (BNF) guidelines.

The service maintained records in relation to dental radiography. Records demonstrated all the necessary documentation in accordance with ionising radiation regulations (IRR 1999). The IRR99 aims to protect staff who work with ionising radiation. This legislation requires radiology services to
produce ‘local rules’, which are a set of rules describing the systems and processes in place to protect staff in individual services. The local rules had been developed by the Radiation Protection Adviser and were stored on in the services electronic radiation protection file.

The dental service ensured that all x-ray sets were serviced and calibrated according to IRR99. We saw that the service records for each x-ray set used across the service indicated that they were safe for use.

Dental x-rays when prescribed were justified, reported on and quality assured every time. The 10 dental records we saw confirmed that this was the case. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations IR(ME)R and protected staff and patients from receiving unnecessary exposure to radiation. IR(ME)R, is a framework that deals with the safe and effective use of ionising radiation when exposing patients and designed to minimise the risk of unintended, excessive or incorrect medical exposure.

There were clear signs in areas where ionising radiation was used, including lights and warning notices. We saw that there were working instructions for these areas and access was restricted to staff authorised to use the area.

We noted on the service risk register of an open risk in relation to the environment and equipment within the service which had a current risk rating. The risk related to the ownership and maintenance of equipment. We saw that steps had been taken to address this issue.

The service had a domiciliary visit protocol. When domiciliary visits were carried out a full risk assessment was completed. This included whether emergency medicines or equipment needed to be taken and whether there were any potential issues with infection control. We saw evidence of completed risk assessment documents.

**Assessing and responding to patient risk**

We observed at the general anaesthetic session that the dental and theatre staff involved in the treatment of two patients carried out in full the World Health Organisation five steps to safer surgery check list to prevent incidents such as a never event from occurring.

At each site, we inspected, there was a range of equipment to enable staff to respond to a medical emergency. This included an automated external defibrillator, emergency medicines and oxygen. The emergency medicines were all in date and stored securely, with emergency oxygen, in a central location known to all staff. This was in line with the Resuscitation UK and British National Formulary (BNF) guidelines.

Throughout our inspection, we looked at examples of dental treatment records at each location. We found that dental staff always recorded patient safety alerts. For example, medical histories were always taken by dentists and updated when patients attended for dental treatment. These medical histories included any allergies and reactions to medication such as antibiotics.

The staff ensured that patients and carers received appropriate post-operative instructions following dental surgery. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage or infections.

There were processes in place in to assess risks to patients and to monitor and maintain patients’ safety. Staff we spoke with were aware of the process to follow if a patient became acutely unwell in dental services and required transfer to an emergency facility. If a patient required emergency resuscitation that would be carried out by a trained member of staff and patient would be transferred by an emergency 999 ambulance if required.
The service had access to a radiation protection advisor (RPA) in line with IRR99 regulations. The RPA was able to provide radiation advice and assist with risk assessments. The contact details for the RPA were in policies and protocols and on display in diagnostic areas.

There was clear guidance for staff on who could make referrals or requests for diagnostic imaging in line with IR(ME)R guidelines.

The service received national patient safety alerts such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). Where relevant, these alerts were shared with all members of staff at staff meetings.

**Staffing**

**Total numbers – Planned vs Actual**\(^{15}\)

- Information provided by the service showed that staffing levels were 97.8% compared with establishment figures.

**Vacancies**\(^{16}\)

- Between July 2016 and June 2017 the trust reported an average vacancy rate of 9.3% in community dental services. This was above the trust’s overall target vacancy rate of 5.17%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Average annual vacancies (%) (Jul 16 – Jun 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery registered</td>
<td>5.5%</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>13.1%</td>
</tr>
<tr>
<td>Other</td>
<td>8.3%</td>
</tr>
<tr>
<td>Core service total</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

- As of June 2017, the trust reported an overall vacancy rate of 5.2% in community dental services.

**Turnover**\(^{17}\)

- Between July 2016 and June 2017, the trust reported an average turnover rate of 0.9% in community dental services, which is better than the trust’s overall target turnover rate of 9%.

**Sickness**\(^{18}\)
• Between July 2016 and June 2017, the trust reported an average sickness rate of 5% in community dental services, which is worse than the trust’s overall target sickness rate of 4%.

Nursing – Bank and Agency Qualified nurses

• Between June 2016 and May 2017, the trust reported no bank and agency usage of qualified nursing staff in community dental services.

Nursing - Bank and Agency Healthcare Assistants

• Between June 2016 and May 2017, the trust reported no bank and agency usage of healthcare assistants in community dental services

Medical locums

• Between June 2016 and May 2017, the trust reported no bank and agency usage of medical staff in community dental services

Suspensions and supervisions

• Between June 2016 and July 2017 the trust have reported no cases where staff have either been suspended or placed under supervision within community dental services.

To ensure staffing resilience the service had developed a bank system for dentists working in the dental access centres. Before dentists went on annual leave cross cover was arranged with other dentists in the team.

Appropriately trained nurses supported the dentists carrying out sedation on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were treated safely and in line with current standards of clinical practice. All staff involved in the provision of sedation had completed immediate life support training.

The staffing levels at each location we inspected were appropriate and we found that teams worked well together demonstrating an effective and cohesive team.

We were told at Queen Victoria Centre that there was a vacant space for a dental therapist. This had not yet been advertised and staff felt this would take the pressure off the dentists.

The appointment diaries at each location we inspected showed that appropriate appointment slots were allocated for both patient assessment and treatment sessions.

Quality of records

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19 Universal RPIR – bank/agency tab
20 Universal RPIR – bank/agency tab
21 Universal RPIR – Medical locum tab
22 Universal RPIR – suspension or supervised tab
The individual patient records were a mix of computerised and paper records. The service carried out audits of the quality of record keeping; the last audit was carried out in September 2017. We saw the results of the audit results were discussed during the clinician’s peer review meeting.

Clinical records were kept securely so that confidential information was properly protected. Information such as written medical histories and referral letters were kept in individual patient files. These were archived in locked and secured cabinets not accessible to the public in accordance with data protection requirements. Computerised records were password protected.

We observed 10 sets of patient records across the sites we inspected. We found that they were well-maintained by each dentist and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records.

All 10 clinical records we viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Dental staff recorded patient safety alerts in these records. These included allergies and reactions to medication such as antibiotics.

**Medicines**

We found that there was a recording system for the prescribing and recording of medicines used in the provision of conscious sedation; this included the reversal agent for the sedative medicine.

The medicines used for conscious sedation were stored in locked wall mounted metal cabinets at Whitegate Health Centre, Queen Victoria Centre, and Ashton Road Dental Clinic that provided conscious sedation.

We found medicines for emergency use were always available, in date and stored correctly. We saw that dental nurses used a checklist for monitoring the expiry dates of the emergency medicines at each site we visited.

Prescription pads were stored securely when not in use. We saw evidence of prescription logs for each prescription pad. We noted a system for monitoring each individual prescription was not in place. We discussed this with the head of service who assured us this would be reviewed.

A prescribing audit was carried between July and September 2016. This helped the service ensure the dentists were following guidance from the Faculty of General Dental Practice: Antimicrobial prescribing for general dental practitioners. We saw an action plan was in place to address compliance with regards to the prescription of antibiotics.

**Safety performance**

There had not been any never events at the community dental services between July 2016 and June 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. An example of a never event in dentistry is a wrong tooth extraction.

A never event had occurred in the maxillo-facial service at the trust. Learning from this never event had been disseminated to staff working at the community dental services.

We saw systems and processes based on National Safety Systems for Invasive Procedures (NaTSSIP’s) guidelines were used for patients undergoing general anaesthesia. The team checked that before any procedure was carried out; the patients’ identity was correct, along with
their medical details, relevant information about a patient’s social history and the details about the specific procedure to be undertaken.

Incident reporting, learning and improvement

Serious Incidents - STEIS\(^{23}\)

- Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community dental services, which met the reporting criteria, set by NHS England between, April 2016 and May 2017.

Serious Incidents (SIRI) – Trust data\(^{24}\)

- Between July 2016 and June 2017, trust staff in community dental services reported no serious incidents.

The hospital had a comprehensive incident management policy and used an electronic system for reporting and recording them. The head of service was responsible for investigating incidents within the dental service. The dental service reported incidents using the trust electronic reporting system. Staff we spoke with demonstrated to us how the system worked. We were shown examples of how they followed up issues resulting from reported incidents. For example, the changes made to a process as a result of a near miss involving an x-ray machine.

We were shown an example of an incident where the duty of candour had been applied. The incident had not met the trust’s threshold for a notification. However, due to the nature of the incident the patients involved were fully informed and given a full apology.

Three sets of staff meeting minutes we saw showed that incidents were discussed to facilitate shared learning. There were also standing agenda items relating to health and safety alerts, risk management issues and clinical audit.

Incidents were discussed at divisional governance meetings and departmental meetings for an opportunity for shared learning.

Is the service effective?

Evidence-based care and treatment

The dentists used national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health and the Faculty of General Dental Practice. Dentists we spoke with were knowledgeable about these guidelines and the standards that underpinned them.

\(^{23}\) STEIS  
\(^{24}\) Universal RPIR – incidents tab
The trust’s dental services delivered conscious sedation services according to the standards set out by the dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists ‘Standards for Conscious Sedation in the Provision of Dental Care 2015.

Special care dentistry included domiciliary care and patients with complex medical and mental health and social impairments were delivered according to best practice as set out by the British Society for Disability and Oral Health.

Dental staff used the Department of Health’s ‘Delivering Better Oral Health Toolkit 2013’ when providing preventative advice to patients on how to maintain a healthy mouth. This was an evidence based tool kit used for the prevention of the common dental diseases.

The dentists used rubber dam when carrying out root canal treatment in line with guidance from the British Endodontic Society.

**Nutrition and hydration (only include if specific evidence)**

Children and adults having procedures under sedation were appropriately advised by dentists on the need to fast before undergoing their procedure. We saw that patients were given an advice leaflet detailing fasting arrangements. Patients undergoing conscious sedation also received appropriate advice from dentists and dental nurses regarding eating before this procedure.

**Pain relief (only include if specific evidence)**

Dentists assessed patients appropriately for pain and other urgent symptoms. For example, in cases of very young children where local anaesthesia was not appropriate for tooth extraction, general anaesthesia under the care of a hospital anaesthetist was used as an alternative.

Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures such as dental fillings and extractions.

**Patient outcomes**

Due to the nature of the contract with NHS England the service was not required to measure patient outcomes. The service carried out audits of dental care records, X-rays, infection control and hand hygiene. Results of audits were fed back to staff and clinicians through regular meetings. Results of audits were also discussed at a divisional level. Results of the most recent audits we saw showed the service was performing well.

As part of the nurse led dental anxiety management service they had monitored the levels of anxiety for patients. Patients were asked to complete a modified dental anxiety questionnaire which showed on a scale of 5 to 25 how anxious they were about visiting the dentist and having treatment carried out. Patients completed the modified dental anxiety questionnaire before and after a course of dental anxiety management. We saw that the modified dental anxiety scores had reduced as a result of the service.

**Audits – changes to working practices**

- The trust have recorded no clinical audits in relation to community dental services which they have participated in as part of their Clinical Audit Programme.
Competent staff

Appraisals for medical staff

- For the period April 2016 to September 2016, 87.9% of medical staff within community dental services had received an appraisal.
- For year to date (April 2017 to July 2017) 34.5% of medical staff within community dental services have received an appraisal.

The head of service encouraged dentists within the service to undertake additional professional training to provide services to an ever-increasing complexity of patient.

All staff involved in the provision of conscious sedation were trained in intermediate life support techniques.

We found that some dentists had taken additional postgraduate qualifications enabling them to deliver dental care to an increasingly complex cohort of patients. We saw that some dentists had postgraduate master’s degrees and diplomas in special care dentistry and paediatric dentistry and some were on the General Dental Council’s specialist register.

To compliment the specialist dentists, the community dental service placed great emphasis on the benefit of using extended duty dental nurses. We found that most dental nurses had further training in conscious sedation and general anaesthesia in relation to dentistry, oral health promotion, dental radiography and fluoride varnish applications.

The service also provided outreach training for undergraduate dental students from the University of Central Lancashire (UCLan) at Whitegate Health Centre and Queen Victoria Centre Dental Education Centre. This involved 3rd, 4th and 5th year students being supervised by staff from the community dental service. Clinics ran most days during the week and provided students with a holistic approach to dentistry. Students we spoke with were positive about the staff and facilities.

Records we saw showed that as of November 2017 96% of all staff had been appraised during 2017. We saw two appraisals were outstanding and were booked to complete during November.

Clinical meetings including peer review amongst the dentists occurred each month where dentists brought interesting clinical cases or cases where there had been particular difficulties in reaching optimum outcomes for patients. The clinical lead also conducted regular one to one sessions with the dentists to identify any problems and create action plans.

Multidisciplinary working and coordinated care pathways

There was effective and collaborative working across disciplines involved in a patient’s care and treatment. For example, patients would often present with complex medical conditions requiring consultation with the patient’s consultant physician or surgeon. We found that there were coordinated hospital theatre sessions for patients with a complex learning disability. During these sessions, patients received various speciality inputs that included dentistry, podiatry and ear, nose and throat services. The dental team would often take a lead role in providing these sessions for special care patients.

Multidisciplinary team meetings were arranged when required.
Health promotion

Dental staff used the Department of Health’s ‘Delivering Better Oral Health Toolkit 2013’ when providing preventative advice to patients on how to maintain a healthy mouth. This was an evidence based tool kit used for the prevention of the common dental diseases.

The service in the south employed an oral health educator. The oral health educator visited nurseries and childminders in Blackpool to provide supervised tooth brushing. In addition, they would liaise with the health visitors and provide toothpaste and toothbrush packs to children. This is part of the “Blackpool Better Start” programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards

- The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between July 2016 and June 2017 that were pertinent to community dental services.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).

Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to staff trained in working with vulnerable patients, such as the trust’s safeguarding team. The dentists we spoke with explained how they carried out a mental capacity assessment and that a best interest’s decision would be made in those cases where the patient lacked capacity to consent for treatment.

There was an effective system for obtaining consent for patients undergoing general anaesthesia, relative analgesia sedation and routine dental treatment. 10 sets of records we saw showed that valid informed consent was obtained.

The consent documentation used in each case of general anaesthesia consisted of the referral letter and clinical assessment including a complete written medical, drug and social history. Full and complete NHS consent forms (1, 2, 3 or 4) were used by each dentist each as appropriate in every case during the consent process for each patient.

