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

East Lancashire Hospitals NHS Trust was established in 2003 and is a large integrated trust providing acute and community healthcare to the people of East Lancashire and Blackburn with Darwen, in Lancashire, and specialist services for the people of Lancashire and South Cumbria. It serves a population of approximately 550,000. There are two acute hospital sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community hospital sites: Accrington Victoria Hospital; Clitheroe Community Hospital and Pendle Community Hospital. The trust also provides services from community sites across East Lancashire.

The Trust employs 8,000 staff and treats over 700,000 patients a year from the most serious of emergencies to planned operations and procedures. The trust has 1079 beds across 48 wards on five hospital sites.

The trust provides a full range of acute hospital and community services and is a regional specialist centre for hepatobiliary, head and neck and urological cancer services. The trust also provides specialist cardiology services and level three neonatal intensive care.
## Registered locations at the trust

A list of the registered locations at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accrington Pals Primary Health Care Centre</td>
<td>1 Paradise St, Accrington, BB5 2EJ</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
<tr>
<td>Accrington Victoria Hospital</td>
<td>Hayward Road, Accrington, BB5 6AS</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
<tr>
<td>Barbara Castle Way Health Centre</td>
<td>Simmons' Street, Blackburn, BB2 1AX</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
<tr>
<td>Blackburn Birth Centre</td>
<td>Park Lee Road, Blackburn BB2 3NX</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
<tr>
<td>Burnley General Hospital</td>
<td>Casterton Avenue, Burnley BB10 2PQ</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
<tr>
<td>Clitheroe Community Hospital</td>
<td>Chatburn Road, Clitheroe, BB7 4JX</td>
<td></td>
</tr>
<tr>
<td>Pendle Community Hospital</td>
<td>Leeds Road, Nelson, BB9 9SZ</td>
<td></td>
</tr>
<tr>
<td>Rossendale Primary Health Care Centre</td>
<td>Bacup Road, Rossendale, BB4 7PL</td>
<td></td>
</tr>
<tr>
<td>Royal Blackburn Hospital</td>
<td>Haslingden Road, Blackburn BB2 3HH</td>
<td>Burnley, Hyndburn, Ribble Valley, Rossendale, Blackburn with Darwen</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request)
Is this organisation well-led?

Leadership

The trust had a unitary board which consisted of executive directors, non-executive directors and an associate non-executive director. The board was made up of the following members:

- chair
- chief executive
- director of finance and deputy chief executive
- director of nursing
- director of service development
- medical director
- six non-executive directors
- director of communications (non-voting member)
- director of operations (non-voting member)
- director of human resources (non-voting member)
- one associate non-executive director

The trust had a very stable executive team. There had been only one change to the executive team since our inspection in September 2016, which was the appointment of the director of operations, in December 2016. Most of the executive directors had been with the trust through its journey from being a trust in special measures to its good rating at the last CQC inspection.

The trust executive leadership team had an appropriate range of skills, knowledge and experience to deliver the trust’s strategy. Senior leaders were committed to the trust and their roles. The performance of the executive leadership team was reviewed and monitored through an annual appraisal process to ensure that they maintained the skills, knowledge and integrity to carry out their roles. The executive team had portfolios which were balanced to ensure they had capacity to deliver the trust’s strategy. Executive directors were supported by deputy directors with specific responsibilities, aligned to their portfolios, to support them in their roles.

Leaders had a clear understanding of the challenges to quality and sustainability faced by the organisation. The executive team were all able to articulate the financial, performance and quality challenges to the trust in the short and long term. The board members all understood integration of health and social care services as essential to the sustainability of the trust and clearly articulated the trust’s role in the changes to the health and social care economy within Pennine Lancashire.

The trust’s talent management strategy from 2015 incorporated a succession planning process for business-critical roles. The trust identified that the strategy had not been embedded and needed to be updated to reflect a system-wide approach to talent management and succession planning, in line with the integrated care partnership for Pennine Lancashire. While the formal succession planning process had not been embedded, senior leaders had identified prospective leaders within their teams and from their deputies. The chief executive knew the successors to all executive roles and said that directors had a line of sight through the organisation for future leaders.

Senior leaders understood the importance of the visibility of leaders across the trust, including at the community locations. There were up to eight planned patient safety walkaround sessions each month by non-executive directors and directors, at different areas of the trust. Executive directors attended corporate inductions, took part in ‘back to the floor’ sessions, where they carried out a
shift with staff across the trust, as well as attending a range of staff meetings and events. As well as formal sessions, directors visited areas of the trust, including notably the emergency department at Royal Blackburn Hospital, during periods of high demand.

Non-executive directors had a variety of skills, knowledge, and experience and were from a range of industries and backgrounds. They had or still worked in senior positions in law, finance, local government, academia and journalism. As the trust is not a foundation trust, NHS Improvement are involved in the recruitment process for non-executive directors. Non-executive directors’ performance was reviewed by an annual self-assessment and appraisal by the chair. The non-executive directors told us that their objectives were specific to the skills and knowledge they brought to the board. Non-executive directors were expected to attend and participate in external events and forums to represent and further the interest of the trust, in addition to their formal role on the board and in committees.

The chair reviewed the collective skills, knowledge and experience of the non-executive directors as vacancies had arisen, to ensure that an appropriate appointment was made in line with skill gaps and current trust objectives. For example, the chair identified the need for experience of marketing and regeneration, and knowledge of local communities, as gaps after she was first appointed. The trust had appointed associate non-executive directors in order to appoint prospective non-executive directors.

The trust had a board development session every other month with a focus on strategy development. The sessions were programmed to focus on key objectives, for example engagement with the health and care system. Some of the sessions had been delivered by an external governance consultancy, who also carried out the last governance review of the trust.

**Board Members**

Of the executive board members at the trust, none were British Minority Ethnic (BME) and 22% were female.

Of the non-executive board members 11% were BME and 33% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>22%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>All board members</td>
<td>6%</td>
<td>28%</td>
</tr>
</tbody>
</table>

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

The make-up of the board, and senior leadership positions throughout the trust, was not representative of the local population. The chair and chief executive were aware of this and in future recruitment of non-executive directors the chair aimed to increase the number of BME candidates applying.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had a fit and
proper person’s procedure for all executive and non-executive directors. The procedure detailed the requirements for new directors and annual reassessment for existing directors.

We saw evidence that directors completed annual fit and proper person test self-declarations and checks were carried out by the trust. We reviewed personnel files for executive and non-executive directors and found most files complied with the Fit and Proper Persons Requirement. However, one file did not have references on file, which was a requirement of the policy. Three files did not have a full employment history, which providers are required to have on record. It was unclear from the files if directors had declared whether they had any health conditions relevant to their capability to properly perform tasks intrinsic to their roles.

The development of a culture of compassionate and inclusive leadership was a priority for the executive team and trust. The trust was participating in the NHS Improvement culture and leadership programme, with the aim of promoting a culture of compassionate and inclusive leadership at the trust. At the time of the inspection the programme was at the end of the discovery stage, which involved a diagnostic of the current position. The trust was moving towards the design phase at the time of the inspection.

The trust had a suite of leadership programmes for aspiring and current leaders of all levels. The trust had leadership programmes for healthcare professionals at different levels, which were well embedded. The trust had recently relaunched a leadership programme for consultants, with a focus on the stages of a consultant’s career. The trust was forming a talent management strategy group to update the 2015 talent management strategy, which it identified was not fully embedded.

Vision and strategy

Trust strategic framework

(Source: Routine Provider Information Request)

The trust had a vision to ‘be widely recognised for providing safe, personal and effective care’. The vision was firmly embedded at the trust. The vision was prominent in all trust documents and
reports, was clearly displayed across the trust, was referred to consistently by senior leaders and understood by staff. The trust had four objectives to achieve the vision and five values that underpinned the objectives. The trust also had a series of operating principles and five improvement priorities. Senior leaders clearly articulated how their work linked to and contributed to achieving the vision and strategic objectives.

The trust had a suite of strategies for delivering its vision and objectives, including the quality strategy 2017-2019; clinical strategy 2016-2021; information management and technology strategy; an estates strategy, and the organisational strategy. The trust had developed a ‘plan on a page’, which had been shared with partners to capture its strategy concisely. The trust routinely engaged and consulted with staff, patients and partners in the development of new strategies.

The quality strategy set out the quality aims under the safe, personal and effective domains. For each of the aims it identified areas that it would focus on and how they would be measured. The clinical strategy set out the longer-term strategy for the trust and wider health economy under six strategic and transformational themes. The trust monitored progress against delivery of the strategy and local plans through performance review meetings and in the annual quality accounts.

Leaders clearly articulated the trust’s strategy, in terms of the delivery of its current hospital and community services; the role within and contribution to the Pennine Lancashire integrated care partnership; and the role within, and contribution to, the Lancashire and South Cumbria integrated care system.

Sustainability and transformation plans are part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The trust was part of the Pennine Lancashire integrated care partnership which had a strategy ‘Together A Healthier Future’ to deliver the transformation programme. The trust’s strategy was closely aligned to the local plans and the trust was clear about its role within the future delivery of services, for example in the delivery of new models of care, which was a key objective of the clinical strategy.

The trust had taken steps towards an integrated system and was looking to align its procedures, strategies, services and workforce. The trust had recently agreed a control total for the Pennine Lancashire integrated care partnership. Control totals are annual financial targets that must be achieved to unlock access to national funding and other financial benefits. The agreed control total for the system would provide incentive for closer joint working and integration. The trust already provided both acute and community services and had recently set up a partnership for the delivery of six GP practices within the Pennine Lancashire area.

The trust was also active in the development of the Lancashire and South Cumbria integrated care system. Leaders told us this was less developed than the Pennine Lancashire integrated care partnership and had only recently created a shadow board. The trust was clear that it was essential the trust influenced discussion and decision making about the delivery of specialist services across Lancashire and South Cumbria and, where appropriate, the consolidation or sharing of services between the acute hospital trusts and localities.

The trust had an annual operational plan which set out the plans and strategy for the forthcoming year. The operational plan was a realistic plan which covered a range of areas and was linked to the vision and strategy. The operation plan for 2018-19 covered five areas: activity; quality; workforce; finance; and future health and social care delivery.

The trust was proactive in bidding for tenders for the delivery of services within the East Lancashire area. The trust had a defined structure for the proposal and delivery of bids, with clear oversight through to the board. The trust had been successful in 14 of the last 15 bids for services.
In line with the trust’s clinical strategy and the recommendations of the Carter Review (Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, February 2016), roll out of the trust’s dedicated ward pharmacist programme ensured that pharmacists were integrated into the ward multidisciplinary team and that more time was spent delivering clinical pharmacy services. This was bringing improvements in the timely completion of medicines reconciliation and facilitating discharge. Additionally, early discussions were underway to define the need and offer, for pharmacy support to the emergency department. The trust had a non-medical prescribing lead and a strategy for the development of non-medical prescribers to support patient access to medicines and more flexible team working.

The trust’s five-year medicines optimisation strategy for 2017 to 2022 was approved by the quality committee in March 2017. Good progress was made with the 2017-18 objectives including for example, continued roll out of the trust’s dedicated ward pharmacy project and an increase in the number of non-medical prescribing pharmacists; chemotherapy dose banding and closer working with local clinical commissioning groups. However, progress with the rollout of electronic prescribing and medicines administration had stalled following the cyber-attack in May 2017. An updated work plan for reinstatement and future trust-wide roll out of electronic prescribing and medicines administration was being agreed.

Aligned to the ambitions outlined in the NHS Five Year Forward View for delivery of a seven-day service the acute medical units had a dedicated pharmacy team from 7am-11pm seven days a week. Additionally, a weekend clinical pharmacy service was provided to all wards, 9am-4pm at the Royal Blackburn Hospital. There was no weekend clinical pharmacy service at Burnley General Hospital.

**Culture**

Staff and senior leaders were patient-focussed and we saw evidence that quality and patient safety were at the heart of decisions. Leaders consistently referred to delivering safe, personal and effective care as priorities. Within the year before the inspection, the trust had focussed on embedding a safety culture at the trust following a series of never events. A standing agenda item had been added to divisional and trust wide meetings, giving staff the opportunity to raise safety concerns, with monthly safety bulletins on key safety themes had been sent to every staff member. Staff were committed to patient safety which was demonstrated by a 92% uptake of the flu vaccination by staff in 2017-18 which was the highest uptake rate of any acute trust in England.

The trust performed very well in the most recent staff survey, with results better than the average for similar trusts in 28 key findings. The trust reported that in 16 of 32 key findings the trust was benchmarked in the top 20% for acute trusts. During the inspection we found that most staff felt supported, respected and valued by their immediate managers and the senior leaders in the trust. However, this was not the case for all staff and there were small pockets of staff who did not feel that they were always valued, specifically when staff were moved between areas to maintain safe staffing or because of increased demands on capacity.
The trust has 28 key finding(s) that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>92%</td>
<td>86%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.08</td>
<td>4.05</td>
</tr>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in last 12 months</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>KF29. Percentage reporting errors, near misses or incidents witnessed in last months</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.80</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.73</td>
<td>3.65</td>
</tr>
<tr>
<td>KF17. Percentage of staff feeling unwell due to work related stress in last 12 months</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.72</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>53%</td>
<td>51%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>59%</td>
<td>71%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.83</td>
<td>3.76</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.93</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.93</td>
<td>3.90</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.81</td>
<td>3.71</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.45</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.51</td>
<td>3.44</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.78</td>
<td>3.74</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.02</td>
<td>3.92</td>
</tr>
<tr>
<td>KF3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.85</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>KF23. Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. Percentage of staff reporting most recent experience of violence</td>
<td>76%</td>
<td>67%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>52%</td>
<td>45%</td>
</tr>
</tbody>
</table>

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

The trust has no key findings worse than the average for similar trusts in the 2017 NHS Staff Survey.

(Source: NHS Staff Survey 2017)
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care from August 2017 to July 2018.

(Source: Friends and Family Test)

With few exceptions staff felt proud to work for the organisation. Senior leaders were passionate about the trust, the services it provided and its achievements. The trust understood that most staff lived locally so they and their families used the services, which gave an added impetus for providing services that staff would expect to receive.

Sickness absence rates

The trust’s sickness absence levels from May 2017 to April 2018 were higher than the England average.
In response to the sickness absence rate, which had been higher than the national average, the trust had developed a strategy and action plan for improving absence. This was aimed at managers, supporting them to try to reduce sickness absence. The progress against the action plan was being monitored by the human resources team.

The trust had processes to act upon and address poor performance and behaviours not in line with the trust values. To facilitate early resolution to workplace conflict, the trust had recently replaced its bullying and harassment and grievance policies with a resolution policy. In addition to the formal disciplinary procedures the trust had a mediation service and had recruited a mediation manager. The medical director had also started a ‘doctors in difficulty’ group to provide support to doctors with performance or behaviour concerns. Although leaders were confident about the processes for handling poor performance and behaviours, we were informed of staff who did not feel that they had been treated fairly through the processes.

During our inspection we found that staff across the organisation were open and honest and were happy to report incidents and speak up if they had concerns. The trust leadership team were supportive about raising concerns, for example when serious incidents or never events happened.

At every board meeting a report was submitted which listed all of the items discussed in private at the previous board. This enabled the public to know what subjects could not be discussed in public and the reasons for this.

During the last inspection we told the trust it must take action to ensure that it complied with the duty of candour. 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. Since the last inspection and following an internal audit of the trust policies, the trust had updated its procedures for how it complied with the duty of candour regulation. The trust created a daily report on the compliance with the duty of candour which was shared with divisional teams. An escalation
report was shared with the medical director to support with resolution of issues and ensuring compliance. Assurance reports were sent to the patient safety and risk assurance committee, which reported to the quality committee, and a report of the serious incident requiring investigation panel went to the board and quality committee. Between May and July 2018, the trust had notified all individuals within 10 days for all incidents with moderate or serious harm.

Freedom to speak up guardians work with trust leadership teams to create a culture where staff can speak up to protect patient safety. The role of the freedom to speak up guardians had been created because of recommendations from Sir Robert Francis in February 2015. The trust had a full-time freedom to speak up guardian who was also the chair of the North West network for freedom to speak up guardians. At the time of appointment, the guardian launched a communication strategy to raise awareness. The guardian attended inductions, was on-call, attended safety walkabouts with executives and non-executive directors and published articles in the staff newsletter. During our inspection we saw posters displayed prominently around the trust and staff were generally aware of the guardian. The guardian told us that if concerns were raised she would spend time in that area to make herself more visible.

In the year between May 2017 and April 2018 there were 143 formal concerns raised to the guardian and one whistleblower. This was an increase of 74% on the previous year, since the newly appointed guardian came into post. The guardian reported themes and numbers in six monthly reports to the quality committee, and an annual report to the board. The report also set out an action plan to address themes.

The trust was committed to the learning and development of staff. Completion of mandatory training was high across all areas and the trust offered a range of other opportunities to staff, including coaching and mentoring. Appraisal rates were high across the organisation. In April 2018 the appraisal rate was 91% across the trust, with medical staff appraisal rates at 97% and consultant appraisal rates at 98%.

The trust was in the process of developing a health and wellbeing strategy for 2018-2021, this had been developed following a health and wellbeing survey for staff. The trust received more than 1,000 responses which it had used to develop the strategy. The trust had a health and wellbeing manager in post and staff had access to an employee assistance programme for providing advice and support.

Staff Diversity

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

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Medical &amp; dental percentage of whole</th>
<th>Nursing percentage of whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3.28%</td>
<td>27.82%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.29%</td>
<td>0.21%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.15%</td>
<td>2.81%</td>
</tr>
<tr>
<td>Black</td>
<td>0.20%</td>
<td>0.14%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.20%</td>
<td>0.05%</td>
</tr>
<tr>
<td>Other</td>
<td>0.34%</td>
<td>0.60%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.30%</td>
<td>0.13%</td>
</tr>
</tbody>
</table>
Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

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

- 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?

(Source: NHS Staff Survey 2017)

The trust was clear on its priorities when it came to driving improvement for BME staff through the Workforce Race Equality Standard. However, in discussions with BME staff, it was clear that staff were unaware of any of the solutions that the trust had proposed to reduce any gaps in BME and white staff experience, as shown by the Workforce Race Equality Standard.

The trust acknowledged the importance of supporting the development of black, minority ethnic staff. Feedback from the staff survey 2017 and the Workforce Race Equality Standard report prompted the trust to develop an action plan to support the inclusive development and engagement of the black and minority ethnic staff group.

The trust’s workforce strategy for 2015 to 2020 incorporated all related strategies and this included equality and diversity. Equality and diversity was also identified as a separate theme within the overall workforce strategy. The trust was working with a diversity consultancy to embed equality
and diversity principles into the trust, for example in recruitment processes. The trust had also held unconscious bias training for all recruiting managers and other staff.

The trust had developed a Workforce Race Equality Standard action plan, however when this was reviewed we found that although some actions were due for completion in 2019, a number of detailed actions had no progress completion dates recorded on the plan.

The trust supported pharmacy staff development. A core group from the pharmacy team had completed an improvement science course developing the skills to map processes, test change and iteratively improve service delivery. A strategy for pharmacist leadership development was supported through the pharmacy training and education committee.

The trust actively used electronic referral, ‘refer to pharmacy’ to support ‘at risk’ patients through the timely communication of medicine related information to the patient’s usual community pharmacy on discharge. In the year to April 2018 over 3,000 referrals were made. The trust estimated that this had prevented at least 100 readmissions. Additionally, in the East Lancashire area, domiciliary support was provided to vulnerable patients by the trust’s medicines support team.

We saw cooperative, supportive and appreciative relationships between the board members and other leaders. The leadership team were very respectful of each other, understood each other’s roles and challenges and worked collaboratively. This was also reflected in the core service inspections where we saw strong team working across teams, disciplines and between the community and acute sites.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed in the middle 50% of scores for all indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had an annual staff awards ceremony and monthly employee or team of the month awards. In 2018 the trust awarded 15 different ‘star’ awards for individuals and teams in recognition of their contribution to the trust. Awards included unsung hero, patient choice, outstanding achievement, compassionate care and leadership award. The awards were presented at an awards ceremony at a local hotel. Employee of the month awards were prominently displayed in busy corridors at both sites.

Governance

There was an integrated governance structure with reporting lines from divisions and committees to the board. The board met every other month and received reports from five sub-committees: audit committee; quality committee; finance and performance committee; charitable funds committee; and remuneration committee. Attendance at the board was by executive and non-executive directors was good.
We observed a board meeting during the inspection period and saw that there was effective scrutiny and challenge by the non-executive directors of the reports and decisions escalated to the board. We saw evidence that the board understood and considered the key risks and challenges to the trust at that time, including the experience of patients with mental health needs using the trust’s urgent and emergency services. Board agendas followed a standard structure which covered an appropriate range of business, covering quality and safety; strategy; accountability and performance; and governance.
Sub-committees of the board were chaired by a different non-executive director. The finance and performance committee met monthly (except August and December), the quality committee met in alternating months and the audit committee met five times a year (four times to conduct business and an additional meeting for the annual accounts and report). From July 2018, the quality committee had three non-executive directors and the finance and performance and audit committees had two non-executive and one associate non-executive director. Attendance at the sub-committees was generally good, although at the last two quality committee meetings of 2017-18 only four of the seven members had attended. Prior to the inspection neither the interim chair or non-executive director on the quality committee were from a clinical background. The committee and other board members did not feel that this was a gap nor did this inhibit the effectiveness of the committee.

Sub-committee chairs presented a report to the board with an update of the most recent committee. This report was also shared with the committees which reported into the sub-committee. Chairs of committees reporting to the quality committee also presented reports, with an update of the most recent meetings. There was a standing agenda item which included whether any items should be escalated to the board for action or information, or delegated to committees. While we saw evidence that issues were escalated through the committee structure and committee and board reports, we did not see evidence in any of the minutes we reviewed that items had been identified for escalation or delegation through this route.

There were clear reporting lines from the divisional committees to the trust wide committees and to the board. The interface and links from the divisional structures to the board was set out in the trust’s performance accountability framework. Divisional committee structures mirrored the committees that reported to the quality committee. For example, divisions had their own patient safety and risk committees which reported to the trust’s patient safety and risk assurance committee.

Board members told us that there was some repetition between the papers at the board and at committees. For example, the quality committee and board both received the same reports on the board assurance framework, corporate risk register and serious incidents requiring investigation. While some board members were happy with the content and volume of papers, other board members told us that would like to see summaries rather than full papers. Staff we interviewed identified this as an area for development.

The functioning and performance of the board was reviewed by members at the end of every board meeting and sub-committee meeting. We saw evidence of feedback about what could have been done better, or staff who should have been at the meeting. The terms of reference of each of the sub-committees was reviewed annually to ensure that they were current and effective. The trust last had an external review of its governance at the end of the 2015-16 financial year. The external company who completed the governance review had delivered strategy sessions in the year before the inspection about improving governance systems and processes and providing robust assurance.

In addition to the committee and divisional structures the executive team escalated and shared information through frequent planned meetings with their teams. The chief executive had weekly meetings with the executive team and senior leadership team, and other executives had a clear schedule of meeting with their deputies and other leaders across the trust.

The chief executive held overall accountability for medicines use within the trust, with the medical director holding board level responsibility for medicines safety. The trust’s medicines safety and optimisation committee focused on all aspects of trust medicines safety and delivery of the
medicines optimisation strategy. However, membership did not include a patient representative to support learning, for example through patient stories (NHS England Patient Safety Alert March 2014. Improving Medication Error incident and reporting). The medicines safety and optimisation committee had escalated concerns to the patient safety and risk assurance committee, due to a lack of assurance from divisions with regards to the ward security and controlled drug audit reports. The director of pharmacy advised that this had now improved with greater ownership at ward level, supported by the dedicated ward pharmacists. Following a review of incidents, the insulins safety group had been reformed in 2018 to promote the safer use of insulin.

The trust’s controlled drugs accountable officer ensured that the required controlled drugs quarterly reports were submitted to the local intelligence network. Appropriate governance arrangements were in place for non-medical prescribing. Both community practitioner nurse prescribers and independent supplementary prescribers completed an annual non-medical prescribers’ declaration agreed with their clinical lead.

Management of risk, issues and performance

The trust had a clear structure and processes for reporting and monitoring performance. Performance was monitored trust wide by the monthly operational delivery board, which reviewed the integrated performance report and financial performance report. The operational delivery board was chaired by the chief executive and attended by trust wide and divisional leaders. The operational delivery board received reports from divisional delivery boards which monitored performance at divisional level. The finance and performance committee also received the integrated performance report and financial performance report to provide additional scrutiny of performance measures. In addition to the performance reports, the finance and performance committee received exception reports where the trust was underperforming against targets.

The framework for monitoring divisional performance was set out in the performance accountability framework. Divisional performance was assessed over a number of domains (linked to the CQC domains), each with an associated set of indicators. Performance against the indicators gave a score for each domain which contributed towards an overall escalation score for the division. The level of escalation determined the interventions and any actions required.

The trust had a suite of performance reports to measure and monitor performance. The integrated performance report monitored performance against quality indicators and the financial performance report reported the financial position. The sustaining safe, personal and effective care report monitored performance against the cost improvement programmes, known as the safely releasing costs programme and transformation programme. In addition to performance against cost improvement programmes, the sustaining safe, personal and effective care report set out the progress against the transformation programme’s ongoing aim to improve efficiency and the sustainability of services.

Performance at ward level was assessed using a ward accreditation scheme, the nursing assessment and performance framework. Wards and clinical areas were assessed using a number of metrics based on the CQC key lines of enquiry. Red, amber, green and silver awards were given depending on the score, which determined the frequency of the next assessment. Red wards were revisited in 8 weeks and had an action plan to address the areas which needed improvement. Wards that were rated green three times in a row could be awarded silver status which entitled staff to wear a different uniform, with this attainment awarded by the board. As of July 2018, six areas had silver awards, 19 were rated green, 15 amber and three red. Reports of the tool were received by the clinical effectiveness committee and the quality committee.
Financial performance had been consistently strong over several years. Cash, capital and revenue plans had been realistic and the trust had consistently delivered the control total, improving the financial position over and above the control total in both 2016-17 and 2017-18. The trust had delivered its financial outcomes in line with plans and national requirements.

Divisional and directorate financial performance was monitored through the operational delivery board and divisional delivery boards. Directorates had autonomy to spend income generated in their area. This was governed by an approval process through the operational delivery board.

The trust had a systemic programme of clinical and internal audit to monitor quality and processes. The trust had an annual internal audit programme agreed with the internal auditors. This included a mixture of routine audits of processes and requested audits by committees or directors. Progress against the audit programme and the outcome of audits and actions plans was reviewed by the audit committee. The trust also commissioned external auditors for a statutory audit of financial statements and value for money arrangements. Progress of the external audit was also monitored through the audit committee.

The trust had an annual clinical audit programme for the year which incorporated national audits, national confidential enquiries and audits for trust wide or divisional priorities. The plan categorised audits by four priority levels: level one, external must do; level two, internal must do; level three, divisional priorities; and level four, low priority. Progress against the audit programme was monitored by the clinical effectiveness committee which reported to the quality committee.

The trust’s clinical effectiveness team had developed its role to provide assurance that care was delivered in line with best practice through clinical measurement against national and local guidance. The team had a ‘portfolio’ of standards for each directorate against which they monitored their performance which was reviewed every other month by the clinical effectiveness committee.

The trust had a risk management strategy and a risk management procedure for 2018-21 which set out the approach for the identification, assessment, monitoring, management and governance of risks. The strategy set out the responsibilities of committees and individuals. The trust used an electronic risk management system, with directorate, divisional and a corporate risk registers. The trust scored the likelihood and consequence of each risk out of five, giving an overall score out of

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£479m</td>
<td>£496m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£3m</td>
<td>£3m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£476m</td>
<td>£493m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£476m</td>
<td>£493m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)
25. Risks scored between one and eight were added to the directorate risk register. Risks scored between nine and 12 were added to divisional risk registers and risks scoring 15 and higher were added to the corporate risk register. The strategy set out the accountability, process and frequency of review depending on the risk scoring.

The trust had a risk assurance meeting whose purpose it was to review, scrutinise and approve all risks scored above 15 across divisions and corporate areas for inclusion or de-escalation from the corporate risk register. The trust had a risk manager with a responsibility for leadership of the development and implementation of effective risk management strategies and policies.

In early 2018 the trust had commissioned an internal audit of the systems and processes for reporting and managing risks at divisional level. The audit gave limited assurance as there were gaps identified in training, the assurance reporting process, the design of the risk management system, the content of the risk register and the policies and procedures. The trust had an action plan with 30 actions, of which 22 were complete at the time of the inspection. The trust was yet to deliver training or review all risks on the registers, and the associated actions plans, controls and assurance.

The corporate risk register contained a mix of specific risks and aggregated risks each with a current and target rating. Aggregated risks included links to individual risks related to the aggregated risk. Leaders told us that the corporate risk register was a dynamic document with risks moving onto the risk register when they emerged or developed and from the risk register when the risks reduced or had been mitigated. We saw evidence of changes to the risk register in the months before and during the inspection. While there was evidence that risks scores had been reviewed the register did not record the target date or completion date for actions or controls, where appropriate. As a result, the risk register did not show when risks were likely to be mitigated or reduced by actions and controls.

Board assurance Framework

The trust provided their Board Assurance Framework, which details five strategic risks:

- Transformation schemes fail to deliver their anticipated benefits, thereby impeding the Trust’s ability to deliver safe personal and effective care
- Recruitment and workforce planning fail to deliver the Trust objectives
- Lack of effective engagement within the partnership organisations (ICS and ICP) results in failure to work together causing a detrimental effect on the health and wellbeing of our communities
- The trust fails to achieve a sustainable financial position and appropriate finance risk rating in line with the Single Oversight Framework
- The trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil the regulatory requirements defined in the NHS constitution and relevant legislation.

(Source: Trust Board Assurance Framework)

The board assurance framework listed the key risks that could impact on the trust achieving its strategic objectives. The risks on the board assurance framework were those articulated by senior leaders during our inspection, who understand the actions and controls to mitigate the risks. The risks were linked to a strategic objective and assigned to a responsible director. Each risk had an
initial, tolerated and current risk score, controls, assurance, gaps in controls, gaps in assurance and action plans. The reports to the board and the sub-committees gave detailed information on the changes to the risk scoring and how the controls, assurances and actions had changed. While this demonstrated active review of the risks on the board assurance framework, many of the actions did not have dates for when they would or had been completed.

The risk management strategy stated that the risks should be assigned to a sub-committee of the board for a deep dive at each meeting and to ensure risks on the corporate risk register were aligned to the board assurance framework. While it was not clear from the board assurance framework which sub-committee risks were assigned to, we saw evidence that sub-committees had discussed risks relevant to that committee.

While some of the risks on the corporate risk register were connected to the risks on the board assurance framework, for example the risks around workforce, there were no clear links between risks on the two documents. The trust said this was an area for development which they hoped to improve on.

The trust had a process to review the impact on quality of cost improvement plans. For every cost improvement plan a quality impact assessment was completed and had to be approved by the director of nursing and medical director before the programme could be signed off. Directors said that plans received appropriate challenge through the quality impact assessment process the director of nursing said that while plans had not been rejected it had led to further information being required.

The trust achieved the commissioning for quality and innovation (CQUIN) target in terms of reducing piperacillin-tazobactam usage and for total antibiotic consumption. However, the trust was failing to meet all its internal audit standards for antimicrobial prescribing, with regard to stop/review date, recording indication and compliance with formulary. The divisions completed a quarterly action plan monitored by the infection prevention committee. However, the results for January 2018 had not shown improvement from those reported in January 2017.

We also saw examples where a complete audit cycle had resulted in improved practice. An initial audit of oxygen prescribing in the emergency department found that over half of patients on oxygen did not have documented target saturations. The implementation of oxygen prescription champions, oxygen posters and guidance led to demonstrated improvement at re-audit.

Medicines management was included in the trust’s ward accreditation scheme, the nursing assessment and performance framework. The assessments had identified a low uptake of the trust’s online medicines training and inconsistent documentation of medicines omissions. The trust’s medicines safety officer was working with the nursing team to look at how medicines were assessed within the assessment. For example, the question relating to the safe storage of medicine had been strengthened to include the accurate recording of minimum and maximum temperature readings and appropriate escalation.

At our inspection we found medicine fridge temperatures were not consistently well recorded. We noted that the trust had identified a concern regarding fridge temperature monitoring in July 2018. However, that had not been escalated at the time of our visit and did not consider locations outside the main hospital sites. In response to our concerns the trust took prompt action considering a range of options to improve temperature monitoring.
Information management

Performance was reported to the board, the finance and performance committee and the operational delivery board in an integrated performance report which included a range of metrics covering quality, safety and financial performance. The metrics were each linked to the CQC domains. The report used a mixture of graphs, narrative, RAG (red, amber, green) ratings and sparklines (graph to plot trend) to demonstrate performance against agreed thresholds and over a period of time. The performance report was clearly set out and had a good mixture of measures to give a comprehensive picture on current performance and performance across the preceding 12 months. The performance report included the views of patients with friends and family test results and complaints.

Performance measures reported and monitored by the trust included those set nationally, such as the four-hour A&E performance indicator and those set locally, such as mandatory training and appraisal rates. Targets or thresholds were reviewed and set annually and performance against the targets reported every month.

Senior leaders told us that the integrated performance report had been an iterative document and there were plans to develop it in the coming year to reflect system wide metrics rather than focussing just on trust wide metrics.

The trust reported financial information in a financial performance report which was reported to the finance and performance committee and then reported to operational delivery board which set out the current financial position. Performance against cost improvement plans were reported separately in the sustaining safe, effective and personal care report.

The trust shared its data directly with its commissioners and partners using a business intelligence system. Commissioners were given access to the range of contracting and activity reports used to monitor activity and quality, so they could access it directly. They could query the information directly and embedded analysts from the clinical commissioning groups, who worked with the trust’s business intelligence team, could engage at the early stages of contract queries, rather than waiting until an issue escalated.

The trust’s business intelligence service and divisions were using and developing bespoke performance reports using the business intelligence system, these covered theatre activity, outpatient, inpatient, A&E services and contracting information. Detailed, graphical and interactive screens (available on both a PC and a mobile platform) were available for business managers to review system management and quality of care. All information relating to wards completing the nursing assessment and performance framework assessment were also available. The trust was working with the developer of the business intelligence system to enhance the product for greater use in healthcare settings.

Board and committee papers ranged in volume, although at certain meetings were lengthy. Some of the non-executive directors highlighted that the papers could be more concise which was something they hoped to consider in the coming year.

The trust published its safe staffing data, a mandatory requirement by NHS England, as part of the integrated performance report. In addition to providing information about fill rates and care hours by ward the trust triangulated the data with information about the number of pressure ulcers acquired, falls with moderate harm and above and hospital acquired infections, to identify if staffing levels had an impact on safe care.

Meetings across the trust all had significant coverage of delivery of quality and sustainability. Cost improvement plans and transformation programmes had a dedicated report which were received
by the board and the operational delivery board and strategic updates on the integrated care partnership and integrated care system featured prominently on the agenda of meetings.

In the board meeting we attended, and in the minutes of board meetings and committee meetings we saw evidence of challenge and scrutiny from staff, including the non-executive directors of the performance information and actions taken to investigate issues.

The trust did not yet have a fully integrated electronic patient record, although had some systems which were electronic such as a bed management system and some patient assessments. The trust was in the process of procuring an electronic patient record system which would be implemented in 2020. The trust only had limited real time information, although used the bed management system to monitor performance. A dashboard was displayed in a prominent area in the trust headquarters. Leaders said that the new electronic patient record system would improve visibility and access to information to monitor quality and performance.

Community services at the trust had access to an electronic patient record system, which was also used by other healthcare professionals in the community. This was accessed on mobile and fixed devices to deliver care in a patient’s home setting.

Clinicians at the trust had access to a Lancashire patient record exchange service. The trust told us it was instrumental in developing the portal and shared over 3,000 pieces of correspondence daily. The portal allows clinicians to share and access patient information from any other acute trust in Lancashire and South Cumbria (for example, discharge letters, referrals, A&E attendance information). The portal also gives clinicians access to the GP record. There are plans to extend this to encompass social care information.

In August 2018 the trust launched a digital letter programme which meant that appointment letters and supporting information could be viewed on a digital platform instead of being sent by mail. Letters could be translated or accessed in text-to-speech format and appointments confirmed, cancelled or rebooked online. The programme had already seen a reduction in the rate of patients not attending appointments.

The trust was affected by the May 2017 cyber security attack, with more than 2,500 computers being affected within an hour. The trust had put in place an action plan to mitigate risks of a future attack and carried out an internal audit of the cyber security and the associated response to the attack. The audit gave assurance that the required actions were being undertaken and that significant work had been completed to mitigate the risks.

The trust had processes to ensure that data and notifications were submitted to other organisations. The daily incident triage group identified incidents which needed to be notified to the strategic executive information system (StEIS), the clinical commissioning group, the Information Commissioner’s Office or other organisations. The trust had a process for acting on external notifications, such as those from the central alerting system (CAS). These were triaged by the risk and safety team and allocated to a named individual and committee. This process had been strengthened following a review of the process. This was triggered by a never event, involving a patient being connected to air instead of oxygen, which had been addressed in a national patient safety alert.

The trust had an information governance steering group to monitor the safeguards for and appropriate use of patient and personal information and ensure compliance with the NHS information governance toolkit. In December 2017 the Information Commissioner’s Office carried out a data protection audit of the trust and found gaps in a number of areas. The Information Commissioner’s Office recommended 106 actions and at the time of the inspection 13 were still outstanding.
In 2017-18 the trust referred eight information governance cases to the Information Commissioner’s Office and no further action was required in all eight cases. In 2017-18 the self-assessment for the information governance toolkit was a pass of level two or three for every standard and an overall pass rate of 81%. The internal audit of the information governance structures found them to be operating effectively.

Engagement

In 2018 the trust had updated its patient, care and family experience strategy for 2018-21. The strategy was developed following patient engagement events and feedback from local organisations and staff. The strategy identified the key issues for patients, how the trust would deliver on its values, how patients’ experience would be monitored and measured. Patient experience was monitored through the trust’s patient experience committee which reported to the quality committee.

The trust had a patient safety story at the start of each board meeting and an open forum at the start and end of each board meeting where members of the public could ask questions to the board. At the board meeting we attended the board proposed action as a result of a public question.

The trust had a shadow council of governors to represent the views of local people and staff. As the trust was not a foundation trust there was no requirement to have a council of governors. The shadow council of governors was made up of seven local people, elected to represent local areas, and three elected staff governors. Shadow governors participated in trust groups such as the bereavement strategy group and nutrition and hydration steering group as well as employee of the month and annual award event judging and other activities. The trust also invited members of the public to become members of the trust to contribute to how the trust made changes and improved patient experience.

At the time of the inspection the trust was recruiting patient participation panels. The panels would create a formal structure for engaging with patients and seeking patient views in the design or changes to services.

The trust had links with patient and carers organisations in the local areas, including Healthwatch. The trust worked with the organisations to seek patient feedback on the services. The trust had some initiatives to reach hard to reach groups such as a learning disabilities user group, work with colleges to identify younger service users and engagement with local mosques.

The trust had a monthly staff newsletter which included news and features about successes, awards, charity events and staff initiatives. In addition, the trust had a monthly team brief video which was recorded by the chief executive and shared on the website. The chief executive also wrote a weekly blog which was posted on the website and the board held monthly ‘meet the board’ sessions where staff could ask board members any questions. The chief executive had a page on the intranet where he could be contacted directly by staff, patients or members of the public.

The trust had a systematic approach to engage with staff through a system devised by the trust called the 10 enablers of employee engagement. The trust routinely involved staff in changes and decision making. The trust gave examples of where staff were consulted when changes would affect them such as a change in shift patterns to 12 hour shifts or were involved in the development or planning of new projects such as more than 50 clinical staff being involved in the procurement decision for a new electronic patient record.
The trust had strong partnerships with other stakeholders in the local area which had been a driver for the progress towards the Pennine Lancashire integrated care partnership. Board members had clear links to external groups and meetings and had identified key partnerships, such as within the local authorities. The chief executive was chair of the A&E delivery board and sat on the shadow board for the Lancashire and South Cumbria integrated care system and the Pennine Lancashire Leaders’ Forum, made up of the chief officers of the six statutory health and social care organisations. The trust was working with partners to deliver new services, for example with the plans to develop and deliver a new frailty pathway.

The trust was a member of the East Lancashire medicines management board along with the two local clinical commissioning groups streamlining decision making and promoting consistency of approach to the use of medicines within the local health economy.

Learning, continuous improvement and innovation

The trust had a systemic approach to quality improvement. The trust had its own improvement methodology ‘7 steps to safe, personal and effective care’ which had been in operation for three years. The trust’s quality improvements triage group examined the detail of quality improvement projects ensuring that plans had details of the change idea, aims and measures as well as details of the support required. Agreed projects were recorded on a register which was reviewed by the group and reported to the clinical effectiveness committee. The trust held quality improvement coaching drop-in sessions across trust sites and a monthly introduction to quality improvement training session to support staff with quality improvement work.

The Trust had been selected to be in the first cohort of the new three year NHS Improvement Lean programme (Vital Signs). The trust was the only member who would be participating across the local healthcare system and were seeking to develop a single improvement methodology across Pennine Lancashire called - ‘the Pennine Way’.

The trust had identified the need for resources to contribute to the delivery of the Lean programme and to deliver larger, systemwide changes so had recently established a transformation team in January 2018. The transformation team had started a project to redesign the frailty pathway across Pennine Lancashire. As part of the project the team had led a value stream analysis involving stakeholders from across the health and social care economy, mapping the current state, ideal state and plans deliver a new pathway. The transformation team had a schedule of work with the next focus on theatres. The trust had a governance framework for transformation projects which reported to the partnership delivery group, which reported to the finance and performance committee. Transformation schemes were also reported in the sustaining safe, personal and effective care report.

The trust told us that there were staff across the organisation who were trained in quality improvement methodologies, but the aim was for quality improvement to be part of everyone’s role. The trust was planning to use ‘improvement kata’ principles, a pattern for improvement thinking and behaviours originally identified in the Japanese motor industry.

The trust was involved in the Getting It Right First Time programme (GIRFT) and used the model hospital tool. The Getting It Right First Time programme is an NHS programme helping to improve the quality of care by bringing efficiencies and improvements. The model hospital tool is a digital information service designed to help NHS providers improve their productivity and efficiency. The trust was involved in the programme to improve productivity in surgical theatres.
The trust was aiming to achieve national commissioning for quality and innovation (CQUIN) goals in a range of areas including staff health and wellbeing, infection, mental health needs in the emergency department, care planning, discharge and medicines optimisation. Performance against the goals was monitored through the integrated performance report.

The trust looked at national reviews to identify any learning or gaps which were relevant to the trust. Reviews of national reports were reported to the quality committee. We saw evidence of the committee considering the independent review into Liverpool Community Health NHS Trust, which the trust told had also been shared with the local clinical commissioning group.