We observed 10 patient assessment treatment records that demonstrated the systems and processes for obtaining consent by dentists were carried out. We also observed treatment sessions involving conscious sedation and general anaesthesia and noted that consent had been obtained in accordance with the trust policy.

Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient’s representatives and other healthcare professionals.

Dentists we spoke with were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Is the service caring?

27 Universal RPIR – DoLs tab
Compassionate care

We observed staff treating patients with dignity and respect. Staff were considerate of the patient and their family’s anxieties and provided them with reassurance and were clear about the treatment. During the general anaesthetic session, a clinician went to speak with the family to keep them fully informed about the progress of treatment and any changes to the provisional treatment as the treatment proceeded.

We observed positive interactions between staff and patients during our visits. Through our discussions with staff, it was apparent that they adopted a holistic approach to care concentrating fundamentally on the patient’s social, physical and medical needs. We were provided with a good example of a situation whereby staff modified the environment to accommodate a patient’s fear and anxiety.

We received feedback from 23 patients. They commented staff were “Excellent”, “Amazing”, “Helpful” and “Friendly”. Many comments praised the service for how they treated nervous patients.

Privacy and confidentiality was maintained in the reception area. Receptionists spoke discreetly when necessary and private areas were available for confidential conversations.

Staff respected peoples’ individual preferences, habits, culture, faith and background.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care and fully understood the emotional impact dental treatment could have on a patient’s well-being. Patients told us that staff provided support to help them cope emotionally with the treatment.

At Queen Victoria Centre Dental Access Service, they had implemented a nurse-led dental anxiety management (NDAM) service. This was a talking therapy service used to help patients overcome their dental anxieties. They used techniques such as acclimatisation, desensitisation and distraction to help patients accept dental treatment without the need for conscious sedation. The service had trained several members of staff to be involved in the process so that patients had a continuity of care from liaising with a receptionist to having the sessions with a trained dental nurse then having the dental treatment done by a dentist. We were shown a video testimonial of a patient who had been through a course of dental anxiety management. This patient had not been able to tolerate dental treatment for many years. As a result of this they had neglected their teeth and had subsequently suffered from pain. After sessions with a dental nurse they were able to receive dental treatment without the need for conscious sedation. They were currently training staff at Whitegate Health Centre to provide this service for patients there.

Understanding and involvement of patients and those close to them

A range of pictures and models were available to assist the dentists demonstrate to patients, relatives and/or their representatives different treatment options. Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found that planned care was consistent with best practice as set down in national guidelines for special care dentistry including those set out by the British Society for Disability and Oral Health.
Our observations of interactions between staff and patients confirmed that staff communicated with patients in a manner that helped them to understand their care and treatment.

Patients were given information about who to contact if they had any concerns or questions after their appointment.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The dental service was commissioned by NHS England. These services were due to be re-tendered and a business plan had been completed in preparation for the organisation to bid to continue providing community dental services.

Referrals to the service were made by general dental practitioners and health professionals to meet the needs of people who could not use the general dental service. These included patients with medical, physical or social issues and patients with dental anxiety.

Reasonable adjustments had been made to all the locations which we visited. These included step free access, automatic doors and accessible toilet facilities. The locations we visited had adequate seating in reception and waiting area.

Dental appointments were available Monday to Friday 9:00am to 5:00pm at Whitegate Health Centre and Queen Victoria Centre. There were arrangements for an emergency on call service outside these hours.

Domiciliary visits were carried out from Queen Victoria Centre on a Wednesday morning. However, we were not able to observe a visit. These visits were for patients whom could not access the service due to medical, physical or social issues.

There were systems and processes in place to identify and plan for patient safety issues in advance including any potential staffing and clinic capacity issues. For example, at the GA session at Ashton Road Dental Clinic, we were told staff would have a morning huddle to discuss the patients who were attending for that session. Staff also called the parents of the patients two days prior to their appointment to ensure they fully understood the pre-operative instruction for GA.

**Meeting the needs of people in vulnerable circumstances**

The dentists we spoke with felt that they had adequate time to carry out clinical care of patients. They gave us examples of when they would adjust practice to meet patient’s individual needs. Dentists had clinical freedom to adjust time slots to consider the complexities of the patient’s medical, physical, psychological and social needs.

Patients had access to a variety of information about their dental treatment in leaflet form. This information included pre-and post-operative instructions and advice that helped them manage their dental care effectively before, during and after treatment.

Domiciliary visits were available from Queen Victoria Centre. These would be for patients who could not attend a clinic due to a physical or learning disability, or with mental health needs.

**Access to the right care at the right time**
The 2011 Census showed that white British people were the majority of the population in the area covered by the trust. According to the Census, 93.6% of the population of Blackpool Unitary Authority (UA), and 89.7% of the population of Lancashire (excluding UAs) identified as white English, Welsh, Scottish, Northern Irish or British.

According to the Census the largest ethnic minority groups in these two local authorities were as follows:

**Blackpool UA**

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White – other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Mixed/multiple ethnic group - White and Black Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian/Asian British – Indian</td>
</tr>
</tbody>
</table>

**Lancashire (excluding UAs)**

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
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</tr>
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<td>Fourth largest</td>
<td>White - Irish</td>
</tr>
</tbody>
</table>

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service.

Patients who either did not have a dentist or who could not access emergency care though their regular dentist were able to book appointments for emergency treatments the same day at Queen Victoria Centre Dental Access Service and Whitegate Health Centre. Patient feedback confirmed this.

Adult’s requiring a general anaesthetic appointment were referred to Blackpool Victoria Hospital. We were told the increased waiting times for these patients was due to the fact that there were only single gender recovery areas at Blackpool Victoria Hospital and clinics were not as frequent. Staff also told us the winter pressures would also affect the frequency of general anaesthetic clinics at Blackpool Victoria Hospital.

**Learning from complaints and concerns**

**Complaints**

- Community dental services received five complaints between July 2016 and June 2017. The main complaint themes were administration and treatment issues.

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28 Universal RPIR – Accessibility tab; 2011 Census  
29 Universal RPIR - complaints
Compliments

- The trust received 42 compliments during the last 12 months from July 2016 to June 2017 which related to community dental services. 13 of these related to the Dental Education Centre at Blackpool.

Complaints were managed by the trust’s complaints department and the dental services manager. In complaints relating to clinical issues, the dental clinical leads would also provide input.

Written information in the form of leaflets was available in every clinic informing people how to raise concerns and complaints.

At each dental staff meeting, complaints, both formal and informal, were discussed by staff to allow learning and reflection to take place. We saw examples of staff meeting minutes, which confirmed this had taken place.

We reviewed three formal complaints which had been received. We saw patients were offered a face to face meeting with the dental services manager to discuss the complaint further. We saw evidence complaints were responded to appropriately and in a timely manner.

Is the service well-led?

Leadership

Leadership was provided by the dental services manager who was supported by two dental team leaders (north and south). Clinical leadership was provided by the dental clinical leads. There was one responsible for the clinicians in the north and one in the south.

Staff felt well supported by immediate managers throughout the service. Staff told us the dental service manager and leads were approachable and supportive.

Management structure charts were readily available at all location we visited. These showed the lines of accountability within the service.

Vision and strategy

The trust’s values were “Person centred”, “Positive”, “Compassion” and “Excellence”. We were told these values formed part of all staff’s annual appraisal.

Dental services were commissioned by NHS England. These services were due to be re-tendered and a business plan had been completed in preparation for the organisation to bid to continue providing community dental services.

Culture

Staff were passionate and proud to be working within the service and providing high quality care to their patients. They felt empowered and were aware of their responsibility to raise concerns if the need arose.
Staff were aware of their responsibilities under the duty of candour. The dental services manager gave us an example where they had applied the duty of candour in response to an incident which had occurred.

Staff told us they worked as a team across the whole service. One receptionist told us they often had meetings with other receptionists from other locations. They told us this was good for support.

**Governance**

There were effective governance procedures in place to enable the smooth running of the service. Policies and procedures were readily available on the trusts intranet page. Staff we spoke with were fully aware of how to locate policies.

The service carried out audits of dental care records, X-rays, infection control and hand hygiene. Results of audits were fed back to staff and clinicians through regular meetings. Results of audits were also discussed at a divisional level. Results of the most recent audits we saw showed the service was performing well.

The dental service manager attended regular divisional board meetings where matters of governance were discussed. These followed a set agenda and informed the divisional report that went to the trust board.

Monthly team meetings were carried out at each location. These followed a set agenda and covered topics such as training requirements, complaints, compliments and significant events. Feedback from the divisional meetings were also disseminated to staff at these meetings.

The clinicians held monthly meetings where they were able to discuss cases which they have been involved in treating. It was also an opportunity to discuss significant events, staff development, upcoming training, audit projects and service development.

All meetings were well minuted and readily available for staff who are unable to attend.

**Management of risk, issues and performance**

The service had a comprehensive risk register which was reviewed on a regular basis. The risk register was discussed at divisional board meetings. We saw the latest risk register and there were two entries which related to equipment maintenance and ownership. The service had taken action to make sure all equipment was adequately serviced and maintained according to manufacturer’s guidance. This ensured patients were treated safely.

**Information management**

The service collected, analysed, managed and used information well to support all its activities.

A divisional performance report was produced monthly. This included details of finances, quality performance, operational performance and workforce performance.

Staff had completed training in information governance and were aware of the importance of protecting patients’ personal information. We saw computers were password protected and were told these were backed these up to secure storage. Any paper records were stored in lockable cabinets. We saw staff locked computers when they moved away. Staff were able to access patient’s dental care records remotely from any of the locations.
Engagement

The service participated in the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. We saw at Ashton Road Dental Clinic they displayed the latest results of the FFT which also included patient’s comments. Results of the most recent FFT showed that for all locations over 94% of patients would recommend the service to friends and family.

Information was cascaded through team meetings on a monthly basis. There were also clinical leads meetings, dental nurse team meetings and receptionist meetings. We were told by one receptionist that the meetings are good support and for sharing ideas.

Staff were able to feedback to managers about any issues where they felt improvements could be made. One example we were provided with was a process to report back to the staff member who had raised a significant event.

Learning, continuous improvement and innovation

The service was involved in providing training to undergraduate dental students from UCLan. This forms part of a student’s clinical training. Students were supervised by qualified clinicians at all times. This scheme provided the dental students with experience of what is was like working in a practice environment. Feedback from the dental students was positive with regards to the facilities and experience which they gained at the clinics.

The service had adopted a “dental passport” for the special care patients. This was filled in by patients, relatives and/or their representatives. This provided the dental staff with information about how they liked to be treated. Examples include, how they like to be seated at the dentist, how they cope with injections and how they let people know if they are in pain. There was also a section where they could fill in things they like and things they don’t like. At the back of the passport there was a log of what treatment the patient had completed and what they need to do at home, such as “brush the back teeth more”.

At Queen Victoria Centre Dental Access Service they had implemented a nurse led dental anxiety management (NDAM) service. This was a talking therapy service used to help patients overcome their dental anxieties. They use techniques such as acclimatisation, desensitisation and distraction to help patients accept dental treatment without the need for conscious sedation. The service had trained several members of staff to be involved in the process so that patients had a continuity of care from liaising with a receptionist to having the sessions with a trained dental nurse then having the dental treatment done by a dentist. We were shown a video testimonial of a patient who had been through a course of dental anxiety management. This patient had not been able to tolerate dental treatment for many years. As a result of this they had neglected their teeth and had subsequently suffered from pain. After sessions with a dental nurse they were able to receive dental treatment without the need for conscious sedation. They were currently training staff at Whitegate Health Centre to provide this service for patients there.
Sexual health

Facts and data about this service

A team of doctors and nurses provide all age community sexual health services across Blackpool and Lancashire. They deal with a variety of sexual health related conditions, providing testing and treatment of sexually transmitted infections (STI’s), including HIV, in line with national guidelines. On its website the service describes itself as a community outreach service.

The trust provides community sexual health services from a total of 34 locations including primary care centres, health clinics, hospitals and saunas.

Is the service safe?

Mandatory training

The trust set a target of 95% for completion of mandatory training. The overall training compliance for staff in community sexual health services in 2016/17 was 82% against this target. However, we found discrepancies between the sexual health services internal mandatory training compliance figures and those provided by the trust.

An example of this was the sexual health services own estimate of its children’s level 3 safeguarding training compared to the trusts 2016/2017 figures.

The management team of the service shared an internal training log from December 2017 which we have reviewed. The log evidenced that 91% of staff had undertaken level 3 safeguarding training and in comparison the trusts records stated only 77% of staff had undertaken the course.

We also saw further evidence of a mismatch between internal compliance figures and those of the trust on mandatory training whilst on inspection.

A nurse in the sexual health service showed us her completed training course certificate which had been presented almost three months previous to our inspection. The attendance on the course had not been updated on the trusts central system.

We were told by the trust that the discrepancies were due to the time lag between course completion and management system catching up. This issue affected the trust’s ability to clearly establish mandatory training figures centrally.

A full breakdown of compliance for mandatory training courses in 2016/17 for staff in community sexual health services was provided to us below.

The data showed that the staff had achieved the trust target completion rate in one of their annual mandatory training areas, namely information governance. All other training completion rates were above 75% with the exception of conflict resolution, risk management and medicines management.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Sum of Number of eligible staff last year</th>
<th>Sum of Number of staff trained (Last Financial Year)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>162</td>
<td>117</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Consent</td>
<td>148</td>
<td>115</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>162</td>
<td>130</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>162</td>
<td>127</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>162</td>
<td>130</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>138</td>
<td>103</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>162</td>
<td>126</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>162</td>
<td>157</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>78</td>
<td>46</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>148</td>
<td>107</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (Object)</td>
<td>148</td>
<td>111</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Practical (People)</td>
<td>126</td>
<td>95</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>162</td>
<td>124</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Management</td>
<td>162</td>
<td>113</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>66</td>
<td>51</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>0</td>
<td>0</td>
<td>95%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>96</td>
<td>74</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>162</td>
<td>132</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Venous Thromboembolism (VTE)</td>
<td>0</td>
<td>0</td>
<td>95%</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

We found that staff in community sexual health services undertook a wide range of courses which were both face to face and also e-learning based. The courses included fire safety training, anaphylaxis, child sexual exploitation, safeguarding children, basic life support and manual handling and Mental Capacity.

**Safeguarding**

Sexual health services provided us with information which showed that the service as a whole was 91% compliant with Level 3 safeguarding training. We saw 81 of 89 staff were compliant with the training. This is a marked improvement on the trust figures for 2016-2017, although it is still just outside the trust target of 95%.

Sexual health services adult safeguarding training compliance was 81%.

We found safeguarding policies and procedures were in place. Staff we interviewed knew how to access and understand policies and clearly understood safeguarding principles.

The staff in Blackpool sexual health services were able to give examples of safeguarding concerns they had faced, how they were reported and also provided us with examples of positive outcomes in the protection of adults and children.

Safeguarding arrangements were in place for assessing patients' needs and staff provided us with examples of how the service provided early help for individuals.
The service evidenced a multi-agency approach to dealing with safeguarding concerns, including sharing information with other services, when appropriate, including multi-agency panels, child in need meetings and social care teams and the police.

The service had a safeguarding champion who was the lead nurse in the service. The lead nurse linked into structures in the trust. The champion was trained to a level three competency in safeguarding children and delivered practical support to team members as well as structuring the processes on reporting of concerns in the team. The lead nurse was knowledgeable and supportive to staff and understood the complexity of need of patients who might need to be referred.

We found safeguarding was discussed throughout all the structures of the service. The staff accessed safeguarding supervision, when required.

We were able to review the treatment of individuals through records and assess how the services systems kept both adults and children safe. We found that people who were highlighted as concerns were discussed in supervision, team and managers forums. The records showed high levels of intervention with good record keeping.

Staff used assessment processes, which were based on British Association for Sexual Health and HIV (BASHH) guidelines for assessment, which prompted staff to discuss and record safeguarding issues. The British Association for Sexual Health and HIV are a national organisation which promote excellence in the treatment of sexual health.

We found that the service used a nationally recognised electronic recording system. Documentation on the service’s electronic recording system highlighted safeguarding as a core requirement of the patients on-going assessment and triggered discussion.

Arrangements were in place to safeguard and refer victims of sexual assault in accordance with British Association for Sexual Health and HIV guidance.

The service used a British Association for Sexual Health and HIV recognised pro-forma “Spotting the Signs” which was based on national best practice for child sexual exploitation.

Arrangements were in place to safeguard and refer victims of Female Genital Mutilation (FGM) in accordance with British Association for Sexual Health and HIV guidance. The service had a screening process in its assessment documentation and a pathway was in place for referral of victims to the safeguarding team and the police.

The service undertook Partner Notification. Partner Notification is the process of providing access to treatment or information to the partners of patients who have been at risk of infection due to sexual contact with the patient.

**Cleanliness, infection control and hygiene**

The service had an infection prevention and control policy and this was supported by the nurses who had a secondary role as infection prevention and control leads.

There were service policies in place for infection control and hand hygiene, which were in date at the time of the inspection.

Staff were provided with mandatory training on infection prevention and control. The mandatory training log for 2016/17, which was provided by the trust, showed that community sexual health services had a 75% compliance rate across the service.

On the evidence provided to us, the service had not met the 95% compliance rate set by the trust.
Clinical sites and waiting areas were clean and safe. We visited six clinic rooms, in the core service at Whitegate centre and the two at health centres. All the clinical areas were visibly clean and well maintained.

Hand gel dispensers, which were full and ready to use, were located in various places around the three buildings and the rooms had hand washing facilities.

A sharps policy was in place, as were sharps bins. Staffs we talked to were aware of the policy and yellow sharps bins were stored appropriately and were labelled. Blackpool sexual health services had clear guidance on what to do if exposed to blood borne viruses.

Appropriate arrangements were in place for managing clinical waste and handling clinical specimens. The service had good decontamination processes in place.

The services had appropriate waste disposal services for non-clinical waste.

The service had a contract with landlords that provided cleaning services on a daily basis. The clinical staff also undertook daily cleanliness checks to ensure hygiene standards remained high when needed.

Deep cleans of the clinical environment were available, if and when needed.

The staff had access to appropriate personal protective equipment (PPE), such as gloves and aprons. We saw these being used in consultations.

**Environment and equipment**

The service was situated in multipurpose buildings in a number of sites across Lancashire. The three sites we visited were based in a large health centre, a small health clinic and a late night satellite service, which was in a small health clinic.

The main service we visited at the Whitegate Centre was provided on the ground floor of a health centre. The other two clinics were also on ground level and all were easily accessible.

The clinical areas were suitable for the treatments and diagnosis carried out. The clinic rooms and patient spaces were visibly clean, airy and well decorated.

We found that a large percentage of the equipment used for the measurement of blood pressure needed recalibrating and had recently fallen outside their testing date by a month.

The service was positive in response to our concern and took immediate action to resolve the situation.

We were able to see that all blood pressure equipment and weighing scales had been collected at a central point and were due for recalibration the next day after we raised the issue.

All other equipment in clinics conformed to the relevant safety standards and items were regularly serviced, maintained and were clean.

We checked a sample of needles, swabs packs and instruments, which we found to be within the manufacturers’ expiry dates.

The waiting area in the main service in Blackpool was spacious and enabled administrators and staff to have private discussion.

The two satellite services were less spacious, but staff and patients were able to find areas to have confidential discussion.
We found large spaces between seating areas and the reception desk which allowed patients to have private discussions with reception staff.

The services had confidential interview and clinic rooms which enabled staff and patients to have private discussion and were sound proof.

The service gave us an example of an environment audit in one of its sites in Poulton dated 7 September 2017. The Poulton building passed every one of the 31 questions on the compliance form.

**Assessing and responding to patient risk**

When a patient attended the sexual health service, staff undertook an assessment to identify risks and look at the patients’ needs.

The assessment was based on questions incorporated in the British Association for Sexual Health and HIV guidelines. The assessment questions are national recognised and are set out by sexual health experts across the country.

The service used British Association for Sexual Health and HIV assessment documentation to monitor the risk associated with each patient.

The service had assessment documentation which focussed on social risk as well as medical related risk. It worked closely with partners to help assess and respond to other patient risk; partners included the police and social care services as well as the council.

Patients and staff had access to the team doctors and consultants in different clinics at different times of the day. Staff told us that if a patient became unwell they could seek medical advice from specialist nurses, or if need be from doctors and consultants who were present in services or contactable by phone in other services. Oxygen was available if required.

Staff told us that they could call an ambulance if patients deteriorated.

The clinic rooms we visited had a supply of oxygen in each room which was secure and full and grab bags were available in all clinics.

Anaphylactic shock equipment was present in each room, if patients deteriorated.

**Staffing**

**Total numbers – Planned vs Actual**

We found the staffing levels of services we visited sufficient to meet the needs of patients. As of 31 October 2017, the community sexual health teams had 93 of its 97 commissioned staff in post.

Staff members and managers told us they felt they had enough staff to have a functioning team and provide the level of care needed by patients.

The service had not set caseloads. Caseloads were unpredictable and patients could visit the service and request a consultation at any time, which made it more difficult to plan for staffing. The service had periods where patient capacity became problematic.
Staff had designated bases and roles throughout the community, but also worked from any base to provide cover when needed.

**Vacancies**

The trust provided evidence of vacancy rates. The vacancy rate for medical and non-medical staff in sexual health services was low with only five vacancies across all professions in the service. The main vacancies were in its North service with 2.5 Health Care Assistant vacancies.

**Turnover**

Between July 2016 and June 2017, the trust reported an overall turnover rate of 8.1% in community sexual health services. This meets the trust target of having a turnover rate of 9% or lower.

The trust did not provide a breakdown by staff group but a breakdown by service was available. The HIV service had the highest turnover rate of 21.1%. However, in this service, staff numbers were relatively small, making turnover rates exaggerated if a member of staff left.

The service had seen substantial increases in its staffing in the last year. It had procured a successful tender in its North Community Sexual Health Services for all ages across Lancashire. In Blackpool, the service procured a successful tender for all ages and young people. From July 2017, the service procured a successful tender for HIV services across Lancashire and South Cumbria.

. We were told that there had been some displacement of staff. A small minority had decided to leave the service and or stay with the old provider.

The services substantive staff and leavers can be seen below;

<table>
<thead>
<tr>
<th>Service</th>
<th>Total number of substantive staff, June 2017</th>
<th>Total number of substantive staff leavers, July 2016 to June 2017</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackpool Sexual Health – HIV</td>
<td>4.7</td>
<td>1.00</td>
<td>21.1%</td>
</tr>
<tr>
<td>North Community sexual health services - 114370</td>
<td>69.0</td>
<td>7.0</td>
<td>10.1%</td>
</tr>
<tr>
<td>Blackpool Community sexual health service - 114122</td>
<td>37.0</td>
<td>1.00</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

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32 Universal RPIR – Vacancy tab  
33 Universal RPIR – Turnover tab
Sickness

Between July 2016 and June 2017, the trust reported an overall sickness rate of 5% in community sexual health services. This did not meet the trust target of having a sickness rate of 4% or lower by a small margin.

As with the turnover rate, the trust did not provide a breakdown by staff group but a breakdown by service was available.

The highest sickness rate was in the HIV service: 9%. However this services staff numbers were relatively small, making sickness rates exaggerated if a member of staff was ill.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Total permanent staff sick days</th>
<th>Total % permanent staff sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackpool Sexual Health - HIV - 114123 Total</td>
<td>161.5</td>
<td>9.0%</td>
</tr>
<tr>
<td>Blackpool Community sexual health service - 114122 Total</td>
<td>796.0</td>
<td>5.8%</td>
</tr>
<tr>
<td>North Community sexual health services - 114370 Total</td>
<td>1053.6</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Nursing – Bank and Agency Qualified nurses

The trust did not supply any nursing bank and agency data for either qualified nurses or healthcare assistants for its community sexual health service. We were told on inspection that any gaps in post were covered by the permanent staffing group.

Nursing - Bank and Agency Healthcare Assistants

The trust did not supply any nursing bank and agency data for either qualified nurses or healthcare assistants for its community sexual health service. We were told on inspection that any gaps in post were covered by the permanent staffing group.

Medical locums

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34 Universal RPIR – Sickness tab
35 Universal RPIR – Bank/agency tab
36 Universal RPIR – Bank/agency tab
37 Universal RPIR – Medical locums tab
The trust did not supply any medical locum data for its community sexual health service. We were told on inspection that any gaps in post were covered by the permanent staffing group.

**Consultant cover**

The service had better than average clinical cover with consultant posts making up 3.98 full time equivalent of all posts.

There were:
- 1.42 full time equivalent associate specialist posts allocated in the service.
- 1 full time equivalent registrar posts allocated in the service.
- 5.5 full time equivalent speciality doctors posts allocated in the service.

**Suspensions and supervisions**

The trust reported that there were no suspensions or supervisions in their community sexual health service between June 2016 and July 2017 (up to 21 July 2017).

**Quality of records**

The service took part in a national case note review which was undertaken by British Association for Sexual Health and HIV in 2017 for syphilis case note recording. The audit focussed on results from the largest sexual health team which is based at Whitegate Centre in Blackpool. It therefore did not reflect all parts of the service. The results showed positive findings with the service achieving 97% successful audit outcomes.

An audit of records was undertaken in November 2017 as part of a wider process in its clinical division. The audit results were positive.

In line with the trusts record keeping policy, 20 sets of records were analysed. This audit took place monthly and records were reviewed across the whole service. The reports were submitted to the trust corporate governance team.

The service used a nationally recognised electronic recording system which was specific to sexual health service’s needs. The system had automatic questions which related to risk factors associated with sexual health.

The notes were systematic meaning staff had to fill in areas of essential information before the system would allow them to fill in the next section of the electronic records.

We examined five sets of electronic records in our inspection. The intervention period in sexual health records are usually of a short duration, however the electronic notes were clear and concise and showed assessment information, case work and care planning processes were evident.

We saw that electronic notes were accessed by password.

Patient’s treatment information was shared with GPs with the patients consent

**Medicines**

Medicines were not of high risk, there were no controlled drugs on the premises. Drugs were stored correctly and locked up safely.

Medication levels were monitored by staff to ensure the right dosages were released and logged.

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38 Universal RPIR – Consultant cover tab
39 Universal RPIR – Suspensions and supervisions tab
Selected appropriate staff had access to medication.

We found that oxygen cylinders were full and cylinders and emergency medical bags, used in emergencies, were checked by staff in the main Blackpool clinic.

We found the oxygen tank in the Poulton late night clinic was full; however the two nurses on duty from the sexual health clinic were unable to confirm if the grab bags and oxygen levels had been checked by sexual health staff or any other staff in the surgery recently.

We were told the reason for this uncertainty was that the service provided by the sexual health team was a satellite which was used occasionally on a weekly basis and was not the trusts property.

Therefore staff from sexual health had not checked if the equipment was in working order and relied on other healthcare staff in the health centres to check equipment. The sexual health staff agreed that it was their responsibility to check if equipment was in good working order for their own patients.

Whilst we were unable to check on oxygen cylinder audits in community sexual health services because of time limitations. We were assured that the situation would be resolved on the day we left.

Safety performance

There were no ongoing concerns about safety performance.

The service had participated in a number of national quality audits in the last year.

Incident reporting, learning and improvement

There were trust wide corporate policies and procedures that guided staff on the reporting of any incidents or concerns, investigation and learning procedures. These policies and procedures were available to staff via the trust’s intranet.

Staff understood incident reporting, giving examples of the types of incidents they would report. This included incidents that resulted in patient harm and patient confidentiality breaches.

During the inspection, we identified concerns such as a patient confidentiality breach and a serious patient incident that had been formally reported using the incident reporting system. We saw evidence that staff and managers had discussed these issues during routine team meetings. We saw records to show how improvements were made and reviewed by managers.

One of the teams had developed a team board which provided up to date information on incidents and learning.

Serious Incidents - STEIS

Trusts are required to report serious incidents to the Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community sexual health services, which met the reporting criteria set by NHS England between August 2016 and July 2017.

The service were linked into, the Freedom to Speak Up Guardian. There were no concerns raised for Q1 2017/18. No other results were supplied.

**Serious Incidents (SIRI) – Trust data**

Between August 2016 and July 2017, trust staff in this core service reported no serious incidents.

**Prevention of Future Death Reports** (Remove before publication)

The Chief Coroner’s Office publishes the local coroners’ Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations made by local coroners with the intention of learning lessons from the causes of deaths and preventing deaths.

In the last two years, none of the prevention of future death reports sent to the trust related to its community sexual health service.