The trust updated its approach to reviewing deaths in December 2017, following the NHS National Quality Board guidance on Learning from Deaths. The learning from deaths guidance required NHS trusts to produce and publish an updated policy on learning from death. The trust used a structured judgement review methodology to review patient deaths. The trust process attributed a score to particular care elements and an overall score for the patient’s care. Certain scores triggered further investigation and a root cause analysis if appropriate. Mortality data and outliers were reviewed by the mortality steering group. At the time of the inspection there were no mortality outliers and the hospital standardised mortality ratio was below expected mortality.

The trust had processes to investigate, monitor and share learning from serious incidents. All incidents recorded on the electronic incident report system were reviewed daily by a triage group with representatives of each division. Serious incidents requiring a rapid review were identified and where appropriate clinical teams were stood down to participate in a round table discussion to review the incident and identify any immediate learning. Serious incidents were investigated using a root cause analysis methodology by staff trained to carry out root cause analysis. Family liaison officers were appointed to be the point of contact for patients and their families.

Serious incidents were monitored through the serious incidents requiring investigation (SIRI) panel which reported to the quality committee and the board. The trust told us that the serious incidents requiring investigation (SIRI) panel had been an iterative process and had been developed to cover both progress of individual serious incidents and to focus on a review of themed incidents, to identify wider learning. Leaders told us that all clinicians involved in serious incidents attended the panel about incidents they were involved in.

During the inspection we reviewed a sample of serious incidents and found that each investigation had understood the facts of the incident, identified learning and made recommendations. Investigations had been carried out by staff independent of the incident and were clearly written and proportionate to the incident and risks. In each case, the family had been kept in regular contact with the progress, although from the root cause analysis investigation reports it was unclear whether the family had been involved in developing the terms of reference for the investigation.

Between April 2017 and March 2018, the trust had seven never events, with another never event in April 2018. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The never events were categorised as wrong site surgery (five), retained foreign object post procedure, misplaced nasogastric tube and unintentional connection of a patient requiring oxygen to an air flowmeter.

The trust carried out individual investigations of each of the never events and developed action plans including changes to the World Health Organisation checklists, site marking and specimen policies and new theatre white boards. The trust also introduced a 10,000ft initiative in theatres which empowered any member of the theatre team to call 10,000ft to reduce the noise level and
increase concentration if they felt safety was potentially compromised. This was initiated by an operating department practitioner based on practices used in the airline industry. The trust also introduced an ‘ID Me’ campaign to improve ID checking. Following the never events the trust sent a safety bulletin to every member of staff and the outcomes of the investigations and actions were discussed at share to care meetings.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>25 working days</td>
<td>Achieved in some cases</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>50 working days</td>
<td>Usually achieved and first response provided, although unexpected delays can prevent closure (i.e. 2nd responses, meetings etc) within timescale</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Appropriate timescale agreed with complainant during 'being open' discussion. Usually 45 working days</td>
<td>Achieved in most cases as target timescale</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1,125</td>
<td>N/A</td>
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(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 344 complaints from April 2017 to March 2018. Medicine received the most complaints with 111.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>111</td>
<td>32.3%</td>
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<tr>
<td>AC – Outpatients</td>
<td>89</td>
<td>25.9%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>65</td>
<td>18.9%</td>
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<tr>
<td>AC – Surgery</td>
<td>52</td>
<td>15.1%</td>
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<td>AC – Gynaecology</td>
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<td>3.8%</td>
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<tr>
<td>AC - Critical care</td>
<td>4</td>
<td>1.2%</td>
</tr>
<tr>
<td>AC – Maternity</td>
<td>4</td>
<td>1.2%</td>
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</tbody>
</table>
Formal and informal complaints were handled by the customer relations team. The team reported to executive and divisional leads to ensure compliance with the standards. All complaints letters were reviewed by either the medical director or a deputy medical director to ensure that they were clinically accurate. The trust held quarterly complaints review panels led by a non-executive director to review a sample of complaints to ensure the process was followed and the quality of the response, actions and learning.

The trust measured complaints as a proportion of patient contacts, which was reported in the integrated performance report. The trust had seen significant improvements in the last five years with the number of complaints per contact currently at 0.19, compared to 0.53 in 2013.

We reviewed a sample of complaints and found that in every case the complainant had been given good support in making that their complaint and a thorough investigation of each complaint had been carried out. The responses clearly set out the outcome and where appropriate gave apologies.

Compliments

From April 2017 to March 2018, the trust received a total of 383 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC – Surgery</td>
<td>151</td>
<td>39.4%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>81</td>
<td>21.1%</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>46</td>
<td>12.0%</td>
</tr>
<tr>
<td>AC – Gynaecology</td>
<td>20</td>
<td>5.2%</td>
</tr>
<tr>
<td>AC – Diagnostics</td>
<td>17</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>4.4%</td>
</tr>
<tr>
<td>AC – Maternity</td>
<td>15</td>
<td>3.9%</td>
</tr>
<tr>
<td>CHS - Urgent Care</td>
<td>14</td>
<td>3.7%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>13</td>
<td>3.4%</td>
</tr>
<tr>
<td>AC – Outpatients</td>
<td>5</td>
<td>1.3%</td>
</tr>
<tr>
<td>CHS - Community Inpatients</td>
<td>3</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
(Source: Routine Provider Information Request (RPIR) – Compliments)

The trust also had a compliment log which was used internally to gather compliments received at ward or department level. Results were published monthly on the trust’s intranet and also reported at the patient experience group committee meetings.

During April 2017-March 2018 there were:

- 3721 cards
- 386 thank you letters
- 3855 chocolates
- 1197 gifts
- 4736 comments

The trust had made significant progress with the sentinel stroke national audit programme (SSNAP) moving from the bottom rating (E) to the top rating (A). Progress was monitored by the stroke steering group and was facilitated by changes, including the appointment of two nurse consultants in stroke care and changes to processes.

The trust shared learning with other NHS trusts as part of a membership network of 14 NHS trusts who focused on improving quality and safety. The aim of the organisation was to work together, share challenges and design innovative solutions to provide the best care possible for patients and staff. Member trusts participated in programmes which included experience days (visits to other member trusts), improvement science for leaders, theatre safety culture and employment improvement. The trust was also member of a North West based membership organisation to improve the quality of health and care. The organisation had been involved with training staff in improvement methodologies and human factors training.

The trust had been commissioned by NHS Improvement to support a trust in special measures to improve. The buddying arrangement involved the trust providing support with quality, patient safety, stakeholder engagement and financial performance.

The trust invested in developing its estate and in innovative equipment and technology. The trust was currently building a £15.6 million new ophthalmology, outpatient and maxillofacial facilities at Burnley General Hospital which was the final stage of a 15 year phased £60 million development programme. The trust had other future building plans, which were being considered at the time of the inspection, to develop a new emergency village at Royal Blackburn Hospital. In 2015 the trust purchased a surgical robot. This had been used in specific urology procedures which had reduced the length of stay for patients the trust was planning to use it more widely in other areas. The trust had just installed a new computed tomography (CT) scanner at Royal Blackburn. It was the first UK hospital to install the scanner which was capable of recording 80 views (slices) of the body in a single scan rotation.

The trust was involved in research studies and had increased the number of patients participating in research studies in the previous year. In 2016-17 1,487 patients had been involved in 79 clinical studies which was a 41% increase on the previous year. This was the largest increase of an acute hospital outside London and the South East of England.

The trust’s two acute sites had been awarded teaching hospital status in 2016 with the opening of a medical school at the local university. The trust and hospital were developing a joint strategy for
education and research and during the inspection a number of staff had been awarded honorary professor and honorary senior clinical lecturer status by the university.

The trust had workforce transformation plans to address the workforce issues, which was one of the trust’s key risks. The trust had worked with the workforce repository and planning team (WRaPT) at Health Education England to develop the plans. The trust was using innovative recruitment practices and had developed different clinical roles to address clinical vacancies across the trust. The trust had appointed three nurse consultants, had trainee nurse associate and physician associate programmes ongoing or planned, and was in September 2019 starting an apprentice nursing programme with a local university. The trust was involved in a global learning programme to recruit nursing staff from other countries who would work at the trust for a fixed period before returning home with additional skills and experience.

The trust’s medicines support team worked as part of the multidisciplinary integrated neighbourhood team within one of the local clinical commissioning groups to provide support for individual patients where there were medicines safety concerns. Referrals to the service came from a wide range of services including: GPs, social care, voluntary services and community pharmacy. There were 1,052 patients referred to the service in 2017-18 and 1,957 home contacts were carried out.

The trust was engaged with Health Education England to support three trust pharmacists to complete advanced clinical practitioner training with the aim of developing innovative roles for experienced non-medical prescribing pharmacists, to enhance capacity and capability within multi-professional teams on medical wards.

**Accreditations**

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Medicine (including older people's care)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>Laboratories ISO 15189</td>
<td></td>
</tr>
</tbody>
</table>

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

The East Lancashire area had become the first area in the country to receive the United Nations Children’s Fund (UNICEF) UK baby friendly initiative gold standard. The standard is in recognition of the advice and support given to families with new babies for nurturing and feeding.

Staff and teams across the trust had been nominated for, and won, national awards in recognition of their work and achievements. In the year before the inspection the trust had been nominated for two quality improvement initiatives at a national patient safety award, one for the placental clinic which increased the detection of fetal gown restriction and still births and the second for the
respiratory assessment unit. At the same awards the trust had been nominated for an improving safety in medicines management award for the dedicated ward based pharmacy teams. In September 2018 the Women and Newborn Centre at Burnley General Hospital won the Kate Grainger Award for compassionate care. This was for being the first trust to formally establish a ‘skin-to-skin’ caesarean standard.
Urgent and Emergency Care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Urgent and emergency services are provided through an Emergency Department on the Royal Blackburn Hospital site, Urgent Treatment centres at Royal Blackburn Hospital and Burnley General Hospital, and a Minor Injuries Unit at Accrington Victoria Hospital.

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

Burnley General Hospital

Urgent care services are provided at Burnley General Hospital by the urgent care centre, which is run under the trust’s integrated care group division. The urgent care centre was re-designed in 2007 from an Accident and Emergency (A&E) department. The urgent care centre moved into a new building in January 2014 which is shared with a GP out of hours service. Services operate 24 hours a day, seven days a week.

The urgent care centre provides treatment for injuries or illnesses requiring immediate or same day care but not serious enough to require an emergency department visit or to result in the need for a hospital admission.

Patients requiring emergency care are transferred to emergency departments (ED) in other local hospitals. The nearest ED is at the trust’s other site, Royal Blackburn Hospital, which is also run under the trust’s integrated care group division. Patients with minor injury or illness could also be seen at the trust’s minor injury unit in Accrington.

Between September 2017 and August 2018, the urgent care centre saw 49,890 patients of which
13,011 were children, averaging 137 patients each day. During this time there were 1,247 attendances resulting in an admission.

Most patients self-present to the urgent care centre, approximately 2.2% per day were brought in by ambulance. There is a designated entrance for these patients. Self-presenting patients at the urgent care centre are directed to the adult or children’s waiting area.

We planned our inspection based on everything we know about services including whether they appear to be getting better or worse.

We carried out an unannounced inspection between 4 and 6 September 2018. As our inspection was unannounced, staff did not know we were coming. This enabled us to take an accurate snapshot of routine activities and staffing levels. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During the inspection we spoke with seven patients who were using the service and observed care and treatment. We sought the views of relatives, friends and carers. Six patients gave us their views on the service via comment cards placed in clinical areas and waiting rooms during the inspection.

We spoke with nineteen members of staff including integrated care group leads, medical staff, matrons, nurses, healthcare assistants, cleaners, receptionists and allied health professionals.

We reviewed nine patient records, five incidents and five complaint files. We observed staff interactions with patients, handovers and multidisciplinary team working.

We previously inspected the service in October 2015. The service was previously rated as good.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at East Lancashire Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018**

From July 2017 to June 2018 there were 172,034 attendances at the trust’s urgent and emergency care services as indicated in the chart above.
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In 2016/17 the proportion was higher than the England average.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from April 2017 to March 2018

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.

Mandatory Training

The department provided mandatory training in key skills to all staff. Training consisted of core skills with additional mandatory training dependant on their roles and responsibilities. The matron practice educators and newly appointed unit manager had oversight of mandatory training completion rates, due dates and the dates staff were booked onto courses. We spoke with staff who had completed their mandatory training and they told us that they had been given protected time to complete this. Training was delivered by a mixture of e-learning though a ‘learning hub’ and face-to-face sessions.

Staff in the reception area were required to undertake a full range of mandatory training which was accessed and completed online.

The rota co-ordinators and business managers tracked the mandatory training figures.

Staff informed us that the mandatory training completion rates were a lot better since there were two dedicated practice educators in place.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.
(Source: Routine Provider Information Request (RPIR) – Training tab)

A breakdown of compliance for mandatory courses from August 2017 to July 2018 for nursing staff in the urgent care centre is shown below:

Mandatory training completion by module for the urgent care centre – Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Staff compliant</th>
<th>Staff non-compliant</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution L1</td>
<td>93%</td>
<td>90%</td>
<td>29</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality Diversity &amp; Human Rights</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety, Health and</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Safety

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Staff compliant</th>
<th>Staff non-compliant</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention % Control</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent (preventing radicalisation)</td>
<td>100%</td>
<td>90%</td>
<td>29</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>97%</td>
<td>90%</td>
<td>28</td>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all mandatory training modules shown above for nursing staff at the urgent care centre.

(Source: the trust, additional data requests)

### Mandatory training completion by module for staff in the urgent and emergency department across all sites.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Staff compliant</th>
<th>Staff non-compliant</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support</td>
<td>90%</td>
<td>90%</td>
<td>159</td>
<td>17</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution L1</td>
<td>99%</td>
<td>90%</td>
<td>183</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality Diversity &amp; Human Rights</td>
<td>98%</td>
<td>90%</td>
<td>180</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>96%</td>
<td>90%</td>
<td>177</td>
<td>7</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention % Control</td>
<td>98%</td>
<td>90%</td>
<td>181</td>
<td>3</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>78%</td>
<td>90%</td>
<td>144</td>
<td>40</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>99%</td>
<td>90%</td>
<td>182</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>95%</td>
<td>90%</td>
<td>174</td>
<td>10</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for the majority of mandatory training modules shown above for staff in urgent and emergency department across all sites. The module with the lowest completion rate was information governance at 78%.

(Source: the trust, additional document requests)

The completion rate for information governance was below the trust target. Senior managers told us that they had plans to address this through individual managers in each department and by allowing staff to take time out from clinical duties to complete their training. Managers monitored individual compliance with mandatory training in their annual appraisal with staff.
All staff in the urgent care centre were required to undertake adult and paediatric safeguarding training, including those staff working in the reception area. All staff training in safeguarding was delivered to safeguarding level 3.

The staff that we spoke with and observed during the inspection knew how to report a safeguarding concern and were aware of their own responsibilities. Staff described how they had access to the safeguarding team and would phone them for advice when required.

We spoke with a number of staff who confirmed that they were up to date with their adult and paediatric level three safeguarding training.

The department had two link nurses for safeguarding, one for adult safeguarding and one for paediatric safeguarding.

We witnessed a member of the reception team challenging a male patient and stopping them from going into the children’s waiting area. This patient did not have an accompanying child or any reason to be in this area.

There were several posters on display throughout the department including child exploitation awareness, no excuse for abuse and summer worker safety tips.

There were screening tools in place for the assessment of physical abuse in adults and children. The department followed the trust policy ‘The procedure for the use of Child Protection Information Sharing (CP-IS) system and compliance with this policy was audited. There was a pathway to follow for safeguarding children already known to social care including referral to paediatric liaison.

The presence of age concern within the department enhanced safety and management of elder abuse.

There was a well maintained safeguarding information board on display in the department. Information included; a clinical governance and adult safeguarding flow chart, making a referral to children’s social care, paediatric referral to SAFE centre, responding to disclosures of domestic abuse, safeguarding children flow chart, bruising or injury to non-mobile children and information relating to the suspicion of child sexual exploitation.

In the matron’s monthly newsletter for September 2018 we saw that the practice educators and safeguarding team lead were planning for information about female genital mutilation (FGM) to be cascaded and discussed.

There were also domestic abuse helpline posters in the toilets with tear off contact numbers to enable people to conveniently retain the information.

In the twelve months prior to the inspection the emergency care division had made 257 contacts to the children’s safeguarding team, 50 referrals to children’s social care, 98 contacts to the adult safeguarding team and raised 162 formal adult safeguarding alerts. Approximately 10% of referrals and alert were from the urgent care centre.

At the time of the inspection 93.3% of nursing staff had completed their level 3 safeguarding training.
Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses for nursing and medical staff 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 rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>28</td>
<td>29</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust told us that the safeguarding training modules included training for Mental Capacity Act and Deprivation of Liberty Safeguards.

(Source: the trust, additional document requests)

Cleanliness, infection control and hygiene

The service maintained high standards of cleanliness, infection control and hygiene, which helped prevent the risk of acquiring or spreading infection.

There were hand gel dispensers at the entrance and throughout all the areas that we inspected. There was clear signage on dispensers found at entrance points to remind patients, their carers and visitors to wash their hands or use the hand sanitising gel. We observed staff washing their hands before and in-between procedures. We did note that there was an empty dispenser at the entry point to the urgent care centre, however this was replaced immediately once the issue was raised.

The urgent care centre had a day and night cleaning checklist which was in addition to the scheduled cleaning of the department. The check list included cleaning drip stands, electrocardiograms (ECG), patient kitchens, fridges, the plaster room and wheelchairs. There were also checklists for the sluice cleaning, commode cleaning, equipment in the eye room and consultation rooms. We examined the checklist for the period August 2018 to the inspection date and found that all checks had been completed.

The toys in the children’s waiting area were cleaned daily. During the inspection period we noted that domestic cleaning staff were a visible presence in the department.

We were informed by staff that if any gaps were identified in the cleaning schedules that they were escalated to the nurse in charge.

Areas within the department were deep cleaned once a week and as required for infectious patients. Cubicle curtains were changed every three months or when contaminated.

We saw dated ‘I am clean stickers’ on equipment throughout the department, including the ophthalmology and ear nose and throat (ENT) room. Stickers were also placed on the glass doors
of cubicles and treatment rooms to show that the room had been cleaned and was suitable for treating patients.

We saw a patient who was being cared for in a cubicle to isolate them from other patients. Their condition made them susceptible to infection and at increased risk of complications if acquired. The patient was awaiting transfer to Royal Blackburn Hospital.

We asked staff how they managed infectious or potentially infectious patients. Staff informed us that they used universal precautions. There was a laminated ‘stop’ sign for doors which covered the source of isolation, precautions to take such as wear gloves and keeping the door closed. Each consultation and treatment room contained aprons, gowns, gloves and orange bags for infectious waste.

We received a number of positive comments from patients who thought that the department was very clean.

Aseptic non-touch technique (ANTT) wound care and ANTT peripheral cannulation posters were on display in the department. There was a dedicated infection prevention and control board displaying information on hand hygiene techniques and training, the chain of infections and arms bare below the elbows. There was also an algorithm for the ‘management of suspected acute viral respiratory tract infections.’

We examined the department performance board and found that there had been 100% compliance in their hand hygiene audit for the preceding month.

Senior nursing staff informed us that if there was a dip in their monthly infection prevention and control audits then staff would be re-educated using the ‘prompt to protect’ education system and staff came in to deliver the training.

Staff told us that their infection prevention and control audits included mattress checks, chair rips, hand hygiene and ANTT.

In the latest monthly matrons’ report for August 2018 the urgent care centre at Burnley had achieved 100% for peripheral venous catheter insertion and cleaning and decontamination including bedside, commode, hands, mattress and water flushing.

In the last three months infection prevention and control audits the blood culture contamination rate for the department averaged 1.4% with two out of the three months achieving 0%.

**Environment and equipment**

The premises and equipment were suitable for their intended purpose and were well maintained. All the areas we visited were visibly clean, very neat and tidy and dust free. The cubicles and treatment rooms were purpose built as part of a ‘new build’ in 2014. They were spacious, light and airy, with large glass doors and frosted screening to maintain the privacy of patients.

There was a central reception area for patients to present and book in to be seen. Two separate waiting areas were available for children and adults. Access to the children’s waiting area and to clinical areas was secure. An authorised electronic card entry system was in operation.

Adults and children had access to a dedicated triage room 24 hour a day, seven days a week.

A sub-waiting room was available for ambulatory patients awaiting transfer off-site for treatment at other health care settings. The room contained ambulatory chairs suitable for patients receiving
infusion therapy. The room was also used as a ‘safe’ mental health room when required. It was sited close to the main nurse’s station and was covered by closed-circuit television (CCTV). The room had a wall strip panic alarm system for raising urgent assistance.

Patients received care and treatment in one of 14 treatment and consultation rooms. There was one treatment room and a room with specialist equipment for ophthalmology and ear, nose and throat patients (ENT). The remaining 12 rooms were cubicles.

Two rooms were designated for children. There was also a dedicated plaster room for patients with fractured limbs.

The X-ray department was sited next to the urgent care centre and with easy access for patients. To maintain security patients returning to the urgent care centre from X-ray used a buzzer to regain access.

Staff in the reception area all carried personal alarms.

Resuscitation equipment was securely sealed and checked once weekly or whenever the seal was broken. Certain equipment was checked daily. We examined the adult and paediatric resuscitation trolley checklists for August 2018, up until the inspection date, and found that all checks had been completed. We checked the contents of the adult resuscitation trolley alongside a member of staff. The manufacturers’ expiry dates of consumables on the trolley were highlighted as a preventative measure. All consumables and equipment were present and within the manufacturer’s expiry date.

We checked the paediatric resuscitation trolley. We found that that most of the consumables and equipment were present and within the manufacturers’ expiry dates. The oxygen and suction unit on the trolley was checked and found to be working. However, there was no paediatric pocket mask present on the trolley, even though this item had been ticked on the checklist for that day as being present. The Resuscitation Council UK Quality standards for cardiopulmonary resuscitation Acute hospital care – paediatric, airway and breathing state that a pocket mask with oxygen port – paediatric must be immediately available.

We reviewed the last three months’ adult and paediatric resuscitation trolley checks and found that there was a high level of compliance. The paediatric pocket mask was indicated as being present at the end of August 2018.

There was a separate secure waiting area for children which had colourful furnishings a range of toys to play with and a television to watch. The waiting area led to two separate children’s consultation rooms with secure access. There was audio and visual separation of the adult and children waiting areas.

The department had a dedicated housekeeper who ensured that the department was free of clutter and who oversaw the replacement of equipment and furnishings. As part of their daily tasks they checked stocks and reported any damages of equipment or furnishings. They were also responsible for ordering replacement items.

The electro-biomedical engineering department were responsible for fixing faulty equipment and for the safety testing of equipment. The department maintained an equipment faults log. Requests for equipment replacement and upgrading were submitted to the finance department for approval before orders could be placed.

We examined the equipment maintenance for calibration and testing register for the department and found that most of the equipment was within service date and where gaps were identified there were explanations given.
There were fire extinguishers placed throughout the department which were within their service date. All fire exits and alarm points were clear from obstruction.

There were adequate numbers of call bells in the department and these were placed within the reach of patients.

We observed good management of waste across the department. Foot operated clinical waste bins were in use. Sharps bins in clinical areas were labelled appropriately and not over filled. Waste was stored in code locked waste rooms with segregation of clinical and non-clinical waste. Waste bags were sealed and labelled appropriately. Staff informed us that orange infectious and potentially infectious waste bags were used for waste arising from infectious and potentially infectious patients.

**Assessing and responding to patient risk**

The urgent care centre had no inclusion or exclusion criteria for patients that self-presented as all patients were seen and risk assessed on presentation to ensure patients were clinically appropriate. If patients were assessed and found to be clinically high risk, immediate treatment was established and an urgent transfer arranged to the emergency department at Royal Blackburn Hospital. This system helped to ensure that only patients well enough to receive urgent rather than emergency care were treated at the urgent care centre.

Patients arriving by ambulance were assessed by paramedics using the ‘paramedic pathfinder’ protocol. Pathfinder is a reductive, consistent, and evidence based triage system to enable accurate face-to-face assessment of individual patient needs on scene, identifying the most appropriate care pathway for that patient. Over the period September 2017 to August 2018 we saw that 2.2% of patients were brought into the department by ambulance.

The reception staff we spoke with had over sixteen years’ experience in their role. Most of their training was experience based. Staff in this area did not follow any set protocols or pathways for identifying patients who needed to be seen urgently by staff in the clinical areas. Staff were aware of the need to notify clinical staff if patients arrived with problems such as chest pain, suspected strokes and patients on chemotherapy.

Nursing staff followed the Manchester triage system and there was an allocated nurse to triage. The Manchester triage system is an evidence based triage system widely used across the UK and Europe. It enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis. Under this system patients were prioritised as non-urgent, standard, urgent, very urgent and immediate.

Patients were streamed from triage to see an urgent and emergency care doctor, an emergency care practitioner or physiotherapist and a GP stream for minor illness. The advanced nurse practitioners saw patients allocated to the doctors or minor illness stream. There was an agreement in place with the GP 111 service for patients triaged suitable for GP to be seen by them if they had capacity. Patients presenting to the GP service with, for example, chest pain, could be referred to the urgent care centre.

There was a primary care pathway in place. There was also a ‘primary care streaming – urgent care centre’ standard operating procedure (SOP) in place which stated that once triaged it may be more appropriate for patients to be seen by the out of hours GP or advanced nurse practitioner.
where capacity was available.

Staff were positive about the new model of triage which had been in place for approximately six weeks. If the nurse in triage queried conditions such as sepsis or abdominal pain then patients were seen by a nurse in the treatment room for their bloods, electrocardiograms (ECG) and urinalysis to be done before they were seen by a doctor. This system ensured that tests and treatment could start at triage.

We observed patients who were triaged comprehensively. They were asked a range of questions including the nature of their clinical condition, past medical history, pain, medicines, allergies and next of kin.

We requested the percentage of nurses and doctors up to date with training (either trained, or refreshed) in intermediate life support, advanced life support, paediatric intermediate life support and advanced paediatric life support. We were informed the overall current compliance level was 90%. We saw training dates available for paediatric and adult life support recertification.

The department uses the early warning score system (EWS) and paediatric early warning score system (PEWS). An early warning score is a guide used to quickly determine the degree of illness of a patient. It is based on vital signs, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Early warning score and wristband audits were performed in the department. We looked at the latest audits available for the department from May to June 2018 and saw that the overall compliance rate was 94.3%, results were all reviewed at the integrated care group patient safety and risk committee meeting.

There needed to be at least one advanced paediatric life support trained nurse on duty at all times in the department and at least one tier three doctor (middle grade). For an adult resuscitation the crash team would be called. For paediatric resuscitation the consultant anaesthetist was called. There was also access to a paediatric registrar in the children’s minor illness unit when it was open and neonatal intensive care unit on the site.

Adult patients undergoing a cardiac arrest could be treated in the urgent care centre before being transferred to the Royal Blackburn Hospital emergency department. If a paediatric arrest occurred in the department the patient would be stabilised and transferred immediately for treatment at Royal Blackburn Hospital. Other time-critical patients, for example, stroke patients requiring thrombolysis, were also transferred urgently via an emergency ambulance.

Staff informed us that most patients requiring a transfer were ‘priority category two’ requiring an emergency response within 20 minutes. A ‘priority one’ transfer request would trigger an appropriate multi-resource response with a response time of 8 minutes. The department followed an interfacility protocol ‘requesting an inter-facility ambulance transfer from a stand-alone urgent care centre/midwife led unit’ derived from the national framework. This protocol outlined the criteria for critical, emergency, urgent, non-urgent and routine transfers. For ‘priority category two’ patients if they were time-critical this could be overridden.

Patients were also transferred to other local NHS trusts for specialised treatments such as neurology, plastics and adult or paediatric trauma centres.

Staff followed the trust’s policy ‘Guidance for the Safe Transfer of Adult Patients’ to ensure that patients were transferred safely to other trust sites or other trusts. This policy included a patient decision transfer matrix which used clinical indicators to categorise patients from low risk to critically ill and clearly outlined the equipment, level of monitoring and personnel required. This policy also covered paediatric transfers. Children for transfer were risk assessed according to their
paediatric early warning score from low risk through to high risk. The type of transport, minimum accompanying personnel, equipment and minimum skills required to support the transfer were all clearly defined.

The department had a flow chart for the ‘Management of Seriously Unwell Children Attending Burnley UCC [urgent care centre].’ Staff informed us that unwell children were stabilised before being transferred. This policy outlined the steps that were taken depending on whether the children’s minor illness unit was open. If children’s minor illness unit was open then the child was transferred to resuscitation area and was urgently assessed by a paediatric middle grade doctor and senior nurse. The trust informed us that the urgent care centre is staffed with senior emergency department doctors and nurses to provide care for sick children. On the occasion that the minor illness unit has closed, advanced nurse practitioners are deployed to the urgent care centre to support any sick children arriving to the department. There was also provision of anaesthetic support should a child require emergency care and the urgent care centre would use ambulance services to support emergency transfer to other providers.”

Staff expressed concerns with the frequent closure of the children’s minor illness unit and the lack of back up support for poorly children attending the urgent care centre. We were informed that if a child needed transfer and needed respiratory support then a senior medic from the unit would accompany the child leaving the unit unsafely staffed. We noted that the children’s minor illness unit being closed for the day was raised as an issue during handover and that paediatrics would support if required.

The electronic patient tracking system enabled staff to see where patients were located. The system also contained flag alerts for oncology patients, care plans, do not attempt cardio pulmonary resuscitation order and individualised notes. The system was also used for an electronic ‘Situation, Background, Assessment, Recommendation’ (SBAR) handover and could be viewed in other departments prior to handover. For poorly patients a verbal handover was also performed.

For patients attending the department who already had care plans in place, their plans were printed and placed into the patients’ notes. These patients are also flagged to alert staff on the central alerting system.

We observed patient consultations. The patient’s clinical presentation was explored, including, how their injury had occurred and further questions relating to medicines including the use of anticoagulants. Patients were examined thoroughly and given verbal advice for discharge, including, managing their condition at home and leaflets for reference relating to their condition.

We observed a number of patient interventions. We noted one patient whose wound had been sutured and dressed by an advanced nurse practitioner.

We observed a staff handover in the department. All patients were discussed including their clinical condition, recent history, investigations performed, including bloods and imaging, pain relief, to take home medicines and multidisciplinary team input.

Staff informed us that mental health patients were risk assessed at triage, assessed and referred directly to the mental health liaison team by telephone. A member of staff from the mental health team attended the department to do a mental health assessment. If a patient required admission, the patient remained in the department whilst awaiting a bed and an escalation action card was followed. Patients were also risk assessed for shared care and one-to-one supervision and this was provided when deemed to be in the patient’s best interest. Patients were attended to daily by psychiatrists and medical doctors.
We saw that a ligature risk assessment had been completed to identify various ligature risks throughout the department and this had been placed on the department’s risk register. There were no ligature risks identified for the mental health consulting room and there were controls in place for patients requiring care and treatment in other areas of the department.

There was a ‘hypo box’ sited on the department. A ‘hypo box’ is a one-stop care kit that provides a range of glucose products for use in cases of low blood sugar and in the management of patients with diabetes.

Staff had access to timely blood and blood products provision with a ‘blood bank’ sited in the hospital. A flow chart for ‘Massive Haemorrhage in Adults’ was on display in the department. Staff had access to the trust’s ‘Management of Massive Haemorrhage’ policy which covered massive haemorrhages in children. Nursing staff underwent face-to-face training and e-learning.

Staff used a Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale for assessing and treating patients undergoing alcohol withdrawal. This tool was also used to assess patients who may require urgent transfer and treatment at the emergency department at Royal Blackburn Hospital.

Patients with suspected sepsis in the urgent care centre were given a bolus of antibiotics. Compliance with sepsis figures had improved since the introduction of sepsis champions, local NHS ambulance crews pre-alerting when transferring septic patients to the emergency department at Royal Blackburn Hospital, sepsis trolleys and raising awareness by initiatives such as a sepsis awareness week. At the time of the inspection 80% of patients with suspected sepsis in the were receiving antibiotics within an hour.

Staff described that there was raised awareness of a sepsis care bundle. We were informed that the sepsis group produced the bundle and cascade trained staff. Following identification of a patient with sepsis, staff followed the trust’s antimicrobial guideline to administer the appropriate antibiotic.

Sepsis training was overseen by the two clinical educators for the department, they were also responsible for keeping the staff training matrix up to date. There was a study day held for staff from the urgent care centre and sepsis was included in the agenda. There was also an educational ‘sepsis game’ available for staff to aid their learning. The current sepsis training completion rate for the department was 90%.

Nursing staff expressed concerns with the removal off intravenous (IV) pumps for the delivery of antibiotics for patients with sepsis. They were concerned that a number of medicines such as gentamicin could not be administered by bolus. We were informed that the consultants did not wish for the IV pumps to be used as the urgent care centre was not an emergency department. For patients with severe sepsis, best practice guidance recommends that antibiotics should be given intravenously.

The department had an updated, comprehensive and detailed major incident plan in place. Staff told us they received major incident training and were trained in treating patients presenting with Ebola or severe acute respiratory syndrome (SARS).

Nurse staffing

Nursing staff of different grades were assigned to different areas of the department including triage and treatment. Staff grades included staff nurses, sisters, emergency nurse practitioners and
advanced nurse practitioners.

The leadership team informed us that there was a bigger establishment of emergency nurse practitioners at the urgent care centre compared with the Royal Blackburn Hospital emergency department due to the number of minor illnesses seen there.

The leadership team informed us that greater funding had been secured to increase the nursing establishment in the emergency medicine division.

We noted 1.8 nurse staffing vacancies at the time of the inspection. A band six junior sister was being appointed. A new post of ‘unit manager’ had been created. An existing member of nursing staff was recruited to this role during the inspection. The department was fully recruited to band two and three nurses and there were more band five nurses appointed with start dates.

The department had a set establishment of nursing staff covering each shift over a 24-hour period. Staffing levels had been set using a workforce planning tool called the ‘Baseline Emergency Staffing Tool’ (BEST).

We checked the nurse staffing board on display in the reception area. This board was updated daily. We examined this board and over the inspection period found that the planned and actual registered nursing and assistant nursing staffing levels for the early, late and night shifts were met.

There was a shift co-ordinator on duty in the department to ensure the smooth running of the urgent care centre. They ensured that staffing levels were adequate for each shift and to meet patient needs. Other duties include scheduling relief nursing coverage for all shifts. We observed nursing and medical staffing levels for the day being discussed during handover.

Staff informed us that the flow of patients increased throughout the day and peaked at late evening. There was also a ‘tea time rush’ in the department between 5pm and 6pm and staff indicated that this was sometimes difficult to manage. Senior nursing staff informed us that the nurse staffing rota was staffed to meet these peaks. If there was a surge of workflow in the department then the co-ordinator would provide support.

Staff described the preference to use bank staff rather than agency staff to cover staffing shortfalls. Recent data had shown a reduction in the use of agency staff when compared with the previous 12 months and an increase in bank staff. We were informed that a number of bank staff took up substantive posts with the trust.

Nurse staffing levels were described as challenging during the month of August 2018 with a number of emergency nurse practitioner and advanced nurse practitioner staffing shortfalls being covered by junior doctors. There were two qualified advanced nurse practitioners in the department with an additional two advanced nurse practitioners identified to join the team.

The department were looking to introduce longer day shifts, which would enable an extra person on the early shift daily.

Staff highlighted the need for additional support workers for tasks such as stock keeping when clinical tasks were also incorporated into their roles.

The level of nursing staff sickness at the time of the inspection was 5.4%, of which 4% was long-term, and 1.4% was short term.

Vacancy rates

From August 2017 to July 2018 the Urgent Care Centre at Burnley General Hospital reported a
vacancy rate of 13.3% for nursing staff, this was higher than the trust’s target of 5%.
(Source: the trust, additional document requests)

Turnover rates

From August 2017 to July 2018 the Urgent Care Centre at Burnley General Hospital reported a turnover rate of 0.08% for nursing staff, this was lower than the trust’s target of 12%.
(Source: the trust, additional document requests)

Sickness rates

From August 2017 to July 2018 nursing staff at the Urgent Care Centre at Burnley General Hospital had a sickness rate that ranged from 2.1% to 13.3% (average 5.9%). The trust’s target was 3.75%.
(Source: the trust, additional document requests)

Bank and agency staff usage

From September 2017 to August 2018, 515 nursing staff shifts were filled by bank staff, and four shifts were filled by agency staff.
(Source: the trust, additional document requests)

Medical staffing

A ‘tier 3’ doctor was available in the department for 24 hours a day for seven days. Tier 3 doctors are middle grade doctors who have completed four years full time postgraduate training or equivalent and of which two will be in a speciality training programme such as emergency medicine.

The department was a consultant led unit with a consultant present in the department for eight hours a day on weekdays. Outside of these hours an on-call consultant was available covering the remaining 16 hours over a 24-hour period.

We examined the clinical staffing rota for seven days, including the inspection period. The rota outlined the type and tier of staff required (where applicable), expected staffing levels and minimum staffing levels per shift. We noted that for six out of the seven days that there were gaps in the rota of between one and three expected members of staff.

We spoke with medical staff who rotated between the urgent care centre in Burnley General Hospital and the emergency department at Royal Blackburn Hospital. They told us that staffing had been an issue for a while due to recent changes in the rota and timings. There were pressures in the department that week due to sickness and they were under pressure having to make up for the shortfall. The new rota had changed in August 2018 and discussions with management were ongoing with regards to the issues raised.

The leadership team told us that there had been significant medical staffing issues over the previous
couple of weeks. Agency staff were not picking up the shifts. We were also informed that the clinical staff rotas minimum staffing levels had inbuilt additional staffing to allow for different productivity levels of staff.

The nursing shift co-ordinator informed us that they would always book a higher tier of doctor to provide cover if the same tier of doctor was not available. We noted that during the period December 2017 to July 2018 that the department had most of their cover shifts provided by bank staff with a decreasing usage of agency staff seen.

The emergency division had worked with NHS Improvement’s Emergency Care Improvement Programme to overhaul their medical staffing rotas. They used the programme’s capacity and demand model to do this work and had incorporated for the first time the advanced nurse practitioners, advanced paediatric nurse practitioners, emergency nurse practitioners and physiotherapy practitioners onto the medical staffing rotas for each department.

At the time of the inspection there were two physiotherapy posts with recruited staff in post. Two advanced nurse practitioner posts with one member of staff in post and another one due to start end of September 2018, two trainee advanced nurse practitioner posts had been recruited to and had started training. The advanced nurse practitioner and physiotherapy practitioners worked across sites in the emergency department at Royal Blackburn Hospital and urgent care centre.

Middle Grade doctors had been split into two tiers in line with the recommendations from the Royal College of Emergency Medicine. There were now two rotas one for tier four doctors (most senior middle grade doctors) and one for tier three doctors (junior middle grade doctors). The tier four doctor rota consisted of a 16-doctor rota of which 14 posts were filled. The two vacant posts were being advertised. The vacant shifts were filled either by the permanent tier four doctors doing extra shifts or locum doctors who work for the trust as bank doctors.

The tier three doctor rota consisted of a 19-doctor rota of which 15 of the posts were filled. The vacant posts were being advertised and two further applications were in the process of having interviews arranged. The tier two doctor rota was a 21-doctor rota. These posts were recruited to by the deanery. There were five vacant posts being advertised, which were being filled by bank locums. The tier one doctor rota was made up of five foundation year one doctors. These doctors were supernumerary and were not included in the numbers for staffing.

At the time of the inspection across the emergency division there was funding for a 11 whole time equivalent consultant rota. There was a 10-doctor consultant rota in place with eight whole time equivalent posts filled and two new whole time equivalent consultants undergoing a period of induction. Vacant shifts were filled using bank consultant Locums. Plans had been submitted to increase the consultant staffing to 15 whole time equivalent.

The division were in the process of recruiting fully to their rotas, the full impacts had not yet been reviewed.

Vacancy rates, turnover rates, sickness rates

As part of the inspection process we sent the provider an information request for their medical staffing vacancy rates, turnover rates and sickness rates. Following the inspection, we requested this information as an additional document request. The staffing information relating to medical staff was collated for the emergency division as staff work across the Royal Blackburn and Burnley General hospital sites.
Vacancy rates

From August 2017 to July 2018 the emergency division reported a vacancy rate of 34.4% for medical staff, this was significantly higher than the trust’s target of 5%.
(Source: the trust, additional document requests)

Turnover rates

From August 2017 to July 2018 the emergency division reported a turnover rate of 55.9% for medical staff, this was significantly higher than the trust’s target of 12%.
(Source: the trust, additional document requests)

Sickness rates

From August 2017 to July 2018 the emergency division reported a sickness rate for medical staff that ranged from 0% to 3.53% (average 2%). The trust’s target was 3.75%.
(Source: the trust, additional document requests)

Bank and locum staff usage

From August 2017 to July 2018, 747 shifts were filled by bank medical locum staff, and 600 shifts were filled by agency medical locum staff.
(Source: the trust, additional document requests)

Staffing skill mix

From March 2018 the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the 40 whole time equivalent staff working in urgent and emergency care at East Lancashire Hospitals NHS Trust.

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<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>23%</td>
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</tbody>
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^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Reception Staffing

Staff described how the reception area was not always fully staffed with two members of staff on at all times. On certain shifts the reception area was manned by one member of staff who could not leave the area unmanned due to the risks of patients becoming unwell in the waiting area or unwell patients entering the department. We were also informed that there had been a four-hour period were no reception was available and this resulted in a back log of patients not booked on to the hospital IT systems properly. This issue had been highlighted during the previous inspection of the service.

Records

We reviewed nine patient records. Patients records were hand written and paper based. These records were held within the department for two weeks for ease of access. After this time records were scanned onto the trust’s electronic document management system and then collected by an external storage facility. We noted that records were stored securely in an office which was locked when unattended.

Records were legible and accurate throughout. Patients allergies were noted and there was reference made to pain management and provision, where applicable. Where patients had
declined analgesia, this was also documented in the patients’ notes.

There was evidence of multidisciplinary input in patients notes with district nurses, a national charity for older people based within the department, radiology, physiotherapy and multidisciplinary team discussions documented.

We saw evidence of completion of necessary risk assessments, which were also undertaken in the correct time frames such as early warning score, mental health risk assessments, pain scores and a completed Clinical Institute Withdrawal of Alcohol Assessment (CIWA) scale for a patient.

The department did not audit patient’s records, or documentation. For patients who were admitted to the wards their records would be included in trust wide records audits. We were informed that band six and seven staff performed spot checks and fed back to staff when any issues were found.

**Medicines**

At the time of the inspection the department had two advanced nurse practitioners who were nurse prescribers. We saw training days offered to staff in medicines management and medicines management patient group directions for those who triage.

There was a drug chart in patients’ records. No inpatient prescriptions were recorded in here, these were done on the ward.