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**Is the service effective?**

**Evidence-based care and treatment**

Community sexual health services had a lead nurse consultant who in conjunction with the consultant focused on the quality of clinical delivery.

The service followed British Association for Sexual Health and HIV (BASHH) guidance. The guidance is developed on a national basis in conjunction with a wide range of experts to promote excellence in the treatment of sexual health and HIV.

The service followed Faculty of Sexual and Reproductive Health (FSRH) clinical guidelines, which are nationally recognised by NICE. The faculty is a national specialist committee which develops training, puts on events and provides training resources.

We found that the service adhered to standards set by the faculty, accessed training for staff and attended events where appropriate.

The service provided us with evidence that all of its contraceptive patient group directives were based on FSRH guidance. A patient group direction (PGD) is a written instruction for administration of medicines to groups of patients which is based on best practice in this case from the faculty.

The service provided us with evidence that it followed FSRH guidance on Genito-Urinary medicine through its PGDs.

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41 STEIS
42 Universal RPIR – P85 (supporting documents)
The service provided evidence that it followed best practice guidance on the assessment of contraceptive history. The template is used on its electronic records system and was developed by the FSRH effectiveness unit in 2016.

The service used a comprehensive ‘Under 16’s Fraser Assessment’ which was developed in 2017. The assessment was based on British Association for Sexual Health and HIV ‘Spotting the Signs’. The guidelines were developed to assist professionals in working with young people to identify and assess the risk of child sexual exploitation (CSE).

Good practice was shared across services through documented service meetings which were held on a monthly basis. An example of this is that FSRH guidance was shared with all staff through emails and bulletins.

The service was actively linked with both regional and national networks where information on best practice was shared.

**Patient outcomes**

Audits – changes to working practices

The community sexual health services took part in a generic record keeping audit rolling programme, this involves a review of 20 records on a monthly basis.

The service has participated in a number of national quality audits in the last year.

The service participated in the British Association for Sexual Health and HIV (BASHH) National Clinical Audit in 2017 on the management of syphilis with positive results. The compliance target was 100% the service outcomes were 97%.

A new risk assessment for young people and vulnerable adults was introduced into the sexual health services in November 2016. The assessment was based on a Pan Lancashire Child Sexual Exploitation standard operating protocol. The tool incorporated national guidelines on the management of sexually transmitted Infections and guidance from Faculty of Sexual and Reproductive Health (FSRH) and British Association for Sexual Health and HIV.

20 records were reviewed as part of the audit and it showed that 100% compliance had been achieved in completing the risk assessment.

The service had partaken in the National Health Service England (NHSE) Cervical Cytology audit 2017. The audit examined, which venues in the service had least patients who did not attend appointments and the reasons why. The audit was used as learning tool to improve engagement and the responsiveness of the service.

Community sexual health services took part in a generic record keeping audit in November 2017. The outcome was not provided. The service was due to audit its Best Practice Care indicators where 10 patient records were to be reviewed across its localities.

**Competent staff**

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43 Universal RPIR – Audits tab
All the staff we spoke with in the community sexual health service told us they felt competent and well supported with their training needs.

They staff told us they had good access to training regarding their professional development.

The service had a number of staff who were FSRH accredited trainers. The training helped to ensure staff were aware of national best practice in sexual heath.

The service had been asked by Lancashire county council to ensure that 80% of its staff were dually trained in long acting reversible contraception (LARC) and in sexually transmitted infections (STIs).

Historically sexual health training was divided into these two separate streams but in the last few years dual training was seen as best practice. Dual training allowed services to be flexible and act as a one stop shop for sexual health issues.

The percentage of specialist Sexual Health nursing staff dually trained in LARC and STI screening was 98%.

Staff held group discussions to facilitate learning and were also provided with training through managers in the service.

**Appraisals for permanent non-medical staff**

The trust supplied appraisals data for only one reporting unit within their community sexual health service: the HIV unit at Blackpool Victoria Hospital. The trust also did not include a breakdown by staff type.

For the period April 2016 to September 2016, all six members of staff within this unit received an appraisal.

For year to date (April 2017 to July 2017) none of the six staff within this unit had yet received an appraisal.

However we received up to date information on the services appraisals which was dated 23 November 2017. The service evidenced that:

- It had completed 135 appraisals across all its teams.
- It had 11 appraisals in progress across all its teams.
- It had 9 appraisals which it had not started across all its teams.

In total the service had completed and was in progress in 146, or 94% of appraisals across all teams.

**Appraisals for permanent medical staff**

Medical staff underwent annual appraisals. All medical staff had completed appraisals. Community sexual health services had 12 of 12 (100%) medical staff who had completed their appraisals.

Staff were inducted into teams. We talked to a new member of staff, who told us that they felt supported in their induction.
The community sexual health services had a formal induction process for new staff. The induction gave newly appointed staff basic information about the trust and the organisation and allowed staff to shadow other members of the team for up to four weeks.

Staff were able to access specific courses on sexual health both on a local and national level.

**Multidisciplinary working and coordinated care pathways**

Entry to treatment was mainly through a self-referral basis. However referrals could be made from the individuals families and local statutory and none statutory organisations with patient consent.

In some cases care pathways did not need consent. Information was shared on a need to know basis and was primarily focused on the risk that the patient presented.

The services had comprehensive links with other services across its local area and co-ordinated pathways. Partnership work was highlighted as good with clear links to the local authority and other local providers in its localities.

A full range of services supported the work of teams including social care and criminal justice services as well as other health providers, for example substance misuse services.

A large number of clinics were located in the same building as other health providers i.e. health centre and health clinics.

The service had a good working relationship with safeguarding teams in other organisations as well as in its own organisation.

The community outreach team worked closely with organisations that supported individuals with additional needs.

**Health promotion**

The service had links across both primary and acute care services, which it could utilise if, need be.

The sexual health service provided health promotion, education and training. Advice lines were advertised in information leaflets and on the provider’s website to support people seeking help and advice.

The service worked in a number of GP surgeries as well as health centres.

Outreach staff engaged communities across the three localities, regarding safe sex and sexual health planning and testing.

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

Staff had access to guidance around seeking consent from adult patients as well as patients less than 18 years old. Staff had a good understanding of these issues and also had good access to advice from clinicians and managers.

We found the staff understood the relevant consent and decision making requirements, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

Staff understood how to apply the Gillick competency (used to decide whether a child is mature enough to make decisions) to balance children’s rights and wishes with the responsibility to keep children safe from harm.
The team offered a confidential service. Young patients gave verbal consent to treatment and advice and levels of maturity were assessed using BASHH guidelines.

Patient records showed the service supported the consent process through integration of consent questions in patient records. We found staff gained consent appropriately from each patient and this was documented clearly on all the records we reviewed.

Staff could ask senior managers or senior clinicians in the service for support and advice around consent, if needed.

Patient records showed staff sought support from professional’s, for example, social workers and the police, where vulnerable young patients were assessed as lacking the capacity to make their own decisions.

Deprivation of Liberty Safeguards\textsuperscript{46}

The trust reported that no deprivation of liberty safeguard (DoLS) applications were made to the local authority between July 2016 and June 2017 that were pertinent to its community sexual health service.

\section*{Is the service caring?}

\section*{Compassionate care}

Due to the sensitive nature of some of the services, we spoke with only two patients during the inspection. They spoke positively about the care and treatment they received. They described the staff as being kind, supportive and non-judgmental towards them.

One patient described returning to the service for a yearly check-up because they felt comfortable with staff.

We found staff demonstrated a good understanding of people’s needs, particularly in terms of the social stigma attached to visits to sexual health services. The staff understood the physical and mental issues relating to problems with sexual health and how these issues could affect adults and children.

The staff we spoke with demonstrated a good understanding of people’s personal, cultural, social and religious needs.

Staff were clear that patients’ privacy and dignity was key in the provision of a good service.

We observed positive interaction from staff with patients in waiting areas. The staff made patients feel at ease.

Staff were passionate about patient care and were proud of the service they delivered. Staff talked about prioritising patients before themselves and making a positive difference to people’s lives, they had a strong commitment to choice regarding treatment and equality.

We saw evidence that patients were fitted into appointments which they had missed due to unexpected delay. Staff including doctors stayed behind after hours to see patients rather than sending patients away.

\textsuperscript{46} Universal RPIR – DoLS tab
Emotional support

During the inspection we saw many occasions where young people were accompanied by their friends. Staff allowed peers to support patients whilst in waiting areas. The staff told us this enabled people to feel supported and increased the likelihood of engagement in the treatment process.

We were told of a situation where members of staff had physically gone to patient’s houses to drop off HIV medication, in part to support the patient’s treatment but also to check on welfare.

A member of staff described how outreach colleagues had engaged a vulnerable young person who had been a missing person. The staff brought the young person breakfast out of their own money until police arrived to assist.

The service accepted referrals via relatives, carers or support workers. However, patients had to individually agree to assessment and treatment.

Understanding and involvement of patients and those close to them

Staff in the psycho sexual service clearly recognised the effect of sexual dysfunction and the emotional impact it had on individuals. The counselling services provided specialist emotional support by competent trained professionals.

As well as psycho-sexual counselling, patients were sign-posted to other support services including HIV support and counselling services, for example, rape crisis and termination of pregnancy (ToP) counselling.

The two patients we met told us they were kept fully informed and staff were clear at explaining the care and treatment options to them in a way they could understand.

As part of an approach to support patients to be fully involved in decisions affecting their care, the lead HIV consultant and specialist nurse had taken part in “dinner with the doctor”. Patients across all localities were invited to attend. Patients were encouraged to bring partners, family and friends.

Is the service responsive?

Planning and delivering services which meet people’s needs

Blackpool sexual health services had a flexible, wide range of choice of services in place to meet the needs of the local population. The sites we inspected were based with numerous other services, which also focussed on the well-being of both young people and adults.

The service had extended and variable opening hours in different sites for example colleges, youth cafes and treatment rooms. The service catered for patients with evening appointments and appointments at weekends.

Patients could access sexual health services directly through drop in and also request visits and appointments.

Staff were available during the week and worked flexibly on weekends, when needed.
We found examples of multi-agency pathways for patients with complex needs. High risk patients could be discussed in multiagency forums and services were co-ordinated to meet individual need through a combined approach to care planning.

The service worked closely with social care providers and education providers to address the needs of the local population, for example the training of school nurses and social care staff.

The services focussed on a number of public health outcomes which included reducing teenage pregnancy, chlamydia screening and GUM interventions.

Blackpool sexual health services, commissioned by Blackpool Council, provided outreach training sessions to other agencies and high risk groups.

In a six month period, between April 2017 and November 2017, there were a total of 13 outreach training sessions conducted across Blackpool. The training reached 124 people.

The service was providing training for ‘champions’ in which other professionals identified by the doctors surgeries lead on the promotion of National Chlamydia Screening Program in primary care.

Meeting the needs of people in vulnerable circumstances

The service provided comprehensive and extensive education, training and services to its communities.

Clinical outreach teams worked with individuals and groups who could not access mainstream services.

An example of this was the services participation in supporting saunas and other targeted environments. The purpose of delivering the clinics was to educate and protect individuals and also to minimise the potential public health risk of a Sexually Transmitted Infections (STI's) outbreak.

The service provided sexual health advice for women who have recently left prison and were particularly vulnerable because of the risk of pregnancy.

Advice and information was provided to young people struggling to access mainstream schooling.

Training was on offer to professionals in contact with young people who were at potential risk of being sexually exploited.

Young people with learning difficulties or unable to attend mainstream higher education were also seen by the service to ensure access to good sexual health advice and treatment.

Fresher’s Week in a number of colleges were targeted so that students could either see health professionals or gain insight into where they could access sexual health services.

Access to the right care at the right time

The service had specific performance reporting structures in each area and this was reviewed and monitored by commissioners on a quarterly basis.

The service was usually open access which meant that the majority of visits did not require an appointment. Some consultations such as HIV consultations and other procedures were arranged through scheduled appointments. Patients were either seen by arranged appointment or in an open access clinics and in outreach services.
Patients had access to a range of clinics at different times including evenings and on weekends. The clinic could be accessed either through direct contact with teams or through the services website where appointments could be booked. 93% of the 44 patients surveyed in a recent survey thought the clinics were convenient.

The service had a target of 80% of patients being seen within 48 hours of referral across Lancashire. At the time of our inspection the service saw 78.3% within a 48 hour margin.

The local authority had set a target of 70% for the percentage of service users completing a service user experience survey that rated the service as good or excellent. The services performance was recorded as 98%.

Call back requests could be made by potential patients to improve contact with the service.

Patients could request home visits dependent on their vulnerability and personal circumstances.

The service produced quality reports on a monthly on-going basis for commissioners that included data on patient access and types of procedures under taken and their uptake. A number of the targets were focussed on providing audits as well as hitting targets.

The Lancashire County Council quality reports provided to us for the period of July 2017 to 2018 were comprehensive and showed that the service was performing well across a number of areas including auditing and long-acting reversible contraceptives (LARC) uptake.

There were high levels of take up in Chlamydia screening and access to psycho sexual services.

One of the areas for improvement was the number of all attendances screened for human immunodeficiency virus (HIV).

The service had a range of staff including health care assistants, qualified nurses’ doctors and consultants who provided a wide range of services and broad level of expertise.

Referral to specialist services (e.g. termination of pregnancies) was available and could be arranged with the assistance of staff.

The psycho sexual service had developed a team board which provided up to date information on progress against targets. The staff had access to Did Not Attend (DNA) rates, active cases and numbers of referrals that the service had received.

Accessibility

The 2011 Census showed that white British people were the majority of the population in the area covered by the trust. According to the Census 93.6% of the population of Blackpool Unitary Authority (UA), and 89.7% of the population of Lancashire (excluding UAs) identified as white English, Welsh, Scottish, Northern Irish or British.

According to the Census the largest ethnic minority groups in these two local authorities were as follows:

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
</table>

Accessibility

Universal RPIR – Accessibility tab; 2011 Census
### Learning from complaints and concerns

**Complaints**

There was a complaints procedure in place that outlined the process for handling patient complaints.

Complaints about the services were investigated by the team manager or service manager. The complaints were also recorded on a complaint log so they could be reviewed for trends.

The staff we spoke with understood the process for receiving and handling complaints. Information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.

We found the number of complaints were low in community sexual health services.

The trust’s community sexual health service received three complaints between July 2016 and June 2017. The complaints were minor in nature with no specific pattern.

**Compliments**

The trust received 55 compliments between July 2016 and June 2017 which related to its community sexual health service.

Patient feedback was also obtained through Survey Monkey. 44 patients completed the last survey in October 17. The response showed that 90% felt it was easy or very easy to book an appointment. 93% of patients thought the clinics were convenient.

96% of patients were satisfied or very satisfied with the service they received at clinic. Clients were also asked for suggestions on improvements to the service.

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### Is the service well-led?

**Leadership**

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The overall lead for the services was the service manager. We found that their leadership was visible across all three locality areas of the services.

Staff spoke highly of their managers. All the staff we spoke with told us they understood the reporting structures clearly and described the managers as approachable, visible and providers of good support.

The service had a clear leadership structure where the manager reported to a directorate manager and was supported by nurse consultants’ team managers and a lead consultant.

The service manager was responsible for the administrative staff and the education and wellbeing of teams. It was clear that recent tender acquisitions had placed considerable pressure on the management structure, with managers having to establish new services across a considerable geographical area.

We were told the experience of incorporating new services was difficult but rewarding. Managers told us they were listened to by senior managers in the trust and extra resources were given including extra management structures.

The manager was clearly proud of the service and its recent achievements in terms of expansion. She felt that the expansion was based on commissioners seeing the benefits of economies of scale and also the expertise levels in the service.

There was strong clinical leadership through a consultant lead and nurse consultant. The clinical leadership were aware of best practice in the provision of sexual health services.

**Vision and strategy**

The staff were aware of the trust values.

The service did not have an individual documented strategy. The trust had an overarching strategy which all its services aligned into. It was going through a period of transition where new localities had combined with previous trust services. A considerable amount of time had been directed towards making the service collective whole, rather than disparate organisations covering a wide area. The managers were very clear that the present strategy was shaping the services into collective and utilising shared resources and learning.

**Culture**

The service had expanded considerably in the previous year through the acquisition of locality services across Lancashire.

Staff we talked to were positive about the change that occurred and shared the same values. The service was centred on the needs of local people and improving their sexual health understanding.

Staff told us they felt valued and respected and that the service was a good place to work.

The staff turnover rates and vacancy rates were outside of the trust’s compliance target but were within reasonable boundaries and indicated that staff morale seemed to be positive.

**Governance Management of risk, issues and performance**
There was a clear governance structure in place in community sexual health services. The service fed into its division which then fed into the trust board.

There was a divisional risk register in place and any high rated risks were escalated to the corporate risk register.

There were routine local staff meetings where information on safeguarding concerns, performance, complaints, incidents and audit results was shared with staff.

The service manager and other central leaders such as nurse consultants and the consultant lead attended routine clinical and operational meetings involving other managers from the services other locations.

The service manager logged identified risks to the services on a local risk register. We saw the risk register listed key risks.

There was a corporate risk register in place and any ‘high’ rated risks rated were escalated to the corporate risk register.

Routine audit and monitoring of key processes took place across the services to monitor performance against objectives. A lead nurse consultant coordinated most of the audit activity and maintained the service’s audit schedule.

A lone working policy was in place and staff were aware of it and were able to articulate what they would do if it occurred in their role.

**Information management**

The service manager produced monthly and three-monthly activity and performance reports. These were submitted to the service commissioners and the provider.

**Engagement**

Staff participated in team meetings and locality meetings.

The service engaged with patients through survey monkey.

We saw evidence of an electronic staff information board based on the intranet. This was kept up to date by managers. Staff were able to see information regarding governance and patient feedback as well as information on the trust.

The service used social media including its own web site to inform patients of projects in its localities. The service had developed a range of ways to engage with young people such as use of social media platforms and text services to engage with people. The services were actively involved in Facebook and twitter.

**Learning, continuous improvement and innovation**

The service was in the process of implementing a new self-tests in some of its localities. Chlamydia self-test kits were sent by using a texting system to young people under the age of 25.

It is hoped that the kits will increase the uptake of testing in the under 25 age group, who are presently targeted nationally for screening.
The service developed an electronic team board which allowed staff to instantly access commissioned targets and governance information.
Mental health services

Specialist community mental health services for children and young people

Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitegate Drive</td>
<td>CAMHS</td>
<td>16 for medical staff. Varied for other clinicians</td>
<td>Mixed</td>
</tr>
</tbody>
</table>

Is the service safe?

Safe and clean environment

(Appplies only if patients are seen on provider premises.)

The child and adolescent mental health team for Blackpool was located at Whitegate Health Centre. The health centre had a range of other health services in the same building including an NHS walk-in centre and the child and adolescent mental health team for other parts of Lancashire run by the local mental health trust.

The team offices used to see patients were clean with a welcoming reception area and well equipped interview rooms. The reception area was appropriately designed to ensure the safety of reception staff with a high, broad, fixed reception desk. Staff controlled access to other parts of the building through unlocking doors and escorting patients through the building.

Interview rooms were equipped with an alarm system for staff to request assistance if they were concerned about personal safety. This led to a response by the on-site security staff as well as mental health staff.

The building in which staff worked and patients were seen were well maintained with appropriate furniture across all the rooms. The maintenance of the building was covered as part of the private finance arrangements of the health centre. There were appropriate checks in place to ensure that the buildings were well maintained. For example, we saw that fire equipment had been checked annually.

Teams had systems for visitors to sign in and out of the building. This ensured that staff were aware who was in the building for fire safety. The teams had regular fire tests to test that the fire alarms were working properly and fire drills to practice evacuating the building. There had been a robust fire safety check carried out recently. Although there was a small amount of cladding on the
front of the building, the team manager had received assurance when the building was checked that the cladding was safe and not combustible.

Although there were no designated clinic rooms at the service, there was equipment to measure the weight and height of patients. If required, staff could utilise a clinic room within the health centre, for example if an examination couch was required.

The team had an infection control policy which directed the cleaning of equipment specific to the child and adolescent mental health team. For example, play equipment and toys were cleaned to prevent infection. There were signs to promote good handwashing techniques.

This all meant that patients were seen in a safe environment with a well-maintained building and range of meeting rooms where patients could be seen safely.

**Safe staffing**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The team had an establishment level of one service manager, two Band 7 nursing staff, 14.5 whole time equivalent Band 6 senior clinician staff and 4.8 whole time equivalent support work staff. The team also had administrative support staff and a receptionist. The established medical staffing was two consultant psychiatrists.

**Definition**

Substantive – how many staff in post currently.

Establishment – substantive plus vacancies, for example how many the trust want or think they need in post.

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td>June 2017</td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td>July 2016 to June 2017</td>
</tr>
</tbody>
</table>

**Vacancies and sickness**

<table>
<thead>
<tr>
<th>Vacancies and sickness</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td>June 2017</td>
</tr>
</tbody>
</table>

**Establishment and vacancy (nurses and care assistants)**

<table>
<thead>
<tr>
<th>Establishment and vacancy (nurses and care assistants)</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment levels qualified nurses/clinicians paid at Band 5 or above(WTE*)</td>
<td>June 2017</td>
</tr>
<tr>
<td>Establishment levels nursing assistants/support work staff (WTE*)</td>
<td>June 2017</td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses/clinicians paid at Band 5 or above (WTE*)</td>
<td>June 2017</td>
</tr>
<tr>
<td>Qualified nurse/clinician paid at Band 5 or above vacancy rate</td>
<td>June 2017</td>
</tr>
</tbody>
</table>
Establishment, Vacancy, Levels of Bank & Agency Usage

The team had an establishment level of 14.5 whole time equivalent Band 6 staff. This included nursing staff, but also senior clinicians with other professional experience such as clinical psychologists. There were 2.9 whole time equivalent Band 6 staff vacancies which gave a revised vacancy rate of 20% of whole time equivalent Band 6 staff.

The team had one vacant consultant psychiatrist post. This was covered by locum consultant psychiatrists where possible and the recruitment to replace the vacant post was being advertised. Patients received timely access to a consultant psychiatrist at short notice if they required specialist medical assessment or input either directly or through advice via a team clinician.

This core service has reported a vacancy rate for all staff of 3% as of June 2017. Where there were vacancies, managers were working to address these with well advanced plans to recruit staff. This included offers recently being sent out to successful staff. We did not identify any significant impact on patient care as a result of the team holding these vacancies, with the exception of the lack of a nurse prescriber on the team which meant that patients requiring medication for attention deficit hyperactivity disorder needed medication prescribing and reviewing by the psychiatrist on the team.

The trust did not provide any data in relation to bank and agency usage at this core service.

Turnover

The turnover rate for this core service was 15% between July 2016 and June 2017.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Sickness

The sickness rate for this core service was 7.6% between July 2016 and June 2017. The most recent month’s data June 2017 showed a sickness rate of 11.2%. In October 2017, the sickness rate was 4.7%.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Staff reported having manageable caseloads which enabled them to monitor patients to provide safe and effective care. For example, staff were managing a caseload of between 30-40 cases at any one time, including some patients with less intense support such as patients with a diagnosis of attention deficit hyperactivity disorder where the patient did not require appointments as regularly. Staff told us and records confirmed that caseloads were managed in supervision and reviewed regularly. Staff received regular monthly management supervision.

Training data summary

Staffing - Mental Health services v4

Staffing Mental Health services v4

Staffing - Mental Health services v4
The compliance for mandatory training courses as of June 2017 was 81%. Of the training courses listed nine failed to achieve the trust target and two failed to score above 75%. Equality and diversity, health and safety, safeguarding children level 1 and safeguarding vulnerable adults all had the highest training compliance with 100%. There were eight staff eligible for the training course and all eight were up to date with the course. Fire safety and risk management scored the lowest out of all the training courses with 63% each. There were eight staff eligible for each training course and five were up to date.

Key:

<table>
<thead>
<tr>
<th>Below CQC 75%</th>
<th>Between 75% &amp; trust target</th>
<th>Trust target 95% and above</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service</th>
<th>Trustwide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>Safeguarding Vulnerable Adults</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>Consent</td>
<td>88%</td>
<td>86%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>88%</td>
<td>81%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Mental Capacity Act and DOLS</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>Resuscitation (Basic Life Support)</td>
<td>88%</td>
<td>71%</td>
</tr>
<tr>
<td>Health Record Keeping</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Moving and Handling Theory</td>
<td>75%</td>
<td>83%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>63%</td>
<td>73%</td>
</tr>
<tr>
<td>Risk Management</td>
<td>63%</td>
<td>72%</td>
</tr>
<tr>
<td>Core Service Total %</td>
<td>85%</td>
<td>81%</td>
</tr>
</tbody>
</table>

On inspection we saw that the staff uptake of training below 75% had improved. For example training in risk management (which related to health and safety risks) had improved with 92% of relevant staff attending the course. We also saw that staff uptake of training in fire safety had improved with 100% of relevant staff attending the course, with a small number of staff coming up for renewal at the time of inspection.
This meant that most staff were keeping their skills and knowledge up-to-date by attending mandatory training required to carry out their specific role.

Staff working in the child and adolescent mental health team had received a disclosure and barring check when they first started working for the trust. The disclosure and barring checks ensured staff did not have any undeclared or unspent criminal convictions which the trust should know about when they assessed whether potential staff were of good character before offering them employment. However, staff did not undergo routine periodic disclosure and barring checks to provide ongoing assurances that staff remained of good character when working with patients in vulnerable circumstances. The trust's policy relied on staff self-disclosing any convictions on an ongoing basis and a rolling programme of three yearly self-declarations to all staff eligible for DBS checks. While we did not identify any concerns about the character of staff working in the child and adolescent mental health team, local managers concurred that routine periodic disclosure and barring checks would provide better ongoing assurance that staff remained of good character when working with patients in vulnerable circumstances.

Assessing and managing risk to patients and staff

Referrals were screened primarily by the single point of access worker or duty member of staff who would assess the referral information on each person and determine if the person was accepted into the service for a more formal assessment.

We looked at 15 care records including the assessment and management of patients’ risk at initial referral and on an ongoing basis. Staff undertook patient risk assessments at initial referral including risk to self or others. Out of 15 records we looked at, 11 records were lacking in relation to risk management plans with minimal information or where risks were identified in other records but not reflected on the risk assessment. Eight out of 15 risk assessments records had not been reviewed for some considerable time. In two cases there was no separate patient risk assessment document held on file at all.

Where risk assessments were kept up-to-date and were of a good standard, these usually related to patients presenting with self-harm or suicidal ideation, to enable any staff member to understand the risks presented for each patient. We saw that most patients who were at risk of self harm produced a 'my safety plan' which was a patient led tool for patients to identify the key things to keep themselves safe and the coping strategies to reduce or avoid self-harm in the future.

Our observations of care evidenced that staff were looking at ongoing assessment and management of risk in discussions with patients and parents.

Some of the risks patients posed were mitigated by the fact that certain categories of patients were referred onto other agencies and more complex cases followed different specialist pathways. For example, patients over 14 with suspected or actual psychosis were referred to the nearby mental health trust's early intervention service; patients with more complex eating disorders were referred to the specialist eating disorder service run by the local mental health trust and patients with higher levels of need on the autistic spectrum were referred and seen by the trust’s complex cases team.

Management of patient risk
When patients were referred into the service, the referral was screened by a duty worker from the child and adolescent mental health team who carried out an initial triage including the screening and management of risk. Children and young people had access to crisis care through attending the emergency department at Blackpool Victoria Hospital where they could be seen by the child and adolescent self-harm emergency response team into the evenings and weekends. Where a patient was admitted to a paediatric inpatient ward in, staff completed a detailed risk management plan to guide hospital staff on the measures they needed to take to keep patients safe. However when patients were discharged into the community, risk management plans were not always detailed or updated to guide parents or carers on the measures they needed to take to keep their child or young person safe. For example, management plans stated ‘parents to monitor’ or ‘parent to manage home situation’.

Records indicated that some patients posed other risks such as risk of arson and endangering life, risk to others, risk of abuse or exploitation or vulnerability. Staff did not update risk management plans or review them on an ongoing basis. For example we saw one patient had records showing they had a significant interest in fires and were a potential arson risk. The risk management plan for this patient did not identify this as a current or historical arson risk and there was no risk formulation to understand if the patient still posed a risk or whether their interest in fires had waned as they matured. We also saw one record which contained information from a youth counsellor to the child and adolescent mental health team that one patient divulged an incident of harm to a family member and thoughts of harming others. These risks were not reflected in the patient’s risk management plan, even after an incident which should have led staff to believe that thoughts of harming others may still persist. Some risk management plans were not dated or signed so it was unclear when patients’ risks had been managed. We judged that staff were not doing all that was reasonably practicable to mitigate risks to the health and safety of patients due to the current quality of risk management plans records.