There were a number of patient group directions in place, which covered a lot of medicines issued to patients by the department. Patient group directions are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. We checked approximately forty patient group directions and found that three of them had expired. We highlighted this issue with a senior member of staff from the department.

Medicines were stored securely with colour coded key access and key security maintained.

We spoke with a pharmacy assistant who told us that patients to take home (TTO) medicine stock levels were checked and co-ordinated with written prescriptions. Used stocks were then replenished. To take home medicines were documented in a dedicated ledger and on a to take home prescription sheet. All the to take home medicines checked tallied with the corresponding documentation. When to take home, packs were issued the prescriptions were retained and pharmacy replenished them. We found that there was a robust system in place.

Pharmacy visited the department three mornings a week to restock medicines. There was a contingency plan in place for heavy stock medicines usage and subsequent shortfalls. Extra stocks were kept in an emergency drug cupboard which staff could access. The department liaised with the pharmacy department for the needs of mental health patients who take regular medicines due to their increased length of stay in the department.

We checked the contents of the fridges and found that medicines were stored appropriately and not overfilled. We noted that daily fridge checking had been performed and recorded on the appropriate check list. We checked fridge monitoring completion for the five weeks prior to the inspection date. However, we noted that fridge temperatures had been recorded as reaching a maximum of 9.2°C for the last five out of seven days with no action documented. There was no means to know if this was due to the maximum temperature not being re-set, or if this had corresponded to period when the fridge doors had been opened.
Labile medicines were stored appropriately in a refrigerator. We noted that ambient temperatures were not recorded by the department.

The controlled drugs cupboard (CD) was checked daily. We found that controlled drugs had been stored appropriately and that the levels were correct, checks were in place, order books were completed correctly and registers were complete.

Stock cupboards were maintained well. We looked at the storage of medical gases and saw that oxygen and nitrous oxide were kept in separate ‘gas’ room.

We noted an opened medicine container intended for reuse was clearly labelled with the opening date and expiry date.

**Incidents**

Staff we spoke with knew how to report incidents using the trust’s incident reporting system software.

We were informed that most incidents were twelve-hour mental health patient breaches and that there had been a few incidents recorded for the department related to missed sepsis targets for one hour to receive antibiotics.

The incidents were given to the band seven nurses and the information and learning from incidents was disseminated to staff.

We looked at five incidents which had been investigated and had resulted in learning for staff. We saw evidence of investigation, actions taken and lessons learned fed back to staff via one-to-one meetings, staff meetings, the matrons’ monthly report, the ‘emergency trumpet newsletter’ and staff communication files.

We saw a file in the staff room which contained feedback from incidents. Information relating to incidents was also displayed monthly on a board in the staff room.

We saw evidence of learning from incidents. We looked at an incident relating to non-recording of early warning scores, staff were given pocket early warning score reminders for adults and children. We saw another incident where a patient with a neurological deficit and who did not meet their admission criteria was brought to the urgent care centre by ambulance. The department had regular fortnightly meetings with the local NHS ambulance service where incidents such as this were discussed.

The nurse in charge held monthly meetings with staff in the department and incidents were discussed here as well as complaints. There was an agenda for these meetings and staff are given the opportunity to add in items to the agenda.

Incidents were fed up to the assistant director of nursing and at directorate meetings, monthly governance meetings and the divisional management board.

We examined three matrons’ monthly reports, each report outlined the top five incidents in the emergency directorate. In all three months we note that the majority of incidents related to problems with discharge and transfer relating to mental health delays for admission. There was also a number of incidents relating to re-diagnosis failure or problems, problems with appointments or admissions, communication problems, treatment problems or issues, pressure ulcers, moisture lesions and medicines. The report also outlined plans to include the top five incidents in handovers and for root cause analysis to be shared more frequently with staff.
We were informed by senior nursing staff that there were no concerns relating to serious incidents in the department. There had not been any serious incidents reported by the urgent care centre from July 2017 to June 2018.

Duty of candour is a requirement under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Staff we spoke with understood the duty of candour and the need to be open, honest and transparent with patients.

Never Events

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

From July 2017 to June 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - OBIEE NRLS STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from July 2017 to June 2018.

(Source: NHS Improvement - OBIEE NRLS STEIS)
Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Urgent care centres do not record safety thermometer data.

We examined the departments performance board. Figures for July 2018 showed that there were no avoidable pressure ulcers, unavoidable pressure ulcers, cases of Clostridium difficile or methicillin resistant Staphylococcus aureus (MRSA) reported.

There were no falls audits conducted in the urgent care centre. Any falls in the department would be reported via the trust’s incident reporting system.

Is the service effective?

Evidence-based care and treatment

We saw that the department had policies, guidelines, pathways and care bundles in place and staff knew how to access them as hard copies or online on the trust’s intranet. These documents were based on National Institute for Health and Care Excellence guidelines, the Royal College of Emergency Medicine standards and Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee transfusion guidelines.

We examined a number of pathways and care bundles including a paediatric pathway for ‘bronchiolitis emergency management’, ‘for the child with feverish illness’, ‘for children presenting with seizures’ and ‘for the child with eczema.’ We also looked at a number of paediatric care bundles including; ‘gastroenteritis 0 - 5 years’ and ‘the management of sepsis in under 16 years.’

We examined a number of policies in use within the department including ‘Management of the seriously unwell child at Burnley General Hospital.’ ‘Operation policy for the urgent care centre.’ ‘East Lancashire Hospitals Trust (ELHT) Intra-organisational Adult Patient Transfer – standard operating procedure’ and ‘Transfusion Management of Massive Haemorrhage.’ All policies had been reviewed and were in date.

The department followed National Institute for Health and Care Excellence guidance for managing sepsis and updated their information according to National Institute for Health and Care Excellence guidance updates.

There was a clinical guideline in place for the ‘Treatment of Acute Hyperkalaemia in Adults.” We also examined a number of orthopaedic pathways for adults.

We asked how changes to national guidance, or central alerting system (CAS) alerts were identified, reviewed and actioned. The central alerting system is a system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others. We were informed that alerts were reviewed and current systems assessed for compliance. Action plans were developed and time scaled to implement required changes.
Nutrition and hydration

There were drinks and snack dispensers in the patient waiting area. They contained drinks such as tea, coffee, hot, chocolate, canned drinks, crisps, chocolate and nuts. There was a sign in the reception area saying that patients could be given a drink of water upon request.

There was a ‘beverage bay room’ in the department for patients. Sandwiches, snacks and drinks were available. For patients staying longer than 12 hours in the department food could be ordered via the hospital catering service. There was a number of options to meet patient’s dietary requirements, preferences and religious or cultural beliefs.

The department did not often require support from dieticians but patients were referred to them if needed. Patients with mental health conditions resulting in such conditions as anorexia where referred to their dieticians as part of their overall care needs.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

Pain relief

On the nurse training and development board we saw that nursing staff were offered training in acute pain management.

We observed patient’s pain management being discussed during handover, this included their pain relief medicines, levels of pain and to take home pain relief medicines.

All of the patients we spoke with described being offered or given adequate and timely pain relief.

The department intended to include pain management and pain relief reviewed in their audit schedule. This audit had not started at the time of the inspection.

The triage nurses used a protocol based on the ‘World Health Organisation pain ladder’, this is a step-wise approach to the use of analgesics depending on the severity or pain. Pain was scored between 0 to 10 and then categorised as no pain, mild pain, moderate pain and severe pain. The triage nurse initiated pain management and was supported by clinicians for the intravenous administration of controlled drugs. Pain control needed to be reassessed within 30 minutes for severe pain and whining and within 60 minutes for moderate pain.

The department had a paediatric pain bundle. This consisted of a paediatric pain assessment with a faces scale score between 0 to 10 and considered behaviour and injury type. The administration of analgesia before attendance was documented as well as a 60 minute pain reassessment and a paediatric analgesia algorithm following pain assessment.
For people with communication difficulties or cognitive impairment the department used the abbey pain scoring scale. The pain scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 6.9 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

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<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
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<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.1</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>6.9</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>6.3</td>
<td>About the same as other trusts</td>
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</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

**Patient outcomes**

The leadership team told us that they monitored the effectiveness of the care and treatment they provided and benchmarked their performance with other services and national standards. Quarterly audit meetings were held to look at the outcomes from audits, for learning sets to be developed and action plans formed. The division used a ‘plan, do, study, act’ approach to quality improvement which included a number of small sample audits linked to action plans.

The emergency care division had an annual audit plan for audits which were completed, ongoing or planned. Audits included the management of uncomplicated urinary tract infections in adults, feverish child, pain in children and renal colic in adults. All audits were assigned evidence standards such as the Royal College of Emergency Medicine (RCEM), priority levels, clinical leads and support by the clinical audit department.

An audit on young people’s mental health had been completed and submitted to the National Confidential Enquiry in Patient Outcome and Death (NCEPOD) as part of a child health review programme.

A venous thromboembolism (VTE) committee was set up to develop a pathway for VTE prophylaxis in lower limb injuries. Following an audit of this pathway a VTE care bundle had been produced for patients. A care bundle is a set of interventions that, when used together,
significantly improve patient outcomes. Multidisciplinary teams worked to deliver the best possible care supported by evidence-based research and practices, with the ultimate outcome of improving patient care.

In January 2018 we saw that the trust had received a letter from NHS England’s clinical effectiveness arm for being one of the most improved trust on sepsis indicators relating to timely identification and timely treatment of sepsis. At the time of the inspection 80% of patients with suspected sepsis in the were receiving antibiotics within the hour. We reviewed the performance dashboard for the emergency care division for July 2017 to July 2018 and saw that sepsis screening was at 100% for each month set against a target of 90%.

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

From July 2017 to June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

**Unplanned re-attendance rate within seven days - East Lancashire Hospitals NHS Trust**

![Graph showing unplanned re-attendance rate](image)

**Competent staff**

Staff in the department told us that there was a lot of learning and development available. Their training was overseen by two practice educators who were based at Royal Blackburn Hospital. One of the practice educators was more involved in overseeing the urgent care centre. They booked and monitored training and held classroom and practical based training days for staff in the department to attend. Learning and development updates were given once a month in for example sepsis and stroke.

Induction for new staff included a presentation, welcome pack, competencies and a buddy system.
Staff were supernumerary for two to four weeks and if newly qualified for eight weeks. Triage training took six months. Staff underwent ‘train the trainer’ courses and then cascaded the updated Manchester triage system. There was also e-learning and competencies to complete.

Since the last inspection the urgent care centre had increased their number of paediatric nurse practitioners from two to three to care for the needs of unwell children. We spoke with one paediatric advanced nurse practitioner with over twenty years’ experience in urgent and emergency care. At the time of the inspection they delivered paediatric resuscitation training to staff in the department.

**Appraisal rates**

From April 2017 to March 2018, 89% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Numbers Required</th>
<th>Numbers completed</th>
<th>Percentage Completed</th>
<th>Trust Target (95%) Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>435</td>
<td>6071</td>
<td>UCC Receptionists</td>
<td>RBTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6074</td>
<td>UCC Nursing Staff</td>
<td>BGTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6076</td>
<td>UCC Receptionists</td>
<td>BGTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6064</td>
<td>Emergency Dept Nursing Staff</td>
<td>ICG</td>
<td>110</td>
</tr>
<tr>
<td>435</td>
<td>6070</td>
<td>ED Nurse Practitioners</td>
<td>ICG</td>
<td>14</td>
</tr>
<tr>
<td>435</td>
<td>6062</td>
<td>ED &amp; UCC Management</td>
<td>ICG</td>
<td>9</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>192</strong></td>
<td><strong>171</strong></td>
<td><strong>89%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(*Source: Routine Provider Information Request (RPIR) - Appraisal tab*)

We noted that the current appraisal rate for nursing staff in the urgent care centre was 56.6%. The appraisal rate for staff who rotated between the urgent and emergency departments at Royal Blackburn Hospital and the urgent care centre was 67%. The trust target for the number of staff who should receive an appraisal was 95%.

The leadership team informed us that appraisal rates were at 95% at around the same time last year as there had been a big push to raise the levels. There had been work completed to address the current levels and this had been escalated through to executive level. Plans were in place to spread appraisals out so that they were not all due at the same time and for band seven staff to oversee this. We were also informed that there was a desire to get staff to be able to appraise the band below them.

Senior staff informed us that advanced nurse practitioners were given protected time for service development and appraisals. A number of advanced nurse practitioners were doing Royal College of Emergency advanced nurse practitioner pathway training.
Staff described the nurse practitioners as being very experienced emergency department nurses who were permanently based in the department. The nurses had the option to rotate if they desired to.

Staff informed us that most of the advanced nurse practitioners could plaster. The department had two band four ‘plaster practitioners’ who cascade trained staff and kept them regularly updated.

There were numerous link nurses in the department including for infection prevention and control (IPC), health and safety, sepsis, mental health lead, vulnerable adults, safeguarding, blood transfusion, end of life and bereavement, and IT. Each link nurse had their own responsibilities which included updating their information files, attending at least 85% of link nurse meetings and monthly updates with practice education facilitators.

One member of staff in the department oversaw point of care testing training for staff.

We examined a number of staff competencies. Band four nursing staff in the department were competent to perform the same tasks as band five staff nurses apart from medicines management.

Staff were offered training in personality disorders, understanding and managing challenging behaviour and understanding and working with suicide risk to aid staff in caring for patients with mental health needs.

Staff were given the opportunity to do the trauma nursing core course and we were informed that a lot of nurses had completed the course.

Middle grade doctors recruited from overseas were given 12 months to adjust to working in the NHS and then they could specialise in areas such as emergency medicine.

The leadership team told us that junior clinical fellows were given four hours off roster time a week and given a lot of support with their learning.

There was an emergency department medical staffing bank of internal doctors. They were given logins, passwords, 24-hour IT support, learning to complete and yearly appraisals if the trust was their only permanent place of work. Staff told us that there was a new induction system in place for bank and agency staff.

There was an up-to-date nurse training and development board on display in the department with details of twenty-four different training and development events which staff could attend along with the dates they were being held. Examples included; wound interest groups, blood transfusion induction and refresher, fluid balance, mental health first aid and acute illness management.

To make sure that staff had time to complete their e-learning training in subjects such as sepsis and early warning scores staff could access learning packages at home and then get their time back.

**Multidisciplinary working**

Staff had access to a ‘hot reporting’ service ran by reporting radiographers in the X-ray department. We were informed that the reporting radiographers were mainly based at Royal Blackburn Hospital.

Physiotherapists worked as autonomous practitioners in the urgent care and they were included in the clinical rota. They assessed patients with limb and spinal injuries and performed acute wound,
tendon, nerve function, skin assessments and depending on their specialities patients with rib and chest injuries. They requested and looked at imaging as part or and could refer patients to services such as neurosurgery and orthopaedics or as an outpatient. Physiotherapists could also refer patients to community services if they required support at home or social care and the integrated therapy teams to perform home assessments.

A national charity for older people had an office in the urgent care centre. They accepted referrals from medical staff and clinical staff described how they “actively came out” to see patients. They provided adults over the age of 18 with support and could even take people home.

The emergency department and the orthopaedics department worked together to produce a new venous thromboembolism (VTE) pathway and care bundle.

Regular meetings were held between the emergency department, in Succeed Thrive Empower Pennine (STEP), mental health teams, safeguarding teams, local NHS ambulance services and the police to discuss ‘frequent attenders’ to the department.

Children presenting to the urgent care centre with certain conditions such as a high temperature could access children’s minor illness unit located next to the department. This unit offered a step-up in care for children requiring observations and assessments. Sicker children were transferred to the Royal Blackburn Hospital.

Staff worked closely with the local NHS ambulance service in ensuring a safe and timely handover of patients arriving into the department and for patients requiring transfer from the department to other healthcare facilities.

We observed staff arranging for a district nurse to attend and see a patient’s leg injury in their own home within a couple of days post discharge.

Staff described working closely with school nurses, the paediatric liaison team, the mental health liaison team and social services.

**Seven-day services**

The urgent care centre including the reception area was open for 24 hours a day for seven days. Physiotherapists were available in the department from Monday to Friday from 8am to 6pm. The leadership team informed us that the physiotherapists were not required to work later in the evening due to the number of emergency nurse practitioners in the department.

The service had access to radiology provision for 24 hours a day for seven days. Plain film X-rays could be done on site. Access to computerised tomography (CT) scans was not always available, with no radiographer onsite to do CT scans out of hours. There was no magnetic resonance imaging (MRI) performed on site.

The radiology ‘hot reporting’ service was available from 9am to 5pm Monday to Friday and 9am to 1pm on weekends and bank holidays. The service was run cross-site at Burnley General and Royal Blackburn hospitals. The average turnaround time for all hot reporting was 16 minutes for weekdays and 10.4 minutes at weekends. The percentage of patients waiting over an hour was 0.7% for weekdays and 0.14% at weekends. The clear majority met the one hour for critical time-frame.

Nursing staff told us X-ray reports were usually received within 20 minutes for non-complicated x-rays.
Health Promotion

As part of patient’s treatment and care planning, when required the physiotherapy team discussed the benefits of exercise with patients including exercise classes and gentle exercise such as walking.

The department planned to have a health promotion board on display in the department with information on topics such as sugary drinks, smoking cessation and fireworks safety.

There was an information poster on display in the patient waiting area outlining the ‘risks zones’ associated with Lyme disease and the precautions that people should take to stay safe.

For general health promotion there were a number of leaflets available for patients including advice on head injuries in children and adults, dressings, deep vein thrombosis and suspected sepsis. There was a leaflet outlining when to take antibiotics and self-care ways to look after yourself or your family when you are unwell, have a cold or flu.

A leaflet on falls prevention included the benefits of activity and exercise and how physical activity can improve general health. We saw information for a service which provided advice for families, carers and friends worried about someone else’s drug or alcohol misuse. There was information available promoting healthy lifestyle opportunities to keep people active.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff we spoke with could describe the consent process and the Mental Capacity Act.

Documented and verbal consent was taken for patients receiving care and treatment in the department. We examined a number of records and found that consent had been documented correctly.

Staff had access to a trust wide policy for ‘Consent to Examination or Treatment.’

Staff completed online training on the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Staff training included a number of case study presentations such as ‘supporting a vulnerable person with mental health and physical health needs’ and ‘learning disabilities and decision making’ covering the Mental Capacity Act, capacity, best interest decisions and the right to make unwise decisions.

The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person’s best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty.

Staff had access to the trust’s policy ‘How to Implement the Mental Capacity Act 2005 and apply the Supporting Code of Practice.’ The policy contained a framework for assessing capacity in adults, children and young people and aimed to ensure that the principles of the Mental Capacity Act 2005 and its supporting Code of Practice, were upheld in making the decision. The policy also
outlined the Deprivation of Liberty Safeguards process and how it is essential that a Deprivation of Liberty Safeguards application is considered for those patients who lack capacity and are subject to continuous supervision and control and are not free to leave the hospital.

We saw safeguarding care plan documentation which staff could access and complete for vulnerable patients. The documentation referred to assessing for mental capacity regarding to patients’ ability to maintain their own safety and wellbeing.

During the inspection period there were not any patients in the department who required a Deprivation of Liberty Safeguards to be put in place and the staff that we spoke with informed us that they had not had to use a Deprivation of Liberty Safeguards in the department.

Staff described how they could interact with the safeguarding team when making a capacity assessment and Deprivation of Liberty Safeguards.

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

The trust set a target of 90% for completion of safeguarding training. The trust told us that the safeguarding training modules included training for MCA and DoLS.

A breakdown of compliance for safeguarding courses for nursing and medical staff 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 rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults level 3</td>
<td>28</td>
<td>29</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Including: MCA &amp; DoLS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>27</td>
<td>29</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Including: MCA &amp; DoLS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: the trust, additional document requests)

**Is the service caring?**

**Compassionate care**

We observed staff caring for patients with compassion and all the patients and relatives we spoke with praised the care provided by staff. One patient said that the staff were “empathetic and deserve a gold medal,” they also went on to say that “staff here are brilliant and need credit and praise.”
We observed staff in the department delivering care and treatment to patients in a warm, friendly and caring manner. Patients described staff as being “friendly, polite, nothing too much trouble.”

On the positive patient feedback board, we noted a number of comments from patients including, “thank you for the care and compassion and for all you have done for me at this time”, “very friendly yet very professional manner” and “I can’t thank you enough for all the fantastic care you gave.”

**Friends and Family test performance**

In the latest matrons’ monthly report, the department’s Friends and Family test response rate for August 2018 was 19%. We saw that 83% of patients would recommend the department and 10% of patients would not. We examined the patient feedback board on display in the adult waiting area and found that the urgent care centre Friends and Family test response rate and patient ‘would recommend’ percentage for the same month were on display.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from July 2017 to June 2018.

**A&E Friends and Family Test performance - East Lancashire Hospitals NHS Trust**

![Graph showing Friends and Family Test performance](image)

(Source: NHS England Friends and Family Test)

**Emotional support**

A patient described how a member of staff had checked on her wellbeing frequently and provided one-to-one support. Another patient described how staff had put them at ease and chatted with them whilst performing an invasive procedure.

Positive feedback comments from staff included “I felt reassured from the moment I came in.”

We saw staff reassuring a patient who was concerned about an injury sustained to their face. They
were very professional but also friendly and pleasant and put the patient and their relative at ease. Another patient described the department as being “clean and safe” and that they felt “listened to.”

Understanding and involvement of patients and those close to them

There was a ‘you said we did’ area on the patients’ experience board. In response to patients’ comments on not being seen in time order the service were developing patient information leaflets explaining how the urgent care centre worked.

There was a ‘your views matter board’ on display in the patient waiting area. This board asked patients to “tell us what you think of our services.” The board contained the contact details of the matron for the department.

We saw reception staff taking a patient from the waiting room into the clinical area to enable the co-ordinator to explain how much longer they would be waiting and why. The patient was concerned about their clinical presentation and staff called the patient in to be seen shortly afterwards.

Positive feedback comments from staff included “I appreciated the care and understanding by you all” and “staff were fantastic in keeping us informed.”

One patient and their relative described the “name call” of patients in the waiting room as being “inaudible.”

A number of patients and their relatives outlined the difficulties they found in understanding whether to present for treatment at the urgent care centre in Burnley or to attend the emergency department at Royal Blackburn Hospital. Comments included, “it’s very difficult to know whether to come here or go to Blackburn ED.”

Emergency Department Survey 2016

The trust scored about the same as other trusts for all 25 questions.

<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>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>were worried about your condition or treatment after you left the emergency department?</td>
<td>other trusts</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

During the inspection we observed two patients with mental health needs who had been waiting in the department between two to four days for a bed with appropriate mental health services. One patient described feeling “guilty” about being in the department for four days before being discharged home. Staff in the department described the timely provision of mental health services for patients at Burnley General Hospital as being a “big issue” and “very concerning.”

The trust had a ‘shared care policy’ with a local NHS mental health trust and access to a mental health liaison team. Staff told us that the one-to-one care provided by this service was not always available. Staff contacted the clinical site managers when support was required to provide this level of care in the urgent care centre. Staff outlined the difficulties in delivering the urgent care service and managing patients with mental health needs when no mental health beds were available. Access to mental health beds was controlled by a ‘bed hub’ ran by the local NHS mental health trust.

The shared care policy between the trust and the local mental health NHS trust outlined the current shared care pathways. It also described how each member of the multidisciplinary team from each trust contributed to the delivery of the agreed care pathway to ensure the required key care standards were met. Patients were to be seen and assessed by a mental health worker within one hour of emergency and urgent care referral to a mental health service. Patients were to have a personal management plan in place that included a named care coordinator. The patient needed to be discharged to appropriate care environment within four hours of referral.

The leadership team informed us that when the decision to admit a patient had been made and that patient required a bed, senior management support ensured that those patients needs were escalated. The site managers liaised directly with the clinical commissioning groups, mental health liaison and the local NHS mental health trust.

We were informed by staff and patients that there was still confusion surrounding patient presentation at the Burnley urgent care centre and this was evident to us during the inspection. There was a perception with some parents that ill babies and children could attend the urgent care centre as the maternity unit and some paediatric services were based here.

Staff described how people presented to the department with a higher acuity than expected and that they had a lot of inappropriate presentations especially at night. Patients also reattended with the same presentations that could not be managed in an urgent care centre. Staff told us that lots of patients presented to the department with strokes and even traumas as they preferred to come to Burnley General Hospital.
A patient told us that there was a problem in the area and “people don’t when to go to the “A & E” or the urgent care centre.” They felt that they had to “self-diagnose” and that “there is a leaflet but to the man in the street it doesn’t mean much.”

We reviewed the leaflet which the service had developed that contained information about the department. There was a section in this leaflet for ‘who can we see at the urgent care centre.’ The department was described as being “a walk in NHS service for patients whose condition is urgent enough that they are unable to wait 48 hours for a GP appointment, but do not need to visit the emergency department (ED).” They offered an alternative to the ED for minor injuries, illnesses and urgent medical problems.

The leadership team were asked about the issues surrounding patient presentation at the urgent care centre. We were informed that there had been a lot of work on this as patients in Burnley preferred to be seen in their own area. The service sent out a letter to homes and schools when the Burnley accident and department closed in 2007 to inform the public where to send a sick child and what the urgent care centre was for. New mothers were given leaflets informing them if their baby became ill to attend the emergency department at Royal Blackburn Hospital.

We were also informed that the department had previously been an accident and emergency department for many years. Getting this across to patients had been difficult. Staff told us that there was information available on social media outlining what they do at the urgent care centre and at the Accrington minor injuries unit (AMIU).

There was a local NHS service pathfinder policy which outlined which acuity of patients the department would accept to be brought in via ambulance. Staff said paramedics on the scene used this and that the system worked well.

The national charity for older people was based in the urgent care Centre. They provided hospital after care services for adult patients aged 18 and upwards including, taking them home, organising occupational therapy, reviewing their medicines and physiotherapy, social assessments and sourcing equipment for patients. The service helped patients to avoid admittance by providing them help in the community.

Staff we spoke with from the charity also emphasised the utmost importance of addressing peoples’ mental health. The service signposted people to a number of different services including ‘mind matters’ and a befriending service. Other services provided to help people stay at home included a ‘shop and clean service’. The service offered an integrated care program with packages of help for wellbeing and avoiding isolation for people over the age of 55.

The charity had produced and supplied numerous information leaflets for patients including, a guide to keeping warm and well in winter, hospital aftercare services, care home checklists, home shopping services, helplines for older people and free hearing and eye tests.

The department had a clear pathway for patient referrals to the district nursing teams. This included contact details for referrals made during office hours and out of hours.

There was a full range of orthopedic fracture pathways with clear instructions for determining when referral for patients to other health care services was appropriate.

In the patient waiting area there were helpline posters on display for people to access services related to mental health and wellbeing and domestic abuse.

There were three large ‘think’ display stands in the patient waiting area. These stands were designed to make people stop and think about other services which may be more appropriate for their needs such as pharmacies and GPs. However, the boards had been placed behind the
chairs in the waiting room and the information was out of view. There was also a poster on display outlining the service that pharmacists provide for minor concerns.

Staff described how their patients had access to services to support them in the community after discharge. There was an ‘intensive support service’ and a ‘children’s respiratory support team.’

The department had a self-payment prescription kiosk. This kiosk was added to the department to speed up processing times, giving patients the opportunity to sort out their own payments quickly, securely and effectively. The kiosk also helped to ensure that staff have more time for patient care as they no longer need to oversee the handling of prescriptions.

The trust provided a free inter Hospital Shuttle bus between Burnley General Hospital and Royal Blackburn Hospital for patients and visitors. This service was available Monday to Friday with a reduced service at weekends and on Bank Holidays.

We saw lots of information leaflets in the department signposting patients to other services such as carers support services, the 111 services for urgent medical care and late-night pharmacy services. There were also numerous patient advice leaflets in the department including those for patients with knee injuries, dealing with a mental health crisis or emergency, suspected sepsis, physiotherapy, advice on wound care, head injury in adults/children and soft tissue injuries.

Meeting people’s individual needs

The service had developed a ‘safer hands’ symbol for placing on the door of rooms containing patients with mental health conditions and who were at increased risk. The service described their aim to balance privacy with risks, doors were opened to check on patient’s welfare and could be kept shut if a patient had one-to-one supervision.

In the urgent care centre there was an observation room for patients with mental health needs which was sighted opposite the nurses’ station. Cubicles were assessed for ligature points and measures such as breakable curtains were introduced. Patients were individually risk assessed for their mental health needs. Consultant psychiatrists come into the department daily to assess patients and patients’ needs were escalated on an hourly basis as required. Staff informed us that it took up to two hours to get patients reviewed.

For patients with mental health needs the service was developing activity boxes for patients with colouring and mindfulness activities. They were also considering providing hand held computer access for patients. We were informed that these ideas had been developed by the staff.

We saw a number of information leaflets for patients with mental health needs and for wellbeing including, combat stress for service veterans, the wellbeing and mental health helpline, wellbeing services, ‘mindsmatter’ services, and for independent mental capacity advocates.

We saw one patient for whom the charity for older people based on site were arranging a pendant alarm. The pendant alarm service is an emergency alarm call service which involves a unit and pendant linked to a response centre by a telephone line. This patient lived alone and had fallen at home, resulting in a presentation to the unit with an injury sustained in the fall.

There was one hearing loop in the department to enable patients with hearing loss to hear staff in the reception area. Staff stated the need for another hearing loop to assist them in booking patients into the department.

There was a staffing board on display in the adult waiting area. This did not identify the staff
working in the department nor did it display their roles, responsibilities or staff uniforms. Patients, carers and visitors to the department could therefore not readily identify the skill mix of staff attending to them.

We saw patient information leaflets were available in different languages and formats such as large print, audio book or braille. However, the friends and family test leaflets and guide for raising concerns and complaints were available in English only with no signposting in alternative languages or formats.

Staff had access to translation services and interpreters for communicating with patients in different languages.

The urgent care centre did not have access to a frailty or falls team. Occupational therapists and physiotherapy practitioners performed these assessments within the department. There was an area in the department with purpose built physiotherapy steps for performing stair assessments on patients. During these assessments a person’s mobility, posture, gait and risk of falls was assessed.

There was a falling leaf system in place for the management of falls. A yellow leaf identified a patient at risk of falls and a red leaf was used for patients who had fallen. We saw an information leaflet for patients containing advice for people to help reduce their risk of falls.

For ‘frequent attenders’ with more complex needs, separate multidisciplinary team meetings were held. These were more involved meetings which had representations from services such as safeguarding and the probation service.

The department offered dementia training dates to staff and there was a dementia link nurse in the department. Patients had access to a dementia box with twiddle muffes and teddy bears as ‘one use’ comforters.

The department used a butterfly symbol to identify patients who had dementia. A blue butterfly meant that a patient had a permanent diagnosis of dementia and an outline of a butterfly indicated that a patient had possible delirium or possible undiagnosed dementia. This prompted all staff to follow a special response plan, known as REACH. There was a dementia specialist nurse in the department.

There was a learning disabilities specialist nurse in the department who ran a learning disabilities course for staff.

There was a ‘starlight’ box available for treating children. They were used in instances such as performing invasive procedures to try and minimise distress. The box contained visual devices and contained toys with bright lights.

Staff informed us that bariatric equipment was available for patients including bariatric beds, crutches and frames.

One patient who had a knee injury and had been waiting in the department for three hours described the hard chairs in the waiting area as being uncomfortable.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all three questions.
(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

**Access and flow**

There was a shift co-ordinator in the department for each day. Their roles included organising the urgent care centre workload including admission, transfer or discharge of all patients during their shift.

During busy periods the service used one of their cubicles which was suitable for triage and to manage flow in the department. Clinical staff told us that the design of the department helped with flow as there was a lot of space and patient cubicles.

In the adult and paediatric waiting rooms there were waiting times on display to keep people informed. Most patients we spoke with were happy with the amount of time they had been in the department waiting to be seen.

The physiotherapy team described the flow as working well in the department as they could double triage as there was enough cubicles to do this. Normal staffing varied between one or two staff members, due to Mondays being busy there were often two physiotherapists in the department on this day. Staff told us that there were not any issues with discharging patients to community services and that equipment required for patients discharge such as crutches, frames and commodes was readily available.

The department had shared cubicles with the out of hours GP service. Patients triaged as suitable could be referred from the urgent care centre to the GP out of hours service when they had free slots.

All advanced nurse practitioners and a number of senior nurses in triage could refer patients directly for X-rays. Nursing staff in triage could triage patients with suspected hand and knee fractures. Advanced nurse practitioner and physio-practitioners could examine a wider range of limbs and minor back injuries. Staff told us that triage times were audited.

The department had introduced a new streaming pathway model on the 1 June 2018. As part of this new model of working in the urgent care centre clinicians and advanced nurse practitioner were allocated their own consultation rooms. This model of room allocation was like that used in GP led primary urgent care and staff said that the new system was working well. The co-ordinators also liked the new model of working.

The key elements of the new urgent care centre clinical model also included a standardised process for streaming to appropriate pathways, staffing aligned with cubicle numbers, tracking productivity, streaming direct to ambulatory care and the surgical triage unit and an agreed

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<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
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<td>Q11. Overall, how long did your visit to the emergency department last?</td>
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<td>Q20. Were you given enough privacy when being examined or treated?</td>
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principle of zero tolerance to cubicle blocking.

Since the introduction of the new model the four-hour target performance figures had increased from 92.6% for the period January to May 2018 to 94.6% for the period June to July 2018. There had also been an increase in attendances for the period May to July 2018. The department was undertaking work to ensure that the new urgent care model was embedded.

During the inspection there were times when patients had breached the operational standard for A&E waiting times in that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department.

We noted that one patient was waiting for a troponin T cardiac marker diagnostic test to be completed on bloods that had been taken in the urgent care centre and transferred to Royal Blackburn Hospital for testing. A ‘point of care’ testing service for the troponin T cardiac marker was being developed to enable this test to be performed onsite, improve patient flow through the department and was hoped to have a positive impact on the performance figures.

The patient had been kept in the department due to issues with patient flow in the emergency department at Royal Blackburn Hospital. The trust was an outlier for metrics measuring patients wait for a bed.

Comments from patients were extremely positive about the staff and the service overall but there were numerous negative comments about the lengthy waiting times. One patient described being in the department before and felt that there was high demand and that staff were under a lot of pressure. They described waiting four to five hours previously.

During the inspection period there were four cubicles occupied by patients with mental health needs and awaiting surgical and medical admissions.

Staff on the department maintained oversight of patient flow via paper records and an electronic patient transfer system for ‘tracking and flow.’ This system also displayed the times for patient breeches and could also be used for making bed requests for patients.

Staff told us that they didn’t often need to speak to the bed team and that most of their referrals were to the acute medical unit or surgical triage and occasional straight to orthopaedics at Royal Blackburn Hospital. The department had a transfer vehicle for transferring patients but told us that most patients were transferred by the local NHS ambulance service and that time-critical patients were transferred in this way to the emergency department.

The matrons went to the bed managers meetings at Royal Blackburn Hospital and flow at the urgent care centre was discussed. Escalation of flow issues were made via the co-ordinator to the matrons and business managers based at Royal Blackburn Hospital. There was also a clinical flow team to escalate patients to the mental health liaison team.

Staff described the flow as being “awful” in August 2018 and a big challenge. The service was looking at this including looking at their local NHS ambulance service usage figures. Staff described the trust as being heavy users of this ambulance service.

Patients could not be admitted from the urgent care centre into Burnley General Hospital at night unless they required acute obstetric gynaecology admission as these were the only acute wards on site.

The service had a number of systems in place for ‘frequent attenders’ to the department. They worked with sustainability, transforming and empowering people (STEP) and accessed other services in the area such as substance misuse services to provide support. These patients were given formal care management plans which could be accessed on the electronic patient tracking
system. The emergency care division looked at their top 100 attenders (50 of which were from the urgent care centre) and held meetings to discuss their management and care pathways. Meeting to discuss frequent attenders were now held weekly and the majority were seen to be patients with mental health needs.

There had been a reduction in the in the presentation of frequent attenders to the department for whom management plans were in place. These patients were signposted to more appropriate services. The department were also carrying out a piece of work focusing on the help provided to frequent attenders with personality disorders attending the department.

Staff informed us that the urgent transfer of patients by the local NHS ambulance service could not always be fulfilled in the specified time scale. The system of transferring had improved since the introduction of a transfer category list. During the inspection staff described raising an urgent ambulance transfer for a patient with neutropenic sepsis. This ambulance arrived quickly to the department to transfer the patient urgently to the emergency department at Royal Blackburn Hospital.

For an urgent time-critical transfer, the response time was stated to be “recently very quick.” The department did not currently differentiate between urgent and non-urgent transfers when collating their data. Between January 2018 and August 2018 there was an average of 170 transfers from the department a month with an average overall wait of 81 minutes.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust failed to meet the standard and performed worse than the England average.

Four-hour target performance - East Lancashire Hospitals NHS Trust

![Graph showing four-hour target performance](image)
Burnley urgent care centre four-hour target Performance

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The average four-hour target performance from August 2017 to July 2018 was 93.7%
From August 2017 to July 2018 the trust met the standard on five out of 12 months.

(Source: the trust, additional data request)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than to the England average.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - East Lancashire Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 65 complaints about urgent and emergency care services. The trust took an average of 55 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 50 days. Of these 65 complaints, 30 were recorded under ‘all aspects of clinical treatment’.

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

From April 2017 to March 2018 there were eight formal complaints made about the urgent care centre. Five of these complaints were not upheld, two were upheld and one was partially upheld. None of these complaints had been referred to the Parliamentary and Health Service Ombudsman. Most complaints related to care and treatment. We saw evidence of learning from complaints and explanations given to the complainant.

We reviewed five complaint files which were relating to complaints submitted by patients attending the urgent care centre. These complaints had been categorised as level two informal.

All complaints were reviewed by the matron and administered by the complaints lead who was also the personal assistant for the department. The complaints lead followed a checklist which tracked the progress of complaints and anything still outstanding.

Three out of the five complaints reviewed showed that the complainant had received a response and apology letter from the matron only, this was done in a timely manner. One showed clear reasoning for being allocated as an informal complaint and evidenced attempted telephone contact. One complaint was waiting consultant review but the complaint had been sent to them within 10 days.

The main theme for all complaints received in the department related to waiting times.

We saw a file in the staff room which contained feedback from incidents and complaints. Information relating to incidents and complaints was also displayed monthly on a board in the staff room.

On the patient experience board, we saw patient feedback results on display for the period July to August 2018. The department had received 30 compliments and three complaints during this period.

In the latest matrons’ monthly report, the number of outstanding level two and more in-depth level three and four complaints were outlined along with the number of completed complaints. Complaints were also categorised into formal and informal.

All of the patients we spoke with were aware how to raise a complaint or concern and described raising complaints and issues with staff directly or via complaints forms.

We reviewed a ‘Guide for patients, carers and relatives and visitors to the trust.’ This guide contained details on raising concerns, making a formal complaint, the independent complaints advocacy service and the customer relations team. Patients were also informed that if they remained dissatisfied with the outcome of the local resolution they could contact the Parliamentary and Health Service Ombudsman for an independent review of their concerns.
Information was also available for the patient advice and liaison service for people who wished to make a comment or raise concerns.

**Number of compliments made to the trust**

From April 2017 to March 2018 the trust recorded 81 compliments linked to urgent and emergency care. The trust received 15 compliments in April 2017, the highest number it received in any one month.

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

**Is the service well-led?**

**Leadership**

Staff told us that there had been eight different department managers overseeing the department over the past four years. The leads for the department described how they addressed the inconsistency in management support by appointing a number of managers to provide consistent manager support for staff and to oversee new developments, approaches and strategies. Managers described their desire to have a sustainable leadership team.

During the inspection there was one matron overseeing the emergency department and urgent care centre at Royal Blackburn Hospital, the urgent care centre at Burnley General Hospital and the minor injuries unit at Accrington Victoria Hospital. The matron was based at Royal Blackburn Hospital and aimed to visit the (urgent care centre) once a week. The integrated care group had appointed another matron to replace a second matron who had changed roles.

Staff described their matron as being visible and said that they regularly attended the department.

A new unit manager had been appointed for the urgent care centre during the inspection period. The leadership team said this new appointment was needed to ensure consistency in the urgent care centre. Staff indicated that they were looking forward to having a unit manager in place.

Band six and seven nurses were given the opportunity to go on leadership courses and personality days where staff explored their personality type within a team environment.

Staff had also requested and were given access to recruitment and selection courses to enable them to interview.

**Vision and strategy**

There was an emergency department improving together plan. Staff were given regular updates on this via the divisional newsletter. The improving together plan included the creation and roll out of a health and wellbeing strategy, creation and sign up to the staff charter and Winter planning.
There were engagement and communication plans in place for Winter 2018-19 which included the make the right choice campaign. This gave directional support to ensure that the right service was chosen for the right treatment at the right time.

The 2018-19 Action on A&E Programme was focusing on conveyance avoidance, which would include pathways for mental health needs.

The emergency division was committed to ensuring that the new urgent care model was embedded in the urgent care centre and that improvements to flow through the department were realised.

Culture

Staff described being treated “supportively and empathetically” during periods of illness. Other staff said, “we have a cracking team.” Staff who had worked in the department during their placements were now working in the department as qualified nursing staff and described “loving the unit.”

Staff in the department worked together well as a team and supported each other in the delivery of services for their patients. They were looking forward to having a new unit manager in place. Staff also described the training and development opportunities in the department as being good.

Senior nursing staff said that they were “proud of the department.” As part of the wellbeing strategy wellbeing champions were being recruited for the emergency division.

The leads described how there had been a big change in how staff within the department felt and that they felt supported and listened to.

Medical staff described the introduction of the new model of allocating clinicians to rooms and how this had made them feel valued and have a sense of ownership.

The leadership team outlined how they supported their emergency care practitioners by giving them opportunities for training and education. They were looking to expand their skills to practice and as a result a number of emergency care practitioners had left. To support the new emergency care practitioners and to ensure that they did not feel overwhelmed they narrowed down the cases they could see to ensure that they were not too complex. Staff responsibilities were then tailored to fit their agenda of training and education support.

There was a staff nominations box in the department to nominate the “employee of the month.”

Staff told us that they all “work as a big family, they are a fantastic bunch of people with different levels of experience.”

Medical staff described how “the nursing staff were fantastic and lovely, they were like a big family, a lovely team and very organised.”

We saw a thank you card on display in the department saying “I have looked working with you all. It has been one of the best places that I have ever worked.”

The culture in the department was described as being good and diverse and we were told that staff were encouraged to take their breaks and their religious beliefs were supported.

The trust had a freedom to speak up guardian. Most of the staff that we spoke with were aware of the role of the guardian and how they could raise concerns and speak up confidentially. Staff told us that the guardian was visible and they were given contact cards for the service.
Governance

There was an accident and emergency delivery board consisting of the medical director, director of operations, the chief executive, clinical commissioning groups, the local council, NHS improvement and the NHS mental health trust. From the board information flowed down to the accident and emergency delivery group. The urgent care commissioning team and the local NHS ambulance service sat on this group. Under this performance meetings, governance meetings and mental health meetings were held. Information from these meetings flowed into the integrated care group division.