We did not identify any episodes of actual harm as result of shortfalls in written risk management plans. In addition, other data corroborated that staff were managing patients’ risks well such as low levels of reported serious incidents, no coroners’ rulings, no deaths of patients or actual suicides in service, small numbers of patients being admitted to child and adolescent mental health inpatient beds and other indicators. We also saw that managers of the team had recently carried out an audit of records and recognised the need for improved recording. Managers were in the process of disseminating the results to staff to seek their views on improvements and were producing an action plan.

Safeguarding

Safeguarding referrals (Internal use only - Remove before publication)

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted.
to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust has only provided information regarding safeguarding referrals at a trust level. We are therefore unable to attribute this data to specific core services.

Most staff had been trained in safeguarding children level 3 with 94% of staff having received this training and safeguarding vulnerable adults with 100% uptake of training which was mandatory. The safeguarding training included information and alerting staff to the dangers of child sexual exploitation and female genital mutilation. There was information in the team office and in the waiting area about safeguarding and how staff, patients or carers could raise an alert to the local authority.

Staff understood the safeguarding arrangements and when to make an alert to the local authority. The multidisciplinary ‘team brief’ session attended by staff from a range of disciplines, included comprehensive discussions about specific children and young people in their care including discussions in relation to safeguarding and child protection concerns.

Staff from the child and adolescent mental health teams attended children’s safeguarding meetings, where appropriate. Records showed that staff contributed to discussions and decisions on child protection concerns including informing children’s social workers of progress and ongoing concerns informally and formally at case conferences.

Following on from an incident where sexualised behaviour of a patient was not properly identified, staff used a formal age-related assessment tool to categorise the sexual behaviours of young people, where appropriate. The assessment tool helped staff understand healthy sexual development and distinguish it from harmful behaviour. This also helped staff make decisions about safeguarding children and young people, in particular those at risk of child sexual exploitation.

Serious case reviews/external reviews (Internal use only - Remove before publication)

A serious case review occurs if a child or vulnerable adult dies, or is seriously harmed, as a result of abuse or neglect. The case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children or vulnerable adults.

The trust has submitted details of eight external case reviews commenced or published in the last 12 months, however none relate to this core service. The team manager confirmed, and the national serious case review library database corroborated, that there had not been any recent serious case reviews involving Blackpool’s child and adolescent mental health team or children or young people referred to or open to the team.

Staff access to essential information

There were multiple patient recording systems including staff recording care and treatment mostly on paper records but some information was also stored in electronic records. The team were looking to move over to electronic records in the future in line with other services provided by the trust. However staff at present would only record the time, date and that the patient had received contact with the child and adolescent mental health team on the trust’s electronic record. This
helped alert staff in other trust services such as the emergency department, school nurses or health visitors that the patient was seen by the child and adolescent mental health team.

Some clinical records held by the child and adolescent mental health team such as care plans, risk assessments and ongoing care were not filed in chronological order. A small number of records were not signed or dated by staff or patients so it was sometimes unclear when assessments or interventions were carried out. This meant that key information about care, treatment and risks was sometimes difficult to find, follow or could be overlooked and records did not always comply with good record keeping practice guidelines.

Care records were held in the team offices in Central Blackpool about a mile and half away from the main Blackpool Victoria hospital site. Records were transferred between the two sites when required. For example if the patient was admitted to the paediatric ward. There was no system to access written records or child and adolescent mental health team records out of hours. This meant that staff working in the child and adolescent self-harm emergency response team at the emergency department at Blackpool Victoria Hospital did not have access to comprehensive information about patients open to the child and adolescent mental health team. The trust was in the process of rolling out an electronic recording system which would mitigate these issues.

**Medicines management**

Medication was not stored or dispensed from the team offices. The consultant psychiatrist was the only prescriber in the team. The specialist nurse for patients with attention deficit hyperactivity disorder was currently undergoing training to be a nurse prescriber.

Patients would receive a prescription from the prescribing doctor or via their GP to get their own medication and store it in their homes. Prescription pads with blank prescriptions were stored appropriately to prevent misuse.

Where patients received medication, records showed that staff were carrying out necessary physical health checks. On occasions these were difficult to find due to records not being filed appropriately or chronologically. This included patients being treated for attention deficit and hyperactivity disorder having regular checks on their height and weight plotted on a growth chart. We saw that where one patient who was given antipsychotic medication based on the recommended dosage for children and young people, records showed they had their baseline health checks such as height, weight, blood pressure and pulse checked as well as their blood tests. In another case, the child had refused ongoing health monitoring and the psychiatrist had requested that one of the school nurses monitored the patient’s height, weight, blood pressure and pulse rate but there were no assurances that these had been carried out recently in the records we saw.

**Track record on safety**

**Serious incidents requiring investigation**

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

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57 Universal PIR – Incidents
Between July 2016 and June 2017 there was one STEIS incident reported by this core service. This was a confidential information leak/information governance breach.

A ‘never event’ is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

<table>
<thead>
<tr>
<th>Type of incident reported on STEIS</th>
<th>CAMHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidential information leak/information governance breach</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This reported incident related to basic clinical information, such as appointment times and details, being sent to the wrong patient address due to human error and the patient’s change of address not being reflected on the patient record.

**Reporting incidents and learning from when things go wrong**

‘Prevention of future death’ reports58 (Internal use only - Remove before publication)

The Chief Coroner’s Office publishes the local coroners’ Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations. These are made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been six ‘prevention of future death’ reports sent to Blackpool Teaching Hospitals NHS Foundation Trust. None of these related to this core service.

Staff knew how to raise safety incidents and the types of incidents to report. Incidents were inputted onto the trust’s incident recording system. A recent incident that had been reported was a patient assaulting a member of staff during a participation appointment. The minor assault took place in an unalarmed interview room immediately opposite reception and was categorised as low harm.

Data from the trust showed that there had been a total of seven incidents reported in the last 12 months, including near misses. None of these met the criteria requiring a formal investigation.

We saw that lessons had been learnt when incidents had occurred. Following the data breach incident of clinical information of appointment times and details being sent to the wrong patient address, staff had took action to prevent a reoccurrence with reception staff routinely checking change of address details on each visit.

Following the assault on staff, as well as the individual staff being supported, measures were put in place to make sure that patients were only seen in alarmed interview rooms.

58 https://www.judiciary.gov.uk/
There was no other significant information of concern highlighted that involved the child and adolescent mental health team. This was corroborated through the data provided by the trust and by managers in the teams who confirmed that that there had not been any other significant safety incidents recently.

The managers of the child and adolescent mental health team told us, and incident records confirmed that there had not been any incidents that met the harm threshold identified in the duty of candour regulations. Staff were aware of the need to apologise when things went wrong. The families’ management team met monthly and oversaw any reported duty of candour incidents to ensure that the trust’s obligations were met.

### Is the service effective?

#### Assessment of needs and planning of care

The child and adolescent mental health team used a choice and partnership approach model to the care and treatment needs of children and young people. This was a nationally recognised model of care used by many child and adolescent mental health services. Staff assessed patients’ needs as part of a choice appointment where the services available were outlined and patients, carers and staff could identify the most relevant treatment, programme or pathway. Staff then arranged participation appointments which included the treatment choices as identified by the patients’ views and their agreement to ongoing treatment.

We looked at 15 care records including the assessment and management of patients’ needs at initial referral and on an ongoing basis. Staff undertook initial assessments at initial referral including risk to self or others. Initial assessment documentation was usually comprehensive and contained details of the patient’s issues, goals and their wider social circumstances. From this patients were matched with a staff member who would assist them in meeting their identified goals. For example, patients with anxiety may be offered a staff member trained in cognitive behavioural therapy.

We found that the written care plans were not always individualised or specific and the care and treatment provided was not always clearly formulated into a single care planning or goal based participation document. For example, most care plans lacked clear details of the type of intervention or therapy which patients were receiving. They often stated ‘provide therapeutic interventions’ without clearly defining what interventions were being offered to patients and what the therapeutic goal was. Out of 15 records we looked at, six records were lacking in relation to detail in the care plans with very limited details, with no personalised or outcome focus.

Four out of 15 care plans had not been reviewed for some time and some were not signed or dated. We identified that when the care records were taken as a whole, we could evidence that staff were providing evidence based care and reviewing that care. For example this was evidenced fully when we looked at the care plan, medical letter reviews which included a treatment plan and the ongoing running records in conjunction. However this was not always easy to find as care plans, risk assessments, medical letters and ongoing care records were not always filed in chronological order.

We spoke with the managers of the team and they accepted the shortfalls in care recording. In October 2017, managers in the child and adolescent mental health team carried out an audit of care records. The audit identified similar shortfalls in the care records which we found. At the time
of the inspection, managers were in the process of disseminating the results to the staff and the recommendations were still being implemented.

**Best practice in treatment and care**

Staff worked within National Institute for Health and Care Excellence guidance in relation to the treatment of attention deficit hyperactivity disorder, depression and anxiety.

Where patients were receiving treatment for attention deficit hyperactivity disorder, staff were monitoring patients’ height and weight as required by National Institute of Health and Care Excellence guidance. This guidance stated that when treatment is given height should be measured every 6 months in and weight should be measured 3 and 6 months after drug treatment has started and every 6 months thereafter in children, young people and adults. Staff were monitoring the height and weight in children and young people; these measurements were plotted on a growth chart and reviewed by the healthcare professional responsible for treatment as National Institute of Health and Care Excellence guidance stated.

Patients assessed as presenting with psychosis were referred on to the early intervention service run by the nearby local mental health NHS trust. The early intervention service specialised in working with individuals aged 14 to 35 at risk of, or currently experiencing, first episode psychosis. Staff considered patients’ physical health where this was appropriate when antipsychotics were administered such as regular blood tests.

Patients also had access to psychological therapies. The trust provided a “Youtherapy” service which was part of the children and young people’s improving access to psychological therapies programme. The child psychology service were provided by the nearby local mental health trust and were available on a direct referral basis. We did not directly inspect either of these services during this inspection.

Staff were also trained in, and could offer, eye movement desensitization and reprocessing therapy which was a structured therapy that encouraged patients to briefly focus on trauma memory while simultaneously experiencing eye movement stimulation. This was in line with National Institute of Health and Care Excellence guidance on the management of post-traumatic stress disorder (clinical guideline CG260). The expected outcome for the patient was a reduction in the vividness and emotion associated with the trauma memories.

**National and local audits**

This core service participated in clinical audits as part of their clinical audit programme in the last 12 months. All 18 undertaken were part of Trust wide audits.

**Skilled staff to deliver care**

The child and adolescent mental health team included a consultant psychiatrist, service manager, clinical psychologists (both employed directly and from the nearby mental health trust), specialist nurses, senior and assistant child and adolescent mental health practitioners, children’s wellbeing practitioners, social workers, and occupational therapists and administrators. This meant that patients had access to a multidisciplinary team with medical, nursing, psychological, and psycho-social input.
However, there were no registered nurses with specialist learning disability training on the team. We saw that it could be difficult for the service to meet the needs of children with learning disabilities. For one child, the service had requested commissioners fund access to specialist learning disability team support provided by another trust.

Information provided by the trust and through speaking to, and observing, staff; we concluded staff were appropriately qualified and competent to carry out their work. For example, staff had undertaken additional training in cognitive behavioural therapy or family therapy.

Staff attended regular professional development. Staff received ongoing training through regular monthly continuing professional training events. Recent training topics attended by staff included cognitive assessment, attention deficit hyperactivity disorder, working with children with trauma, drug and alcohol addiction in young people and brain injury awareness.

Senior clinicians also made contact with the local mental health trust for ongoing learning and individual case review for second opinions if they felt they would benefit from a further medical or clinical opinion.

Staff told us they felt supported in their role and by their direct line manager. Staff took responsibility for their personal and professional development. Staff were committed to providing high quality community care, which met patients’ needs.

**Appraisals for permanent non-medical staff**

The trust did not provide data relating to appraisal compliance for non-medical staff for this core service. On the inspection, staff told us that they had received an annual appraisal in the last year with the exception of one member of staff who had recently joined the team. Figures provided after the inspection visit confirmed that most staff within the team had received an annual appraisal in the last year with 82% of relevant staff (23 out of 28 staff) having had an appraisal in the last 12 months. Where appraisals had not occurred, data from the trust showed it was administrators rather than clinicians who had not had an appraisal.

**Appraisals for permanent medical staff**

The trust did not provide data relating to appraisal compliance for medical staff for this core service. The consultant psychiatrist confirmed that they had undergone appraisal and revalidation.

**Clinical supervision**

The trust provided their clinical supervision data at a trust wide level; therefore we are unable to report on the clinical supervision rates at this core service. On the inspection, data from the trust and corroborated by staff, showed that 91% of relevant staff (21 out of 23 staff) had received the 4-6 weekly expectation of clinical supervision. The weekly team brief sessions helped staff to reflect on their practice and formulate care, treatment and risk management of patients in their care.

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60 Universal PIR – Appraisals
61 Universal PIR – Appraisals
62 Universal PIR – Clin supervision
There were no staff under any performance improvement or disciplinary processes at the time of our inspection.

**Multidisciplinary and interagency team work**

There was a weekly multidisciplinary team brief session, where staff discussed new referrals, allocated workers to work with newly admitted services for a choice appointment and discussed more complex children and young people. We observed a multidisciplinary team brief session and saw that it was well attended with 15 professionals from a range of disciplines, with clinicians having comprehensive discussions about specific children and young people in their care including discussions around assessment and treatments, physical health and development.

There was appropriate interagency working including working with the local paediatric inpatient ward, mental health wards and community health staff such as school nurses and health visitors.

Staff had developed close links with local schools. For example, staff had provided awareness and training to school staff to better equip them to support young people with mental health and emotional wellbeing. In addition, staff worked with the special educational needs co-ordinators in schools to identify young people requiring ongoing support.

Staff liaised with workers in the youth offending team to discuss individual cases to help address the mental health and emotional wellbeing needs of young people in contact with the youth justice system.

**Adherence to the Mental Health Act and the Mental Health Act Code of Practice**

None of the current patients open to the child and adolescent mental health team were subject to the Mental Health Act, either in hospital or in the community. The service had not placed any young person on a community treatment order.

**Mental Health Act training figures**

The trust did not provide any data regarding training compliance in the Mental Health Act for this core service, in advance of the inspection. On the inspection we checked and saw that all 12 recommended clinical staff (100%) had undergone training on the Mental Health Act. The wider staff team were also due to attend a development session on the application of the Mental Health Act for children and young people to understand their responsibilities if someone required detention or was placed on a community treatment order.