Governance meetings were held monthly. All staff were invited including senior managers, consultants, matrons and staff nurses. Staff described topics such as the development of new documentation for minor injuries being discussed at these meetings. Staff meetings were held monthly where matrons disseminated information and ‘lessons learned.’ The ‘emergency trumpet’ newsletter was emailed to all staff. Information disseminated included sepsis figures and areas for improvement such as fluid balance charts.

We looked at the last three months emergency medicine governance group meeting minutes which included domains on safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, public health and paediatrics. There was discussion on a number of items including new pathways, updates from the Royal College of Emergency Nursing, National Institute for Health and Care Excellence guidelines, serious untoward incidents, mental health patient items, audit overviews, complaints and the matrons’ report.

The department participated in Succeed Thrive Empower Pennine (STEP) care review and planning meetings. In these meetings senior clinical and operational staff met to discuss and develop action plans to respond to identified service users risk planning and management needs. Individual plans were developed to respond to service user’s needs and for each organisation to respond to and develop actions.

The trust had a mental health shared care protocol and a shared mental health action plan with their local mental health NHS trust for the management of service users requiring mental health assessment in acute settings. At the time of the inspection this protocol was under joint review.

The middle grade clinicians who worked across the urgent care centres and emergency departments at Burnley and Blackburn held monthly meetings for communication, support and practice development within the middle grade team. We were informed that the meetings had led to improved engagement and opportunities for development, with a number of doctors engaging in projects. One of the attendees represents the middle grade body at directorate governance meetings.

Management of risk, issues and performance

Weekly performance meetings were held at Royal Blackburn Hospital to look for themes. The band six co-ordinator from the urgent care centre dialled into these meetings. Issues raised during the meeting were recorded in a departmental log book. The log book was used as a
communication tool and to give a background narrative. The newly appointed unit manager for the urgent care centre was expected to attend performance meetings moving forward.

The matron overseeing the urgent and emergency care services at Royal Blackburn Hospital, Burnley General Hospital and Accrington Victoria Hospital produced a matrons' monthly report. We reviewed the last three reports for April, August and September 2018. They were comprehensive and covered topics such as nursing documentation, staff communication, vacancies, handovers, nursing assessment and performance framework, incidents, infection prevention and control performance summary score card data and exceptions, friends and family test results, key performance indicators and themes, PLACE action plan updates, development work and quality indicators, complaints, complements and lessons learned.

During the period April to September 2018 we were informed that the matron had been asked to focus attention on clinical practice and maximum presence to support staff and administrative work was kept to the absolute essentials.

For senior support the lead nurse and lead consultant at Royal Blackburn Hospital were contactable and sent support when required.

We reviewed the A&E performance report for the period August 2017 to July 2018. This report contained information on department attendance figures, breeches, four-hour performance, quality and safety figures, incidents by directorate and complaints. From the data which was split by department and by site we saw that the urgent care centre attendance figures were higher for the last three months. The department breached on average 254 times a month with the department exceeding this average in two out of the last three months. The departments four-hour performance averaged 93.7% over the time period, this increased to 94.6% for the period June to July 2018 and the introduction of the new streaming model.

The four-hour performance targets for urgent care centre had improved since the new model of working despite an increase in the number of attendances since the beginning of 2018. We were informed that medical staffing gaps continued to impact on performance but work was on-going to minimise this with the new multi-disciplinary team model and recruitment plans.

The trust was working with NHS Improvement’s emergency care improvement programme. This is a clinically led programme offering intensive support to urgent and emergency care systems across England. A dashboard was developed to benchmark against over 33 other NHS trusts which was monitored twice weekly.

The leadership team outlined they actions they had taken to address issues with recruiting middle grade doctors. They looked at programmes ran by other health care providers and split their doctors staffing rota. They also recruited 17 middle grade doctors. A number of doctors were recruited from overseas and they were supported to do this. The rota included an advanced nurse practitioner, physiotherapists, emergency nurse practitioners and GPs and was based on ‘substantive consistent seven-day modelling.’

The leadership team performed an audit on every patient attending the urgent care centre to see which patients needed to see a doctor and which patients needed to see a physiotherapist. After midnight patients attending the department tended to attend with problems such as chest and abdominal pain and required to see a doctor. The new rotas incorporated this information.

The emergency division had also utilised an NHS Improvement demand and capacity tool in the development of new integrated staff rotas. Workforce planning meetings were held to discuss productivity and placed in line with the new rotas. The service was creating a dashboard to
maintain oversight of efficiency, patient care and outcomes and to ensure that a correct balance was maintained.

We had noted a number of instances on the clinical staffing rota over the week of the inspection where staffing had gone below the minimum outlined on the rota. We were informed by the leadership team that there had been unforeseen doctor sickness that week and that doctors were sent over from the emergency department at Royal Blackburn Hospital to cover. We were also informed that the urgent care centre was generally very well staffed.

Sickness and absence figures for the division trust wide were 8% at the time of the inspection. To address this the service had developed a ‘health and wellbeing strategy’ to look at changing roles and improving lives. As part of this strategy staff were given time off the rota to go to mindfulness sessions and team building away days. Staff rotation was also cited as helpful for some staff groups and a new rota had recently been introduced to rotate the advanced nurse practitioners between the emergency department at Royal Blackburn Hospital and the (urgent care centre). We were also informed that not all sickness was work related.

The issues relating to the care and treatment of mental health patients in the department was on the departmental risk register and one of the top three corporate risks. The leadership team outlined how there had been an exponential increase in routine and complex presentations. There were difficulties in looking after patients for the timescales they were in the department as their medical and psychiatric needs changes and due to their needs, such as meals and personal care.

A number of action plans had been developed in conjunction with mental health liaison, the local mental health NHS trust, the police and the local council who held meetings monthly. There was a shared care protocol in place with the local mental health NHS trust. To address the issues with band three availability to provide one-to-one support, a number of band three staff were being upskilled and provided training to enable them to do this. There was also a formal action plan to increase the band three workforce by recruiting more staff.

The shared mental health action plan included a thematic review of 12-hour breeches, the development and implementation of a formal internal escalation policy, increasing staffing capacity and frequent attenders review.

The leadership team felt that mental health patients in the department were being looked after better and that this included a number of frequently attending very dependent patients. Directorate to directorate meetings were held to discuss mental health patients waiting for a bed. Issues relating to patients with mental health needs were discussed across the region. Representatives from the local mental health NHS trust attended bed meeting to discuss patient flow. The emergency care improvement programme performed a ‘deep dive’ into mental health and the findings went to the accident and emergency delivery board.

The division participated in action in A&E events with representation also for local ambulance and mental health NHS trusts. Projects have been presented to other trusts in the region for shared learning and the division also benchmarked themselves against other providers of urgent and emergency care.

Staff informed us that their biggest risk was violent behaviour and that this was on their risk register. They had access to security 24 hours a day, r seven days a week, but security staff did not always cover patients requiring one-to-ones. Police stayed with patients detained under section 136 of the Mental Health Act.
Information management

The management team monitored performance daily via score cards which contained key performance metrics reported on an electronic patient tracking system. Information was monitored via an electronic overview board.

Managers have oversight of a live escalation report of patients in the department. There was no consultant weekend cover on site at the urgent care centre and this report was also used to monitor during this time.

Staff could access personal computers by a ‘single sign on’ process. Single sign on is a technology intended to facilitate easier and faster use of electronic health records and other clinical information technology applications.

The trust held scanned copies of patients’ health care records on its electronic document management system. The trust was moving towards the introduction of an electronic patient record.

Posters were on display in the patient waiting area informing patients how their information was shared. This poster outlined why information was shared and how the service maintained the security of their information. There were also information leaflets for people outlining how their information was used, what records were kept and how they could access their records.

There was a link nurse in the urgent care centre for information technology.

We received conflicting information from staff regarding issues with their discharge letters. Staff described issues with their discharge letters, which were based upon clinical coding. Patient discharge information sent to GPs via download software had been explored but was described as being “too time consuming.” Staff described this issue as being a priority. Other staff did not feel that discharge letters were an issue and said that they contained additional information boxes which could be populated to provide more in-depth information to GP or outpatients.

Engagement

The leadership team described how staff took part in changes rather than change just happening to them. Staff were actively involved in developing the new model of urgent care which had been developed in conjunction with NHS Improvement’s emergency care improvement programme. The ideas came from the staff who wanted to improve and were supported through benchmarking. Staff were invited to provide feedback during feedback sessions and through this forum had suggested the changes.

The service had responded to a “disappointing” staff survey and had undertaken a lot of work during the last year to improve communication and engagement with staff. To gain staff feedback and to identify themes 20% of staff within the urgent and emergency care department were interviewed and feedback sessions were held with staff. From this feedback an emergency department improving together action plan was developed which included the development of departmental communication boards, the emergency trumpet newsletter, a wellbeing strategy and staff champions.

The emergency trumpet newsletter started in June 2018. We reviewed the newsletters for June and July and found that they contained news updates and information including, star of the month staff nominations and winners, recruitment, safety first with the top five incidents and quality
表演指标、评估和培训，提高在一起，工作场所的压力，新的急诊护理模式，新路径和表现针对关键绩效指标等，如‘四小时’目标。

新的沟通策略实施已有四个月。领导团队描述他们的计划进行员工调查，看看结果是否有所改善。

会议每两周举行一次，参与者是当地NHS救护车服务的工作人员，讨论问题如周转时间。

所有不同的会议日期，工作人员可以参加或贡献的日期都在员工房间展示，方便参考。还有一个在社交媒体网站上的私人群组，供工作人员在紧急护理中心工作。

工作人员被要求设计一个新符号来标识精神健康病人的病人。病人也被征求他们的意见，这个新符号描绘一对手的图案被判定比先前的红色点标志更为亲切。

领导团队告诉我们，急救部门与社区有强有力的联系。

信托有一个系统广泛的沟通和参与计划，以提高人们对急诊和紧急护理服务的意识，替代方案、自我护理和‘做出正确的选择’。

信托有一个社交媒体计划，积极参与‘做出正确的选择’。信托的网站被灵活使用，当需要时，有关急诊护理服务的关注度被提高。在网站主页上，实时等待时间被发布，包含有关何时和如何服务的信息。信托经常与患者和社区代表，包括Healthwatch，患者声音小组和地方议员沟通。

尽管领导团队概述的沟通和参与措施，我们被意识到在检验期间，工作人员感到对外界对急诊护理中心的介绍不适当。我们与之交谈的病人似乎在决定什么构成紧急或急救护理和他们的选择时感到困惑。工作人员告诉我们，这些观念不对，人们带着生病的儿童和婴儿来。

救护车服务被恢复到该部门，以及女性在那里分娩并认为有新生儿ICU，也在模糊人们的理解。

学习，持续改进和创新

一个新的候诊室为门诊病人创建，通过与急诊和紧急护理部门的工作人员合作。

在‘最佳安置奖2018’中，该部门被学生护士来自当地大学的学生护士提名。在‘最佳导师奖2018’中，该部门的一名员工也被提名。

工作人员告诉我们，他们一个超声波机器被放在他们的‘愿望清单’上，寻求资本补助。计划在伯恩利综合医院建立一个新的救护车站，这将使伯恩利急诊护理中心能够获得当地NHS救护车服务的快速转移病人。
The service had worked with the local NHS ambulance service to develop a simplified poster for staff in the urgent care centre to follow 'requesting an inter-facility ambulance transfer from a stand-alone urgent care centre/midwife led unit'.

The department were working with NHS Improvement to develop new streaming models for triage and managing flow.

Staff described the development of a troponin T cardiac marker ‘point of care testing’ service. This service was being developed to lessen the time patients needed to wait for their test results.

The emergency division had secured funding for a consultant for five programmed activity (PA) per week as an educator role. This consultant will work alongside any of the medical staff in the department to provide shop-floor educational supervision.

The emergency division had launched an 'improving together' initiative covering patient safety, communications, staff wellbeing and security. The aim of the initiative was to improve communications and relationships within the team and to do this a staff charter was introduced.

The staff charter promoted behaviours in line with the trust values, encouraged all staff to respect each other and outlined the expectations individuals working within the emergency department and urgent care.
Medical care

Facts and data about this service

The medical care service at the trust provides care and treatment for respiratory, medicine for older people, gastroenterology, diabetes, endocrinology and cardiology amongst other specialities. There are 515 medical inpatient beds located across 22 wards.

A site breakdown can be found below:

- Royal Blackburn Hospital: 470 beds are located within 20 wards.
- Burnley General Hospital: 45 beds are located with two wards

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

The trust had 53,578 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 29,754 (56%), 971 (2%) were elective, and the remaining 22,853 (43%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 31,095
- Gastroenterology – 12,770
- Cardiology – 2,976

(Source: Hospital Episode Statistics)

Medical care is provided at Burnley General Hospital for patients who have been transferred following initial treatment and acute care from Royal Blackburn Hospital. Patients continue to receive general nursing care and rehabilitation, on ward 16 and the Rakehead rehabilitation centre, prior to being discharged. Some patients may also be transferred directly to the Rakehead rehabilitation centre from other NHS acute hospitals. Ward 16 has 28 inpatient beds, including eight side rooms. The Rakehead rehabilitation centre provides accommodation for 17 patients. Both the ward and the rehabilitation unit are extensively involved in planning for patients’ discharge, including where any adaptations or social care arrangements are identified.

We carried out an unannounced inspection between 4 and 6 September 2018, (staff did not know we were coming), to enable us the observe routine activity. During the inspection we visited medical ward 16 - elderly care, and the Rakehead rehabilitation centre.

We spoke with 25 members of staff including divisional directors, medical staff including consultants and junior doctors; nursing staff including matrons, ward managers, nurses and healthcare assistants; allied health professionals; administrative and housekeeping staff. We spoke with and received comment cards from 19 patients and relatives.

We observed care and treatment and reviewed 15 patient care records and seven prescription charts.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff and compliance with this training was high.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 at trust level for staff in medicine is shown below:

The trust has not included any staffing group data with their training return, so the data cannot be broken down into nursing and medical staff.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention</td>
<td>2,143</td>
<td>2,195</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>2,173</td>
<td>2,227</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2,167</td>
<td>2,227</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>2,165</td>
<td>2,227</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>2,153</td>
<td>2,232</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>2,148</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>2,131</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent</td>
<td>2,113</td>
<td>2,227</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance*</td>
<td>2,098</td>
<td>2,227</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>1,699</td>
<td>1,874</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>2,012</td>
<td>2,227</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* The target for this module was 95%.

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

Staff received effective mandatory training in safety systems, processes and practices. During the inspection we observed throughout the service, staff compliance with mandatory training was high.

During inspection we saw local records of mandatory training, held by managers at ward level, which confirmed compliance was above 98% on medical wards.

Managers reviewed staff completion of mandatory training at annual appraisals and staff received email reminders to prompt them when their mandatory training was due. At the time of inspection,
three nurses on ward 16 were due to complete mandatory training updates and two staff on Rakehead rehabilitation centre were booked for updates in basic life support training. A practice educator was based on ward 16 to support staff in training updates when these were identified. The ward managers made allowances for any staff who needed to complete their mandatory training in their own time.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were clear about safeguarding practice and followed trust procedures for this.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 at trust level for staff in medicine is shown below:

The trust has not included any staffing group data with their training return, so the data cannot be broken down into nursing and medical staffing.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>2,153</td>
<td>2,232</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>2,131</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

We reviewed ward level records of safeguarding training for staff during inspection. These confirmed staff were compliant and up-to-date with the trust target for level one and two safeguarding adults training.

Staff were aware of safeguarding procedures at ward level and we saw examples of safeguarding concerns which had been followed up appropriately. Safeguarding champions were available on the wards to share safeguarding information and best practice. Safeguarding champions met together every three months for discussion and updates. Staff could also access members of the trust’s adult safeguarding team for any additional support when this was required.

We were informed that patients could be admitted to the Rakehead rehabilitation centre from age 16 years. Staff in this area had all completed level one and level two safeguarding adults and children’s training and could also access support from specialist children’s safeguarding practitioners in case of any need.

There were 80 safeguarding champions trust wide to assist the trust’s safeguarding team and support staff on different wards.
Cleanliness, infection control and hygiene

The service controlled infection risk well and staff followed trust guidance for infection prevention and control. Although, we observed staff nursing a patient isolated in a side ward for infection control, without observing handwashing protocols.

The medical wards we visited were visibly clean and orderly.

The trust had an infection prevention and control policy and we observed staff followed trust guidance for arms ‘bare below the elbows’ when providing treatment and care to patients.

We saw one patient who was being barrier nursed in a side room, to limit the risk of infection to others. Whilst we saw notices displayed on the patient’s room to alert staff and visitors prior to entering the room, we observed two members of staff entering the room without washing their hands and not wearing aprons and gloves. Also, the door was left open whilst staff went in and out of the room; this was not in accordance with the trust’s isolation procedures.

Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in all the wards we visited. We saw staff, in general, washing their hands and using hand gel in between patient contacts. Patient equipment was labelled with “I am clean” stickers, when cleaned after each patient use. The trust monitored handwashing compliance through regular monthly audits. Information from audit reports showed 100% compliance for May, June and July 2018.

Environment and equipment

The service did not always ensure equipment was looked after well. We observed some items of equipment where maintenance was overdue.

We found the environment was appropriate on the wards we visited and the equipment provided was suitable for providing care to medical patients. Lifts were available to provide access to the building and treatment areas had suitable entry and exit controls.

The Rakehead rehabilitation centre was spacious, allowing patients room to mobilise safely. The unit was located at a distance from the main hospital building, however there were no concerns about any possible impact of this on the ability of medical staff to respond in an emergency.

We checked resuscitation equipment in the wards we visited and saw resuscitation trolleys were located appropriately for access in an emergency. Staff checked resuscitation equipment and maintained accurate and up-to-date records of the daily and weekly checks.

We checked other equipment available on the ward for patient use, including blood pressure machines, commodes and hoists. We saw electronic equipment was safety tested. On ward 16 at Burnley General Hospital we found two patient hoists which had not been serviced within their next service due date. We raised this to the senior nurse in charge for their attention.

Oxygen cylinders for use on the Rakehead rehabilitation centre were stored in a locked cupboard, with hazard notices clearly displayed.
Assessing and responding to patient risk

Staff assessed patient safety risks and acted on any concerns where these were identified.

The service monitored the condition of patients using a national early warning scores (NEWS) system. This system aims to identify deteriorating patients quickly.

The trust had a procedure for recognising and responding to deteriorating patients, with guidance for escalating any patients with a national early warning score greater than zero. The procedure also included reference to patients who gave cause for concern without a raised national early warning score and those whose condition did not improve despite intervention. The procedure was based on best available evidence and current national guidelines.

Patients were reviewed in nursing safety huddles three times a day. Information regarding any changes in patients’ conditions, including a changing NEWS score and any follow up actions, was shared during the safety huddle.

We reviewed ten records in patient areas and saw that patients’ national early warning scores were documented appropriately. Of these ten, we found one record which did not appear to have been escalated based on the score, in line with trust guidance. However, clinical case notes confirmed the patient’s condition had been reviewed and treated.

The trust monitored the application of the national early warning scores system on medical wards through audit, with these results used to identify improvements. Data provided by the trust showed appropriate actions were identified to improve performance.

The trust had a sepsis pathway in accordance with UK Sepsis Trust guidelines and monitored performance against this. A trust lead nurse for sepsis reviewed education and training for staff, providing additional support where this was needed. There were also sepsis champions throughout the service who disseminated information to other staff members around best practice in relation to sepsis.

All nursing staff on the Rakehead rehabilitation centre had completed basic life support training; five registered nurses also completed intermediate life support training and one nurse with advanced life support training.

Nursing staff completed risk assessments for patients on admission recording these on an electronic recording system. These documented patient risks for falls, nutrition, pressure ulcers and venous thromboembolism (VTE). We reviewed ten of these records and saw risk assessments were completed appropriately.

Nursing staffing

While the service had enough staff to keep patients safe, staff were frequently moved during shifts to other areas of high demand.

The trust has reported their staffing numbers below for the period April 2017 to March 2018 for medicine.

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1,156.0</td>
<td>1,013.7</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>May</td>
<td>June</td>
<td>July</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>1,161.9</td>
<td>1,020.9</td>
<td>1,020.9</td>
</tr>
<tr>
<td></td>
<td>1,171.4</td>
<td>1,009.2</td>
<td>1,004.0</td>
</tr>
<tr>
<td></td>
<td>1,170.4</td>
<td>1,004.0</td>
<td>1,005.7</td>
</tr>
<tr>
<td></td>
<td>1,174.3</td>
<td>1,010.8</td>
<td>1,011.4</td>
</tr>
<tr>
<td></td>
<td>1,168.9</td>
<td>1,010.9</td>
<td>1,011.4</td>
</tr>
<tr>
<td></td>
<td>1,168.9</td>
<td>1,010.9</td>
<td>1,011.4</td>
</tr>
<tr>
<td></td>
<td>1,168.9</td>
<td>1,010.9</td>
<td>1,004.5</td>
</tr>
<tr>
<td></td>
<td>1,168.9</td>
<td>1,004.5</td>
<td>1,000.1</td>
</tr>
<tr>
<td></td>
<td>1,167.7</td>
<td>992.9</td>
<td>999.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 13.7% for nursing staff in medicine, which was higher than the trust target of 5%.

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

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.6% for nursing staff in medicine, which was lower than the target of 12%.

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

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 5.6% in medicine, which was higher than the trust target of 3.75%.

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

There were not always adequate numbers of suitably qualified staff in place to ensure that shifts were covered. The service was taking action to mitigate this, but nevertheless there was an increased risk to patients.

The division had undertaken a staffing review since the last inspection, with recruitment of additional qualified nurse and healthcare assistant staff. The service used the safer staffing tool to determine appropriate staffing levels, based on the acuity of patients. Matrons closely monitored staffing and moved staff to areas of high demand when this was required; any staff moves were determined on the basis of risk assessment. Where there were shortages in qualified nurse staffing this was often compensated for by increased levels of unqualified nursing staff, such as healthcare assistants.

Data provided by the trust at the time of inspection showed that the shift fill rate for qualified nursing staff did not always meet the planned levels identified for wards. The daytime shift fill rate for ward 16 in June 2018 was 79%; for July 2018 was 77.5%; and for August 2018 was 76.3%. For the Rakehead rehabilitation centre, the daytime shift fill rate was 77% for June 2018; 71.5% for July 2018 and 76.3% for August 2018. All night shifts for ward 16 and the Rakehead rehabilitation...
centre were 100% staffed during June - August 2018. We also saw on our inspection that for one shift on ward 16, one agency nurse attended shift and one staff nurse was transferred from a community ward in order to meet the planned levels. Nurse managers advised that staffing was appropriately managed and that whilst there had been occasions of reduced staffing, this had not impacted on patient safety. We saw nurses worked hard to ensure patient safety was not compromised. However, we heard frequent comments from nursing staff we spoke to about staffing being an issue, and being moved to a different area happened usually at least several times a week.

We frequently heard comments from different grades of staff on the ward and in the Rakehead rehabilitation centre, saying that staffing was a regular issue, with staff moves occurring sometimes four or five times a week. We were told this could sometimes feel unsafe and that it was frustrating to not have time to care for patients as fully as they would want to. Medical staff commented this was an issue on night shifts, with bank staff being unfamiliar with the ward and unit.

We discussed the staffing issues that had been raised during discussion with senior leaders. Leaders were clear that the use of the safer staffing tool was an effective mechanism for managing staffing on the ward and unit, however, they acknowledged also that nurse staffing was identified on the divisional risk register.

Healthcare assistant staff were often deployed to provide enhanced care for patients with more complex needs, by way of closer observation and one-to-one care. Where more patients needed to have this level of care, there could be an impact on other ward areas if staff were not available. During the inspection we saw three bays needed to be staffed in this way for patients requiring enhanced levels of care.

There had been many staffing changes on the Rakehead rehabilitation centre during the last 12 months, particularly with recruitment of new healthcare assistants. The ward manager told us staffing was now settled and stable.

During our inspection, the wards we visited displayed information about their staffing levels and we saw these were being met appropriately at the time.

**Bank and agency staff usage**

The trust provided us with information of bank and agency usage at trust level:

For registered nurses 8,854 shifts were filled by agency staff and 13,798 shifts were filled by bank staff during the period of October 2017 to August 2018. A total of 22,652 nursing shifts.

For health care assistants 17 shifts were filled by agency staff and 28,388 shifts were filled by bank staff.

Ward managers, advised that bank staff sometimes did not report for duty and this would be raised as an incident if it occurred. The Rakehead rehabilitation centre used bank staff on occasions and these were regular members of staff who were familiar with the unit.

**Medical staffing**

The trust has reported their staffing numbers below for the period April 2017 to March 2018 for medicine.
<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>171.1</td>
<td>149.3</td>
<td>87%</td>
</tr>
<tr>
<td>May</td>
<td>171.1</td>
<td>148.5</td>
<td>87%</td>
</tr>
<tr>
<td>June</td>
<td>138.5</td>
<td>149.1</td>
<td>108%</td>
</tr>
<tr>
<td>July</td>
<td>138.5</td>
<td>147.1</td>
<td>106%</td>
</tr>
<tr>
<td>August</td>
<td>181.5</td>
<td>144.5</td>
<td>80%</td>
</tr>
<tr>
<td>September</td>
<td>180.7</td>
<td>145.5</td>
<td>81%</td>
</tr>
<tr>
<td>October</td>
<td>180.7</td>
<td>147.5</td>
<td>82%</td>
</tr>
<tr>
<td>November</td>
<td>180.7</td>
<td>148.5</td>
<td>82%</td>
</tr>
<tr>
<td>December</td>
<td>180.7</td>
<td>148.9</td>
<td>82%</td>
</tr>
<tr>
<td>January</td>
<td>193.2</td>
<td>150.0</td>
<td>78%</td>
</tr>
<tr>
<td>February</td>
<td>193.2</td>
<td>150.9</td>
<td>78%</td>
</tr>
<tr>
<td>March</td>
<td>193.2</td>
<td>151.3</td>
<td>78%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Medical staffing levels were sufficient to provide safe care and treatment for patients.

Doctors were based on ward 16 and the Rakehead rehabilitation centre Monday to Friday and reviewed patients in daily ward rounds. All of ten patient records we checked showed patients had been reviewed by a doctor within twelve hours of having been accepted to the ward. Doctors were available to see patients at weekends and at other times during the day or night, whenever this was needed. Nursing staff also had access to medical staff when they needed particular advice about a patient and said doctors responded promptly.

There was appropriate support for junior doctors by senior medical staff if further direction was required. We saw no evidence of any issues of concern, or delays in accessing timely medical advice for patients. Medical staff said they had no concerns; the team were “excellent” and worked well together.

The service used long-term agency and locum medical staff to cover gaps in the medical rota and specialist medical vacancies. One locum doctor we spoke with had been in position for two years and observed the staffing in medical care was well organised and provision for patients was good. The service had an action plan to recruit into these vacancies which included overseas recruitment.

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 15.3% in medicine, which is higher than trust’s target of 5%.

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

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 33.1% in medicine, which is higher than the trust target of 12%. There is a notable peak in turnover in September 2017, which could be due student staff moving department.

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

From April 2017 to March 2018, the trust reported a sickness rate of 0.9% in medicine, which is lower than the trust’s target of 3.75%.

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

Staffing skill mix

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

Staffing skill mix for the 169 whole time equivalent staff working in medicine at East Lancashire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (March 2018)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

The service used both electronic systems and paper-based records of patient care. Nursing risk assessments were completed electronically and care plans documented in paper records. We checked different patient records during inspection and found these were clear and available for staff to refer to. Some nursing assessment documentation was incomplete, however, and of ten patient records we checked, we found three where the patient’s nursing care plan had not included all the patient care needs that had been identified.

Patient records were stored securely in locked trolleys near to nurses’ stations on ward 16 and in the nurses’ office on the Rakehead rehabilitation centre. Staff could access electronic records and guidance documents via the trust intranet, with sufficient computer terminals available for this.
At the time of inspection, the trust was in the process of procuring an electronic patient record system with an approximate implementation plan of eighteen months and anticipated roll out for May 2020. The system would enable all records to be held electronically.

**Medicines**

The service prescribed, stored and gave medicines well and followed trust systems for medicines management. Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges. This ensured medicines were safe and effective to be administered to patients. We checked and saw records were complete and up to date for daily fridge temperature checks. We checked a sample of medicines and found they were all within manufacturers’ expiry dates.

Controlled drugs were stored separately with stock checks correctly recorded. Registers for controlled drugs had been signed by two staff members when these medications had been dispensed. Nursing staff completed and recorded daily checks of controlled drugs and records of these checks we reviewed were correct.

Pharmacy staff were available daily on wards to review medications and ensure that medicines stock levels were maintained. Pharmacists attended daily board rounds to identify any patients who were due for discharge. This assisted in preparing the required medicines for patients to take home and helped avoid any delays for patients waiting for these.

We reviewed six medicine prescription charts and found that medicines were administered as prescribed and that prescriptions were legible and signed for. However, allergies were not clearly documented in three of the six medicines prescription records we checked.

**Incidents**

Staff recognised incidents and reported these and there were mechanisms for sharing feedback with staff. However, systems for sharing learning from incidents were not always robust. Staff were sometimes unaware of the learning from serious incidents and reduced staffing was not always reported as an incident.

**Never Events**

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

From July 2017 to June 2018, the trust reported two incidents classified as never events for medicine.

One of these incidents pertains to a misplaced nasogastric tube, which has been placed into a lung. The other relates to a biopsy being performed on the wrong patient. Both incidents occurred within 30 days of each other.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

- Slips/trips/falls meeting SI criteria with 16 (57% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with four (14% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (11% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (7% of total incidents).
- Pressure ulcer meeting SI criteria with two (7% of total incidents).
- All other categories with one (4% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Staff were aware of different types of incidents that could happen in the different medical wards and reported these using the trust’s electronic incident reporting system. Staff fully completed details of incidents, together with any initial follow up actions. Nurses described how they would also discuss any incidents with the nurse in charge, as soon as possible following the incident, so that they could take any other immediate action that was needed. Staff and managers received feedback and reviewed reports through the electronic reporting system.
Ward managers supported members of staff with individual feedback where any immediate learning had been identified. Information relating to incidents was shared with staff at daily safety huddles, team meetings and by email.

A divisional serious incident review panel reviewed investigations of any serious incidents which had occurred, identifying any shared learning arising from these, together with any follow up actions. The trust also circulated a “share to care” bulletin to all staff on the outcome, themes and learning from incidents.

A resource file was kept on each ward containing minutes of team meetings, updates of policies and other important documents. These included action plans following investigation and root cause analysis of serious incidents. We saw from these files that not all members of staff indicated they had signed to state they had read or reviewed these documents. Also during inspection, a number of staff we spoke with were not clear or always aware of the learning that had arisen following a serious incident. Staff were more aware of and could describe the actions arising from incidents of low harm, such as minor falls, also providing examples of the initiatives to prevent patient falls from occurring.

Staff told us they would try to report shortage of staffing as an incident when this occurred, but most often found they did not have time to complete this.

The service reviewed cases of unexpected or potentially avoidable deaths which had occurred within the integrated care division. Senior medical and nursing staff attended monthly mortality review meetings to identify if there were any trends and to share any learning from these reviews.

Staff also reviewed incidents which had resulted in moderate or severe harm to patients at monthly governance meetings. The trust followed a procedure based on root cause analysis principles to investigate serious incidents, which had resulted in harm to patients. We reviewed investigation reports following serious incidents and saw these had been investigated fully, with appropriate follow-up actions identified and detailed in action plans.

Staff we spoke to were aware of the statutory duty of candour principles and could provide an example of when this would need to be applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff were clear in describing how they might explain any errors that may occur when providing care to patients, demonstrating their understanding of principles of openness and transparency. Such examples included minor delays in implementing treatment or care.

**Safety Thermometer**

The service used safety monitoring results well and this was shared with staff, patients and visitors.

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 three new pressure ulcers, 12 falls with harm and 12 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Lancashire Hospitals NHS Trust

1. Total Pressure ulcers (3)

2. Total Falls (12)

3. Total CUTIs (12)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Source: NHS Digital - Safety Thermometer

During the inspection we saw that safety thermometer information was prominently displayed on the wards we visited. This information was regularly updated 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 were implemented as appropriate. Staff on wards actively following the trust’s focus on falls initiative, with different measures, such as providing non-slip socks to patients who did not have suitable footwear. During the inspection we saw information displayed on ward 16, showing the monthly falls report for August 2018 as “no new falls”.

Nurses completed patient risk assessments for pressure ulcers and falls as part of the nursing assessment documentation and appropriate follow up was identified following this.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Care and treatment was based on national guidelines including National Institute for Health and Care Excellence guidelines. Guidelines, policies and standard operating procedures were reviewed and discussed during governance meetings.

The service had care pathways which staff followed for different conditions, including for conditions such as sepsis and acute kidney injury. Specialist services also had local care pathways, including a frailty pathway which identified patients with higher or more complex care needs.

The safeguarding team had undertaken a review of National Institute for Health and Care Excellence guidance for older people with a learning disability and staff followed a learning disability care bundle, to support patients who had a learning disability. The safeguarding team completed an audit in October 2017 of usage of the learning disability care bundle. The audit results indicated implementation had been slow, however over half of staff recognised the needs of people with a learning disability and there was awareness of the hospital passport.

Therapy staff in the Rakehead rehabilitation centre followed different care pathways, including the goal attainment scale and the UK Rehabilitation Outcomes Collaborative. Allied health professional staff used audit data to benchmark performance within regional clinical networks, undertaking a gap analysis and identifying service improvements further to this benchmarking.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Dieticians and speech therapists were available for patients needing nutritional support.

The trust had a food and drink strategy to promote enhanced nutritional care and healthier eating across hospitals. Staff assessed and monitored patients’ nutrition and hydration needs in accordance with this strategy. Patients we spoke with said they had access to food and drink on request and generally described the food as good. Patients had water jugs at their bedside and staff checked these frequently. There was a choice of meals available, although notable feedback from patients on the Rakehead rehabilitation centre indicated the menus were more repetitive and the food was bland.

Nursing staff monitored patients’ fluid intake. Staff encouraged patients to drink water and completed fluid balance charts for patients where closer monitoring was needed. During ward handover, we heard fluid balance charts were discussed. In 2017, the trust had implemented a programme for improving compliance with fluid balance chart recording; we saw staff followed this documentation and related procedures during the inspection.
The malnutrition universal screening tool was completed where patients were identified at risk of malnutrition. Records we reviewed showed these were monitored and appropriate actions implemented where needed.

Staff had access to resource folders containing information about different patient diets, such as low fibre and gluten free diets. Information included guidance for completing a malnutrition universal screening tool assessment and contact details for dieticians.

Dieticians provided support and nutritional advice for patients when this was needed. Speech and language therapists undertook swallowing assessments for patients and care plans were provided for patients who required assisted feeding and percutaneous endoscopic gastroscopy (PEG) tube feeding. Records we reviewed showed patients were referred to, and reviewed by, a dietician or speech and language therapist when this was needed.

**Pain relief**

Nursing staff assessed patients’ pain levels and recorded these as part of the documentation for national early warning scores. We observed staff carrying out “intentional rounding” checks on patients periodically throughout the day, during which patients were asked about their general comfort or if they had any pain.

Pain relief, including paracetamol and ibuprofen, was available for patients if they needed this. Patients said nurses responded promptly to requests for any pain relief.

Specialist advice was available from the trust’s pain team, for patients who presented with more complex pain and conditions.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. Managers compared local audit results in benchmarking with results from other services, both within the trust and externally.

**Relative risk of readmission**

**Trust level**

From March 2017 to February 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology, general medicine and clinical haematology had a higher than expected risk of readmission for elective admissions.
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions, whereas patients in respiratory medicine and cardiology had a higher than expected risk of readmission for non-elective admissions.
England average: ______________________

Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (March 2017 to February 2018))

Elective Admissions

**Burnley General Hospital**

From March 2017 to February 2018, patients at Burnley General Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
Elective Admissions - *Burnley General Hospital*

![Elective Admissions Chart](chart1)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Non-Elective Admissions - *Burnley General Hospital*

![Non-Elective Admissions Chart](chart2)

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 89.3%, which did not meet the audit minimum standard of 90%. The 2016 figure was 80.8%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.4%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was insert percentage. This is better than expected/within the expected range/worse than expected. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 72.1%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust in 2016 is 35.9%. This is within the expected range. The 2016 figure was not significantly different from the national level.

*(Source: National Lung Cancer Audit)*
National Audit of Inpatient Falls 2017

The trust provided details of monthly audits for sepsis care bundles, undertaken to monitor compliance with national guidance for sepsis management. Trustwide results for August 2018 showed 72% usage of sepsis care bundles for patients with sepsis. The trust had developed actions to make improvements to areas identified from the audit results.

Results in the SSNAPP audit had improved from grade E to grade A over 12 months as a result of this action.

Data from the Rakehead rehabilitation centre was submitted to the UK Rehabilitation Outcomes Collaborative (UKROCC). This is a national clinical database which routinely collects key information about every patient admitted to a specialist rehabilitation unit in England. Different outcome measures included the rehabilitation complexity scale, the functional independence measure and the functional assessment measure. Results from the month three provisional report showed patients’ motor scores had improved from 55.9% on admission to 79.5% on discharge.

The safeguarding team completed an audit in October 2017 of usage of the learning disability care bundle.

The service participated in the National Dementia Audit.

Competent staff

The staff made sure staff were competent for their roles and appraisal completion rates were high. This was an improvement from the last inspection.

Appraisal rates

From April 2017 to March 2018, 90% of staff within medicine at the trust received an appraisal compared to a trust target of 90%. The trust has not supplied data allowing this to be broken down by staffing group.

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

Specialist

Managers completed staff appraisals annually and local records we reviewed during inspection showed these had been completed and were up to date for all staff. Nurses on the Rakehead rehabilitation centre were due to have their next appraisal in September 2018 and we saw arrangements had been made for these.

Staff had the right skills and knowledge to deliver care to patients and were given opportunities to develop their practice in different specialist areas. Link nurses were available on wards for these specialist areas, including for infection control; care of the deteriorating patient; safeguarding; dementia care; tissue viability; blood transfusion; manual handling and continence. Link nurses shared best practice information and supported colleagues with relevant updates.

Clinical educators provided ward support for training and development, assisting ward managers in identifying learning needs and delivering ward-based training sessions. Nursing staff completed competencies in different nursing skills, such as for cannulation and taking blood samples. Practice educators and senior nurses on the ward approved competencies for staff when they had achieved this.
Newly qualified nursing staff completed preceptorship, during which they were supported by a more senior nurse. New healthcare assistants were supported to complete the care certificate.

Records of competencies for bank staff were maintained by the local matron, who would allocate suitably qualified and experienced bank staff to the different ward areas. Ward managers completed a local induction with bank staff to ensure they were familiar with the environment and trust procedures.

Junior physiotherapy staff had rotational posts in which they worked across different areas of acute services; these included working in the stroke unit and the neurorehabilitation unit to broaden their experience and clinical knowledge.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients and there was extensive multidisciplinary working as part of day-to-day practice.

Patients had access to support from a range of different clinical and non-clinical professionals for their treatment and care. Staff from different teams, services and organisations were involved in assessing, planning and delivering care and treatment for patients. This included medical and nursing staff; different allied health professionals, such as physiotherapists, occupational therapists, speech and language therapists and dieticians; also, social workers and discharge coordinators.

We saw that there was good communication between different staff in the medical wards we visited. Different information about patients and their needs was shared in a clear and professional manner and there was an established and comprehensive multidisciplinary teamworking approach in day-to-day practice.

Consultant-led multidisciplinary team meetings were held twice a week on ward 16, although we heard it was difficult for pharmacy staff to attend these regularly. Medical and nursing staff said they were hampered by the lack of a phlebotomy service and that the need for doctors and nurses to take routine blood samples for patients frequently caused additional demands.

A multidisciplinary team of occupational therapists, physiotherapists and speech therapists were based on the Rakehead rehabilitation centre and attended daily multidisciplinary team updates with nursing staff. Regular multidisciplinary team meetings were also held on the unit, including a weekly consultant-led progress review meeting and a weekly discharge planning meeting. Case review meetings were held for every patient once a month; patients’ families and carers were closely involved in these discussions and subsequent plans.

As part of their role, the consultant for the neurorehabilitation unit worked at both Royal Blackburn Hospital, as well as the regional neurosciences and major trauma centre. This allowed for continuity of patient care, for patients who were being transferred to the unit from these hospitals.

Complex case managers worked closely with medical and nursing staff across medical wards to support patients in various ways. These professionals helped nursing and medical staff in planning for patients being discharged from wards, liaising with other community staff for arranging any follow-up. Social workers also participated in discharge planning for any patients to provide for any identified social or community needs. Therapy staff linked with community staff in community integrated multidisciplinary teams, supporting timely and effective discharge as part of the ‘home first’ pathway.
The ward clerk and housekeeper attended morning handover meetings on ward 16, to assist in their knowledge of patient needs and any preparations for patients being discharged.

The trust’s mental health liaison practitioners liaised with ward staff in providing support for any patients with a mental health need. Ward staff told us mental health teams, including the dedicated mental health team for older adults, responded promptly to a request for patient advice and support.

**Seven-day services**

Therapy services did not provide seven-day services and this had particular impact on patients in the Rakehead rehabilitation unit. This had been identified as an issue at the last inspection. Following inspection, the trust confirmed there had been a trust wide divisional review of Rakehead rehabilitation centre since the last inspection. One of the review recommendations was to agree business case approval for extending community rehabilitation services.

Therapy staff did not provide routine services at weekends or out of hours, although a respiratory on call physiotherapy service was available to patients on ward 16 and the Rakehead rehabilitation centre, as part of trust wide provision.

We heard concerns from both patients and staff about the impact the lack of therapy support at the weekends had, and the consequences this had for patients. Rehabilitation patients on the Rakehead rehabilitation centre were individually assessed for a comprehensive therapy programme, to maximise their functional recovery and potential independence. However, patients we spoke with particularly noticed the gaps in continuity for these programmes, such as after a weekend, or particularly following a bank holiday. Therapy and nursing staff also observed that shortages of nursing staff also had a worsening effect on this issue. When there was a shortage of nursing staff, patients could not be supported in individual therapeutic activities identified as part of continuing therapy programmes. This included such tasks as being assisted to walk to and from the dining area as a daily activity.

Complex case managers were available on a more limited basis at weekends to support patient needs, with usually one member of staff covering any immediate work. The “home first discharge service” was provided on a seven-day basis, however patients needed to be booked 24 hours in advance for this service. This service also followed different pathways depending on the patient’s residential local authority area, which could result in delays in discharge for some patients. The service completed a delayed transfer of care report each day and used this to monitor the length and reason for any delay in discharge. The report identified a range of different factors potentially relating to this, including waiting for continuing therapy and medical assessment; funding approval for social care; need for community psychiatric nursing service; or family decision about suitable care home placement.

**Health promotion**

The trust had a smoking cessation service and we saw in patient records that routine referrals were made to the service for patients who smoked. Staff gave patients advice on smoking cessation, which included offering nicotine replacement therapy.
The “#EndPJParalysis” initiative was promoted in elderly care wards and the Rakehead rehabilitation centre to promote patients’ well-being and recovery.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. This was an improvement from the last inspection.

We found staff had good knowledge of the Mental Capacity Act 2005 and consent. Most nurses we spoke with were confident about assessment processes and understood basic principles of the Act. Staff followed the trust’s policy for assessing and documenting capacity assessment, identifying a two stage decision making process, in line with the Mental Capacity Act. The trust’s Mental Capacity Act lead supported staff with advice, training and awareness of trust processes for patients who lacked capacity. We reviewed six patient records for patients who may have lacked capacity. We saw there was clear documentation where patients had been identified as lacking capacity, with documentation of best interests decisions being discussed prior to care and treatment being administered.

Staff we spoke with understood Deprivation of Liberty Safeguards (DoLS) and we found that for patients who were subject to a deprivation of liberty the relevant application had been submitted. Nursing staff completed a paper record Deprivation of Liberty Safeguard application, which was emailed to the trust’s safeguarding team mailbox. The Mental Capacity Act lead completed the final application and maintained an ongoing review and tracking of all applications.

We saw do not attempt cardio pulmonary resuscitation (DNACPR) orders had been placed in some patient notes, where these patients lacked capacity. There was evidence of the patient’s and their family or carer’s involvement, with a clear record of best interest decisions completed.

We reviewed a further six patient records where the patient had a DNACPR in place. In all of these there was evidence within the records that capacity had been assessed in relation to the DNACPR. Staff recognised the importance of continuing to review and update these applications.

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

Staff completed mental capacity act and deprivation of liberty training as part of the trust’s mandatory safeguarding training. Compliance with this training met trust target of above 90% of staff completing and we saw during inspection that all staff on ward 16 and the Rakehead rehabilitation centre had completed level one and two safeguarding adults training.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion and patients we spoke with were happy with the care they had received. Staff treated patients with respect and courtesy.
The Friends and Family Test response rate for medicine at the trust was 56% which was better than the England average of 25% from July 2017 to June 2018.

Staff were caring and showed kindness to patients during their hospital admission, respecting the dignity of patients and those who were close to them. They were aware of patients’ care needs and communicated in an appropriate and professional manner.

We saw staff on the Rakehead rehabilitation centre taking time to respond to each patient, with attentiveness and consideration for each individual circumstance. Staff used a personalised approach in their communication, encouraging patients with understanding and sensitivity. They recognised patients’ different characteristics and senses of humour, and varied their communication styles appropriately to meet these individual differences.
We observed staff interacting positively with patients and those close to them on the different medical wards we visited. Staff encouraged patients to be as independent as they could manage in self-care activities, such as eating and taking medicines. Patients could eat their meals together in a communal dining area, supported by staff to carry their own trays and eat their meals independently.

Staff spoke to patients sensitively and appropriately, with consideration for patients’ individual needs, lowering their voices and closing curtains to protect patients’ privacy when providing care. We heard ward staff asking patients’ permission before undertaking their personal care.

Patients were happy with the care they received from staff and said they were treated well. Patients told us the staff were “caring and respectful … a wonderful team” and “have made a huge difference”.

We heard a few comments from patients during the inspection to say that sometimes response to call bells could be slow; some of these added that this was worse when staffing appeared short. We saw patient call bells were answered appropriately and without delay on the medical wards we visited.

**Emotional support**

Staff involved patients and those close to them in decisions about their care and treatment. Patients, their family and carers were closely involved in long-term goal planning on the Rakehead rehabilitation centre.

We observed staff attending to patients when they were distressed or appeared upset, taking time to sit with patients and speaking with them in a calm and reassuring way. Staff were aware of the different behavioural effects that having conditions such as dementia, or a terminal diagnosis, could have; they took note of and responded to patients’ changing behaviours.

Patients who were more anxious and appeared confused were placed in view of the nurses’ station so they could be observed and reassured by staff who were nearby. Enhanced care was provided by two permanent staff in ward bays, for those patients who were more vulnerable due to their confusion, frailty or medical condition. The staff closely observed and responded to individual patients during the day, providing comfort and ensuring their safety if patients chose to get out of bed and move around.

Specialist staff were available, such as nurse specialists and spiritual leaders, to provide for patients’ emotional support needs. Psychological assessments and advice were available where this need was identified. On the Rakehead rehabilitation centre, patients said “staff are good at listening to me”, “I feel very safe in this centre”

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

Staff provided emotional support to patients to minimise their distress and took time to reassure patients if they were anxious or upset.

Patients told us they were involved in decisions about their treatment. Patients said nurses and doctors explained their conditions, treatment and the investigations that may be necessary as part of their care. Staff introduced themselves and communicated clearly to ensure patients fully
understood. Patients were encouraged to ask questions and were given time to assist their understanding.

Patients on Rakehead rehabilitation centre were involved in goal planning and treatment from the date of their admission, with weekly meetings to review their progress and any changes in plans. Families and those close to patients were invited to contribute towards these review meetings and were active partners in patients’ care.

Wards followed a partnership in care approach for patients who were more vulnerable, including patients who had dementia or Alzheimer’s disease. Relatives and those close to patients were provided with information about how they could be involved with patients’ care. Relatives could be involved in assisting with patients’ personal or physical care during their admission.

Patients who lacked capacity to consent to decisions about their care and treatment and those close to them were involved in decisions about their care. Patients’ individual needs and preferences were communicated to staff by their relatives, and we saw these were recorded and care plans followed. We reviewed documentation for patients who lacked capacity to consent, and saw that best interest decisions were made and recorded for patients who lacked capacity.

**Is the service responsive?**

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

The trust planned and provided services that met the needs of the local people. A range of services were available to support patients appropriately, according to their needs.

The service recognised the needs of the local population and used various sources of information, such as public engagement and local statistical data to design and plan services. Services were reviewed and planned on the basis of this available information, which also included audit results and patient feedback.

The facilities and premises within the integrated care division were suitable for the services that were being delivered. The Rakehead rehabilitation centre provided a fully accessible environment for rehabilitation patients, including quiet and recreation areas and a garden. The unit incorporated a self-contained area, designed as a patient flat, decorated and furnished in the style of a home environment, with a bedroom, living room, kitchen and bathroom. This accommodation provided patients with a living environment comparable to being at home, allowing the experience of independent living, whilst still based on the rehabilitation unit. Patients would use this in preparation for their discharge, still having access to the communal areas on the unit and with access to medical and nursing staff, in case of any emergency.

Patients using this flat in preparation for being discharged were encouraged to bring books, ornaments and pictures from home to enhance this experience. The flat had its own separate entrance door and we saw staff were respectful and courteous when interacting with patients who were using the flat.

The complex case management team worked on the ward and Rakehead rehabilitation centre, involving families in care and discharge planning to identify appropriate care following patient discharge.
Average length of stay

Trust Level

From April 2017 to March 2018 the average length of stay for medical elective patients at the trust was 6.8 days, which is higher than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.5 days, which is higher than the England average of 6.4 days.

Average length of stay for elective patients in general medicine and gastroenterology is lower than the England average. The average length of stay for elective patients in cardiology is higher than the England average, being double the England average.

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

![Graph showing elective average length of stay for all specialisms, with trust level compared to England average.]

*Note: Top three specialties for specific trust based on count of activity.*

With non-elective specialties, performance is much closer to the England average, with only respiratory medicine being lower than the England average.

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

![Graph showing non-elective average length of stay for all specialisms, with trust level compared to England average.]

*Note: Top three specialties for specific trust based on count of activity.*

**Burnley General Hospital**

From April 2017 to March 2018 the average length of stay for medical elective patients at Burnley General Hospital was notably lower than the England average in all specialisms.
Elective Average Length of Stay - Burnley General Hospital

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties is notably higher than the England average, especially in the general medicine and geriatric medicine specialties. This reflected the comparatively longer admission times required for rehabilitation patients on the Rakehead rehabilitation centre.

Non-Elective Average Length of Stay - Burnley General Hospital

Note: Top three specialties for specific site based on count of activity.

Meeting people’s individual needs

The service took account of patients’ individual needs. Staff had good awareness of the needs of patients who were living with dementia or a learning disability and specialist staff were available for additional support

The service responded to people’s individual needs in different ways. Staff were aware of the needs of patients who had dementia and we saw this was routinely considered when providing care. Dementia friendly approaches were established across the service, supported by dementia champions. Carers completed a personalised document for their relative receiving treatment, accessible for staff to use when providing care.

Staff had good awareness of “John’s campaign” for involving family carers when patients living with dementia were admitted to the ward. Patients who were identified as having certain needs had associated symbols in care plans and at the end of their beds to flag these needs. Patients at higher risk of falls had a falling leaves symbol and patients with dementia had a blue butterfly symbol. The environment on ward 16 had been improved to meet the needs of patients living with dementia, with signs bold and clear to make these easier for people to read.
Language interpreters and translators were available to support the needs of patients whose first language was not English. Most patient information leaflets we saw were in English, offering availability in other formats.

Following engagement with patients who had a learning disability, families were involved in review of the trust’s website to make information accessible for patient who had a learning disability. A lead nurse for Learning Disability promoted education and awareness for staff regarding patients who had a learning disability; assisted by safeguarding champions on wards.

The trust offered an ecumenical and interfaith chaplaincy and spiritual care service, providing pastoral, spiritual and religious care to patients, relatives and carers who desired this. The hospital provided a spiritual care centre, with a chapel, mosque and non-faith specific quiet room, accessible 24 hours a day, seven days a week. The spiritual care service could also support patients following their discharge with referral to lunch clubs, local foodbanks and befriending services.

Staff received training in equality and diversity, following NHS guidance for transgender patients and meeting the needs of patients in relation to sexual orientation.

Dietary information was available for patients and alternative menus provided for patients from different cultural and religious backgrounds.

**Access and flow**

People could access care and treatment in a timely way. Following inspection, the trust provided data confirming that referral to treatment times in medicine for the elderly met the 18-week target. There were a high number of bed moves at night within the division overall, however this was predominantly for the acute hospital and there was little evidence of this at the Burnley General Hospital. This was because a higher number of patients were admitted to Blackburn medical assessment units and wards directly from the accident and emergency department.

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

The trust’s performance is similar to the England average, dipping to approximately 80% from October to December 2017, before improving to meet the England average.

*Source: NHS England*

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

One specialty was above the England average for admitted RTT (percentage within 18 weeks).
Three specialties were 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>Rheumatology</td>
<td>93.5%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>25%</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Following inspection, the trust provided data confirming that referral to treatment times in medicine for the elderly met the 18-week target.

**Patient moving wards at night**

From May 2017 to April 2018 there were 7,158 patient moving wards at night within medicine. There were a high number of bed moves at night within the division overall, however this was predominantly for the Blackburn site and there was little evidence of this at Burnley General Hospital.

Ward 16 had four beds permanently allocated for outliers and these patients were managed by nursing staff on the ward, although this allocation was not included as part of the establishment of staffing for the ward overall. Outliers are patients who are placed on escalation areas or wards outside of the required specialty due to there being no available beds on the relevant specialist ward. Any outliers could be reviewed and had access to medical staff on the ward and unit, who would liaise with specialist teams whilst awaiting specialist team review.

During the inspection there were two outliers from ward 16 who were placed on the Rakehead rehabilitation centre. The ward manager said this did not happen frequently and in general, the unit only accepted outlier patients described as “reasonably well”.

The Trust had a medical outlier plan which included arrangements to ensure every medical outlier was reviewed every day, had a named medical consultant and team responsible for their care and that cover. Medical outliners were identified on the trust’s electronic patient information system and communicated, with a daily outlier list collated and circulated each morning by the patient flow team.

Complex case managers linked with specialist teams and community team co-ordinators, who would inform case managers when patients were being admitted. A “yellow page summary” would be placed in the patient’s notes to inform ward staff about any community needs and ongoing plans for these. An electronic system triggered daily updates for patients with complex needs and these were shared with hospital and social care teams to enhance care planning. The service had a frailty pathway which was followed for patients with more complex care needs. This assisted in safe discharge planning for this type of patient. Nurses, ward staff and social workers worked together to identify social care referrals and assist in patient discharge processes.

Rehabilitation patients admitted to the Rakehead rehabilitation centre were now transferred
directly to the unit from acute wards, rather than first being admitted to ward 16, which had previously taken place. There was no waiting list for the unit since this practice was introduced.

Discharge planning began on admission, for patients admitted to the Rakehead rehabilitation centre, with the patient and their family closely involved in multidisciplinary discharge planning.

The trust had implemented a “home first” discharge process within the previous 12 months. This provided patients with an experience of being in their own home whilst being assessed, prior to their final discharge. Physiotherapy and occupational therapy staff accompanied and assessed patients during a trial home visit, whilst the patient’s hospital bed would be kept open. If the patient was deemed to be fit for discharge during this assessment, then arrangements for any immediate equipment and community support needs were made to support the patients’ discharge. If there were any concerns regarding the patient’s safety or other need at this time, the patient could return to hospital for continued rehabilitation, until safe discharge could be achieved.

**Learning from complaints and concerns**

The service treated complaints and concerns seriously, investigated them and shared learning from these outcomes with staff. The service had delivered improvement in complaints management and had reduced the level of complaints since the last inspection.

**Summary of complaints**

From April 2017 to March 2018 there were 111 complaints about medical care. Of these, the vast majority occurred at the Royal Blackburn Hospital with 106 complaints. The trust took an average of 73 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be resolved within 50 days.

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

**Number of compliments made to the trust**

From April 2017 to March 2018 the trust recorded no compliments about medical care. The trust has stated that their data does not include a ‘compliments log’, which is used internally to harvest compliments at a ward level and publishes them on the trust’s intranet.

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

Weekly “share to care” meetings were held on the ward and rehabilitation unit, led by the consultant and attended by different members of the multi-disciplinary team. Ward clerks documented any compliments, concerns and complaints that were discussed during these meetings. Staff we spoke with informed us they would initially try and resolve any complaints locally. At ward level and there were low numbers of complaints. Patients we spoke with informed us they were aware of how to raise a complaint and we saw information was displayed for patients and relatives regarding complaints processes.
The division had a low number of complaints during the reporting period, with a total of 16 complaints formally raised to the trust during the year. The time taken for complaints responses had reduced and was within trust timescales. Patients were offered “meet the matron” appointments as part of the approach to respond to complaints.

Although these were not always reported through electronic systems, during our inspection, we saw numerous thank you cards and letters displayed on the ward and rehabilitation unit. Many included appreciative comments about kind and caring nurses.

Is the service well-led?

Leadership

The service had leaders with the right skills and abilities to deliver services providing high quality sustainable care. Since the last inspection there had been significant development of integrated care services, with associated reorganisation of divisional and team structures.

Both managers and staff reflected this had been a time of change, with some staff feeling unsettled and others leaving the trust. However, there was now a well-ordered leadership structure within the integrated care division and senior leaders were passionate about quality development and clear about the oversight of service delivery through this structure.

Senior leaders in the integrated care division were aware of the key risks and concerns to the quality and safety of care across the service. They spoke openly with us about the changes which were needed to deliver improvements and had identified these changes in development plans. These plans were closely and routinely monitored for progress and outcomes.

We saw strong and effective leadership in allied health professions, with a clear focus on clinical effectiveness and building on the existing professional leadership at all levels within the service. Leaders could describe a number of different initiatives that had been progressed since the last inspection, particularly in the development of integrated care pathways, which supported improvements in the patient journey from hospital to home.

Different grades of staff said there was good leadership support and managers promoted an “open door” policy to support staff when this was required. Staff on wards said they knew who the senior leaders were and they would visit wards and the rehabilitation unit from time to time. Nursing staff expressed confidence in the nursing leadership and the divisional nursing director, who was recognised for their ability to respond to concerns and influence change.

Vision and strategy

The trust’s vision and values were well embedded across the service and staff felt supported and valued.

The trust’s vision was “To be widely recognized for providing safe, personal and effective care” Staff we spoke with were aware of the trust vision and values, saying these reflected the work they were engaged in and the aims they sought to achieve. Staff felt the trust values were meaningful for their work and both staff and patients could connect with these.
The trust’s values were prominently displayed in public and ward areas and we saw these were well embedded across the service. Recruitment strategies, staff induction and staff development reviews were based around the trust’s values, to reinforce staff awareness and focus on these principles, and the connection these had to staff’s roles.

The trust’s strategy had been developed through an extensive engagement programme with staff and this was communicated and shared with staff in frequent updates. The trust’s clinical strategy, led by the medical director, was shared with divisional and directorate teams, the trust board, as well as key partners in the local health economy. Progress in these and other supporting strategies, such as the quality strategy, was regularly reviewed by divisional and executive teams.

Within the integrated care division, directorate plans were identified for workforce development; finance; and quality and safety; these were reviewed in monthly directorate meetings and quarterly strategy meetings.

**Culture**

There was an open and transparent culture within the service and staff of all grades consistently described feeling supported for their work and that they felt valued by the trust. Although many staff expressed concern about staffing levels, and described conditions as difficult when staffing was short, overall morale was high and staff were proud of the services they provided for patients. Staff said they got on well together and it was a friendly place to work.

We heard that staff felt able to, and had on occasions, raised issues of concern to managers, without fear of retribution. When they had done this, staff said they had been provided with information and treated with respect and acknowledgement.

Staff we spoke with were aware of the trust’s freedom to speak up guardian and the purpose of this role. Since 2016, all NHS trusts are required to have a freedom to speak up guardian to support staff and promote a culture of speaking up, in situations where they may have identified concerns. Some staff told us they had raised concerns about staffing to the guardian.

All staff we spoke with consistently described a strong teamworking approach, and during inspection we saw this in evidence. Staff of all grades worked alongside each other, communicating professionally and showing respect for patients, their relatives and each other. There was a collaborative approach to decision making, and where this involved patients and their carers, staff ensured patients were as fully enabled to participate and lead this process as they were able to.

Development opportunities were available for different roles and during inspection we saw several nursing staff being supported by the matron in providing ward cover for a manager. This allowed staff to develop their confidence and experience in new directions and areas of leadership.

We heard some frustration from staff in different therapy services that the opportunities for career progression and development of innovative roles were not always equivalent, when compared to those available in acute services. For some, this meant there would need to be a decision to move away from the medical rehabilitation environment if they wished to pursue more senior roles.

Senior leaders in the division described the improvement initiatives that had been implemented since the last inspection and the positive impact this had on culture within the service. They acknowledged some of the challenges there could be with staffing shortages, recognising the work
that continued to be delivered despite these demanding circumstances. Senior leaders told us they were “incredibly proud of [their] staff”.

**Governance**

The service used a systematic approach to continually improving the quality of its services. Leaders monitored and reviewed different outcome measures to identify continuing service developments from these.

Governance arrangements within the integrated care division were clear and well communicated. A committee structure was established for monitoring clinical quality and patient safety within the division, with regular meetings attended by senior clinical and managerial staff.

Divisional patient safety and risk meetings reviewed incidents, with a serious incident review group to assess incidents resulting in moderate and severe harm to patients. Patient stories were used to open meetings, followed by reflection, discussion and identification of actions, based on the issues raised. Clinical effectiveness meetings were held regularly, reviewing clinical audit outcomes and continuous improvement approaches, providing reports to trust board and sharing these with other directorates.

Senior leaders in the division described an open culture, with an emphasis on learning, through the governance systems and processes that had been established. Through development of the integrated care division, an increased number of pathways into community services had been established, with improved patient experience outcomes and more effective hospital to community communications.

Staff were clear about their own roles and the line management reporting arrangements within the service. Staff followed trust procedures and were aware of how to seek direction when this was needed.

The trust’s nursing performance assessment framework was used to assess the quality and safety of care delivered at the trust. The nursing performance assessment framework process assessed baseline standards in wards and departments, and monitored improvements in these over time. Results from the nursing performance assessment framework provided the trust board with an overview of performance and assisted ward staff to identify their own development areas.

**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 the unexpected. Leaders were aware of key risks in the service and identified improvement plans for these areas.

Risks and performance issues were effectively managed across the service, with risk registers used to identify divisional, directorate and ward level risks. The risk registers were reviewed and managed appropriately, with escalation of risks and a timely response when this was needed. Staffing was identified as a key risk in risk registers at each level, with 180 staff vacancies identified in the division at the time of inspection. Divisional leaders had identified an ageing workforce as a risk, with 15% of the workforce being age 55 and over. The trust’s strategic workforce plan had incorporated measures to resolve and reduce the impact of staffing risks.
Wider issues, such as the health needs of an ageing population, were also considered in the context of risk.

Allied health professional leaders identified data systems as a risk, with a mix of different electronic and reporting systems used. This could compromise the clarity of outcome data, sometimes limiting the ability of effective and accurate reporting.

The Rakehead rehabilitation centre identified violence and aggression, also moving and handling issues, in documented risks. The ward manager described how patients in the unit could have behavioural effects resulting from their condition, such as following a head injury. On occasions, this could result in aggressive behaviour of patients. Similarly, patients on the unit frequently had higher levels of care, and need for moving and handling procedures, in association with their condition or disability. Staff were provided with appropriate training to support the effective management of these risks and these continued to be reviewed.

Leaders of allied health professional services had developed a performance dashboard for allied health professional services, sharing some of this work with the quality faculty at the trust.

**Information management**

The service collected, analysed and used information well to support all its activities. Managers had access to different data and performance reports for reviewing progress.

Senior staff had access to the information they needed to monitor performance and to ensure there was sustained or improved standards of care. Performance information included a mix of quality and financial information. Clinical staff had access to patients’ investigation results and we did not hear any concerns regarding any delays in receiving these.

The division had access to a range of information including audits, performance dashboards, staffing figures, complaints and patient feedback. Leaders of the service used this information to understand, investigate and respond to issues that arose in the division.

Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues. Staff could access relevant information, such as policies and other guidance, via the trust’s intranet.

**Engagement**

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Patient engagement activity was well established in the service, and staff were involved in different forums and engagement activities.

The division completed a divisional patient experience report and action plan, detailing key themes and issues which needed to be addressed for improving patient experience.

The safeguarding team had involved patients who had a learning disability in different engagement activities. These activities had included attending a meeting with the local adult safeguarding board, and a focus group regarding surgery, for patients with a learning disability.
These engagement activities had helped identify and raise awareness of the needs of patients who had a learning disability, and were described as “powerful events”. The team had adjusted the template for friends and family feedback to enable access for patients with a learning disability and were beginning to receive early feedback following this change.

Complex case managers gathered patient experience feedback from patients who had used the ‘Home First’ transfer of care service. Clinical leads had been appointed in therapy services to extend the scope of patient engagement as part of their role.

The spiritual care team worked closely with national charities in providing support for patients, their relatives and carers.

Different forums were available for staff to participate in, including a junior doctors’ forum and doctor’s education forum. The trust had recently held a poster presentation event in which 28 presentations were made by different clinical services, showcasing their developments, services and achievements.

Monthly team meetings were held on the ward and rehabilitation unit. Ward staff also could access a closed social media network for updates, and the trust were active in using social media platforms for different staff communications.

A weekly trust wide bulletin was circulated to all staff via the trust’s intranet. Divisional leaders were aware of the various demands that were faced by staff in their work and had started to introduced health and well-being days to support individuals.

The trust had an employee recognition award scheme called star of the month. An occupational therapist on the Rakehead rehabilitation centre had received one of these awards for their work on the “#EndPJParalysis” initiative.

**Learning, continuous improvement and innovation**

We saw there was a strong focus on improvement and staff of all levels were enthusiastic about learning and engaged in different service developments. Divisional leaders actively considered innovative roles and different ways of working in delivering integrated care services. A chief registrar role had just been established at the trust, as part of the Royal College of Physicians flagship work-based leadership programme for senior trainees.

The trust had engaged in international recruitment drives to fulfil staffing needs and had implemented different roles such as physician’s associates, associate nurse practitioners and apprentice nurses as alternative career pathways. There were three consultant nurses at the trust, one of whom was the clinical director for stroke services.

The safeguarding team had identified and recruited to the role of independent domestic violence advisor to support both patients and staff regarding issues of domestic violence. This had also led to the establishment of a peer support group for staff members to support each other.

The specialist nurse for learning disability and autism had presented findings of a trust learning disability mortality review at a North-West forum of learning disability practitioners.

The allied health professional director participated in a national network of allied health professional leaders. Through this network, the trust was one of 11 trusts nationally involved in the allied health professional trailblazers programme. The service had been appraised through the national trailblazers programme for the development of physiotherapy apprentice standards. The
service was also preparing to host the first national allied health professional day in October 2018, with executive directors attending.

Managers had identified the role of trainee assistant practitioners in therapy services, to support development of inter-professional working in physiotherapy, occupational therapy and speech therapy services. Two staff had been recruited to start in these posts from September 2018, which incorporated one day a week attendance at the local university on a two-year foundation degree programme.

Therapy staff from the Rakehead rehabilitation centre were preparing to host an open day event in October 2018, open to practitioners in the northwest neurorehabilitation network.
Surgery

Facts and data about this service

Burnley General Hospitals is one of seven hospitals and care centres within the trust. It specialises in planned (elective) treatment and has 291 beds. The elective sessions by speciality include; ophthalmology, orthopaedic, ear nose and throat (ENT), urology, max fax, special care dentistry and general surgery.

Elective higher risk patients requiring overnight stay are facilitated at Royal Blackburn Hospital as required.

As part of the inspection we visited; theatres, the urology investigation unit, pre-operative assessment unit, ward six (ophthalmology) and ward 15 (elective orthopaedics).

We spoke with 13 patients, 30 members of staff, observed care and treatment and reviewed eight sets of records. We spoke with a range of staff at different grades including; nurses, doctors, consultants, ward managers, general managers, theatre managers, anaesthetists, matron for theatres, health care assistants, physiotherapists, occupational therapists, ward clerks, housekeepers and electrical bio-medical engineers. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

We previously inspected surgical services at this hospital in April 2015 and rated the service overall as good.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.

Mandatory Training

Staff completed mandatory training in a range of subjects, which included; safeguarding adults and children, safer handling, security, violence and aggression, understanding dementia, valuing diversity and equality.

Role specific induction was offered to all staff when they started work in the division. Newly qualified nurses received a period of supernumerary status until they had their competencies signed off by the ward manager.

Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.
Mandatory training completion rates

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 at trust level for staff in surgery is shown below.

The trust has not included any staffing group data with their training return, so the data cannot be broken down into the nursing and medical staff groups.

The trust set a target of 90% for completion of mandatory training.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>1,588</td>
<td>1,633</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1,573</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>1,573</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>1,556</td>
<td>1,633</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>1,571</td>
<td>1,652</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1,534</td>
<td>1,633</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent</td>
<td>1,517</td>
<td>1,633</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>1,201</td>
<td>1,334</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>1,427</td>
<td>1,633</td>
<td>87%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff in the surgery core service exceeded the trust’s 90% completion rate target eight of the nine mandatory training modules.

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

Safeguarding

Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. Safeguarding training formed part of the trust’s mandatory training programme.

We had reviewed the trust’s safeguarding intranet page which was informative and user friendly. It had contact numbers for escalating and safeguarding issues around adults and children. There was an article on ‘how can I spot abuse’ with a question and answer page. All relevant referral forms could be accessed from this page.

All staff we spoke to knew who the safeguarding lead was and knew how to escalate a concern. Staff had an awareness of child sexual exploitation (CSE) as this was covered in safeguarding mandatory training. Staff were updated by the child safeguarding link nurse.

In the Wilson Hey theatres children were brought down to the theatres by a play specialist who chaperoned the child. The play nurse stayed with the child post operation, during the anaesthetic procedure and in the recovery bay. Parents were also invited to stay with the child at these times and the theatre staff treated them as part of the team.
Protocols were in place for children with safeguarding concerns. We were given an example whereby finger bruises had been seen on a child’s legs and arms during an operation. This was escalated to the safeguarding lead and followed up by social service intervention. Trust data showed that 96% of staff in surgery had completed safeguarding training which was better than the trust target of 90%.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 at trust level for staff in surgery is shown below.

The trust has not included any staffing group data with their training return, so the data cannot be broken down into the nursing and medical staff groups.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>1,574</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>1,567</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff in the surgery core service exceeded the trust's 90% completion rate target for both safeguarding training modules.

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

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The trust audited surgical site infections (SSI’s). Orthopaedic surgical site infections were routinely audited at ward level and sent to Public Health England. Surgical site infection rates remained low. In addition, between the months of May 2017 and November 2017 the trust audited surgical site infections as part of the getting it right first time (GIRFT) programme. This was designed to improve the quality of care within the NHS by reducing unwarranted variations. This audit was established to identify the surgical site infection rates of specific procedures within key surgical specialities and to assess local practice in the prevention of surgical site infections for the specified procedures.

All areas we looked at were exceptionally clean and we were told that ward 15 was cleaned twice daily for infection control, as recommended by the British Orthopaedic Association.

In theatres, checks were conducted daily for cleanliness and signed and dated accordingly. The sister carried out spot checks in patient areas even if the equipment had not been used.

We saw ‘I am clean stickers’ in use on cleaned equipment in the wards.
Ward 15 and ward six both had isolation rooms which could be used to isolate patients if required to prevent the spread of infectious diseases.

The trust was following the decontamination guidance outlined in the Department of Health and Social care’s management and decontamination of flexible endoscopes health technical memorandum. Endoscopes from the Wilson Hey theatres were decontaminated on site.

We saw theatre maintenance assurance lists attached to the doors to theatres, which included the date of the last deep clean carried out. All lists we reviewed were up to date. We were informed that the theatres were cleaned daily and after each patient and deep cleaned annually.

We looked at theatre cleaning records and found them to be in date and the theatres clean.

On ward 15 for elective surgery, a bedside check list was completed every time a patient was discharged. The check list was audited for compliance by the ward manager to ensure that each time the bedside was clean and the bedside cabinet was clean and empty.

Environment and equipment

The service had suitable premises and equipment and looked after them well. All facilities and surgical equipment including resuscitation equipment, was fit for purpose and checked in line with professional guidance.

The only exception was for the anaesthetic machines which we found to be past the servicing date. We looked at six which we found to be in date and over 20 machines were overdue a service. We spoke to the electrical biomedical engineer manager who explained that the servicing had been taken over by the trust, from the manufacturer. The contact was in order and the parts had been ordered, but they were unable to give a time scale for their delivery. We were assured that all the aesthetic machines were safe to use.

There were no spare aesthetic machines available, however, when machines were serviced they planned this around theatre utilisation, ensuring that the surgery department was never in need of the machines when they were being serviced.

We looked at resuscitation equipment in the elective care unit and in ward 15 and found the daily and weekly check lists were all completed correctly and were up to date. However, we found a carrying handle with a blade attached and an intubation stylet (used as an aid to facilitate insertion of the endotracheal tube) which were not in their sterile wrapping. This was escalated to management and addressed immediately.

We found equipment on a difficult airway trolley which was past the servicing date and past the manufacturer’s expiry date. A manual jet ventilator (used for tracheostomies) was past the servicing date. When this was raised we were informed that there was only one replacement to use when servicing and this was currently being used at Royal Blackburn Hospital. On the same trolley we also found a cannula past the manufacturer’s expiry date, this had been recorded on the check list, but not replaced.

We saw appropriate personal protective equipment, including aprons and gloves readily available and used on all wards we visited.

In the Wilson Hey theatre reception area, we saw male and female segregation in the theatre waiting area, these areas had been created by partitioning one large room into three areas. The rooms were stark however, during our visit staff had been thinking of ideas to brighten up the waiting rooms and had already purchased stickers to decorate the children’s waiting area.
The ophthalmology unit, ward six, was located on the second floor at Burnley, with the ophthalmology theatres (three and four) positioned downstairs. We were told by the manager that this had posed a risk to patients as they receive eye drops post-surgery which affect their sight. Patients were escorted to theatres and returned, in wheelchairs, using the lift to mitigate the risk.

An external company carried out annual testing of the ventilation systems in the theatres at Burnley. We saw evidence that where the company had recommended remedial action the service had taken action to resolve it.

**Assessing and responding to patient risk**

There were reliable systems, processes and practices in place to keep patients safe. All patients had a preoperative assessment undertaken prior to their surgical admission. This ensured that any patients at an increased risk of having surgery were identified.

Burnley General Hospital had its own pre-operative assessment unit which ensured pre-operative assessments were carried out in line with guidance. The pre-operative assessment included observations for blood pressure, and a record of height and weight. Pre-operative assessments took place approximately seven days prior to the operation and were valid for up to three months.

We observed staff using the World Health Organisation’s (WHO) surgical safety checklist and the ‘Five steps to safer surgery’ procedures in theatres. Safety checks before, during and after surgery were completed, this demonstrated a good understanding of the five steps to safer surgery procedures.

Audits were carried out for the compliance with the ‘Five steps to safer surgery’ and the World Health Organisation’s (WHO) check list. Staff carrying out the audits completed a ‘Five steps to safer surgery observation list’. We looked at audits for day case surgery, ophthalmology and the Wilson Hey theatres for the last six months. It was evident from these that all staff felt able to speak up if they were not happy with something. We saw evidence of a surgeon being told to switch the radio off during time out, due to it being an unnecessary distraction and a visiting surgeon to the ophthalmology theatres, being told to remain quite as he was trying to initiate a conversation with the operating surgeon during checks. The average score for the audit compliance, for the year 2017 to 2018 was 99.81%.

Each theatre at Burnley General Hospital had a visual white board displayed on the wall, used to record the surgical safety checklist team brief. Patient information written on the board included; awareness of special circumstances, allergies and infection control. A notice stated that each section of the briefing board must be completed for every patient before they were treated and that no boxes must be left blank by the start of the procedure.

However, this team brief was wiped off the board when a new patient arrived and was not recorded anywhere, therefore there was no record of the conversation, or brief for future reference or clarity. We raised the concerns with management and were told that this would be addressed and a possibility was to adapt the original paper debrief form, to reflect the details on the white board for each patient.

We saw patients post-operatively and all informed us that their surgical site had been marked prior to the operation.

Following the five never events the trust had had in theatres (four in Blackburn, one in Burnley), the surgery division had implemented 10,000 feet initiative which had been developed from a
concept borrowed from the aviation industry. If any member of the theatre team felt the need to regain focus during surgery, they could call the phrase “10,000 feet”. This signals the need for a quite environment and concentration. 10,000 feet is an innovative patient safety project, which the trust was the first in the UK to launch.

The WHO checklist had also been adapted and at sign out the question on the form was whether 10,000 feet had been called during the time in the theatre.

The WHO check list was adapted and used in cataract surgery.

Staff knew how to identify and respond appropriately to patient risk. If staff had concerns about a patient with signs of sepsis they would flag this with a ward doctor, or if out of hours, the duty on call doctor if escalation was required, the patient would then be transferred to Royal Blackburn Hospital.

Theatre recovery and nursing records included an early warning score chart to alert staff if a patient’s condition was deteriorating. We saw these had been fully completed in the records we inspected. Staff were aware of the procedure to follow should a patient’s condition deteriorate. Any deteriorating patient would be discussed with the doctor, who would then liaise with the medical registrar to consider being transferred to Royal Blackburn Hospital.

The trust had a policy for sepsis management in place and staff were aware of it. There was a sepsis bundle which staff were trained in.

The staff were aware of and used the aseptic non-touch technique, the standard intravenous technique used for the accessing of all venous access devices. Poor standards of aseptic technique are a fundamental cause of healthcare acquired infections.

Any patient discharged from ward 15 would be provided with the contact number for the ward in case they had any concerns about their operation, or recovery once home.

Falls assessments were carried out on patients when appropriate and on ward 15 (elective orthopaedic ward) we saw that patients were screened on admission to the ward and if there were concerns they would be included in the patients’ care plan.

The hospital had a major haemorrhage protocol which staff were aware of. In each theatre there was a red telephone which linked through to the transfusion laboratory. The team leader would activate the ‘major haemorrhage protocol’ and contact the transfusion laboratory via the phone, the laboratory would instantly cross match the patient’s blood and make emergency blood available. We had sight of the transfusion management of major haemorrhage protocol which included a flow chart for management in children.

At Burnley General Hospital ‘cell salvage’ was in use. Cell salvage is a process that collects blood from an operating site. This blood is then processed in a cell salvage machine and given back to the patient, this means that the patient may not require donated blood from the blood bank. There are many advantages of using this process such as reduced risk of post-operative infections and reduced risk of rare adverse events such as transfusion reactions. Often acceptable to groups with religious or other objections to homologous blood.

We observed the five steps to safer surgery being completed at Burnley General Hospital at this included the venous thromboembolism (VTE) (a condition where a blood clot forms) assessments on sign out and in. A prompt was also found on the World Health Organisation checklist for VTE and stickers were available for further prompts. In the future the flushing of cannulas was a procedure to be added to the check list.
Nurse 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.

Managers told us that staffing rotas were completed eight weeks in advance to enable appropriate cover to be in place. The rotas were completed electronically and any gaps in the rota would trigger bank or agency staff cover. The wards tried predominantly to cover the gaps by using their own bank staff. However, we were informed by managers that there was currently a shortage of bank staff available.

A meeting was held at Royal Blackburn Hospital every Monday at midday, to discuss the staffing situation for the week ahead. On occasions staff from the surgery wards at Burnley General Hospital had been moved to cover ward B24 at Royal Blackburn Hospital. Managers said that the staff were informed in advance so they could report there for the start of their shift.

A staffing meeting was also held at 4pm each day, to address staffing for the following day, ensuring skill mix was considered in all areas of surgery.

The trust has reported their staffing numbers below for the period April 2017 and March 2018.

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>687.5</td>
<td>644.1</td>
<td>94%</td>
</tr>
<tr>
<td>May</td>
<td>700.4</td>
<td>649.3</td>
<td>93%</td>
</tr>
<tr>
<td>June</td>
<td>709.6</td>
<td>642.1</td>
<td>90%</td>
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<tr>
<td>July</td>
<td>707.6</td>
<td>638.2</td>
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<tr>
<td>August</td>
<td>708.7</td>
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<td>90%</td>
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<td>September</td>
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<td>96%</td>
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<td>October</td>
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<td>661.8</td>
<td>97%</td>
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<td>November</td>
<td>683.9</td>
<td>657.3</td>
<td>96%</td>
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<tr>
<td>December</td>
<td>683.9</td>
<td>649.1</td>
<td>95%</td>
</tr>
<tr>
<td>January</td>
<td>712.2</td>
<td>643.3</td>
<td>90%</td>
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<tr>
<td>February</td>
<td>714.4</td>
<td>637.1</td>
<td>89%</td>
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<tr>
<td>March</td>
<td>712.7</td>
<td>633.5</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8,388.8</strong></td>
<td><strong>7,751.4</strong></td>
<td><strong>92%</strong></td>
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</tbody>
</table>

The nurse staffing fill rates were between 89% and 97% from April 2017 to March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 7.6% in surgery.

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

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.8% in surgery.
Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 5.2% in surgery; higher than the trust target rate of 3.8%.

Bank and agency staff usage

The trust informed us that theatres had a shortfall in scrub nurses due to staff carrying out training, sickness and ongoing recruitment issues, therefore there was high usage of agency staff during July and August 2018. The trust told us that surgery needed to continue and agency staff were essential in ensuring theatre lists could be staffed. They expected to be up to full establishment at the end of September 2018 and did not envisage requesting scrub agency staff after that.

Medical staffing

The trust has reported their staffing numbers below for the period April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Month (2017-2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>225.2</td>
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<tr>
<td>May</td>
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<td>June</td>
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<tr>
<td>July</td>
<td>228.5</td>
<td>220.9</td>
<td>97%</td>
</tr>
<tr>
<td>August</td>
<td>227.3</td>
<td>229.3</td>
<td>101%</td>
</tr>
<tr>
<td>September</td>
<td>227.3</td>
<td>231.8</td>
<td>102%</td>
</tr>
<tr>
<td>October</td>
<td>227.3</td>
<td>231.8</td>
<td>102%</td>
</tr>
<tr>
<td>November</td>
<td>227.3</td>
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<td>103%</td>
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<td>December</td>
<td>227.3</td>
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<td>104%</td>
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<tr>
<td>January</td>
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<td>103%</td>
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<tr>
<td>February</td>
<td>230.2</td>
<td>234.1</td>
<td>102%</td>
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<tr>
<td>March</td>
<td>229.2</td>
<td>233.1</td>
<td>102%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2735.2</td>
<td>2757.3</td>
<td>101%</td>
</tr>
</tbody>
</table>

The medical staffing fill rates were between 98% and 104% from April 2017 to March 2018.

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of -0.8% in surgery, which could indicate an over establishment of staff.
Turnover rates
From April 2017 to March 2018, the trust reported a turnover rate of 19% in surgery;
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From April 2017 to March 2018, the trust reported a sickness rate of 1.3% in surgery, lower than the trust target rate of 3.8%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

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

Staffing skill mix for the whole time equivalent staff working at East Lancashire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Surgery at Burnley General Hospital was consultant delivered and led. There was no necessity to have a consultant of the week at Burnley General Hospital as they only had elective surgery cases.

The surgery wards at Burnley General Hospital were nurse led, therefore there were no daily ward rounds by medical staff.

Consultant ward rounds were undertaken daily with ward rounds being undertaken at weekends for new patients and those for whom a review was requested. During our inspection we found surgical staffing was adequate. 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.
Morning ward rounds took place daily and were consultant led and the theatre list for that day was made available.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

We reviewed eight sets of patient records which were completed to a good standard. The hospital predominantly used paper-based records, but planned to implement electronic patient records. We found that patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient’s stay.

Each record contained a care plan that was completed electronically and printed and filed within the bedside record. Risk assessments such as risk of venous thromboembolism, pressure ulcer and falls were completed and updated appropriately.

However, surgical site infection surveillance data sheets were poorly completed and in the four we looked at, only 50 percent of the data required was completed.

Records were stored in unlocked trolleys behind the nurses’ station on ward BG15, however patients and visitors did not have access to this area.

The theatre staff received an alert sheet from the bookings department if there were any additional alerts that they need to know about the patient, such as; allergies, infections, high BMI, or whether an interpreter was required. This information was collated from the pre-operative assessment.

Clinicians in the service also had access to clinical portal which allowed access to records kept by other local acute NHS hospital records such as discharge letters and details of accident and emergency attendances and GP records.

**Medicines**

The service prescribed, gave, recorded and recorded medicines well. Patients received the right medication at the right dose at the right time. However, medicines were not always stored well and we found that fridge temperatures were being recorded as higher than the required temperature, but there was no documented action taken. We found this in the ophthalmology unit and the urgent care unit at Burnley. In addition, no ambient temperature was recorded in clinical areas, where other drugs were stored, all drugs should be stored below 25°C.

Ward six ophthalmology controlled drugs were also found to be stored correctly and Intravenous fluids were locked away. We found eye drops were issued, documented and initialled.