Patients had access to specialist advocacy services for children and young people from the Blackpool Advocacy Hub which included the independent mental health advocacy service. This helped to make sure children and young people received independent support to understand and assert their rights if they were subject to the Mental Health Act either in hospital or the community.

**Good practice in applying the Mental Capacity Act**

The Mental Capacity Act applies to people aged 16 years or over. For children under the age of 16 years, the young person’s decision making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient understanding and intelligence to make some decisions for themselves. If patients under 16 years are not competent
to make decisions, then care and treatment decisions usually fall within the scope of parental responsibility.

**Mental Capacity Act training figures** (Internal use only - Remove before publication)

As of June 2017, 88% of the workforce had received training in the Mental Capacity Act and DoLS compared to the trust target of 95%. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years. Staff we spoke to were aware of the principles of consent for young people, supported patients in decision making regarding their care and treatment and involved parents.

Treatment was agreed with the young person and their families. Where the young person was not sufficiently mature to make decisions, records showed that staff sought agreement from the children’s parents or legal guardians in line with the scope of parental responsibility. Where patients may have sufficient understanding and intelligence to be capable of making particular decisions and had decided they did not want their families to be involved, staff used the guidelines in the Gillick competence case to determine if patients were competent to make their own decisions independently of their parents or legal guardians.

If staff were unsure or wanted advice about the Mental Capacity Act or consent, staff would speak to the senior leaders of the child and adolescent mental health team including the service manager or deputy manager who showed good knowledge when we spoke with them.

The trust had a ratified policy on the Mental Capacity Act which covered consent which had recently been updated. This had a subsection about the Mental Capacity Act and children and young people. This provided guidance to staff to remind them that they needed to follow the Mental Capacity Act for patients over 16 years of age. It did not fully detail the consent position for patients under 16 years of age using the concept of Gillick competence and therefore offered limited guidance to staff in these circumstances.

**Is the service caring?**

**Kindness, privacy, dignity, respect, compassion and support**

We spoke with five patients and five parents/carers. Patients we spoke with were complimentary about the service they received from the staff in Blackpool’s child and adolescent mental health team. Patient told us that they had been able to develop a rapport or bond with the staff they worked with. Patients reported that staff worked with them on coping strategies to improve their mental well-being and/or behavioural disturbances. Patients told us they felt involved in drawing up their goals for treatment.

Patients and carers who had experienced using child and adolescent mental health services in other localities and felt most positive about the services they received from the Blackpool child and adolescent mental health team in terms of being responsive and supportive. One patient attending an initial choice assessment felt that they could have received fuller information about the child and adolescent mental health services prior to attending the appointment so that they were better informed and knew what to expect.

We observed staff interacting with patients. Staff treated patients respectfully and checked with them that they understood the purpose and outcome of the session. In the sessions, staff explained confidentiality arrangements to the children and young people relevant to the age and

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64 Universal PIR – Training
maturity of the child or young person. Staff spent time listening attentively to patients and their carers in the sessions we observed. Staff used plain English and simplified language, where appropriate, to ensure patients understood the options available to them and help them make informed choices about their future care and treatment. When patients were transferred between workers or other services, staff spent time explaining why this was so that patients understood fully why this was happening and so children and young people could feel safe and develop good attachments to the new workers or services.

In the case discussions that occurred in the multidisciplinary team brief session, all staff used respectful language when talking about children and young people including patients that presented with challenging behaviour.

The involvement of people in the care they receive

Most records indicated that patients were involved in their own care and treatment from an initial assessment through to ongoing treatment underpinned by a choice and partnership approach. This included recorded participation as part of a choice appointment where the services available were outlined and patients, carers and staff could identify the most relevant treatment, programme or pathway. It also included participation appointments which included patients’ views and agreement to ongoing treatment. However on most records, care plans did not clearly indicate that patients fully participated in their care plan or fully identify the most important recovery goals from a patient perspective. Six out of 15 records we saw did not include the signature of the patient and/or the parent.

During our observations of care we saw that, where appropriate and depending on the age of the patient, staff saw patients alone so that children and young people could identify any concerns without their patients or guardians being present.

Patients were asked to complete a short questionnaire on how happy they were with the services they received. The questionnaire was easy for children and young people to understand as they rated their experiences by identifying with cartoon faces from a range from very smiley to very sad faces.

Patients had access to specialist advocacy services for children and young people from the Blackpool Advocacy Hub. This helped to make sure children and young people were heard and to help them raise concerns about their care with the appropriate professionals. Support from advocates included support at looked after children meetings and reviews, making a complaint about the care and support provided by Blackpool children’s services, and support with difficulties accessing services, including specialist child and adolescent mental health services.

The child and adolescent mental health team community had recently developed a service user group by young people for young people called Entwined Minds. The group had met monthly since it formed in April 2017. This group ensured young people had a voice in not just their own care but how services were run. The team manager welcomed the input of young people in having a say in the service and coproducing training and tools to improve the service to make it more child and young people friendly. For example at a recent meeting, the group looked at how the waiting room could be improved. The Entwined Minds group had used social media to promote the child and adolescent mental health service, promote mental well-being and reduce the stigma of mental ill health, including on Twitter, Instagram and other social media tools.

The patient participation group ‘Entwined Minds, had developed a short board game to be used in staff training. The game, based on ‘snakes and ladders’, was designed to highlight the potential
impact of support and set-backs for young people on the child and adolescent mental health journey.

In October 2017, the trust’s specialist children and young people’s mental health services attended a special event at the Winter Gardens in Blackpool as part of World Mental Health Day to promote the service and reduce the stigma of mental ill health. Members of the Entwined Minds group had a stall at the event promoting patient involvement.

**Involvement of families and carers**

We spoke with five parents/carers including patients’ parents, foster carers and wider family members such as grandparents. Carers were extremely complimentary about the child and adolescent mental health team. Carers told us that they felt appropriately involved in the assessment and treatment with time set aside for staff to see patients and carers independently and together. Carers were offered the opportunity to receive family therapy, where appropriate. This meant trained staff could support parents, patients and any appropriate wider family member to address issues as a family, to help families to get on better together and to help promote mental well-being amongst the family.

One carer called the team ‘fantastic’, and was impressed that staff spent sufficient time to speak and was impressed by the quality of care that their child or young person had received. Carers spoke positively about how responsive the service was with urgent appointments being available when required. Records showed, and our observations of care confirmed, that families and carers were involved in patients’ care and treatment from getting their perspective on the patients identified needs at initial choice assessment through to records indicating that carers were involved at partnership appointments. Staff consulted with both parents if the patients were separated or divorced to ensure that they received a full development history, current social stressors of the young person and a wider picture of the patients identified needs as detailed by the patients’ main care givers.

Parents of patients with attention deficit hyperactivity disorder were signposted to a parents’ support group so that they received ongoing peer support as well as the support from staff of the child and adolescent mental health team.

Patients and parents/carers were not routinely copied into correspondence between the child and adolescent mental health team and referrers. There was a prompt within the standard assessment paperwork for staff to state that they would not copy patients and parents/carers into correspondence unless specifically requested to do so, rather than patients and carers being sent them routinely and opting out if they did not wish to be copied in. There was no evidence on care records that these conversations had been held during assessment appointments.

**Is the service responsive?**

**Access and waiting times**

The child and adolescent mental health team service was only commissioned to accept referrals for children and young people up to the age of 16 years who were experiencing moderate to severe mental health problems. However, if a young person had turned 16 years of age and had been accessing the service before their 16th birthday, they could continue to receive access to the service for a fixed period of time.
There were developed plans to extend the service to be able to receive referrals for children and young people up to the age of 19 years. Whilst this was being reviewed, staff encouraged young people to self-refer to the Youtherapy counselling service provided by the trust which was available for people up to the age of 25 years.

Children, young people and parents could not refer themselves directly to the child and adolescent mental health team and needed to be referred by professional staff such as a teacher, social worker, GP or by paediatric ward staff.

New referrals were triaged by a duty worker to check whether patients needed to be seen urgently or accepted as a routine referral. The initial assessment evaluated patient’s needs, which service within the child and adolescent mental health team might be appropriate, and the care and treatment options available to them. For example, patients could be referred to the mental health trust’s early intervention service if they were aged over 14 years and experiencing psychosis, or signposted to the Youtherapy counselling service. Patients had access to psychology input through the integrated improving access to psychological therapies service and clinical psychology input from either the team’s clinical psychology staff or the mental health trust’s clinical psychology service. There was clear written criteria to support single point of access duty workers to help them determine whether the patient would be seen by Blackpool child and adolescent mental health team or by the nearby mental health trust’s clinical psychology services.

**Referral to assessment and treatment times**65 (Internal use only - Remove before publication)

Patients had timely access to care and treatment with no significant waiting lists. The average wait from referral to assessment was three weeks and the average wait from assessment to first treatment was four weeks. This meant that patients were seen quickly for assessment and treatment. Under the NHS Constitution, no patient should wait more than 18 weeks for any treatment. There had been no incidents of patients waiting longer than 18 weeks with the range of 13 weeks.

Blackpool community child and adolescent mental health team triaged and then referred on patients with psychosis to the nearby mental health trust’s early intervention service and patients who were treated in the community for eating disorders to specialist eating disorder services so the Blackpool community child and adolescent mental health team were not responsible for meeting national targets set for these specific groups.

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’, however did not initially provide targets for the services. The trust later told us that the target was 71 days from referral to initial assessment and 102 days from referral to treatment (also known as second consultation).

<table>
<thead>
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<th>Name of hospital site or location</th>
<th>Name of team</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
<th>Days from assessment to treatment</th>
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<td>Child</td>
<td>Mental Health</td>
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<td>23</td>
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65 CHS PIR - Referrals

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20171116 900885 Post-inspection Evidence appendix template v3
### Current Waiting Times from Referral to Assessment & First Treatment (Weeks) detailed as mean, range and median numbers

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<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Range</th>
<th>Median</th>
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<tbody>
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<td>Wait to Assessment</td>
<td>3</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Wait to First Treatment</td>
<td>4</td>
<td>13</td>
<td>4</td>
</tr>
</tbody>
</table>

Staff in the child and adolescent mental health team provided a range of flexible support to patients dependent on their needs. This included arranging appointments in the early evening, at other locations and urgent appointments if requested by parents, carers or patients.

Staff could respond promptly if there was a sudden deterioration in a patient's mental health, either directly or through contact with staff from the child and adolescent self-harm emergency response team into the evenings and weekends. Staff stated that they could be flexible with patient contact times to meet patients’ needs; patients and parents confirmed this. We saw examples of patients receiving timely access to a consultant psychiatrist at short notice if they required specialist medical assessment or input either directly or through advice. While the team had one vacant consultant psychiatrist post, this was covered by locum consultant psychiatrists where possible and the recruitment to replace the vacant post was being advertised.

Patients waiting in the waiting area were told to come back to the reception to request an update if their appointment had not started 10 minutes after the allotted time so reception staff could identify the delay and keep patients informed.

Staff within the team had good links with the child and adolescent self-harm emergency response team who provided an out of hours response to children experiencing mental distress and staff on the paediatric wards to make sure that children and young people who used services were admitted to and discharged from hospital when clinically appropriate.

There were good arrangements for managing the transition from children and adolescent mental health services to adult mental health services.

This included joint working when patients were in transition from children and adolescent mental health services to adult mental health services. We case tracked patients who had been transferred from children and adolescent mental health services into adult services and saw that there was appropriate liaison between the two services.

The trust had signed up to a multi-agency transition protocol which included standards expected on involving young people and families, collaborative working between services, shared planning, effective communication and information sharing. Monthly transition meetings were beginning to be convened in each locality, with attendance from identified leads in order to discuss young people who have been identified for transition. Records showed that there was a named worker in the mental health trust’s Blackpool adult community mental health team who carried the caseload of transitioned patients.

The trust had a detailed policy to guide staff if patients did not attend appointments with the child and adolescent mental health team. Staff attempted to engage children and young people who missed appointments, mainly by phone calls and letters. If there was no contact without an explanation, staff would check for any other professional contact on the trust’s systems and contact other professionals such as schools to check on the ongoing welfare of the patient.
patients were discharged as they no longer accessed the service, the patient's GP and the referrer would be informed.

Managers gathered the views from current patients to look to reduce the number of appointments where patients did not attend. The key emerging themes from the consultation on potential causes of patients not attending for appointments were:

- Stigma/myths about mental health conditions and treatment
- Parents’ availability to bring young people to regular appointments during the day
- Lack of information about the team and what they can offer young people
- Symptoms such as anxiety inhibiting attendance.

The report included recommendations to improve attendance at appointments which the service was looking to implement and carry forward.

Managers were beginning to look at using technology in better ways to help run the service. For example staff sending patients’ text messages for appointment reminders and medication reviews prompts.

The facilities promote comfort, dignity and privacy

Staff saw patients in buildings that were well maintained, clean and had appropriate furniture. There were plenty of rooms available for individual consultations. Rooms used to see patients had an ‘in use’ sign so that patients could be seen with privacy and without interruption. Rooms were soundproofed to prevent other people hearing conversations.

Staff had made efforts to make the reception, waiting area and interview rooms welcoming to children and young people. This included providing toys and play equipment, murals on some walls and artwork displayed created by children and young people.

Information posters and leaflets were available in reception areas, which provided a full range of information on wellbeing, drug and alcohol, support, family and carer support, community services and support groups in the local area, financial support and advice and recreational activities.

Patients’ engagement with the wider community

Staff supported patients to manage difficulties in school and college. For example, staff liaised with teachers and teaching assistants to try and ensure that reasonable adjustments were made to promote individual patients’ wellbeing and participation at school. In addition, staff worked with the special educational needs co-ordinators in schools to ensure young people requiring support received appropriate assistance. The team also included a primary mental health worker whose role was specifically to liaise with schools and meet with children at school.

Staff supported patients to discuss issues about their sexuality and signposted patients to local lesbian, gay and bisexual young people’s support groups.

Meeting the needs of all people who use the service

The child and adolescent mental health team had a leaflet in plain English which helped explain the service to children and young people. There was also a designated website for children and young people about the trust’s services which included details of the child and adolescent mental health team with artwork attractive to children. The wider trust also had a small range of easy read leaflets about treatments and patients’ stay in hospital.
The team offices were accessible to patients with physical disabilities, with level access into the building and lift access to the team office. Parking included designated parking bays in the car park so that patients with limited mobility did not have to walk far to be seen. The team offices had accessible toilet facilities with appropriate handrails in the waiting area and adjacent to the interview rooms.