On ward six at Burnley General Hospital we found potassium was not segregated, potassium is a toxic drug, though in relatively low concentrations, should be segregated from other fluids. We raised this issue on inspection and the fluids were moved immediately. In the Wilson Hey theatres it was stored separately from other fluids.

The majority of drugs administered were given under patient group directions. Patient group directions allow staff to administer medicines without the need for a prescription. We reviewed two current patient records which confirmed that staff were authorised to use the patient group
directions and we found this fully documented. We saw examples of other drugs prescribed correctly and administration recorded in the patients’ notes.

The trust recorded all the patient group directions on their intranet site and all were in date, though a number were missing an authorisation signature from the service lead.

We reviewed ten patient prescription records and all allergies were clearly documented.

Incidents

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. When things went wrong, staff apologised and gave patients honest information and suitable support. We were given examples by managers of when the duty of candour was implemented, one example was regarding a fall by a patient when their sock stuck to the floor. The family were informed promptly.

Any incidents were reported by staff on their intranet system, all staff we spoke with knew how to do this. The incident was then reviewed by a band six or seven nurse and then escalated to the management team for investigation if necessary. Feedback to staff was provided through email or one-to-one.

From July 2017 to June 2018, the trust reported two incidents classified as never events for surgery which were both investigated fully. A recent investigation into the failing of air flow in the Wilson Hey theatre, resulted in a full investigations and themes were identified. This resulted in lists on theatre doors indicating, where the service dates were recorded for the equipment and when it is due. The portable equipment maintenance programme by the electro bio-medical engineers was also updated, resulting in ‘medical device alerts’ being sent via email to the matron from the quality and safety department, when equipment was due to be serviced.

Never Events

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

From July 2017 to June 2018, the trust reported two incidents classified as never events for surgery.

(Source: Strategic Executive Information System (STEIS))
The never event which took place in surgery at Burnley General Hospital in 2016 resulted in much learning for all the departments. The incident was a retained foreign object following a gall bladder removal procedure. This was identified by the pathology department as the specimen pot received had been empty. Because of the never event an action plan was produced. We reviewed the action plan which instructed a number of improvements to be implemented; retrieval bags must be included in the instrument/swab count, a verbal statement to be made during the procedure that the retrieval bag had been inserted into the patient and a verbal acknowledgment that it has been removed, incident bag description and serial number to be recorded, and the Medicines and healthcare products regulatory agency (MHRA) to be informed, the purchase of clear histology pots in a larger size, so the specimen could be seen and checked before being sent out of theatre without opening the pot and risking hazardous spills and finally staff instructed not to pre-label specimen pots. A new specimen book was also introduced and the pathology department now had to sign in each specimen and produce a receipt. In addition to these changes, the swab policy was reviewed.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

- Pressure ulcer meeting SI criteria with four (25% of total incidents).
- Slips/trips/falls meeting SI criteria with three (19% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (19% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (13% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (13% of total incidents).
- All other categories with two (13% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, eight falls with harm and five new catheter urinary tract infections from June 2017 to June 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at East Lancashire Hospitals NHS Trust

1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

National Institute for Health and Care Excellence (NICE), 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. The clinical effectiveness committee and divisional management group reviewed and actioned any changes. Any deviation or planned departure from the guidance such as that deemed ‘relevant but not implemented’ was risk assessed, barriers to implementation ascertained and these were agreed through governance committees and documented accordingly. Where relevant this was reported to the divisional risk register.

Patients’ physical, mental health and social needs were assessed and their care and treatment was delivered in line with national guidance. National Institute for Health and Care Excellence guidance was followed and any updates or changes were cascaded down from the audit team manager. A recent example was changes for doctors when prescribing analgesics to also prescribe laxatives for the patient at the same time.

Sepsis care bundles were implemented immediately if the ward doctor identified sepsis in a patient. If the situation escalated then the medical registrar would be alerted and the decision to transfer the patient to Royal Blackburn Hospital would be discussed.

**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.

At Burnley General Hospital staff used the malnutrition universal screening tool (MUST), a five-step screening told to identify adults who are malnourished, undernourished, or obese.

In ophthalmology, if there were any delays in the operating list, staff would view the patients who were fasting before surgery and after a discussion with the surgeon, would offer the patients sips of water if the delay was going to be substantial.

On ward 15, meal times were protected for patients. Signs showed that the meal times were from midday to 1.30pm and 5 to 6pm. We were informed that if a patient needed assistance with eating, visitors could assist.

On speaking to patient’s, a number made comment as to the poor quality of the patient food. If patients missed a meal, nurses would bring sandwiches, snacks and hot drinks to them on request.

Patients’ fluid intake was only monitored for patients who stayed in overnight or were deemed at risk. If this was the case, a fluid chart was started and the fluid monitored with a balance chart.

**Pain relief**

Following surgery patients were given effective pain relief. All patients we spoke with told us they had been asked about pain relief regularly after their operation.

There was no pain team resident at Burnley General Hospital, but staff would liaise with the duty anaesthetist for advice, or contact the pain team at Blackburn if required.
Patients undergoing hip or knee surgery were given booklets which asked them to assess their pain score daily. They were invited to place a cross on a line which went from a 'happy', yellow face, to a red, 'sad' face, to indicate what level their pain was to assist nursing staff on prescribing the correct level of pain relief.

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

**Trust level**

From March 2017 to February 2018, the trust had an overall lower risk of readmission than the England average. Urology has a higher risk of readmission than the England average, whereas the risk of readmission for general surgery and trauma and orthopaedics were both lower than the England average.

**Elective Admissions – Trust Level**

![Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

All surgery patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity
Burnley General Hospital

From March 2017 to February 2018, all patients in surgery at Burnley General Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Burnley General Hospital

All patients in surgery at Burnley General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Burnley General Hospital

National Hip Fracture Audit

In the 2017 National Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.3% which was within the expected range. The 2016 figure was 7.6%.

The proportion of patients having surgery on the day of or day after admission was 72.5%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 75.7%.

The perioperative medical assessment rate was 94.9%, which failed to meet the national standard of 100%. This was within the middle 50% trusts. The 2016 figure was 91.4%.

The proportion of patients not developing pressure ulcers was 98.1%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 99.3%.

The length of stay was 23.8 days, which falls within the middle 50% of trusts. The 2016 figure was 27 days.
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

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 the performance on groin hernias was about the same as the England average.
For Varicose Veins, the performance was about the same as the England average.
For hip replacements, the performance was about the same as the England average.
For Knee replacements the performance was better than as the England average.

(Source: NHS Digital)

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.

New ward based staff received a two-week induction to the ward. They were given a four-page induction booklet to assist them. New staff were supported by a band five mentor and had a supernumerary period whilst on induction.
**Appraisal rates**

From April 2017 to March 2018, 90% of staff within surgery at the trust received an appraisal. This compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Numbers Required</th>
<th>Numbers completed</th>
<th>Percentage Completed</th>
<th>Trust Target (95%) Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>435</td>
<td>4188</td>
<td>BGTH Chemotherapy Dept</td>
<td>Surgery</td>
<td>14</td>
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<tr>
<td>435</td>
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<td>BGTH</td>
<td>Surgery</td>
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<td>Hearing Therapy</td>
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<td>Surgery</td>
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<tr>
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<td>4380</td>
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<td>BGTH</td>
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<td>Oral Surgery Outpatients</td>
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<td>Surgery</td>
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<tr>
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<td>5101</td>
<td>Gen Surg Advance Nurse Prac</td>
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<td>435</td>
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<td>Surgery</td>
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<td>5116</td>
<td>Vascular Medical Secs</td>
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<td>Percentage Completed</td>
<td>Trust Target (95%) Met?</td>
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<td>435[5193]Newborn Hearing Screening</td>
<td>RBTH</td>
<td>Surgery</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>435[5247]Ortho Trauma Team</td>
<td>Surgery</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>435[5372]Enhanced Recovery</td>
<td>RBTH</td>
<td>Surgery</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>435[5376]Trauma &amp; Orthopaedic Medical Secretaries</td>
<td>RBTH</td>
<td>Surgery</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>435[6051]Dermatology Med Secs</td>
<td>BGTH</td>
<td>SAS</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Surgical &amp; Anaesthetic Services</td>
<td>170</td>
<td>166</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>435[5362]Critical Care</td>
<td>RBTH</td>
<td>Surgery</td>
<td>117</td>
<td>113</td>
</tr>
<tr>
<td>435[5142]Ward C14A</td>
<td>RBTH</td>
<td>Surgery</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>435[5366]Ward B24</td>
<td>RBTH</td>
<td>Surgery</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>435[5110]Pre-Op Assessment</td>
<td>RBTH</td>
<td>Surgery</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>435[5105]Medical Secretaries General Surgery</td>
<td>RBTH</td>
<td>Surgery</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>435[4960]Cancer Services Dir Mgmt</td>
<td>ELHT</td>
<td>Surgery</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>435[5163]Oral Surg Max Fac Outpatients</td>
<td>RBTH</td>
<td>Surgery</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>435[5146]Ward C18B</td>
<td>RBTH</td>
<td>Surgery</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>435[4360]Ophthalmology Medical Secretaries</td>
<td>BGTH</td>
<td>Surgery</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>435[6087]Cancer Nurse Specialist</td>
<td>ELHT</td>
<td>Surgery</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>435[4351]BGTH Theatres</td>
<td>BGTH</td>
<td>Surgery</td>
<td>145</td>
<td>131</td>
</tr>
<tr>
<td>435[4438]Ward 6 Day Case</td>
<td>BGTH</td>
<td>Surgery</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>435[4328]Elective Centre BGTH</td>
<td>BGTH</td>
<td>Surgery</td>
<td>49</td>
<td>44</td>
</tr>
<tr>
<td>435[4596]Dermatology Dept</td>
<td>ELHT</td>
<td>SAS</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>435[5189]RBTH Ophthalmology Outpatients</td>
<td>RBTH</td>
<td>Surgery</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>435[5119]RBTH Ward B20 - Vascular</td>
<td>RBTH</td>
<td>Surgery</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>435[6086]Oncology Med Secs</td>
<td>ELHT</td>
<td>Surgery</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>435[5378]Orthopaedics Fracture Clinics</td>
<td>OPD</td>
<td>RBTH</td>
<td>Surgery</td>
<td>23</td>
</tr>
<tr>
<td>435[5179]ENT Outpatients</td>
<td>RBTH</td>
<td>Surgery</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>435[5131]RBTH Theatres</td>
<td>RBTH</td>
<td>Surgery</td>
<td>139</td>
<td>117</td>
</tr>
<tr>
<td>435[5519]Elective Admissions</td>
<td>RBTH</td>
<td>Surgery &amp; Anaesthetics</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Ward</td>
<td>Number of Employees</td>
<td>Numbers Completed</td>
<td>Percentage Completed</td>
<td>Trust Target (95%) Met?</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Acute Care Team</td>
<td>24</td>
<td>20</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Orthoptic Services</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Ward 15</td>
<td>41</td>
<td>34</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Ward C14B</td>
<td>23</td>
<td>19</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Audiology Med Secs</td>
<td>11</td>
<td>9</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>RBTH Day Case Ward</td>
<td>22</td>
<td>18</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Surgical Divisional Management</td>
<td>10</td>
<td>8</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>RBH Audiology</td>
<td>9</td>
<td>7</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Surgery Trans Team</td>
<td>4</td>
<td>3</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Surgical Triage Unit</td>
<td>33</td>
<td>23</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>General Surgery Directorate Management</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>BGH Audiology</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>BGH Ward 11</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>&amp;N Dir Mgmt</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>Ward B22</td>
<td>40</td>
<td>21</td>
<td>53%</td>
<td>No</td>
</tr>
<tr>
<td>Urology Dir Mgmt</td>
<td>2</td>
<td>1</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Ortho Dir Mgmt</td>
<td>8</td>
<td>4</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Urology Medical Staff</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

From April 2017 to March 2018, 89% of staff within ophthalmology had received an appraisal. This compared to a trust target of 95%, however on inspection we were showed that the department had now met the trust’s target.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw team working between staff in theatres and wards and information was shared well between all teams.

Physiotherapists attended on ward 15 (orthopaedic) daily for the morning handover, led by the band seven nurse. Each patient was seen post-operatively by a member of the physiotherapy team.
Discharge was nurse led and on ward 15 (elective orthopaedic) the nurses worked with a multidisciplinary team which included; physiotherapists, occupational therapists and an advanced nurse practitioner. A collective discussion assessed the needs of the patient and whether they were medically fit for discharge. One consideration was the mobility of the patient and the physiotherapist would look at the patient’s ability to walk, whether they would require extra care at home, their rehabilitation and re-enablement. A trusted assessment document would be completed with input from the multidisciplinary team, prior to discharge. A letter was then sent to the patient’s GP.

Complex care managers were also involved in the discharge of patients, they were based in ward 16, but also covered ward 15.

**Seven-day services**

The physiotherapy service was available seven days a week; week days cover was 7am to 4.30pm and weekends and bank holidays were covered in the mornings by a physiotherapist and an assistant.

Occupational therapists were available only on weekdays from 8 to 4pm.

Pharmacy service were available five days week, Monday to Friday and out of hours, weekend and bank holidays were not covered. Management for ward 15 told us that they try to predict any patient discharges that may happen at the weekend and prepare in advance. It had not been an issue to date.

Surgical sessions at the hospital were arranged so each speciality had enough sessions each week for their surgery lists. Each specialty had at least one surgical session each week.

**Health Promotion**

All patients attending hospital for a hip or knee surgery had the opportunity to attend a class prior to operation. The ‘hip and knee school’ informed the patient of everything they needed to know pre-operation, during the operation and post-operation. It enabled the patient to be empowered and supported to manage their own health. From those who had attended at the school, feedback had been 99.9% positive and patients said they valued attending the school before going into hospital for hip or knee surgery.

A patient guide was issued pre-operatively for supporting patients’ recovery. The booklet covered guidance on being as fit as possible for surgery, this included sections on; smoking, eating a balanced diet and alcohol. The booklet was informative and easy to read.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

As all operations at Burnley General Hospital were elective, staff in theatres were made aware of any mental health issues with the patient, prior to surgery. The mental health liaison officer would link directly with the theatre team and when necessary come to theatres with the patient. They
would remain with the patient during anaesthetic procedures and be there in recovery for continuity. Family members, friends or carers would also be involved as much as possible.

At the time of our visit there were no patients on the post-operative wards at Burnley General Hospital with Deprivation of Liberty safeguards in place.

We were told of a recent case where a patient living with dementia had attended at Burnley General Hospital for elective surgery and had wanted to go home. A capacity assessment was carried out by the safeguarding team and a Deprivation of Liberty Safeguard application made.

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

Mental Capacity Act and Deprivation of Liberty training was covered in the safeguarding training. A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 at trust level for staff in surgery is shown below.

The trust has not included any staffing group data with their training return, so the data cannot be broken down into the nursing and medical staff groups.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>1,574</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>1,567</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We spoke to 12 patients during our visit and they all told us staff treated them well and with kindness. One patient we spoke with was waiting to be discharged and told us staff were ‘lovely, happy and attentive’.

Staff were considerate to the needs of family as well as patients. Staff gave an example of a mental health patient who had wanted his mother to stay with him over night, after an operation. The nurses on ward 15 prepared a four-bedded bay that was no longer used, enabling the patient and mother to sleep next to each other in privacy and without disturbing other patients.

During our visit we saw a patient who appeared confused and there was no indication on their notes for this. We brought it to the attention of staff who then periodically went to talk to the patient in a respectful and considerate way, monitoring her condition.

The ophthalmology unit was using a corridor on the ward as an area for eye tests, therefore other patients on the ward could see and hear the procedure. The same corridor was a waiting area for the consultation rooms and at the far end three secure filing cabinets stored patient notes for access by the ophthalmology secretaries. This did not provide privacy and dignity to the patients undergoing the examination.
Emotional support

People were given appropriate and timely support and given time to recover before discharge. Staff provided emotional support to patients to minimise their distress. Play specialists were available to accompany children to theatres and escort them to the ward after. We saw a child being prepared for surgery during our visit. Staff communicated appropriately with the child and everything was explained in an age appropriate manner.

Understanding and involvement of patients and those close to them

Staff communicated well with people so they understand their care treatment and condition and gave advice when they needed it. All six patients we spoke to on ward 15 told us they had been given sufficient information pre-operatively to understand their condition and the procedure.

Patients’ carers, advocates and representatives, including family members and friends, were identified and welcomed to accompany patients who needed additional support, to the theatre and could remain with them in the aesthetic room. Staff in theatres told us, they tried to make family members or carers feel part of the team and would always ensure the support was waiting for the patient in recovery.

Is the service responsive?

Service delivery to meet the needs of the local people

The service planned and provided services in a way that met the needs of local people.

The ophthalmology department was open until 8pm to accommodate patients who could not attend in the working day.

All wards we looked at had good, clear signage for toilets and shower areas. Male and female signs were easily identifiable. We also saw dementia friendly clocks, displaying the day and date as well as the time.

Ward 15 supported the NHS initiative of ‘dressed is best’ to encourage patients to get dressed and get moving, which aims to speed-up patients’ recovery and reduce the length of time people need to spend in hospital. The service also had an; ‘#EndPJParalysis’ initiative. Friends and family of patients were asked to support by ensuring the patient had a change of clothes in hospital, not just their pyjamas.

Ward 15 had a number of volunteers working on the ward who carried out a varying role, assisting with handing out drinks to patients, cleaning and communicating with them.

Information was provided in the ‘patient guides’ about being mobile after the operation and for each post-operative day, listed exercises and goals. On the walls of ward 15 were markers indicating the distance along the corridors so patients were aware of how far they had walked.

The ophthalmology unit had two private side rooms for patients and their carers to wait if they needed privacy or were anxious waiting with other patients.
Average length of stay

Trust Level – elective patients

From April 2017 to March 2018, the average length of stay for all elective specialities exceeded the England average.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust higher than the England average in all specialities except urology. For urology the trust had an average length of stay slightly under the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Burnley General Hospital - elective patients

From April 2017 to March 2018 the average length of stay for elective patients at Burnley General Hospital was better than the England average, other than in breast surgery where it was the same as the England average.

Elective Average Length of Stay - Burnley General Hospital
Burnley General Hospital - non-elective patients

The average length of stay for all non-elective surgery patients at Burnley General Hospital was 1.4 days, which is lower compared to the England average of 4.9 days. The average length of stay for vascular surgery non-elective patients at Burnley General Hospital was 0.2 days, which is lower compared to the England average of 10.7 days. The average length of stay for breast surgery non-elective patients at Burnley General Hospital was 2.5 days, which is lower compared to the England average of 3.9 days.

Non-Elective Average Length of Stay - Burnley General Hospital

Meeting people’s individual needs

The service took account of patients’ individual needs.

On ward 15 all nurses were a link nurse in one area, this included; dementia, mental health, medicine management and tissue viability. Their role as a link nurse was to update the staff of any changes to policy and procedure, new finding or guidance. A file for each link nurse, containing information on their specialist area, was kept in the staff room on the ward.

The wards used the butterfly scheme to identify patients with dementia. A butterfly symbol was placed above the bed of a patient and a white butterfly with a blue outline, indicated that the patient showed signs of dementia and a solid white butterfly showed that the patient had received a formal diagnosis of dementia. This ensured that staff were responsive to the patient’s needs.

When a falls assessment had been carried out, the ward used a ‘leaf’ system for easy recognition of a patient’s vulnerability to falls; a picture of a brown leaf was placed above the patient’s bed if they were at risk of falls and if the patient had had a fall, a red leaf was displayed.

Volunteers who worked with ward 15 operated a welcome home service and ensured that the patient’s homes were warm and fridges stocked with essentials for people on discharge.

The service had access to interpreters and telephone interpretation services for those whose first language was not English. In the urology investigation unit an interpreter, if necessary, was booked in advance by the ward clerk on receipt of the patient’s notes. On referral to the
admissions centre, the need for an interpreter would flag up on the patient’s notes and the interpreter would also be arranged to be in attendance on the day of surgery.

In the recovery ward we saw a new paediatric bay to accommodate three children. The staff were passionate about making it child friendly and private from adult patients. They had trialled various partitions to meet both criteria.

There were separate corridors for male and female patients to walk from the waiting rooms to the elective theatres.

The post-surgery wards at Burnley General Hospital did not have patients that required one-to-one nursing, which included patients living with dementia who may wander confused, therefore patients living with dementia were nursed at Blackburn.

The staff in theatres were made aware of any patients requiring bariatric equipment via the pre-operation assessment unit, in adequate time to prepare and order bariatric day care trolleys.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

We were told by management that there were very few cancelled operations at Burnley, which was reflected in the data provided. A theatre productivity and efficiency programme was on going which was looking at various problems that caused cancellations. The process mapping looked at; pre-operative assessment, the admission process, schedules and theatre flow. The current process was to schedule the list six weeks in advance, for a six-week list. We were informed that the problems occurred as the list was ‘locked down’ at two weeks and changes could only be made by the operations and general manager. The list did however remain open for cancer patients at short notice. We were given the example of theatres for urology running at 140% the week of our visit, because of this over booking of operations, this caused over running in theatres and delays for patients. Any delays due to this were incident reported.

If surgery was cancelled other than for a medical reason, the business manager was informed and the operation re-listed. The waiting list clerk would ensure that the cancelled patient was relisted within 28 days.

When theatre lists were changed they were re-printed on pink paper, in place of the usual white paper, ensuring all relevant staff were aware that the list for the day had changed.

On the ophthalmology ward patients waited for a pharmacist to attend to discuss their medication, prior to being discharged.

We looked at the theatre utilisation for all theatres at Burnley, between September 2017 and August 2018 and figures ranged from 75-78% which was good.

NHS England advises that patients whose operation is cancelled should be offered another binding date within a maximum of 28 days. The percentage of patients whose operation was cancelled by the hospital for non-clinical reasons and were not treated within 28 days was consistently better than the national average.

Nurses were extremely confident in discharge procedures as the wards were nurse led.
Referral to treatment (percentage within 18 weeks) - admitted performance

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average. The most notable departure from the average being a 7% dip below the average in October 2017.

(Source: NHS England)

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

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>78.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.8%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>67.6%</td>
<td>60.4%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>67.7%</td>
<td>76.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>60.3%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>50.0%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The trust performed better than the England average for the entire reporting period, with the percentage of cancelled operations consistently below 5%.
Percentage of patients whose operation was cancelled and were not treated within 28 days - East Lancashire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed a worse performance than the England average. In both 2016/17 and 2017/18, the trust's performance worsened from quarter three to quarter four. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

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. At Burnley General Hospital ‘Feedback Friday’ meetings discussed updates from the board, equipment issues and any complaints or concerns, this was attended by all staff on duty.

‘Message of the day’ also shared immediate learning and informed staff, via the intranet, of recent incidents, complaints and topical issues.

Summary of complaints

From April 2017 to March 2018 there were 52 complaints about surgical care. The trust took an average of 75 days to investigate and close complaints. This is not in line with their complaints policy which states complaints should be resolved within 50 days.

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

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Leadership within the surgical division was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

The ophthalmology unit at Burnley General Hospital was overseen by a matron who also managed wards at Blackburn. In their absence the unit was managed by band six and/or band seven nurses. The nurses completed the rotas for the unit six weeks in advance, although they did not attend the theatre list schedule meeting.

We were told by managers at Burnley General Hospital that they felt they had a good senior leadership team, who had on occasions attended band seven and eight nurse meetings. They had also seen members of the team participating in the ‘Back to the floor’ initiative, to enable senior and junior staff to mix in less formal settings; this included the director of finance and the director of nursing.

The chief executive communicated with staff via social media in a closed page and had a weekly blog to link in with staff.

Management at Burnley General Hospital told us that the senior leadership team had an ‘open door policy’ and they were approachable to communicate with.

The matrons and ward managers we spoke with understood the challenges to quality and sustainability and were always thinking ahead. They were open to new challenges and supported their staff in going forward.

All staff we spoke to at Burnley General Hospital said they were confident to approach their leaders and were not afraid to report matters, or put suggestions forward.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The trust’s vision ‘to be widely recognised for safe, personal and effective care’ was displayed in prominent public and staff areas, including the education centre.

The hospital’s ophthalmology unit and theatres were struggling with their layout and location to each other. Work was being carried out to construct a brand-new building to host the ophthalmology department in its entirety. Staff had been told the move would not be for 12 months, but they felt issues with the environment would be resolved by the move.

A projected plan was underway for a new ward at Burnley. Managers told us that Ward 19 would be predominantly to accommodate patients during the winter pressures and would be up and running by November 2018. The ward would hold 24 beds and patients would be medical patients, but the ward would come under the surgical division. The vision was to further expand this ward by 2019 to 48 beds.
We were told that operations for ophthalmology patients were occasionally cancelled due to the patients’ eyes not dilating in time for the surgery, after the drops had been administered. Management told us they would like to see pellets being used in patient’s eyes. These are very fast acting, are better for the patients, better for infection control and the theatre list would not be disrupted. However, the drops were expensive and the use was being considered by the finance department.

Ways to improve the efficiency of the theatre lists in ophthalmology were being reviewed and a vision was to remove minor operations, such as skin tags and stents, from the theatre list and these procedures would be carried out in the clinics.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke to at Burnley General Hospital felt supported, respected and valued. One junior nurse told us that they were very supported by management when they went through a difficult time, they felt that they went over and above what was expected.

Staff told us that they were listened to by management and could provide ideas and feedback and they were acted upon.

There was a strong emphasis on the safety and well-being of staff. In ophthalmology two of the top risks for the department were about the welfare of staff; lone working and stress. Management told us that they had concerns about lone working as when the unit was open late there were no other units open in the hospital. The concern regarding stress was due to high workloads, though they had no staff sickness on the ward in ophthalmology.

There was a good approach to managing staff stress and anxiety through ‘employee assist’. All staff were issued with an information cared and telephone contacts to access support. Occupational health also provided mindfulness and counselling sessions.

The trust had a freedom to speak up guardian, who was a nominated person staff could speak to confidentially and staff were aware of how to contact them.

**Governance**

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Monthly governance meetings were held at a divisional level where patient stories were shared for learning, route cause analysis, risks and incidents. This meeting was attended by the surgery governance leads.

Directorate of trauma and orthopaedics meetings were held monthly and patient safety and risk were discussed, the matron and ward manager attended this meeting. Outcomes from this
meeting were then fed down to the monthly directorate governance meeting and amongst others, were attended by all band sevens, theatre representatives, physiotherapists and occupational therapists. At a recent meeting a surgery never event was discussed which resulted in a new initiative; ‘ID Me’. This involved posters and leaflets reminding staff to check patient’s wrist bands.

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 surgery division had a ‘risk register’ which highlighted areas of risk to the running of the service. This register comprised of 446 individual risks, 28 of these scored a risk rating of 10 or above. These included risks such as staffing, lack of speciality doctors and failures in divisional performance. Surgical division risks were also captured on the trust wide risk register. Each item on the register was allocated to a department but did not include the name of the individual with designated responsibility of the risk, nor review dates or how long the item had been on the risk register and whether progress had been made on those risks.

Because of the ‘five steps to safer surgery audits’ we saw examples of action plans to reduce further issues and risks. The action plans were concise and showed actions for each risk that were specific, measurable, achievable, relevant and timely. The action plan was easy to read and used traffic light (red, amber, green) ratings. One action we saw for March 2018 was due to a surgeon not being present at the de-brief, the action was to remind all teams about conducting the de-brief before the surgeon leaves the theatre. The evidence showed this had been discussed in the morning huddles and at the team briefs. All action plans were up to date.

The division was aware of its position regarding referral to treatment times and monitored these by speciality. These were discussed in regular performance meetings with divisional managers. Each speciality had an ongoing plan to address any underperformance in referral to treatment times, these were based on short term actions and longer term transformational change. Some examples included the development of ear, nose and throat nurse specialists, reconfiguring services and reviewing job plans. There was also work with the clinical commissioning group colleagues to understand future demand.

The service was working through a theatre productivity and efficiency programme which had seen some positive improvements in performance. This programme was ongoing and plans were in place to continue to build on the progress made, these included launching new events such as ‘lean’ initiatives to seek further improvements in performance and culture in theatres.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust and division collected, analysed, managed and used information well to support its activities. Where these were electronic they used secure systems with security safeguards. There was satisfactory access to terminals and mobile computers to enable staff to access the systems.
Staff had access to the trust intranet which provided a range of internal and external resource materials to assist staff in their day-to-day tasks. Staff also used the system to access training and development information and courses. The used the electronic system to request diagnostics, specialist nurse and speciality referrals such as tissue viability and dieticians.

Ward and department managers had access to various information sources such as staffing and human resources information, equipment and stock information and audit results and performance dashboards to enable them to manage the day-to-day running of their services and offer areas for improvement. The theatres dashboard highlighted details of cancelled operations and theatres utilisation to advise managers of the current performance and support decision making. There were also reports to aid the facilitation of patients with cancer though the pathways.

The trust business intelligence service developed reports to review system management and quality of performance such as nursing assessment performance framework results. The service told us they were working with information technology designers to enhance the use of such systems.

The trust had a ‘share point’ site where useful information could be found such as policies, standard operating procedures and policies. The trust was attempting to achieve a ‘three clicks’ system whereby any information could be found within their intranet system in a maximum of three clicks.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The surgery division was an active member of the local sustainability and transformation plan or integrated care system, they discussed strategies for closer working and alignment of services. The division participated in the North-West surgery and theatre networks, sharing good practice and developments and formulated cross site care bundles.

The service visited other health care providers to see what aspects of care delivery they could use within their own service.

Staff we spoke to felt that that their views were reflected in the planning and delivery of services. A staff guardian was available in HR for staff to speak to, however staff told us that they had not had cause to speak to them as issues were resolved directly with staff. Recently staff were invited for an informal discussion with managers to air grievances.

Feedback Friday was an opportunity for leaders to listen to staff and these sessions were unique to surgery theatres only.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
In December 2016 the Orthopaedics hip and knee school was opened at Burnley General Hospital and was shortlisted for a Nursing times award. There was also evidence that better informed patients gained benefit from taking a more active role in their post-operative recovery.

Share to care’ booklets were disseminated amongst staff periodically. We saw a copy during our visit which gave detailed accounts as to the recent never events and learning for all departments from the events.

The trust has signed up to the ‘vital signs’ programme through NHS Improvement. This was an initiative in which seven trusts came together as a network to share best practice around ‘lean methodology’, a system which aims to improve the quality of patient care; improve safety; eliminate delays and reduce lengths of stay.

There was a divisional transformation team who supported the implementation of change and encouraged continuous improvement. The team had been part of the restructuring of the surgical services when the elective centre at Burnley General Hospital was established.

The 10,000 feet initiative received external recognition when it won a patient safety award in 2018.
Urgent and Emergency Care

Facts and data about this service

Urgent and emergency services are provided through an Emergency Department on the Royal Blackburn Hospital site, Urgent Treatment centres at Royal Blackburn Hospital and Burnley General Hospital, and a Minor Injuries Unit at Accrington Victoria Hospital.

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

The emergency department for East Lancashire Hospitals NHS Trust is located at the Royal Blackburn Hospital site. The hospital operates a 24-hour accident and emergency department for both adults and children. The service is managed by the integrated care group division of the trust.

The department has a reception area and separate ambulance entrance. The children’s emergency department shares the reception but has a separate waiting area and treatment rooms. There is one room dedicated to managing mental health patients brought to the department under the Mental Health Act, within the major’s area. There is also an urgent care centre which is part of the accident and emergency department.

It provides services for people across East Lancashire including Burnley. Patients attending Burnley General Hospital urgent care centre who require treatment in an emergency department are transferred to Royal Blackburn Hospital by ambulance. Between 130 and 140 ambulances arrive at the emergency department each day.

During the inspection we visited all areas of the emergency department including majors and resuscitation. We visited the children’s emergency department and the urgent care centre.

We spoke with 19 members of staff including senior managers, departmental managers and doctors as well as registered nurses, allied health professionals and health care assistants. We also spoke to 13 patients and relatives.

We observed care and treatment and looked at 22 patient care records and two medicine administration charts as well as service performance data.
Activity and patient throughput

Total number of urgent and emergency care attendances at East Lancashire Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018

From July 2017 to June 2018 there were 172,034 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: NHS England)

The emergency department reported a total of 44,293 attendances between September 2017 and August 2018 as follows:

(Source: Additional Document Requests)

The urgent care centre reported a total of 66,868 attendances between September 2017 and August 2018 as follows:
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In 2016/17 the proportion was higher than the England average. (Source: NHS England)

The emergency department reported 25,317 attendances resulted in admission between September 2017 and August 2018 as follows:
The urgent care centre reported 9,820 attendances resulted in admission between September 2017 and August 2018 as follows:

(Source: Additional Data Requests)
### Urgent and emergency care attendances by disposal method, from April 2017 to March 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>35,375</td>
</tr>
<tr>
<td>Discharged*</td>
<td>92,729</td>
</tr>
<tr>
<td>Referred*</td>
<td>29,795</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>945</td>
</tr>
<tr>
<td>Died in department</td>
<td>210</td>
</tr>
<tr>
<td>Left department#</td>
<td>12,494</td>
</tr>
<tr>
<td>Other</td>
<td>486</td>
</tr>
<tr>
<td>Not known</td>
<td>486</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

### Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.

### Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training modules included basic life support, conflict resolution, infection prevention and control, equality diversity and human rights, fire safety, health safety and welfare, information governance and safer handling.

Staff completed training online via the trust ‘learning hub’ which gave access to all online mandatory training and course bookings. Staff were sent an email reminder of any training which was due and the practice educators received a copy of this email. The service had two practice educators, a children’s nurse and an adult’s nurse who co-ordinated training for staff and delivered additional training and induction for all staff.

Practice educators reviewed compliance with core mandatory training monthly and followed up overdue training with staff. At the time of our inspection compliance with mandatory training was 94.1%. The trust target was 90%.

### Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.
The service provided the following updated information on mandatory training compliance rates for all staff in urgent and emergency services across all sites:

<table>
<thead>
<tr>
<th></th>
<th>Basic Life Support</th>
<th>Conflict resolution</th>
<th>Equality, diversity and human rights</th>
<th>Fire Safety</th>
<th>Health, safety and welfare</th>
<th>Infection prevention and control</th>
<th>Information governance</th>
<th>Safer handling theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. compliant</td>
<td>159</td>
<td>183</td>
<td>180</td>
<td>177</td>
<td>182</td>
<td>181</td>
<td>144</td>
<td>174</td>
</tr>
<tr>
<td>No. non-compliant</td>
<td>17</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Total staff</td>
<td>176</td>
<td>184</td>
<td>184</td>
<td>184</td>
<td>184</td>
<td>184</td>
<td>184</td>
<td>184</td>
</tr>
<tr>
<td>Percentage</td>
<td>90</td>
<td>99</td>
<td>98</td>
<td>96</td>
<td>99</td>
<td>98</td>
<td>78</td>
<td>95</td>
</tr>
</tbody>
</table>

The service recognised that compliance with information governance was below the internal trust target and told us it had plans to address this through line managers in the department and allowing staff to take time out of clinical duties to complete the training. Records we reviewed confirmed that managers monitored individual compliance with mandatory training in the annual appraisal with staff.

Staff we spoke with told us they were given enough time to do mandatory training and other learning. We saw compliance with mandatory training was displayed on the corridor in the staff area along with a list of all training courses booked and who was attending in the next three months.

Staff received training in life support and cardiopulmonary resuscitation and in paediatric life support. All registered nurses working in the paediatric emergency department had received advanced paediatric life support training or paediatric basic life support training appropriate to their role. Staff undertook advanced life support or intermediate life support training to staff as appropriate to their role. Staff told us that those on higher grades who had completed advanced life support training did not have to complete intermediate life support training.

The service had staff with advanced life support training on each shift and ensured there were sufficient staff trained. We viewed training records and saw the percentage of total staff who had completed the different levels of training as follows.

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Percentage of total staff trained at end August 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced life support</td>
<td>47%</td>
</tr>
<tr>
<td>Advanced paediatric life support</td>
<td>32%</td>
</tr>
<tr>
<td>Intermediate life support</td>
<td>77%</td>
</tr>
<tr>
<td>Paediatric intermediate life support</td>
<td>77%</td>
</tr>
</tbody>
</table>
We saw training records that showed 50% of staff had received trauma simulation training. Staff told us the service had developed its own training which had been sent to the North-West trauma network for approval. The service had funded ten places on the trauma nurse core course (TNCC), an internationally recognised standard of trauma education for nurses. Three staff had completed the course and two started in September 2018, there were plans that all ten staff would complete the course by March 2019.

**Safeguarding**

There were clearly defined and embedded systems, processes and standard operating procedures that were appropriate for the care setting and understood by staff.

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.

In June 2018 the Royal College of Paediatrics and Child Health – Safeguarding Children and Young People Roles and Competencies for Health Care Staff intercollegiate document enhanced its minimum standard to ensure clinicians had greater competency, understanding and knowledge. Clinical staff working with children and young people, parents and carers should be trained to level three in children’s safeguarding. The service set a target of 90% compliance with level three safeguarding children training. At the time of our inspection the compliance rate was 89.21%. Staff could access senior paediatric consultant opinion 24-hours a day through an on call and bleep system.

We spoke with five staff who told us they also received level three safeguarding adults training which included training the Mental Capacity Act and Deprivation of Liberty Safeguards. We spoke to the safeguarding team who confirmed this was included in level two safeguarding adults and level three safeguarding children training. The service also provided additional bespoke training. Staff could access safeguarding information and resources through the intranet page.

**Safeguarding training completion rates**

The service provided the following updated information on safeguarding training compliance rates for all staff in urgent and emergency services across all sites:

<table>
<thead>
<tr>
<th></th>
<th>Prevent (including radicalisation)</th>
<th>Safeguarding adults</th>
<th>Safeguarding children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. compliant</strong></td>
<td>183</td>
<td>178</td>
<td>151</td>
</tr>
<tr>
<td><strong>No. non-compliant</strong></td>
<td>1</td>
<td>6</td>
<td>53</td>
</tr>
<tr>
<td><strong>Total staff</strong></td>
<td>184</td>
<td>184</td>
<td>184</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td>99</td>
<td>97</td>
<td>82</td>
</tr>
</tbody>
</table>

(Source: Additional Document Requests)
The service acknowledged it had not reached its 90% target for safeguarding children training but had plans to allocate off duty time for staff to do this training.

The service had appropriate systems, policies and procedures to assist staff to identify patients at risk of harm, neglect or abuse. These were available to staff on the online ‘Oli’ system. We saw that discussion on safeguarding vulnerable patients was a standing agenda item on the daily emergency department and urgent care centre safety huddle.

Staff could access additional advice and support from the trust safeguarding team. Staff we spoke with could tell us how they would escalate any safeguarding concerns to managers and the safeguarding team and knew how to make a safeguarding referral. Staff were organised into groups based on areas of special interest. One group led on safeguarding and staff in this group acted as champions for safeguarding issues and training in the department.

**Cleanliness, infection control and hygiene**

There were systems in place that minimised potential error, reflected best practice and were consistently understood by staff.

The service controlled infection risk well and used controls measures to prevent the spread of infection. For example, during our inspection we saw a patient with loose stools was kept on the ambulance until a cubicle could be found. This was line with trust policy to prevent the spread of infection within the department.

The department had alcohol hand gel dispensers at the entrance and exit points to all main areas. Hand gel dispensers were also available inside each cubicle. Staff had access to personal protective equipment when needed.

During our inspection we saw staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed ‘bare below the elbows’ guidance. However, we reviewed the hand hygiene audits from May, June and July 2018 and the audit demonstrated that compliance with standards of hand hygiene had fallen from 60% in May 2018 to 42% in July 2018. This meant that the service could not be assured that all staff consistently observe best practice in hand hygiene before and after providing care.

The service used green ‘I am clean stickers’ on equipment to indicate that it had been cleaned that day and was ready for use. We saw these on equipment in all areas of the department including the paediatric emergency department. We saw staff used surface wipes to wipe down equipment and trolleys before being used by the next patient.

During our inspection we saw domestic staff on the department at all times and saw they dealt with unexpected spillages immediately. They displayed signs to indicate cleaning was in progress and to warn patients, visitors and staff of spillages and wet floors.

Staff told us that practice educators did spot check audits and observations of hand hygiene and personal protective equipment use and sent the outcomes of this by email. We reviewed infection control audit records for May, June and July 2018 that confirmed the hand hygiene audit had been completed monthly.

We reviewed the outcomes of infection prevention and control audits for May, June and July 2018. We saw that spot check on commode cleaning demonstrated 100% compliance with required standards. The environment audit showed 79% compliance with standards in May 2018, 80% in June 2018 and 70% in July 2018.
Staff completed daily cleaning checklists. However, the checklist in the fluid storage room had not been completed on several dates and there was visible dust on the shelves and floor.

**Environment and equipment**

The accident and emergency department was beside the main entrance of the hospital and close to car parks. It had a drop off area for ambulances and a helipad opposite the entrance.

The waiting area was large and provided seating for a large number of people. This was important as we noted that the department was busy throughout our inspection. A large screen displayed information on approximate waiting times to be seen for triage and expected length of time patients may stay in the department.

The department had a single reception area for all outpatient clinics. However, there was a designated paediatric waiting area which was only accessible by a buzzer activated by staff. This provided a secure and separate space away from the adult area for anyone up to the age of 18. The children’s waiting area had toys and books for the children to use and a television showing children’s programmes.

The three treatment rooms in the paediatric emergency department were brightly decorated with colourful murals on the walls and ceilings to help distract the children. All the toilets in the department had call bells and a baby change facility was available.

However, staff in the paediatric emergency department told us that space was limited and at busy times children had to wait in the small corridor in the department on plastic chairs. They also told us the paediatric observation and assessment unit was on another level of the hospital. This meant a nurse often had to accompany a child and parents during transfer to prevent them becoming lost leaving the department temporarily short staffed. The department did not have any cots suitable for babies only trolleys.

The emergency department had an eight-bed resuscitation area with one cubicle designated as the paediatric resuscitation area. Paediatric and adult difficult airway trolleys were available in the resuscitation area. These were clearly labelled and sealed and we saw that staff completed daily checklists.

We checked resuscitation trolleys in paediatric emergency department, the urgent care centre, major’s area and resuscitation area. They were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. Staff carried out weekly checks of the drawer contents and daily checks of the defibrillator. They recorded when the seal had been broken and the serial numbers of seals used. We saw that any incidents of missing equipment had been escalated appropriately.

However, we also found that the drawer on the resuscitation trolley in the paediatric emergency department was difficult to open. Staff told us this had been reported and a new trolley requested.

The environment in the resuscitation and major’s areas and urgent care centre was clean and fit for purpose. The resuscitation area was easily and quickly accessible via large push pads to open wide doors which a trolley could easily pass through.

There was a relative’s room which was clean and bright and contained two reclining chairs. We observed staff using the room to talk to relatives.
The service stored fluids such as glucose and sodium chloride in a locked room. We checked the boxes of fluids and found they were all in date.

The department had two waiting rooms for patients who had been assessed as ‘fit to sit’. The room in the urgent care centre had a call bell for patients to summon help if they became unwell. However, the floor was visibly dirty and a chair with an out of order sign on was stored in the corner. The room in the major’s area did not have any call bells and was cluttered, with equipment stored in the corner.

Other than the paediatric emergency department all areas of the department were accessible from the reception, ambulance entrance or main hospital without swipe or key code access. Staff told us they sometimes felt unsafe as distressed and volatile patients could access all areas of the department. During our inspection we observed volatile mental health patients leaving the mental health assessment room and walking through the department shouting and approaching staff and patients.

Senior managers told us the emergency planning officer for the trust had walked the department to identify issues with the environment and security. This had led to them approaching the company which owned the building to request they reinstate a locked door between the urgent care centre and major’s department to prevent patients from accessing areas they did not need to. The department had access to security 24-hours a day but did not have a dedicated security presence. Managers also told us they were negotiating with the sub-contractor to provide this in line with the current contract.

The service had arrangements for the routine maintenance of medical devices. We saw they maintained comprehensive registers of equipment which showed when they had been serviced and when the next planned preventative maintenance was due.

The department had one room designated as a secure mental health assessment room. The room was discreet and could not be immediately identified as a mental health assessment room. It was minimally furnished with two sofa benches secured to the wall and floor. There were two doors which opened both ways and the room could easily accommodate four people. The doors had glass observation panels, however there was a blind spot from one of the panels. The room was ligature free but did not have a call bell. Patients using the room could easily leave and access other areas of the department.

Managers told us that cubicles had been ligature assessed for patients experiencing mental ill health and fitted with curtain rails that were designed to snap if used as a ligature point.

**Assessing and responding to patient risk**

The service planned for emergencies and staff understood their roles if one should happen. The service had a major incident plan and staff told us that they practiced major incident scenarios and decontamination. The major incident file was kept in the central hub and was easily accessible to all staff.

The service had a clear triage process based on the Manchester Triage System. The system is widely used across the country to evaluate a patient’s condition and determine their priority for admission to and treatment in the emergency department.

The rapid assessment triage area was staffed at all times by two registered nurses and a healthcare assistant. We reviewed 17 patient care records and saw that 12 patients had been
triaged within 15 minutes in line with national guidelines. In the urgent care centre patients were triaged by a nurse using the same Manchester Triage System and streamed to cubicles to be seen by a doctor.

We observed three triage assessments using these principles and saw it was thorough and detailed.

Staff took observations of the patient’s condition and calculated their early warning score (EWS). EWS is used to monitor patients and recognise any deterioration in their condition. The observation chart contained clear guidelines for staff to escalate high EWS scores. It also had a prompt to screen patients with potential infection with the sepsis care bundle.

Staff asked about patients’ pain and used a standardised tool to identify and assess patients pain levels.

Staff assessed patients’ risk of falling and used a leaf symbol to indicate this. A laminated sheet with an amber leaf was placed in the cubicle of patients at risk of falling so staff could quickly and easily identify them. A red leaf was displayed if the patient had fallen in the department.

We saw all triage assessments were recorded on a rapid assessment triage intervention sheet. The triage assessment identified patients who required blood tests, x-rays, cannula and electrocardiogram scans. It also identified patients who required specific clinical care bundles such as sepsis and chronic obstructive pulmonary disease bundles to be put in place.

During our inspection we observed the care of a patient with a suspected stroke. They were given a computed tomography (CT) scan within 10 minutes of arrival in the department. This is important because it allows staff to identify a stroke quickly and start appropriate treatment.

There was a resuscitation area in the department which was used to manage medical emergencies. This area had a total of eight beds and was equipped to provide treatment to both adults and children. One bay was designated as the children’s resuscitation bay and staff told us a nurse would attend this from the adjacent paediatric department if a child required resuscitation. There was an additional resuscitation trolley in the paediatric emergency department which could be used if the designated bay was in use.

The department ensured that staff were available who were trained in paediatric life support. We saw 77% of nurses were trained in intermediate paediatric life support and 32% in advanced paediatric life support.

**Emergency Department Survey 2016**

The trust is “about the same” as other trusts for all five 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>7.5</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>5.4</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.</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
From the time you arrived, how long did you wait before being examined by a doctor or nurse?

| Q33. In your opinion, how clean was the emergency department? | 8.5 | About the same as other trusts |
| Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? | 9.3 | About the same as other trusts |

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

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

The median time from arrival to initial assessment was worse than the overall England median in six months over the 12-month period from July 2017 to June 2018.

**Ambulance – Time to initial assessment from July 2017 to June 2018 at East Lancashire Hospitals NHS Trust**

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

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust Royal Blackburn Hospital Lancashire**

From July 2017 to June 2018 there was an overall stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Blackburn Hospital Lancashire. Performance degraded between November 2017 to January 2018, with the percentage increasing to a high of 71% in January 2018, with performance improving in February and dropping to 53%, before stabilising around 60-65% for the rest of the reporting period.
**Ambulance: Number of journeys with turnaround times over 30 minutes - Royal Blackburn Hospital Lancashire**

![Bar chart showing the number of journeys with turnaround times over 30 minutes from July 2017 to June 2018.]

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Royal Blackburn Hospital Lancashire**

*Jun-17*

![Line chart showing the percentage of journeys with turnaround times over 30 minutes from July 2017 to June 2018.]

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From May 2017 to April 2018 the trust reported 1,865 “black breaches”.
The service had developed a 12-month action plan to improve rapid assessment triage and reduce ambulance handover times and the number of black breaches. Senior leadership met fortnightly with the local ambulance service to identify appropriate actions to reduce the time patients waited for triage and reduce the potential risks to patients waiting for triage.

An Ambulance Liaison Officer from the local ambulance service worked in the department from 11am to 11pm seven days a week. Their role was to oversee the streaming of patients to triage and monitor patients waiting for triage ensuring that any patients who deteriorated whilst waiting were escalated. Senior managers told us since introducing this initiative black breaches had improved by 30%.

If there were five patients or less waiting the ambulance crew left the patient under the supervision of the ambulance liaison officer and triage nurse in line with trust policy. During our inspection we saw ambulance crews waiting with patients on trolleys and wheelchairs in the corridor when there were more than five patients. The service told us they had seen an improvement in ambulance handover times and at the time of our inspection the average handover time was 15 minutes.

However, we saw some patients had to wait with ambulance crews or under the supervision of the ambulance liaison officer for over one hour before seeing a practitioner in rapid assessment triage. Managers told us they had plans to improve ambulance handover times by introducing consultant led rapid assessment triage. They stated they planned to increase the number of consultants so rapid assessment triage would be implemented in the new ambulatory and emergency care unit. The unit was due to open at the end of September 2018 and we saw that building works were almost complete

During our inspection patients received care and treatment on trolleys on the corridors. The service had implemented a standard operating procedure for a ‘corridor safety traffic light system’ to manage patients in this area. The service did not have any other standard operating procedure for placing or managing patients on the corridor in the department.
The ‘corridor safety traffic light system’ of red, amber and green cards enabled staff to identify how long patients had been on the corridor and when patient observations were required. The service had an additional nurse on each shift who provided care and treatment to patients on trolleys in the corridors. Each corridor was colour coded so staff could easily locate patients.

We reviewed the standard operating procedure for the traffic light system for maintaining the safety of patients nursed in the corridor and saw it was still waiting approval. Following our inspection, the service told us this procedure had been ratified. The procedure stated that patients who were assessed as stable with an early warning score of less than 3 could be suitable to wait on the corridor. It did not include other criteria such as if the patient has additional needs including mental health or dementia. The procedure clearly outlined that observations should take place hourly and any patients on the corridor longer than two hours should be escalated to the nurse in charge.

However, we saw several occasions when patients were cared for on the corridor and the traffic light system was not used. During our inspection the corridor was staffed by an agency nurse who was not able to explain the system and the standard operating procedure. This meant there was a risk that it would not be followed. We spoke to two patients on the corridor who had been there for over two hours and stated they had not spoken to a nurse or doctor since initial triage.

Patients cared for on trolleys in the corridor were not always in a direct line of sight of staff and did not have access to call bells to summon help if they became unwell.

After triage some patients were assessed as ‘fit to sit’ and waited in a designated room. There were no call bells in this room meaning that patients could not summon help if they became unwell. Staff we spoke with told us they felt this was a risk to patient safety.

Staff told us they held board rounds every two hours to discuss all patients including those on corridors. These were recorded in safety huddle checklists. We observed a board round and saw that patients being cared for on corridors were discussed. We reviewed the safety huddle checklists for six randomly selected dates between June and August 2018. We saw the checklist was completed consistently every two hours for patients in resuscitation and major’s areas. However, checklist completion for corridor areas was inconsistent with no checklist completed for four of the six days. The checklist had only been completed once on one date and eight times on the other. This meant the service could not be fully assured all patients cared for on the corridor were discussed in every two-hourly board round.

During our inspection we saw vulnerable patients were cared for on the corridor. We saw an elderly patient with dementia placed on the corridor directly opposite the mental health assessment room which was being used by a patient waiting for a mental health assessment. This patient was agitated and approached the inspector several times asking for assistance. They had several bags of property which staff told us had not been checked. This meant that there was a risk to the personal safety of vulnerable patients in the department.

The service had access to a security team who were available 24-hours a day, seven days a week. Staff informed us security were responsive and attended quickly when needed. We observed security staff attending and staying in the department when needed to monitor patients.

The service had a mental health pathway which used a red, amber and green system to assess risk. This was followed up with an action plan and referral to the mental health liaison team if appropriate. The mental health liaison team was available through a bleep, seven days a week over 24 hours. The liaison team also worked at the urgent care centre at Burnley General Hospital and staff told us this meant there was sometimes a delay in specialist staff attending to carry out a mental health assessment as they travelled between sites.
We reviewed the care notes of a patient living with mental health issues, who had been in the department for two days. We saw they had a care plan and food and drink was documented. We saw observations had been completed until 7.30 am however, no further observations were documented for five hours.

**Nurse 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.

Nurse staffing was planned using an e-rostering system which had been reviewed in March 2018 and was in line with Royal College of Nursing guidance. Any flexible working arrangements were reviewed every six months and accounted for within the e-rostering system.

The rota allowed for one registered nurse for five cubicles in the major’s area, plus two nurses for rapid assessment triage and an additional corridor nurse. The resuscitation area was staffed by four registered nurses and three healthcare assistants. The paediatric emergency department was staffed by two registered nurses, one of which was paediatric trained. Nurse staffing ratios in the urgent care centre were one registered nurse to each cubicle.

We reviewed nurse staffing rotas for four weeks in July, August and September 2018. We saw the service met planned staffing levels using agency and bank nursing staff. saw fully established using bank and agency staff to fill gaps. The service had offered an increased rate to nursing staff from the department who worked additional shifts through the internal nurse bank as an incentive. This meant that bank nurses covering shifts were familiar with the department and were experienced emergency nurses.

Agency and bank nurses were given an induction to the department by a practice educator and the induction record was signed by the agency nurse and the practice educator. We spoke to an agency nurse who told us they had received a comprehensive local induction however, they were not clear on the standard operating procedure for patients cared for on the corridor.

**Vacancy rates**

During our inspection the service reported the following vacancies:

<table>
<thead>
<tr>
<th>Type of staff</th>
<th>Number of vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse band 6</td>
<td>4</td>
</tr>
<tr>
<td>Registered staff nurse</td>
<td>6</td>
</tr>
<tr>
<td>Paediatric nurse band 7</td>
<td>1</td>
</tr>
</tbody>
</table>

The service told us they had an ongoing recruitment campaign and we senior staff were conducting interviews at the time of our inspection.

The service provided the following updated information on full time equivalent vacancies between August 2017 and July 2018:
From August 2017 to July 2018 the emergency department at Royal Blackburn Hospital reported a vacancy rate of 13.42%, this was higher than the trust’s target of 5%.

(Source: Additional Document Requests)

**Turnover rates**

During the inspection the service provided the following information on turnover rates between August 2017 and July 2018:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Leavers FTE</th>
<th>FTE</th>
<th>LTR FTE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Assistants</td>
<td>2.53</td>
<td>28.41</td>
<td>8.89%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>22.60</td>
<td>40.40</td>
<td>55.94%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>4.21</td>
<td>95.66</td>
<td>4.40%</td>
</tr>
</tbody>
</table>

From August 2017 to July 2018 the emergency department at Royal Blackburn Hospital reported a turnover rate of 4.4% this was lower than the trust’s target of 12%.

(Source: Additional Document Requests)

**Sickness rates**

During the inspection the service provided the following information on sickness rates between August 2017 and July 2018:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>% Absent Rate (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Assistants</td>
<td>9.06%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1.41%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>5.50%</td>
</tr>
</tbody>
</table>
From August 2017 to July 2018 nursing staff had a sickness rate that ranged from 5.3% to 10.83%. The trust target was 3.75%.

(Source: Additional Document Requests)

Managers acknowledged high rates of sickness absence amongst nursing staff at Royal Blackburn Hospital. They told us they had developed a number of initiatives to improve this as part of a health and wellbeing strategy for staff. The service provided mindfulness sessions for staff. Mindfulness is a simple form of meditation that focusses on paying attention to thoughts and feelings at that moment and can improve mental wellbeing. The service had identified a room which was to be refurbished as a ‘retreat room’ for staff. Staff had helped produce plans for the refurbishment of the room which would be used as a quiet space for staff use to breaks or after a difficult situation.

Bank and agency staff usage

During the inspection the service provided the following information on the number of shifts filled by agency staff between September 2017 and August 2018.

Agency nurses filled 2,536 shifts in this period and bank nurses filled 3,339 shifts. The highest number of shifts filled by bank nurses was 395 in March 2018.
Medical staffing

The service employed ten consultants who worked on a rotational basis across all three sites. This was in line with Royal College of Emergency Medicine (RCEM) workforce recommendations for emergency medicine consultants.

The service used the NHS Improvement demand and capacity model to identify appropriate medical staffing levels for the department. They had submitted a business case to increase the number of consultants to 15 and managers told us this had been approved by the trust.

The service had introduced an integrated rota to ensure that staffing skill mix was taken into account when planning establishment numbers. The new system included emergency nurse practitioners, advanced nurse practitioners, physiotherapists and advanced paediatric nurse practitioners in the medical rota. It was calculated using the number of staff, the grade of staff and the expected foot fall in line with RCEM guidelines. We reviewed the NHS Improvement demand and capacity model used to develop the rota and saw that the number of planned staff would meet the expected demand.

The consultant cover for the paediatric emergency department was provided by emergency department consultants. The emergency department consultants were not dual trained but staff could access specialist paediatric consultant cover was available 24 hours a day, seven days a week through a bleep. The department had one doctor on each shift and they were supported by an advanced paediatric nurse practitioner between 10am and 10pm for six days a week. Staff told us that the days the advanced nurse practitioners worked were planned based on knowledge of foot fall and peak hours of attendance at the department.

Medical staffing in the urgent care centre was provided by three doctors, one emergency nurse practitioner and one physiotherapist. Between 11pm and 8am there were two doctors. The urgent care centre also had a GP between the hours of 8am and 11pm.

The service told us it struggled to recruit to staff grade vacancies but they were fully established at FY1 and FY2 doctor levels. The service used junior clinical fellows and locums to cover the gaps in rotas left by vacancies.

The service was actively recruiting doctors and had plans to address vacancies through engagement with the CESR programme. This is a training programme where specialists who qualified overseas can apply for evaluation of their specialist training, qualifications, experience and knowledge to determine if it is equal to the United Kingdom’s and therefore can register with the general medical council. The service was also currently training an additional four advanced nurse practitioners.

The service was not able to provide separate data for medical staffing at Royal Blackburn Hospital as medical staff rotated across this hospital and the urgent care centre at Burnley General hospital.

Vacancy rates

The service provided the following updated information on full time equivalent vacancies between August 2017 and July 2018:
From August 2017 to July 2018 the emergency department at Royal Blackburn Hospital reported a vacancy rate of 17.1%, this was higher than the trust’s target of 5%.

(Source: Additional Document Requests)

**Turnover rates**

During the inspection the service provided the following information on turnover rates between August 2017 and July 2018:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Leavers FTE</th>
<th>FTE</th>
<th>LTR FTE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Assistants</td>
<td>2.53</td>
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</tr>
<tr>
<td>Medical and Dental</td>
<td>22.60</td>
<td>40.40</td>
<td>55.94%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>4.21</td>
<td>95.66</td>
<td>4.40%</td>
</tr>
</tbody>
</table>

(Source: Additional Document Requests)

The service told us that the high turnover rate for medical staff was due to the fact they included training grade doctors on rotation in the department.

**Sickness rates**

During the inspection the service provided the following information on sickness rates between August 2017 and July 2018:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Assistants</td>
<td>9.06%</td>
<td>10.03%</td>
<td>9.11%</td>
<td>8.82%</td>
<td>4.11%</td>
<td>1.10%</td>
<td>4.08%</td>
<td>5.14%</td>
<td>9.81%</td>
<td>10.98%</td>
<td>11.41%</td>
<td>10.97%</td>
<td></td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>1.41%</td>
<td>1.30%</td>
<td>3.53%</td>
<td>2.99%</td>
<td>3.11%</td>
<td>3.11%</td>
<td>3.15%</td>
<td>2.98%</td>
<td>2.06%</td>
<td>0.00%</td>
<td>0.17%</td>
<td>0.00%</td>
<td></td>
</tr>
</tbody>
</table>

From August 2017 to July 2018 medical staff had a sickness rate that ranged from 0% to 3.31%. The trust target was 3.75%.

(Source: Additional Document Requests)
Bank and locum staff usage

The service provided the following updated information on bank and locum medical staff usage between August 2017 and July 2018:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Month</th>
<th>ED</th>
<th>UCC BGH</th>
<th>UCC RBH</th>
<th>Unknown Area</th>
<th>Agency Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>138</td>
<td>47</td>
<td>32</td>
<td>0</td>
<td>217</td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>132</td>
<td>58</td>
<td>39</td>
<td>0</td>
<td>229</td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>98</td>
<td>79</td>
<td>67</td>
<td>0</td>
<td>244</td>
<td></td>
</tr>
<tr>
<td>Nov-17</td>
<td>141</td>
<td>47</td>
<td>49</td>
<td>0</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>147</td>
<td>57</td>
<td>54</td>
<td>0</td>
<td>258</td>
<td></td>
</tr>
<tr>
<td>Jan-18</td>
<td>160</td>
<td>82</td>
<td>72</td>
<td>0</td>
<td>314</td>
<td></td>
</tr>
<tr>
<td>Feb-18</td>
<td>179</td>
<td>77</td>
<td>86</td>
<td>0</td>
<td>342</td>
<td></td>
</tr>
<tr>
<td>Mar-18</td>
<td>167</td>
<td>60</td>
<td>51</td>
<td>0</td>
<td>278</td>
<td></td>
</tr>
<tr>
<td>Apr-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>349</td>
<td></td>
</tr>
<tr>
<td>May-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>221</td>
<td></td>
</tr>
<tr>
<td>Jun-18</td>
<td>95</td>
<td>54</td>
<td>44</td>
<td>0</td>
<td>193</td>
<td></td>
</tr>
<tr>
<td>Jul-18</td>
<td>63</td>
<td>39</td>
<td>33</td>
<td>0</td>
<td>135</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>1320</td>
<td>600</td>
<td>527</td>
<td>570</td>
<td>3017</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank</th>
<th>Month</th>
<th>ED</th>
<th>UCC BGH</th>
<th>UCC RBH</th>
<th>Unknown Area</th>
<th>Bank Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>88</td>
<td>34</td>
<td>56</td>
<td>0</td>
<td>178</td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>69</td>
<td>66</td>
<td>61</td>
<td>0</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>111</td>
<td>68</td>
<td>72</td>
<td>0</td>
<td>251</td>
<td></td>
</tr>
<tr>
<td>Nov-17</td>
<td>99</td>
<td>55</td>
<td>76</td>
<td>0</td>
<td>230</td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>108</td>
<td>39</td>
<td>90</td>
<td>0</td>
<td>237</td>
<td></td>
</tr>
<tr>
<td>Jan-18</td>
<td>95</td>
<td>62</td>
<td>52</td>
<td>0</td>
<td>209</td>
<td></td>
</tr>
<tr>
<td>Feb-18</td>
<td>119</td>
<td>73</td>
<td>68</td>
<td>0</td>
<td>260</td>
<td></td>
</tr>
<tr>
<td>Mar-18</td>
<td>132</td>
<td>82</td>
<td>96</td>
<td>0</td>
<td>310</td>
<td></td>
</tr>
<tr>
<td>Apr-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>383</td>
<td></td>
</tr>
<tr>
<td>May-18</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>414</td>
<td>414</td>
<td></td>
</tr>
<tr>
<td>Jun-18</td>
<td>225</td>
<td>127</td>
<td>118</td>
<td>0</td>
<td>470</td>
<td></td>
</tr>
<tr>
<td>Jul-18</td>
<td>255</td>
<td>141</td>
<td>118</td>
<td>0</td>
<td>514</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>1301</td>
<td>747</td>
<td>807</td>
<td>797</td>
<td>3652</td>
<td></td>
</tr>
</tbody>
</table>

From August 2017 to July 2018, 1,847 medical staff shifts were filled by locum staff and 2,108 were filled by bank medical staff.

(Source: Additional Document Requests)

Staffing skill mix

In March 2018 the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the 40 whole time equivalent staff working in urgent and emergency care at East Lancashire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>19%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. The department used a paper based record system that was available to all staff. Paper records were kept in trolleys with lockable covers at the central hub and nursing station to protect patient confidentiality.

We reviewed 17 patient records and saw they had all been dated and signed. The time the patient had arrived in the department and received an initial triage was clearly documented in all but one of the records. The records were legible with accurate detail including documentation of known allergies where appropriate.

All records we reviewed clearly stated the name and grade of doctor who was reviewing the patient and the time they were reviewed.

The service had set a target of 85% of patients records to have a valid diagnosis code. We reviewed the performance dashboard for the service for July 2017 to July 2018 and saw they consistently achieved this target over the period. This meant that the service could be assured that patient care records contained accurate information on diagnosis, which is important to ensure patients received the right care and treatment.

However, senior managers told us the service did not audit the completion and quality of patient records.
Staff described them system for ensuring information was shared with relevant services such as GPs in a discharge letter as ‘simple and straight forward’. Discharge letters were based on clinical coding and printed and sent by reception staff. If more complex or in-depth information was needed in the discharge letter then doctors would complete additional information boxes.

**Medicines**

The service prescribed, gave, and recorded medicines well. All cupboards and fridges which stored medicines were locked and in a room which had key pad access. We reviewed medicines registers including the register for medicines the patient brought with them and saw they were complete. To take home prescriptions and codeine and diazepam were also recorded in the controlled drug register.

The pharmacy team from the acute medical unit attended the department daily. They documented all medicines brought into the department including the patient’s own medicines. There was a box in the major’s area for patient’s own medicines left in the department and the pharmacy team ensured these were either given to the patient if they had been admitted to a ward or were stored securely in the pharmacy department for 7 days before being disposed of.

Controlled drugs were stored securely in the majors and resuscitation areas and the coordinator kept the keys which were signed for in a book. We checked the controlled drug key book in resuscitation and saw it had been completed on each occasion someone took keys.

The controlled drug register was kept on top of the controlled drug cupboard and the order book was kept locked inside. We reviewed the order books and saw they were completed correctly.

Fluids such as glucose, saline and plasma were kept in a locked storage room with keypad entry. In the resuscitation area these were stored behind a curtain to give quick access to them in an emergency. We checked a sample of fluids in the locked room and found they were all in date.

We looked at fridges which stored medicines and saw they were clean and contents were in date. However, we found a prepared syringe of medicine in one fridge with no date or patient name. We told staff about this who immediately removed it.

However, we found the ambient temperature was not recorded in rooms which stored medicines. There was also inconsistent recording of maximum and minimum fridge temperatures. We reviewed fridge temperature records in the clinic room in the emergency department and saw they had not been recorded for 11 days in July 2018 and fridge temperature records had not been completed on 8 days in August 2018 in the urgent care centre. It is important to regularly check minimum and maximum fridge temperatures and room temperatures as some medications can become ineffective if not stored at the correct temperature.

During our inspection we found one clinic room which contained medicines which had been left unlocked. We spoke to staff who immediately locked it and told us that the room was always locked with key pad access.

Staff administered medicines under patient group directions (PGDs). We reviewed the PGDs for the department and saw they were in date and signed. The service had a policy for the self-administration of medicines. The policy for the administration of methadone gave staff guidelines on the dose to prescribe to patients if they were unsure of the current treatment plan or dose.

Two emergency drug boxes with medicines for use in anaesthetic emergencies were kept in the department. We examined these boxes and found that they displayed the date the box had been
filled. Staff told us that the box was filled by one nurse and this was not cross-checked. The service did not record the expiry date on the box and this is not in line with good practice as staff may not be able to see if the medicines in the box are due to expire and therefore if they are fit for use. Royal Pharmaceutical Society guidelines state patients could be harmed if they take out of date medicines.

We reviewed two medicines administration records for patients in resuscitation at risk of sepsis. We saw antibiotics were administered within 25 minutes of being prescribed.

**Incidents**

**Never Events**

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

From July 2017 to June 2018, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement - OBIEE NRLS STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from July 2017 to June 2018.

*(Source: NHS Improvement - OBIEE NRLS STEIS)*

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. When things went wrong, staff apologised and gave patients honest information and suitable support.
Staff reported incidents using an electronic reporting system. Staff we spoke with knew how to use the system and could describe incidents they would report. The incident reporting policy was available to staff on the trust intranet.

Managers told us they encouraged staff to report incidents and they felt there was a culture within the department which supported this. They stated that staff routinely reported incidents such as patients being admitted with pressures sores. We reviewed five incident reports and saw they covered different types of incidents and were submitted by staff of different grades.

The electronic reporting system generated an email to managers to alert them to a report and ensure they reviewed it. Managers reviewed all incidents reported in the department and gave feedback to staff individually following a report.

Learning from incidents was shared with staff in the monthly team meeting and at daily safety huddles. Information about specific incidents and learning was also shared in an alert file and matrons’ communication file kept in the staff room.

We reviewed five incident reports and saw these had been reviewed by managers in a timely manner. Each report contained evidence of actions taken to prevent future incidents and the lessons to be shared with staff in the team meeting. There was evidence that 72-hour rapid reviews had taken place where appropriate.

Managers highlighted any themes and ongoing issues to practice educators who delivered additional training to staff based on this. For example, additional training had been offered to a member of staff following an incident related to accurate recording of triage, which was followed up in writing with an action plan. Managers told us they had introduced the ‘blue hands’ card to enable staff to recognise patients with mental health needs following a patient suicide within the department.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff had not received specific training on duty of candour but all staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

Mortality reviews were undertaken for deaths that had occurred in the department. Mortality reviews are important as they facilitate learning from deaths that have happened in the department, particularly when a death may have been avoidable. The mortality committee met monthly and was attended by the quality and safety lead and divisional director of the integrated care group. We reviewed the minutes of the mortality committee and saw that learning and change in practice was a standard agenda item at each meeting.

Safety Thermometer

Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service. The Safety Thermometer performance data was displayed clearly in the staff corridor and in the waiting area of the paediatric emergency department. The service shared the performance data with staff in weekly performance meetings.

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

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

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

(Source: NHS Digital - Safety Thermometer)

The service had introduced a nursing assessment and performance framework (NAPF) to improve performance and standards of care. Audit teams attended the department on an ad hoc basis to assess performance against core care standards. Staff told us they had been invited to join this team and the audits were carried out by staff from a different area. The service was given a red, amber or green rating and any service assessed as red was revisited within two months.

We reviewed the audit for the service in July 2018 and saw it was rated red and a reassessment planned in two months. We saw a comprehensive action plan had been put in place to address issues highlighted in the audit with clear timelines for actions.

Matrons carried out monthly audits of staff compliance with monitoring early warning scores (EWS) and the use of wristbands. They told us that since introducing the audits compliance had improved. We reviewed the audits and saw that in August 2018 compliance with the use of wristbands in the urgent care centre had increased to 100% from 90% in July 2018. Staff told us additional training had been given on using EWS to monitor patients and we saw an improvement in the audit score. In January 2018 only 46% of EWS audited were completed correctly and this improved to 90% in July 2018.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Several clinical bundles were used to support staff in complying with all aspects of best practice guidance. This included pathways for sepsis, stroke, upper gastrointestinal bleeds and chronic obstructive pulmonary disease. The use of a bundle was recorded on the rapid assessment triage sheet in the patient care record.

We saw staff had access to best practice guidance and evidence on the trust intranet. For example, we saw local microbiology protocols for adults and children were available on the trust intranet as a web guide for staff. These were updated when new information became available.

During our inspection we saw a patient arrive with suspected sepsis. We saw that they were triaged by a nurse immediately and intravenous antibiotics were given within 15 minutes. This is in line with National Institute of Health and Care Excellence (NICE) and the UK Sepsis Trust best practice guidance of giving antibiotics within one hour of arrival. It is important because delays in giving antibiotics in septic shock are associated with a significant increase in mortality.
Nutrition and hydration

Staff told us a regular beverage round took place in the department and patients were offered hot and cold drinks. We saw a drinks trolley being taken round the department during our inspection. Staff also told us that patients who had to stay over 12 hours in the department were offered sandwiches and hot food that was ordered on an ad hoc basis by staff.

We reviewed the care record of a patient who had been in the department for two days and saw they that they had been offered food and drink and their intake had been monitored.

However, we spoke to two patients who were being cared for on trolleys in the corridor. They told us they had been on the corridor for over two hours and had not been offered a drink and had not seen a drinks trolley go past. We reviewed the nursing admission booklet of a further six patients cared for on the corridor and spoke to the patients and their relatives. We saw that four booklets did not contain a record of if food and drink could be offered or if it was given. We saw that one patient had received drinks but no food and one had received no food or drinks and was unclear if they were allowed this. We spoke to the carer of an elderly patient who told us the patient had not been offered any food or drink since arriving at 7am, it was now 3pm and that a relative had brought in drinks and sandwiches for them.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

Pain relief

Staff had access to a variety of medications used for pain management and this was managed in accordance with patient group directions. These allow nursing staff to administer medicines without the need for a prescription. This meant that pain relief could be administered to a patient when they first presented to the department and before they were reviewed by the medical team.

Staff used pain scoring tools to assess levels of pain in adults and children. Staff in the paediatric emergency room used a paediatric pain assessment tool which had been developed in line with Royal College of Emergency Medicine best practice guidelines. The assessment tool contained an analgesia algorithm to assist staff to identify the correct medicine and dose to use appropriate to the level of pain.

We reviewed 17 patient records and saw pain relief was documented and had been given in a timely manner when appropriate. However, during our inspection we saw one patient had not been given pain relief though they had requested it 30 minutes earlier. We told a nurse about this and she administered pain relief immediately.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 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 6.9 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>5.1</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>6.9</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>6.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. They submitted data to the Royal College of Emergency Medicine on a regular basis so that patient outcomes could be compared nationally.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Royal Blackburn Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 40%; UK: 25%.

The department was in the lower UK quartile for two standards:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 51.5%; UK: 77%.
- Standard 5b: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows: Standard 5b (fundamental): within 4 hours (moderate). This department: 8%; UK: 28%.

The department’s results for the remaining four standards were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Royal Blackburn Hospital emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for one standard:

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 0%; UK: 10%.

The department’s results for the remaining three standards were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Royal Blackburn Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 78%; UK: 64.6%.

The department was in the lower UK quartile for four standards:

- Standard 3: \(O_2\) was initiated to maintain \(SaO_2>94\%\) (unless there is a documented reason not to) within one hour of arrival. This department: 0%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 0%; UK: 60%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 0%; UK: 44.9%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 0%; UK: 18.4%.

The department’s results for the remaining three standards were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

Senior managers told us they monitored their performance against Royal College of Emergency Medicine (RCEM) standards at quarterly audit meetings and we saw they had developed action plans to address areas of concern. The service used a ‘plan, do, study, act’ approach to quality improvement which included a number of small sample ad hoc audits linked to action plans.

The service had introduced sepsis champions as part of the sepsis action plan and had a dedicated sepsis week to raise staff awareness. They reported there had been an improvement in their performance against standards in sepsis care. This was evidenced by a letter sent in January 2018 from NHS England confirming there had been great improvements in timely identification and treatment of sepsis in the emergency department. We reviewed the performance dashboard for the service for July 2017 to July 2018 and saw that sepsis screening was at 100% in the emergency department in each month.
The service had an annual audit plan which included RCEM audits and audits of compliance against other national protocols. They had submitted audits on the early diagnosis of pulmonary embolism as outlined in National Institute of Health and Care Excellence (NICE) guidance CG144 and on young people’s mental health to the National Confidential Enquiry in Patient Outcome and Death (NCEPOD).

The service had also conducted a number of ad hoc audits since April 2018 including an adult blood transfusion safety audit and an audit of oxygen prescribing in the emergency department. All audits were assigned a clinical lead who was supported by the clinical audit department. We did not see any action plans developed in response to these audits.

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

From July 2017 to June 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than both the national standard of 5% and the England average.

**Unplanned re-attendance rate within seven days - East Lancashire Hospitals NHS Trust**

![Graph showing unplanned re-attendance rate within seven days]

**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.

**Appraisal rates**

From April 2017 to March 2018, 89% of all staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 95%.
### Ward Numbers Required Numbers completed Percentage Completed Trust Target (95%) Met?

<table>
<thead>
<tr>
<th>Ward</th>
<th>Numbers Required</th>
<th>Numbers completed</th>
<th>Percentage Completed</th>
<th>Trust Target (95%) Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>435</td>
<td>6071</td>
<td>UCC Receptionists</td>
<td>RBTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6074</td>
<td>UCC Nursing Staff</td>
<td>BGTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6076</td>
<td>UCC Receptionists</td>
<td>BGTH</td>
<td>ICG</td>
</tr>
<tr>
<td>435</td>
<td>6064</td>
<td>Emergency Dept Nursing Staff</td>
<td>ICG</td>
<td>110</td>
</tr>
<tr>
<td>435</td>
<td>6070</td>
<td>ED Nurse Practitioners</td>
<td>ICG</td>
<td>14</td>
</tr>
<tr>
<td>435</td>
<td>6062</td>
<td>ED &amp; UCC Management</td>
<td>ICG</td>
<td>9</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>192</strong></td>
<td><strong>171</strong></td>
<td><strong>89%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

At the time of our inspection 67% of staff had received an appraisal. Managers told us that dip in compliance with appraisal rates was because all staff had been appraised at the same time in 2017 when the system was introduced and therefore they were all due an annual appraisal at the same time which led to a backlog. The service had implemented an improvement plan to improve compliance with appraisal rates. The service had introduced a group system for staff development and appraisal. Each member of staff was allocated to a special interest group based on their own areas of interest for example, safeguarding, major incidents or sepsis. The group was led by a senior nurse or doctor who was responsible for the appraisal of staff in the group. Staff in the groups had also received additional training on their area of interest. For example, staff in the major incident group told us they had conducted table top training exercises of major incidents and shared learning from this with other staff through designated social media pages.

Staff we spoke with told us they had received additional training appropriate to their role such as minor injury and illness courses and in-house study days. They told us they received regular clinical supervision from a nurse consultant or other appropriate professional.

The service had two practice educators who used competency based assessments to ensure staff had the skills and knowledge to carry out their roles. At the time of our inspection they were working through a schedule of competency assessments with staff.

The practice educators ensured all staff starting in the department received an induction. We reviewed the induction programme and saw it was comprehensive and covered a wide range of topics. Each new member of staff had to complete a new starter workbook that outlined the competencies completed and was signed by the practice educator when complete. Practice educators assessed the competency of agency and bank staff and we saw records for April to August 2018 which showed all agency staff had competencies assessed and signed off by a practice educator.

Staff attended monthly training sessions led by practice educators. We reviewed agendas for these sessions and saw they covered a wide range of topics pertinent to staff working in an emergency department. We saw that specialist guest speakers delivered some training sessions.
New staff were given appropriate supernumerary time to develop their competencies and skills within the department. New starters to the trust were given four weeks and new starters to the department two weeks. Staff were allocated a buddy during their supernumerary period to offer additional support, assistance and advice.

Student nurses valued the support and experience given by the service. This was evidenced as they had nominated the service for the best placement award from the local university, which they won.

All nurses working in rapid assessment triage had to complete 12 months in the emergency department before moving to a role as a triage nurse. Triage nurses had received classroom based training and competency booklets based on the Manchester triage system. They had regular competency based assessments against these principles with the practice educators. There was also an online learning course which triage nurses had to complete.

Managers told us they dealt with any performance issues informally with staff before taking formal action using trust policies. They stated they used an educational approach to addressing performance issues and gave examples of when practice educators had provided additional support and training to staff who were struggling.

**Multidisciplinary working**

Staff from different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

During our inspection we saw staff working effectively with other speciality teams throughout the trust and staff told us they could easily access specialist support from other departments for patients. For example, we saw a consultant from ear, nose and throat services attend the paediatric emergency department to assess a child and discuss an appropriate care pathway with the nurse and advanced paediatric nurse practitioner.

We observed specialist nurses from the stroke team attending the department to assess patients. We reviewed the records of a patient admitted with a suspected stroke and saw they received the appropriate scan within 10 minutes, were reviewed by a member of the stroke team within one hour and then transferred for specialist treatment within four hours.

The service worked closely with colleagues in the respiratory assessment unit and surgical assessment unit to stream patients to those services. It had instigated rapid referral and triage directly to the respiratory assessment unit for patients with known diagnoses. This meant those patients quickly accessed the most appropriate treatment and flow through the department was improved.

Two play specialists worked in the paediatric emergency department as part of the multidisciplinary team. They had been trained to carry out observations as well as provide specialist support to children. Staff told us they were integrated into the team and were a valuable resource.

We spoke to staff of different disciplines such as emergency nurse practitioners and physiotherapists who told us they worked well together and shared information via an online group application. We observed positive interactions between staff of different grades and disciplines and between different staff teams.
We observed the morning multidisciplinary team ‘board’ round and saw it included colleagues from the frailty team and respiratory assessment unit. We saw all patients were discussed and clear plans established to provide suitable and timely care to patients and maintain flow within the department. We saw a board round was attended by a consultant from the medical speciality to facilitate patient transfer to a ward.

Managers attended the emergency pathway programme board which met fortnightly and included colleagues from acute services and respiratory assessment unit. This board ensured the strategy for the service was coordinated with other relevant departments and services.

The service met fortnightly with North West Ambulance Service to discuss performance issues and to support access and flow. There was an ambulance liaison officer based in the department who worked closely with other staff to facilitate access and flow on a day to day basis.

**Seven-day services**

The emergency department, urgent care centre and paediatric emergency department were open 24-hours a day, seven days a week.

The rapid assessment triage area was staffed by two registered nurses and one healthcare assistant for 24-hours each day. The urgent care centre had medic cover for 24-hours each day which included GP cover seven days each week between 8am and 11pm.

Consultant cover was planned between 8am and 11.30pm, with a consultant resident in the department until 1.30am. There was on call consultant cover overnight from 1.30am until 8am. The paediatric emergency department had access to an emergency consultant between 8am and 11.30pm. They could access specialist paediatric consultants 24 hours a day, seven days a week through a bleep system. We saw the service had submitted plans to increase the number of consultants and provide increased consultant cover across the department.

The service had a psychiatric liaison service provided by a local mental health trust. This was available 24 hours a day, seven days a week through a bleep with increased numbers of staff between 5pm and 1am to match demand and a consultant psychiatrist was based with the liaison team Monday to Friday. We saw members of the psychiatric liaison service in the department throughout our inspection.

The radiology and x-ray service was near the department and provision was available 24 hours a day for seven days a week. The radiology ‘hot reporting’ service was available from 9am to 5pm Monday to Friday and 9am to 1pm at weekends and on bank holidays. The service was run across both Blackburn Royal Hospital and Burnley General Hospital sites. Hot reporting is when a radiologist will review and report results of diagnostic test such as x-rays whilst the patient is in the department.

**Health Promotion**

The service provided information to patients to help them to live healthier lifestyles. They worked with other colleagues and services to signpost people with long term conditions to appropriate additional support. For example, they identified patients who may need additional support because
they were frail and elderly and referred them to the frailty assessment team who worked in the
department to access intensive home support.

The service worked with a local voluntary sector agency to identify patients who were vulnerable
due to mental health or substance misuse and had developed individual action plans for these
patients to signpost to relevant services.

We saw various health promotion leaflets and poster displayed around the department including
information for parents about measles displayed in the paediatric emergency department. We saw
information on breast feeding support was also provided in Arabic.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew
how to support patients experiencing mental ill health and those who lacked capacity to make
decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

Staff we spoke to told us training on the Mental Capacity Act and Deprivation of Liberty
Safeguards was included in the level three safeguarding training and the safeguarding team
confirmed this. The trust provided data that showed 97% of staff had received safeguarding adults
level three training.

The Mental Capacity Act 2005 allows restraint and restriction to be used if they are in a person’s
best interest. Extra safeguards, Deprivation of Liberty Safeguards (DoLS), are needed if the
restriction and restraint used will deprive a person of their liberty. Staff we spoke with could
describe the principles of the act and give examples of how DoLS may be used and how and
when they would escalate this to senior staff.

Staff completed a mental capacity assessment form if they were concerned a patient may lack
capacity to make a decision. The decision outlined in the assessment was temporary and the
assessment was reviewed for every decision made. Staff told us that a registered nurse or doctor
would always complete this form if a patient was attempting to leave the department against
medical advice and they felt they lacked capacity. The assessment was always completed before
any restraint was used or patients prevented from leaving the department.

Staff told us if they were concerned about a patients’ capacity to consent to treatment they would
talk to the mental health liaison service for advice and support and to access an in-depth
assessment.

Practice educators provided additional training on completing the mental capacity assessment
form on an ad hoc basis. They told us some staff had completed mental health first aid training.
This is a national recognised course to teach people to identify, understand and respond to signs
of mental illness.

However, managers told us they were aware that more awareness raising and training on mental
capacity was needed to improve staff’s understanding of the difference between the Mental
Capacity Act and the Mental Health Act.
Is the service caring?

Compassionate care

We observed care and treatment in all areas of the department and spoke to 13 patients and relatives. We saw staff cared for patients with compassion. Feedback from most patients confirmed that staff treated them well and with kindness. Comments such as ‘staff are excellent can’t fault them’ and ‘staff are amazing’ were received from patients and relatives we spoke with.

Patients told us staff dealt with them sensitively and gave them information about their care and treatment. We saw the staff notice board displayed several thank you cards and letters which expressed gratitude for care, kindness, efficiency and a professional approach.

The service promoted the family and friends survey to patients through posters, comment cards and comment boxes through the department.

However, the service scored worse than the national average in this survey for the number of patients who would recommend the service to family and friends. The results of the survey for September 2018 were displayed in the staff corridor and showed that 79.8% of patients would recommend the service.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from July 2017 to June 2018.