This toilet also had full baby changing facilities for children and young people to use if they were young parents themselves.

Records showed that staff provided care and treatment in a non-judgemental way. For example, staff supported patients to discuss issues about their sexuality and signposted patients to local lesbian, gay and bisexual young people’s support group. Where patients had identified as transgender, records showed that staff had discussed this openly with patients and made appropriate referrals to the nationally recognised NHS service involved in supporting and treating transgender patients.

Staff respected people’s diversity and human rights. Staff made good attempts to meet individual patient needs including cultural, language and physical needs. Interpreters were available to staff when required via a small group of trust staff trained in interpreting or through a contracted telephone interpreting service, if a patient or carer’s first language was not English. Where patients required sign language interpreters, face to face sign language interpreters could be booked to assist communication for patients or carers who were deaf or who had British Sign Language as their first or main language.

**Accessibility**

- The 2011 Census showed that white British people were the majority of the population in the area covered by the trust. According to the Census 93.6% of the population of Blackpool Unitary Authority (UA), and 89.7% of the population of Lancashire (excluding UAs) identified as white English, Welsh, Scottish, Northern Irish or British.

- According to the Census the largest ethnic minority groups in these two local authorities were as follows:

### Blackpool UA

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White – other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White – Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Mixed/multiple ethnic group - White and Black Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian/Asian British – Indian</td>
</tr>
</tbody>
</table>

### Lancashire (excluding UAs)

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian/Asian British - Pakistani</td>
</tr>
</tbody>
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66 Universal RPIR – Accessibility tab; 2011 Census
<table>
<thead>
<tr>
<th>Second largest</th>
<th>White – other</th>
<th>1.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third largest</td>
<td>Asian/Asian British - Indian</td>
<td>1.6%</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>White - Irish</td>
<td>0.6%</td>
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</tbody>
</table>

Blackpool’s child and adolescent mental health team provided figures showing that the largest ethnic minority group of patients being seen by the team was white British with 58% of patients, followed by 39% not stating their ethnicity or their ethnicity was not known. The next largest group was patients of any other white background with 0.1% and other ethnic groups making up the other 2.9% of patients. This meant that it was difficult to tell whether patients seen by the team reflected the demographics of Blackpool due to the high proportion of patients not stating their ethnicity or recorded as patients ethnicity recorded ‘not known’.

Listening to and learning from concerns and complaints

Patients were given written information about making complaints within an initial leaflet when patients were accepted into the service. This included details of the trust’s patient advice and liaison service who helped patients to resolve concerns locally, helped patients to raise complaints and ensured complaints were resolved. Information on complaints and the patient advice and liaison service were also available in the reception area.

Children, young people and their carers told us that they would be happy to raise complaints if they were not happy with any aspect of the service they received. Patients knew how to raise concerns.

Formal complaints\(^{67}\) (Internal use only - Remove before publication)

This core service received one complaint between July 2016 and June 2017. This complaint regarded child and adolescent mental health services at Whitegate Drive and was in relation to the attitude of a staff member. This complaint was partially upheld with the staff accepting the shortfall in the way they communicated on this occasion. On inspection, we saw that a further complaint had been received since June 2017. This was partially upheld and related to a cancelled appointment. The patient’s carer was offered a further appointment and an apology given. This showed that the service received a small number of complaints and when complaints were made, managers worked to resolve these.

Compliments\(^ {68}\) (Internal use only - Remove before publication)

This core service received two compliments during the last 12 months from July 2016 and June 2017. Both compliments were received by child and adolescent mental health services at Whitegate Drive.

Is the service well-led?

Leadership

\(^{67}\) Universal PIR – Complaints
\(^{68}\) Universal PIR – Compliments
Blackpool’s child and adolescent mental health team was managed locally by a competent and experienced service manager who had many years experience of working in, and managing, community child and adolescent mental health services. The manager had completed a Masters degree in collaborative healthcare which helped them to work more effectively in the team and alongside organisations that cut across traditional boundaries.

Staff felt well supported by both the child and adolescent mental health team service manager and the emotional health and well-being integrated care manager who oversaw the child and adolescent mental health team. Staff told us that they held the local management team in high regard, including the service team manager and deputy. Staff felt that the managers of the team had an open door policy and were always there to provide sound advice, professional guidance and practical support.

The service team manager had had a good understanding of the services they managed. They could explain clearly the service offered by the community mental health team, what the team did well and what they felt needed improving. They had well developed systems to ensure key performance information was readily available.

Staff felt they had sufficient opportunities to progress personally and professionally and take on more responsibilities as appropriate. This included nurses being able to undergo nurse prescribing training and staff having the opportunity to train as clinical supervisors.

Vision and strategy
The Trust’s mission is ‘Together We Care’, which encompassed the strategic vision for 2020 of operating as a ‘high performing organisation within an integrated care system, which provides quality, safe and effective care. This will be achieved in a financially sustainable way, through our values-driven, skilled and motivated workforce.’

The Trust’s values were:
• People-centred – serving people is the focus of everything we do;
• Excellence – continually striving to provide the best care possible;
• Compassion – always demonstrating we care;
• Positive – having a ‘can do’ response whatever the situation.

The trust had specific targets to meet by 2020 which included improve patient satisfaction, reduce staff vacancy levels and improve the financial sustainability of the trust. While managers understood the trust’s objectives, operational staff from the child and adolescent mental health team did not feel they were fully relevant to them or fully reflected the work that the service did.
However, the child and adolescent mental health team had team objectives which included to:

- provide a high quality child and adolescent mental health service which was responsive and flexible
- be a great place to work with a strong multidisciplinary team and staff development
- have effective partnerships with other agencies.

The team objectives were developed at a team away day following staff discussions. Individual staff members’ contributions to the team objectives were monitored in staff appraisal sessions.

Patients commented positively on the care they had received from child and adolescent mental health team staff which was in line with the trust’s values and targets and the team objectives.

**Culture**

Staff felt respected, supported and valued by their peers and managers. Staff reported morale was good within the team. Staff sickness and absence rates were low.

Staff told us they felt confident that managers would listen to and address any concerns that compromised the quality of patient care. Staff were informed of the trust’s whistle-blowing process and about the role of the Speak Up Guardian on induction. Staff who had required ongoing support were happy with the local and trust support arrangements including occupational health.

Our observations of the multidisciplinary team brief identified that the team worked well together and staff respected each other’s professional roles.

Staff had opportunities to discuss their career development and how it could be supported, for example enhancing their therapy skills or training in supervision skills.
Governance

Managers had good systems and procedures in place to ensure that the team operated effectively, provided good quality care and met performance targets expected of the team. The checks in place corroborated what we found on inspection, namely that:

- premises were safe and well maintained
- staff were trained and supervised with good uptake of mandatory training
- patients were assessed and treated against national guidance
- referrals and waiting times were managed well and well within the maximum 18 week wait
- incidents were reported, investigated and learned from
- there was high levels of patient satisfaction and low numbers of complaints.

The identified shortfall that we found in relation to care and risk records had already been identified by managers of the service. In October 2017, managers in the child and adolescent mental health team carried out an audit of care records. The audit identified what staff were doing well including communicating with young people and parents by letters which also identified the child or young person’s issues and needs. The audit identified a number of shortfalls in the care records including staff not always updating care plan with the review date by care coordinators, staff not always recording consent/agreement with care plan by parent, young person and clear details of the type of intervention or therapy being provided not always recorded. At the time of the inspection, managers had disseminated the results to the staff and the recommendations were still being implemented.

The service was part of, and overseen by the trust’s families clinical division. The families’ management team met monthly and oversaw the team through key performance data and dashboards. In relation to the child and adolescent mental health team this included monitoring face to face contacts, percentage of patients seen within 6 weeks, overall waiting times for second contact and monitoring ‘did not attend’ appointment rates.

Board assurance framework\(^{69}\) (Internal use only - Remove before publication)

The trust has provided their board assurance framework, which details any risk scoring 10 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The six strategic ambitions outlined by the trust relating to this core service were as follows:

1 – **Quality: Mortality** - We aim to achieve our lowest levels of mortality, meeting and then falling below our expected number of deaths; <100 by 2019.

2 – **Quality: Patient Experience** – We aim to achieve our highest levels of patient satisfaction; 98% by 2019.

3 – **Operations: Length of stay** – We aim to achieve top quartile performance, moving to top decile performance, for both non-elective and elective lengths of stay, whilst at the same time maintaining high quality care; Non-elective – 5.1 days by 2018 and 4.4 days by 2021; Elective –

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\(^{69}\) BAF
2.2 days by 2018 and 1.7 days by 2021 and Readmissions within 30 days – 94.2 by 2019 and 79.5 by 2021.

4 – **Workforce: Vacancy rate** – We aim to significantly reduce our clinical vacancy rate, based on future workforce numbers; 2.5% by 2021.

5 – **Workforce: Staff Satisfaction: Friends and Family Test** – We aim to achieve our highest levels of staff satisfaction; 85% by 2021.

6 – **Finance** – We aim to achieve a Use of Resources of 3; 3 by 2019.

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**Corporate risk register** (Internal use only - Remove before publication)

The trust has provided a document detailing their 47 highest profile risks. Each of these has a current risk score of 10 or higher. There were no corporate risks identified which specifically related to community child and adolescent mental health services.

**Management of risk, issues and performance**

The child and adolescent mental health team had a team risk register which identified risks to patients or staff which were managed locally by managers and staff within the team. The current risks identified were:

- possible physical harm to staff and visitors from patients
- waiting/therapy rooms had low sockets with a possible risk of electrocution to patients
- the potential breach of confidentiality due to open plan reception

The risk register had details of how these risks could be mitigated. Following an incident of a staff member being assaulted in an unalarmed room beyond the main offices, staff had been reminded only to use rooms with alarms within the team offices.

The team had a business continuity plan which included identifying and mitigating the risks in relation to disruption of services including flooding or fire, a cyber-attack on the computer system, severe staffing shortages and other key risks.

**Information management**

Staff recorded care and treatment mostly on paper records but some information was also stored in electronic records. Staff at present would only record the time, date and that the patient had received contact with the child and adolescent mental health team on the trust’s electronic record. The team were looking to move over to electronic records in the future in line with other services provided by the trust and the team managers had recently purchased computer tablets to assist with the efficient inputting of records.

Patient records were held in locked cabinets within the offices of the child and adolescent mental health team. The offices were locked to the public at the reception area, the waiting area and throughout the office complex. When staff worked out of other offices and required records, staff stored these in zipped locked bags to ensure they remained confidential.

The service had moved from the trust’s long term conditions clinical division to be overseen by the trust’s families clinical division. The manager of the service was positive about this change as the team were under the same line management arrangements as health visitors, school nurses and...
other professionals working with family, children and young people. This divisional move helped foster better inter-agency working between professionals.

Managers had access to data on team performance, for example, waiting times for assessment and to first treatment data was produced through a monthly generated report which showed trends over time. Incidents were recorded on the trust’s incident management record system.

**Engagement**

The child and adolescent mental health team had a website which explained the work of the team and had been adapted to help make it attractive to children. The website included a short video which included staff and a patient explaining the services, as well as the child and adolescent mental health team leaflet which explained in plain English how they could support children and young people.

The friends and families tests results for the child and adolescent mental health team for the period 1 October 2016 to 31 October 2017 was that 90% of respondents would recommend the service to their friends or family based on 59 responses. The team also asked patients to complete a satisfaction questionnaire and the results of this were positive with 100% of young people responding stating that staff were kind, 92% agreed that staff helped them to understand what was happening, 97% agreed that staff listened to them and 92% of young people said they felt safe.

Managers in the child and adolescent mental health team had recently developed a service user group by young people for young people called Entwined Minds. The group had met monthly since it formed in April 2017. This group ensured young people had a voice in not just their own care but how the child and adolescent mental health services were run.

In April 2017, the trust consulted with patients of the children and adolescent mental health service to gather their views on how they found the service and why they found it difficult to attend appointments, at times. Two focus group sessions took place in with staff and young patients. As a result of the focus group a report was produced, recommendations were developed and a short board game was also developed to be used in staff training. The game, based on ‘snakes and ladders’, was designed to highlight the potential impact of support and set-backs for young people on their journey to mental wellbeing. At the time of the inspection, the recommendations were still being implemented.

The wider trust also had a young person’s patient panel called ‘Victoria’s Voice’ who got children and young people actively involved in the trust’s services by attending regular meetings and discussions with clinical staff where they could put their opinions and ideas across. They also helped ensure that wider trust literature was user friendly to children and young people.

**Learning, continuous improvement and innovation**

The child and adolescent mental health team at Blackpool had a target to extend their service, from providing services to those up to 16 years of age, to patients under 18 years old by April 2018. This was part of the local clinical commissioning group’s strategic objectives to extend the service as detailed in the local children and young people’s resilience, emotional wellbeing and mental health report.

The trust employed an emotional health and well-being integrated care manager who oversaw:

- the child and adolescent mental health team,
- the Youtherapy which was the counselling service for children and young people
• the child and adolescent improving access to psychological therapies contract
• the child and adolescent self-harm emergency response team that provided a children’s crisis/liaison function out of hours but not 24 hours a day, seven days a week.

The emotional health and well-being integrated care manager also had a wider remit to promote health and wellbeing across the trust so for example promoting the mental health offer and encouraging uptake amongst paediatricians, community visiting staff, school nursing staff and others. For example, the manager’s recent work promoted the child and adolescent mental health team and the Youtherapy service to staff working in the diabetic clinic.

The team had recently introduced children’s wellbeing practitioners roles. They delivered ‘low intensity’ brief mental health interventions to children and young people with mild behavioral, mood or anxiety problems.

The team were about to pilot online family therapy though a contact with an external agency. This would pilot the effectiveness of offering family therapy to patients and their families remotely via skype, including offering the therapy in the evenings. The initial plan was to identify 18 families who would be willing to be involved in the pilot and then assess the effectiveness and satisfaction with the new initiative.

Accreditation of services71 (Exception reporting only) (Internal use only - Remove before publication)

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

The trust did not report details of any accreditations undertaken by this core service. The Blackpool child and adolescent mental health team was not accredited under the Royal College of Psychiatrists’ Quality Network for Community CAMHS (QNCC) scheme.

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71 Universal PIR – Accreditation