A&E Friends and Family Test performance - East Lancashire Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

During our inspection we received two ‘tell us about your care’ feedback cards that expressed dissatisfaction with the service and stated staff were ‘unfriendly’ and ‘unhelpful’.
The service did not consistently respect the privacy and dignity of patients cared for on the corridor. Staff had to take observations of patients in full view of other patients and visitors to the department. We saw patients approaching frail and vulnerable patients who were on trolleys in the corridor uninvited. We also observed staff assisting patients to get off the trolley whilst in the corridor. However, staff did this as sensitively as possible and we saw them assisting patients to access the toilet or taking patients into a cubicle to deliver personal care.

**Emotional support**

The service had systems and facilities in place to provide emotional support to patients and relatives. Staff provided emotional support to patients to minimise their distress.

There was a room for relatives which was in a discreet and quiet corner of the department and equipped with comfortable chairs. We observed a doctor using that room with a family to deliver sensitive information in a suitable environment.

During our inspection we observed compassionate and effective emotional support given to a patient in distress due to their mental ill health. The patient was shouting loudly in front of other patients. Nursing staff communicated effectively with the patient to provide reassurance and diffuse the situation.

We observed staff with children in the paediatric emergency department, they were caring and communicated effectively with both the children and their parents. Staff gave children stickers after treatment or going for x-rays to distract them and minimise their distress.

Staff in the paediatric emergency department worked with two local charities to provide ‘end of life’ boxes to parents whose child died in the department, the department also signposted bereaved families to the charities for ongoing emotional support. The boxes were suitable for parents of all faiths or no faith. They contained keepsakes such as soft toys, one of which would go with the child and the other with parent. They also contained equipment to make imprints of the child’s hands and feet. Staff told us they held regular fundraising activities to raise money to work with the charities and buy the boxes.

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

During our inspection we saw staff communicated with patients and their relatives to ensure they were kept up-to-date on their care and treatment. Some patients with spoke with told us staff kept them informed about their treatment stating, ‘they all introduce themselves and explain what they are doing and how long it will take’. We observed staff in the paediatric emergency department explaining treatment to a child’s parent, giving a clear timeline of how long it would take and showing them the x-ray of the child’s arm. We spoke to a relative of a patient with dementia who told us her loved one’s care and treatment plan had been discussed with her as he found it difficult to communicate with staff and she felt involved in his care treatment.

However, some patients we spoke to being cared for on the corridor told us there had been little or no communication from staff. They told us they did not know what their care or treatment plan was and they were not aware of who was responsible for their care. We received one ‘tell us about
your care’ comment card which stated they had been given incorrect information about waiting times.

The emergency department survey demonstrated that the service scored similar to others in giving patients time to discuss their condition and feeling involved in their treatment.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all 25 questions.

<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>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
| Q24. If you were feeling distressed while you were in | 6.1        | About the same as
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>the emergency department, did a member of staff help to reassure you?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. It provided a free shuttle bus between Royal Blackburn Hospital and Burnley General Hospital for patients and visitors. The bus ran Monday to Friday with a reduced service at weekends and on bank holidays.

The service had a shared care protocol with a local mental health trust to enable parallel mental health and physical health assessments. This meant that patients presenting to the department with mental ill health did not have to wait until they were seen by an emergency department practitioner and declared medically fit before having a mental health assessment.

The service had conducted a local review of the needs of patients attending the urgent care centre. The review had been used alongside the NHS Improvement capacity and demand tool to develop the rota for medical staff at the urgent care centre in line with the needs of people attending. As a result, the service had ensured a GP was available seven days a week from 8am to 11pm and had developed the role of physiotherapists in the department.
The design of the new ambulatory and emergency care unit took into account the needs of patients by increasing the waiting area to be suitable for up to 30 patients and locating it close to the acute medical unit.

Staff could access specialist nurses to aid the delivery of care to patients in need of additional support. Specialist end of life, bereavement, dementia nurses and a specialist nurse for learning disability and autism were available for support and advice. Staff could also access safeguarding champions who had additional skills and knowledge in supporting patients with learning disabilities.

Waiting areas met the Royal College of Emergency Medicine quality standards published in 2017. They were furnished with television and Wi-Fi access and a display screen which gave an updated waiting time and approximate length of time in the department. Poster were displayed which outline the triage process and explained to patients the process they would go through following registering with reception.

**Meeting people’s individual needs**

The service took account of patients’ individual needs and there were discreet systems to identify patients with additional support needs.

The service used a ‘leaf’ symbol to identify patients at risk of falling. An amber leaf symbol was attached to the curtain or door of patients deemed at risk of falling to alert staff and ensure they offered appropriate support. A red leaf indicated a greater risk as the patient had already fallen in the department. We saw the leaf symbol displayed appropriately throughout our inspection.

We saw the ‘butterfly’ symbol was used to discreetly identify patients with dementia so care and treatment could be delivered that was appropriate to their needs. The service used a solid blue butterfly to indicate patients with a confirmed and permanent diagnosis of dementia. An outline of a butterfly indicated that a patient had possible delirium or undiagnosed dementia. Staff told us they followed a specialist response plan for patients who had been identified with this symbol but we did not review any during our inspection.

The lead dementia nurse had created a ‘virtual tour’ training tool for staff to experience the emergency department from the point of view of a patient with dementia. Staff had not yet completed this training but managers told us training dates were being organised to take place in the coming months. The service had activity boxes which had been developed by a healthcare assistant. They contained games, colouring books and twiddle muffs and could be given to patients with dementia to distract them and reduce agitation.

Staff in the department could access 24-hour crisis care at home for frail or vulnerable patients following discharge through the frailty assessment team. The team was consultant led and could refer patients directly to an intensive home support team to prevent unnecessary and distressing admission to hospital for patients. They could also access intermediate care beds at a local nursing home. This meant that patients who were frail or had dementia could be discharged home or to an appropriate care setting that met their needs rather than be admitted to a ward.

Staff used a ‘blue hands’ symbol to identify patients with mental ill health. This had been developed following consultation with mental health patients in the department and replaced the previous ‘red dot’ which patients felt stigmatised them as it marked them as potentially dangerous.
The service had accessed funding to provide access to phones for patients in mental distress so they could call mental health helplines.

Staff told us the service used a ‘right patient, right transfer, right time’ tool to ensure that patients’ needs were met when being transferred from the department to other areas of the hospital. The tool identified which patients needed additional support from a nurse or healthcare assistant when transferring to a ward or going for diagnostic tests. We saw information on the tool displayed on a notice board in the department.

Staff told us the chaplain visited the department and spoke to patients on a regular basis. They also attended the mental health liaison meetings in the department.

Staff could access interpreters for patients who did not speak English through an interpretation service.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all three questions.

<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>7.4</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>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017, published October 2017)

**Access and flow**

People could access the service when they needed it. However, waiting times for treatment and arrangements to admit, treat and discharge patients were not in line with good practice or the England average.

The service was working hard to improve access and flow and there were several workstreams and plans to improve this. However, patient flow through the department was restricted due to the number of patients attending the department and pressures other areas of the hospital and mental health services faced.

An ambulance liaison officer worked in department and liaised with the local ambulance service to divert suitable patients to the urgent care centre or ambulatory care unit. However, during our inspection we saw some patients waiting on ambulances for over 20 minutes. Staff we spoke with expressed concerns about the length of time patients had to wait on ambulances and the number of patients waiting for rapid assessment triage review in the corridor, especially at weekends. We saw some patients waited for over an hour for rapid assessment triage reviews during our inspection.

The service had a plan to improve the flow of patients through rapid assessment triage. We reviewed the plan and saw actions had been clearly identified with a time scale, person
responsible and a red, amber, green rating to track progress. A rapid assessment triage steering group had been established to maintain communication with staff and track progress against the action plan. Staff identified patients through rapid assessment triage who were ‘fit to sit’ and transferred these patient to a separate sub-ambulatory waiting area to await treatment.

The service worked with colleagues in other areas of the hospital to transfer patients quickly to appropriate services or direct them to a more appropriate department rather than accident and emergency. For example, staff could refer patients with known respiratory conditions directly from triage to the respiratory assessment unit. Managers were negotiating a protocol with North West Ambulance Service to take appropriate patients directly to the new ambulatory and emergency care unit opening at the end of September 2018 to prevent unnecessary attendance at the department.

We viewed 17 patient records and saw that 10 patients had been seen within an hour of presenting to the department. However, we also saw that one patient had waited six hours to be seen.

At the time of our inspection the new ambulatory and emergency care unit was not open and the service was performing worse than the England average for the time patients had to wait to access treatment.

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

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for the entire 12-month period from July 2017 to June 2018.

**Median time from arrival to treatment from July 2017 to June 2018 at East Lancashire Hospitals NHS Trust**

![Histogram](image)

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

Managers attended a daily bed management meeting to provide an update of how many patients in the department were waiting for a bed on a ward. We observed a bed management meeting and saw the allocation of inpatient beds to patients waiting in the department was discussed. They discussed patients who were waiting in the department over 12 hours and identified patients who could be moved to the discharge lounge so an inpatient bed could be made available.

We saw an update on the number of patients in the department waiting for an inpatient bed was given to the site manager and the Director of Nursing. Managers in the department updated a ‘live’
escalation report which displayed information on access and flow and was displayed on screens in the trust headquarters, senior managers’ computer screens and the bed management office.

Senior managers told us if more than 27 patients were waiting for inpatient beds in the department then the full capacity protocol would be triggered. This identified actions the department would take to transfer patients to the discharge lounge after a full risk assessment and make inpatient beds. At the time of our inspection 24 patients in the department were waiting for an inpatient bed so the protocol was not triggered. Senior managers told us if the protocol call was triggered an additional bed management meeting would be held.

Senior managers were working with local agencies on a frequent attenders’ initiative. The service had identified 100 patients with complex or multiple needs who attended the department frequently. Managers from STEP, a local voluntary sector agency, and a clinical lead from the department attended monthly case review and planning panels and agreed risk and care plans for these patients. We reviewed minutes of the case review panel meetings and saw action plans were put in place with multi-agency involvement to support patients to attend the department less frequently.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust did not meet the standard and performed worse than the England average.

**Four hour target performance - East Lancashire Hospitals NHS Trust**

![Graph showing performance against four hour target]

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

The service had introduced a number of changes in April 2018 in the urgent care centre to improve performance against this target. These included aligning nursing and medical staff with cubicles and streaming patients to clinical pathways such as surgical triage unit or respiratory assessment unit. The service reported that prior to taking action the performance against this target for the urgent care centre at Blackburn Royal Hospital was 83.4% and this rose to 90% in June 2018.
We saw the service tracked performance against this target monthly and examined reasons for the underperformance. These included increases in ambulance attendances, short notice staff sickness absence and issues with flow to inpatient and mental health beds. The service had introduced several initiatives to support achievement of the target including the planned opening of the new ambulatory and emergency care unit and recruitment of medical staff. However, overall performance remained below target and the trajectory against performance had not improved since May 2017. We saw that in July 2018 overall performance against this target was 83.8%.

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

From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. There was a notable decline in performance over the winter months.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - East Lancashire Hospitals NHS Trust**

(Source: NHS England - A&E SitReps).

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

Over the 12 months from August 2017 to July 2018, 149 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in March, June and July 2018.
<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>297</td>
<td>8</td>
</tr>
<tr>
<td>Sep-17</td>
<td>311</td>
<td>1</td>
</tr>
<tr>
<td>Oct-17</td>
<td>537</td>
<td>2</td>
</tr>
<tr>
<td>Nov-17</td>
<td>674</td>
<td>4</td>
</tr>
<tr>
<td>Dec-17</td>
<td>677</td>
<td>4</td>
</tr>
<tr>
<td>Jan-18</td>
<td>909</td>
<td>3</td>
</tr>
<tr>
<td>Feb-18</td>
<td>629</td>
<td>12</td>
</tr>
<tr>
<td>Mar-18</td>
<td>811</td>
<td>23</td>
</tr>
<tr>
<td>Apr-18</td>
<td>538</td>
<td>18</td>
</tr>
<tr>
<td>May-18</td>
<td>370</td>
<td>3</td>
</tr>
<tr>
<td>Jun-18</td>
<td>319</td>
<td>34</td>
</tr>
<tr>
<td>Jul-18</td>
<td>464</td>
<td>37</td>
</tr>
</tbody>
</table>

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

During our inspection we saw one patient waited longer than 12 hours in the department. Staff we spoke with told us the main issue causing patients to wait for longer than 12 hours in the department was the availability of mental health inpatient beds. The service told us the 34 patients waiting over 12 hours in department in June 2018 was for this reason. Senior managers told us that every time this happened a full root cause analysis investigation was conducted and they had developed a shared mental health action plan with the local mental health service. We reviewed the plan and saw that it was comprehensive with short, medium and long term agreed actions allocated to individuals and an analysis of the risks and benefits of each action. The service held a weekly meeting with the local clinical commissioning group and mental health service to review and update the plan.

The service was working closely with the local mental health trust to resolve the challenge of patients waiting for mental health inpatient beds. There was an escalation protocol that was used once a decision to admit a mental health patient was made. This included escalation to the local clinical commissioning group and a daily teleconference, seven days a week, between senior managers in the service and the local mental health trust. The manager from the local mental health trust also attended bed management meetings.

Senior managers told us that following a recent NHS Improvement audit and deep dive session in June 2018 into the challenge of accessing mental health beds a report had been submitted to the accident and emergency delivery board. The board included key stakeholders including mental health services, North West Ambulance Service, NHS Improvement and the local clinical commissioning group. They told us that this report would be used by the board to develop an improvement plan.
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - East Lancashire Hospitals NHS Trust

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

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

From August 2017 to July 2018 performance against this metric showed a performance slightly higher than the England average, with a slight decline in performance over the winter months of the reporting period.
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. The complaints lead for the service tracked the progress of complaints through the trust process and reviewed these weekly with managers and the central complaints team for the trust.

We reviewed complaints records and saw that 127 new complaints were received in July 2018, of these 118 had been resolved at the time of our inspection. We reviewed seven complaints and saw all had received a confirmation when the complaint was submitted and an explanation of the complaints process. They had been reviewed by a consultant before a response was sent. We saw complaints were investigated thoroughly and patients offered the chance to meet with staff, where appropriate.

Summary of complaints

From April 2017 to March 2018 there were 65 complaints about urgent and emergency care services. The trust took an average of 55 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 50 days. Of these 65 complaints, 30 were recorded under ‘all aspects of clinical treatment’.

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

Staff told us learning from complaints was shared in team meetings and in the alert file and matrons’ communication file kept in the staff room. They gave us an example of receiving additional training following learning from a patient complaint. Information on autonomic dysreflexia (a sudden onset of high blood pressure) is now included in the staff induction following
a complaint from a patient that staff did not recognise symptoms of the condition and were
dissmissive of them.

Duty of candour is a regulatory duty that relates to openness and transparency and requires
providers of health and social care services to notify patients (or other relevant persons) of certain
‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with
stated they had received no formal training on duty of candour but were aware of the term and the
principle behind the regulation and could give examples of when the duty of candour would be
applied.

Number of compliments made to the trust

From April 2017 to March 2018 the trust recorded 81 compliments linked to urgent and emergency
care. The trust received 15 compliments in April 2017, the highest number it received in any one
month.

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

Managers told us they shared compliments with individual staff by email and with the wider service
in team meetings and the department newsletter.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing
high-quality sustainable care.

The leadership team consisted of an assistant director of nursing, two divisional clinical directors
and a business manager. They were supported by a matron and recruitment had taken place for a
second matron.

Staff reported that the matron and other leaders were visible and approachable. The clinical
director worked on the medical rota and therefore was highly visible to staff and understood the
daily challenges in the department.

Staff told us managers had an open-door policy and they felt they could speak to them if they had
concerns or issues.

Managers received support to develop their skills and knowledge. For example, the service had
planned a series of study days for managers below matron level based on the Belbin model of
team development to identify strengths within the management team and improve how they
worked together.

However, staff also told us that there had been many changes in leadership at matron level over
the past three years. They felt this had led to a lack of consistency in management approach and
different messages coming from different leaders. Some staff told us they felt comfortable to
approach managers but did not always feel they were listened to when they did so.

Vision and strategy
The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and key groups. It had worked with NHS Improvement on the Emergency Care Improvement Programme (ECIP) to develop the model for the urgent care centres and to develop an ‘emergency care village’ strategy. There was an emergency pathway programme board which included colleagues from acute medicine. This met fortnightly and produced and managed the strategy and transformation programme.

The service had involved staff in developing the model for urgent care through a ‘plan, do, study, act’ session followed by a two-week period during which staff could reflect and feedback any further ideas. The ‘plan, do, study, act’ model is a quality improvement tool which allows services to test an idea by trialling on a small scale, assess its impact and build on the learning before introducing the improvement.

The service had a clear strategy for the future emergency care village and this was broken into four stages, two of which were completed. We saw the new ambulatory and emergency care unit planned as part of this strategy was due to open by the end of September 2018.

The service worked with a mentor from another NHS trust through the ECIP programme to develop a business case which they had submitted to NHS Improvement to build the emergency care village opposite and connected to the current department. They involved colleagues from other services such as medicine to develop appropriate pathways for patients alongside developing plans for the new building.

Leaders told us they were working on a business case for stage four of the strategy at the time of our inspection which would create a short stay observation unit within the emergency care village.

The trust values of safe, personal and effective were displayed throughout the department and on all literature, templates and forms staff used.

Culture

Staff we spoke with gave mixed feedback on the culture of the service. Some staff commented that there was high turnover and sickness absence rates in the department due to the demands of the department. They told us staff had left to go to other wards and teams within the organisation. Some junior medical staff told us they did not always feel supported and valued by managers.

Senior managers acknowledged that morale within the department had been poor and the results of the staff survey in 2017 had highlighted this. They told us they had developed an ‘improving together’ plan with staff to address issues raised by the staff survey. This included the introduction of staff wellbeing champions. We spoke to staff who had volunteered for this role and they were enthusiastic and hopeful it would change the culture within the department.

Staff told us that changes at matron level in the past had led to an inconsistent approach which affected the culture within the department. They told us that there was not always an open and transparent culture as some staff raised issues directly with senior managers rather than immediate managers or their team first.

However, some staff told us they had seen an improvement in the culture in the department and commented positively on how well staff worked together as a team. They commented positively on the impact of the new staff group structure which allowed them to develop specific areas of interest and ensured support was in place for staff from a doctor or manager. Some staff we spoke
with told us they felt the service invested in their development and they had been given opportunities to access leadership courses.

Staff we spoke with were aware of the freedom to speak up guardian and how to contact them. A freedom to speak up guardian works alongside the trust’s senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

**Governance**

The service had a governance structure which allowed information to be shared from ward to board level. There were effective processes and systems of accountability to support the delivery of high quality services.

We reviewed minutes of the monthly departmental governance meeting. We found they had set agenda items including safety alerts, incident reviews, updates on mental health four-hour target breaches, risk management, mortality reviews and complaints as well as training and patient safety issues. All identified actions were recorded on a matrix and a responsible person allocated. Actions were reviewed as part of the meeting.

The meeting was attended by senior managers, consultants, matrons and senior nurses. The minutes were shared with staff in team meetings and a communication file in the staff room. Information from the meeting was fed up to the board via the directorate governance meeting for the integrated care group.

We saw the governance meeting included presentations from relevant staff to share information about specific projects. For example, practice educators had presented the new morphine training workbook to the meeting for approval before implementing with staff.

There was an accident and emergency delivery board chaired by the chief executive officer of the trust and consisting of key partners including NHS Improvement and the local clinical commissioning group. Information flowed from the board to the accident and emergency delivery group which included North West Ambulance Service and mental health services. Members of this group monitored and guided service delivery. This group held performance meetings, governance meetings and mental health meetings. Information from these meetings flowed down to staff through team meetings and to the trust governance structures through the accident and emergency delivery board.

There were monthly communication meetings of middle grade clinicians who worked across the Burnley and Blackburn sites. Staff we spoke with told us the meetings had led to improved support and practice development opportunities for middle grade doctors.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with the expected and unexpected.

Managers monitored performance each day through score cards which contained key performance metrics. The service used an electronic patient tracking system to monitor...
performance and information was displayed in the department on an electronic overview screen. The senior management team reviewed the score cards daily.

Performance issues were escalated through the nurse in charge each day and they maintained a log book of issues and key messages. These were shared at the weekly performance meeting. The weekly performance meeting was attended by all managers including the senior management team.

The service was working with NHS Improvement on the Emergency Care Improvement Programme (ECIP) and benchmarked itself against 33 other NHS trusts. This was monitored twice weekly. We saw the service benchmarked its four-hour performance and ambulance turnaround times against other trusts and reported this in the performance report.

We saw the number of attendances at Royal Blackburn Hospital had increased in May, June and July 2018 due to increased attendances at the urgent care centre. However, the services four-hour performance target had improved over this period to 70.53% in July 2018 from 60.99% in March 2018 since the introduction of the new streaming model in urgent care.

Senior managers told us that a root cause analysis investigation was carried out for every 12-hour breach. They were also reported to the accident and emergency delivery board.

Senior managers monitored performance against Royal College of Emergency Medicine audit standards through quarterly audit meetings. They acted on areas of poor performance and formulated action plans against these. This was evidenced by improvements in care of patients with sepsis and at risk of VTE. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein.

A VTE committee had been set up to develop a pathway for VTE prophylaxis in lower limb injuries. Following an audit of this pathway a care bundle was produced for staff to follow with patients and training was arranged for staff. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes.

The service had also improved the care to patients at risk of sepsis and had appointed staff as sepsis champions to improve awareness of sepsis on the department. The service had provided sepsis trolleys which contained the care bundle and appropriate equipment for staff to use. Senior managers told us since introducing this they had seen an improvement in patient outcomes and the performance report showed 100% of patients were screened for sepsis in the department.

The service had developed plans to cope with the challenges expected from winter pressures. We saw there was a comprehensive plan developed with the wider trust and partners that contained a number of programmes. The plan had been endorsed by the accident and emergency delivery board and built on learning from winter pressures experienced in 2017/18.

We reviewed the risk register and saw that risks recorded on the register aligned with what staff and senior managers told us were their concerns and challenges. We saw 16 risks were recorded for the service and these were clearly described and scored and control measures were in place.

Staff and managers told us that a major area of concern was the number of mental health patients attending the department and delays in transfer due to the availability of mental health inpatient beds. We saw this was recorded on the risk and register with identified control measures in place. Senior managers were working closely with the local mental health provider and had a shared care protocol and mental health action plan in place.
Information management

The service collected, analysed, managed and used information well to support all its activities. It had clear performance measures which were reported in a performance report. We reviewed the July 2018 performance report for accident and emergency department which covered the period July 2017 to July 2018. We saw the report contained information on attendance figures, breaches, four-hour performance targets, quality and safety figures, incidents and complaints which were broken down by site and department.

The matron collected information from audits, patient feedback and daily walk rounds and produced a monthly 'matrons report' which was presented at the governance meeting. We reviewed reports for April, July and September 2018 and saw they were comprehensive and covered key performance and risk issues.

Senior managers had access to a ‘live’ escalation report informing them of the number of patients in the department. This was displayed as a screen saver on senior managers computer screens, in the bed management office and in trust headquarters.

Staff had access to up-to-date information about patients. Electronic screens were displayed in each main area of the department which provided details about the number of patients in the department, where they were located, how long they had been there, care plans and any flags such as dementia or mental health. We saw staff used the screens to share information during two-hourly boards rounds and updated them as they discussed patients. Staff had access to 24-hour information technology support seven days a week to assist them in using the electronic system if needed.

Patient care records were paper based and readily available to staff in lockable trolleys in each area. These were then scanned into an electronic system when the patient left the department or transferred to the patient care record on the ward.

Staff told us they could access the information necessary for them to undertake their roles. Trust policies and procedures were available on the intranet and paper copies were available in the staff room. There were paper copies of tools, pathways and risk assessments available for staff to use on the department.

Engagement

The department participated in the family and friends survey and posters were displayed throughout the department encouraging patients to leave feedback. We saw that feedback from patients was included in the matrons’ monthly reports and the service had made changes using a ‘you said, we did’ model. For example, patients had said the waiting room was dirty and the service had provided managers with the details of the domestic rota so they could ensure domestic staff were in the department to keep the waiting area clean.

The service engaged well with staff and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. We saw they were working with local commissioners, ambulance services and mental health services to improve the care offered to patients living with mental health issues in the department. Staff from the mental health service had provided mental health awareness training to health care assistants in the department.
Following a poor staff survey, senior managers had worked with staff and the Freedom to Speak Up Guardian to gain staff feedback and identify themes. Interviews were held so staff could share information confidentially with the Freedom to Speak Up Guardian. The key issues were then shared with the senior management team. Staff also had the opportunity to attend feedback sessions with managers. From this feedback the service had developed an ‘improving together’ action plan which included a health and wellbeing strategy, the appointment of staff wellbeing champions and development of a staff newsletter ‘the emergency trumpet’. The senior management team told us they planned to measure the impact of these actions through an online survey sent to all staff as they recognised that there would be a delay in seeing results from the formal NHS staff survey.

The trust recognised staff through the annual Star Awards. We saw that the staff in the paediatric emergency department was nominated for clinical team of the year award and displayed a certificate within the department. The service had also introduced a department ‘star of the month’ scheme who was voted for by colleagues in the department.

The service had set up social media accounts and pages to assist with staff communication and share training and learning. All the different training opportunities and wellbeing sessions staff could attend were displayed on a notice board in the staff corridor opposite the changing areas. We spoke to registered nurses who stated they were aware of the opportunities and one told us she had attended a mindfulness session.

The service shared key messages with patients and the public through the trust website and social media. This included a ‘Making the Right Choice’ initiative which raised awareness of which emergency or urgent care service to use and alternatives. It published ‘live’ waiting times on the trust website alongside this advice.

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. It used a recognised ‘plan, do, study act’ quality improvement tool to develop and improve services. For example, the service used this tool with staff when developing the new model for urgent care.

We saw complaints and themes from them were discussed as a set agenda item at governance meetings and learning shared with staff in monthly team meetings. Managers demonstrated a ‘no blame’ attitude to encourage staff to report all clinical and non-clinical incidents and staff we spoke with stated they felt confident to report incidents.

Staff were encouraged to suggest solutions to themes identified. At the time of our inspection the service had introduced the ‘corridor traffic light’ process following a suggestion from staff nurses. Staff had designed the information leaflet and posters for the process.

The staff newsletter shared information on innovations, improvement projects and good news stories as well as learning from complaints and incidents. We saw the service shared the outcomes of improvement projects in posters displayed in staff areas.

We saw the department displayed several information boards that were designated as quality improvement boards for staff to share information. The service had named corridors ‘safety street’ and ‘quality street’ to match the topics displayed on the quality improvement notice boards. Staff were encouraged to take an active part in designing and updating these boards through their staff
groups. We saw the board shared messages on quality improvement initiatives such as sepsis awareness and the corridor traffic light scheme.

The service was working with NHS Improvement to develop new models and pathways to manage access and flow issues. Senior managers worked collaboratively with other local organisations and NHS trusts on improvement projects to address challenges. The service was working with a mentor from a NHS trust in another area to develop a new model of emergency care that developed new patient pathways as well as facilities.
Medical care

Facts and data about this service

The medical care core service at the trust provides care and treatment for respiratory, medicine for older people, gastroenterology, diabetes, endocrinology and cardiology amongst other specialities. There are 515 medical inpatient beds located across 22 wards.

A site breakdown can be found below:

- Royal Blackburn Hospital: 470 beds are located within 20 wards.
- Burnley General Hospital: 45 beds are located with two wards

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

The trust had 53,578 medical admissions from February 2017 to January 2018. Emergency admissions accounted for 29,754 (56%), 971 (2%) were elective, and the remaining 22,853 (43%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 31,095
- Gastroenterology – 12,770
- Cardiology – 2,976

(Source: Hospital Episode Statistics)

We carried out an unannounced inspection between 4 and 6 September 2018, (staff did not know we were coming), to enable us the observe routine activity. During the inspection we visited medical wards B18 (cardiology), coronary care unit (cardiology), D3 (endocrine), B4 (geriatric medicine), B2 (stroke Medicine), C2 (gastroenterology), C11 (geriatric medicine), C5 (geriatric medicine), C7 (respiratory medicine), C6 (respiratory medicine), C4 (gastroenterology), acute medical assessment A (general medicine) and acute medical assessment B (general medicine).

We spoke with 33 members of staff including divisional directors, matrons, ward managers, nurses, nursing associates, health care assistants, consultants, middle grade doctors, junior doctors, a physician’s associate, dieticians, physiotherapists, occupational therapists, porters, domestic assistants, housekeepers, pharmacy and administration staff. We spoke with twelve patients and relatives.

We observed care and treatment and looked at 14 patient care records and twenty-two prescription charts. We reviewed comments from staff focus groups, patient feedback cards and looked at the service performance data.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.
Mandatory Training

Staff received training in basic mandatory processes, systems and safety procedures. Throughout the integrated care division, mandatory training completion rates were high.

Mandatory training was delivered to staff mainly by e-learning with some face-to-face training. All new staff attended a corporate induction day followed by further essential training, dependant on job role. On the previous inspection we said medicine should improve uptake on the medical wards of mandatory training and this had been achieved.

Managers reviewed training with staff at annual appraisals. Any mandatory training due was prompted by an email reminder sent to staff and monitored by divisional leads. We were informed that it was not always possible for staff to complete annual/biannual mandatory training updates whilst at work and staff were given access to on-line training from home. Staff confirmed this, however, some staff said they were not always able to take the time back.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 at trust level for staff in medicine is shown below:

The trust has not included any staffing group data with their training return, so the data cannot be broken down into nursing and medical staff.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention</td>
<td>2,143</td>
<td>2,195</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>2,173</td>
<td>2,227</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2,167</td>
<td>2,227</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>2,165</td>
<td>2,227</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>2,153</td>
<td>2,232</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>2,148</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>2,131</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent</td>
<td>2,113</td>
<td>2,227</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance*</td>
<td>2,098</td>
<td>2,227</td>
<td>94%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>1,699</td>
<td>1,874</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>2,012</td>
<td>2,227</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* The target for this module was 95%.

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

There were systems and processes to keep people safe and safeguarded from abuse. Staff had received appropriate training and were aware of supporting systems and procedures for contacting the safeguarding team.

Staff we spoke with were confident in raising concerns and contacting the safeguarding team for advice and support. The trust held monthly safeguarding educational forums for all staff. There were 80 safeguarding champions trust wide to support the staff on wards in all areas.

The safeguarding team included a domestic violence advisor to support patients and staff regarding issues of domestic violence.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 at trust level for staff in medicine is shown below:

The trust has not included any staffing group data with their training return, so the data cannot be broken down into nursing and medical staffing.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
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<th>Percentage trained</th>
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</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>2,153</td>
<td>2,232</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>2,131</td>
<td>2,227</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Standards of cleanliness and hygiene were measured using a nursing assurance performance framework that included procedures and systems to prevent, monitor and act on infection and hygiene risks to patients.

Wards we visited were visibly clean and had hand gel stations on entry to the main ward and at the entry point of each bay within the ward. We saw the five moments for hand washing and hand washing steps information leaflets at sinks on each of the wards we visited.

Wards had a performance board at the entrance for the number of patients who had contracted Clostridium difficile, methicillin-resistant Staphylococcus aureus and methicillin-sensitive Staphylococcus aureus. The rates on infection and hand hygiene audits were monitored by the divisional patient safety and risk committee’s sub group for infection prevention and control. Recommendations and actions were identified and reported to the board. The July 2018 hand hygiene audit showed all wards were 88% or above compliant. Infection rates for most of the wards was zero for August 2018.
Wards had designated housekeeping staff to complete cleaning duties. Wards were visibly clean and tidy.

We observed staff following infection control procedures, such as barrier nursing before entering an isolation room. All isolation rooms were clearly marked with instructions to contact a nurse before entering the room. We observed all staff working on the wards arms bare below the elbow in line with national guidelines.

The trust infection control team was supported by an accredited microbiology laboratory, available 24 hours a day. We were informed the infection control team oversaw policies which included hand hygiene, isolation of patients, severe respiratory illness, methicillin-resistant Staphylococcus aureus, multi drug resistant organism, aseptic non-touch technique (ANTT), urinary catheter and bowel management.

We reviewed an aseptic non-touch technique audit where care plans were completed on most occasions. One care plan had no documentation of aseptic non-touch technique recorded on initial cannulation but the cannula had been removed within 48 hours of admission, as per trust policy.

The trust had a ward accreditation programme, the nursing assurance framework assessment process which audited wards on cleanliness, infection rates and performance. The frequency of inspection depended on previous ratings (red rated -eight weeks, amber rated - four months, green rated - eight months and silver rated - 12 months). At the time of inspection there were four red wards, seven amber wards, nine green wards and five silver wards. We were informed the red and amber wards had action plans which identified support from senior leaders for performance improvement.

Environment and equipment

The environment on the wards we visited were appropriate with bay areas, side rooms, washing and utility facilities. Lifts were available to transfer patients and visitors to different floors when required and exit signs were clearly visible. Equipment was maintained, checked and decontaminated to provide safe care and treatment to patients.

The wards were made up of a mixture of bay areas and side rooms. We were told the side rooms were generally used as isolation rooms or assigned to patients with lower acuity levels.

One of the wards for the care of older adults had specialist beds that would light up when a patient sat up to alert staff visually before a patient attempted to get out of bed. The ward had had no patient falls for over a year.

The trust had an electronics and medical engineering department which provided in-house servicing and routine equipment maintenance. This followed a monthly schedule recorded on an electronic asset management system. For non-routine maintenance and equipment malfunction a priority system was in place using either a bleep system or urgent call to a helpdesk. For specialist equipment such a mobile hoist and electric safety testing, manufacturers or third-party maintenance companies were used. We checked a selection of equipment including blood pressure machines, glucose monitors, telemetry monitors and found these to be within their check and maintenance dates.

The coronary care unit had a process for cleaning syringe pumps. Each syringe pump had documentation to complete once the pump had been used. When the pump had been used, the
paperwork was completed and placed with the pump in the designated used area. The pumps and paperwork were collected for decontamination and cleaning and returned with new paperwork and fresh “I am clean” stickers.

We sample checked resuscitation trollies on the wards and saw daily and weekly checks were completed. The resuscitation trollies were easily accessible, sealed and emergency medicines were available. However, we found the portable suction on Ward C6 resuscitation trolley was out of the manufacturers’ expiry date.

The service separated and stored waste using separate bins for sharps, yellow clinical bags and general waste. Waste was stored in the dirty utility room on the wards and collected by portering staff and taken to a central location for disposal. The clean utility room was used for medicine storage and point of care testing.

Assessing and responding to patient risk

Patients risks were assessed, monitored and managed so they were supported to stay safe. Staff used risk assessments and national early warning scores to detect deterioration in patients’ condition and escalated for clinician review when needed.

Patient risk assessments were completed for patients by nursing staff and recorded on an electronic system. These included nursing, nutrition, falls and tissue viability assessments. On the last inspection nursing risk assessments were not accessible to agency nursing staff. At the time of our inspection agency nursing staff still did not have access to the electronic risk assessments and this was raised by ward managers as a concern. This meant the agency staff did not have access to the system and were reliant on permanent staff to do this for them.

The venous thromboembolism assessment was performed by medical staff. We found one patient record out of the 14 viewed where the patient assessment for VTE had not been completed. This was reviewed with the ward matron who identified there had been four missed opportunities for review. This was escalated immediately to a clinician for review.

National early warning scores were used by staff to monitor and assess patients for signs of deterioration. Any score above zero was escalated for medical review. We looked at 14 patient records and found patients warning scores had been documented and escalated where appropriate.

There was a trust consultant lead for sepsis and sepsis care bundle pathway which met current national guidelines and best practice. Sepsis was monitored and audited within the trust. The latest sepsis care bundle usage audit was between 70% and 92% during the period of September 2017 to August 2018. Actions had been identified such as completion of fluid balance charts. The trust had seen greatest improvement in indicators for timely identification and timely treatment of sepsis in the commissioning for quality and innovation national goals.

We saw red triangle signs on patient bay doors where patients required turning to prevent pressure sores. There was information with the next turn time recorded as a prompt for staff to turn the patient.

Patients who had been in hospital for a long period of time (over seven days) were monitored and highlighted on ward information boards and hand over sheets. One patient had been on a ward since July (our inspection was in September) and weekly blood tests were taken in addition to observations to monitor blood parameters for nutrition and hydration assessment.
There had been a reduced number in patient falls since the last inspection and further work was continuing as there had been a few unwatched fall incidents. Aggression and violence in elderly patients had become a concern and was noted in the increasing number of incidents in medicine for elderly people. This was currently being assessed and risk assessments for elderly patients living with dementia were in development with the safeguarding team and the appointment of a mental health nurse. Where possible a member of staff was assigned to a bay area at all times (known as bay-tagging). However, due to staffing shortages it was not always possible to bay-tag in all areas. For example, on acute medical assessment area A the establishment on inspection was one health care assistant short to bay-tag each bay and this concern had been escalated to the divisional leads.

**Nurse staffing**

Safe staffing was a priority and measures had been taken to ensure systems were in place to provide each ward with a daily appropriate skill mix of staff. However, there were times where wards did not have the planned staff, but the service had systems in place to mitigate risks.

During the inspection we were informed there were 180 whole time equivalent registered nursing staff vacancies within the integrated care group (this includes the medical core service in addition to community core services). Every ward we visited had registered nursing staff vacancies and some wards had staff on long term sick. Rotas were produced six weeks in advance and ward managers were included in the staffing levels. Each ward had a nursing co-ordinator who was usually supernumerary to the nursing establishment on the shift. The ward managers were given one day a week supernumerary to complete administration tasks.

Divisional leaders had undertaken workforce plans, recruitment drives and skill mix review to support the nursing staff with associate nurse practitioners and health care assistants. At the time of inspection additional health care assistants had been appointed and a business case was in progress to secure funding for the associate nurse practitioner posts.

The division had taken measures to provide safe staffing levels on each of the wards. The shift pattern had been changed from June 2018 which incorporated working long days to reduce the number of shifts to fill. An acuity tool was in operation overseen divisionally to track staffing in accordance with patient acuity. The tool was updated six times a day to reflect real time changes to patients and staffing requirements. Staff were moved across the organisation to ward areas requiring higher patient acuity needs where possible.

Whilst every effort had been made to provide safe staffing, some wards had not met the planned staffing levels even with the use of bank and agency staff the fill rate between April 2017 and March 2018 had not achieved above 88%.

During our inspection concerns were raised regarding staffing levels from different grades of nursing staff. They said staff rota fill rates varied for different grades and there good days and not so good days depending on the skill mix for the shift. Staff also said that they were not always able to give the care they wanted and felt that staffing pressures could put patients at risk. Two patient relatives also expressed concern regarding sufficient staffing to provide safe care and treatment.

The trust has reported their staffing numbers below for the period April 2017 to March 2018 for medicine.
### Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 13.7% for nursing staff in medicine, which was higher than the trust target of 5%.

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

### Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.6% for nursing staff in medicine, which was lower than the target of 12%.

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

### Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 5.6% in medicine, which was higher than the trust target of 3.75%.

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

### Bank and agency staff usage

The trust provided us with information of bank and agency usage at trust level:

For registered nurses 8854 shifts were filled by agency staff and 13798 shifts were filled by bank staff during the period of October 2017 to August 2018. A total of 22652 nursing shifts.

For health care assistants 17 shifts were filled by agency staff and 28388 shifts were filled by bank staff.

---

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1,156.0</td>
<td>1,013.7</td>
<td>88%</td>
</tr>
<tr>
<td>May</td>
<td>1,161.9</td>
<td>1,020.9</td>
<td>88%</td>
</tr>
<tr>
<td>June</td>
<td>1,171.4</td>
<td>1,009.2</td>
<td>86%</td>
</tr>
<tr>
<td>July</td>
<td>1,170.4</td>
<td>1,004.0</td>
<td>86%</td>
</tr>
<tr>
<td>August</td>
<td>1,174.3</td>
<td>1,005.7</td>
<td>86%</td>
</tr>
<tr>
<td>September</td>
<td>1,168.9</td>
<td>1,010.8</td>
<td>86%</td>
</tr>
<tr>
<td>October</td>
<td>1,168.9</td>
<td>1,011.4</td>
<td>87%</td>
</tr>
<tr>
<td>November</td>
<td>1,168.9</td>
<td>1,010.9</td>
<td>86%</td>
</tr>
<tr>
<td>December</td>
<td>1,168.9</td>
<td>1,004.5</td>
<td>86%</td>
</tr>
<tr>
<td>January</td>
<td>1,165.0</td>
<td>999.0</td>
<td>86%</td>
</tr>
<tr>
<td>February</td>
<td>1,166.6</td>
<td>1,000.1</td>
<td>86%</td>
</tr>
<tr>
<td>March</td>
<td>1,167.7</td>
<td>992.9</td>
<td>85%</td>
</tr>
</tbody>
</table>
Medical staffing

Medical staffing levels were sufficient to provide safe care and treatment for patients. However, there were areas where long term locum medical staff were in post.

Consultants reviewed patients on daily ward rounds from Monday to Friday. All 14 records we viewed showed patients had been reviewed by a doctor within twelve hours of admission onto the ward. This included an outlier patient on another ward. Medical staff were available to see patients at night and on weekends via a bleep system.

We spoke with junior medical staff who told us they were supported well and could contact senior medical staff easily. The junior medical staff were also supported by a clinical skills team. There was an associate physician role to support medical staff and they had rotation placements within the hospital. One locum consultant we spoke with had been in the position for six years.

On inspection we found a clinical fellow from diabetes supporting the coronary care unit due to sickness and annual leave. We were informed this did not happen very often. Junior doctors told us sometimes there was a lack of staff due to night rotation and annual leave.

The trust used innovative planning and recruitment processes to support medical cover and vacancies with advance nurse practitioners, consultant nurses and physician’s associates posts.

The trust has reported their staffing numbers below for the period April 2017 to March 2018 for medicine.

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>171.1</td>
<td>149.3</td>
<td>87%</td>
</tr>
<tr>
<td>May</td>
<td>171.1</td>
<td>148.5</td>
<td>87%</td>
</tr>
<tr>
<td>June</td>
<td>138.5</td>
<td>149.1</td>
<td>108%</td>
</tr>
<tr>
<td>July</td>
<td>138.5</td>
<td>147.1</td>
<td>106%</td>
</tr>
<tr>
<td>August</td>
<td>181.5</td>
<td>144.5</td>
<td>80%</td>
</tr>
<tr>
<td>September</td>
<td>180.7</td>
<td>145.5</td>
<td>81%</td>
</tr>
<tr>
<td>October</td>
<td>180.7</td>
<td>147.5</td>
<td>82%</td>
</tr>
<tr>
<td>November</td>
<td>180.7</td>
<td>148.5</td>
<td>82%</td>
</tr>
<tr>
<td>December</td>
<td>180.7</td>
<td>148.9</td>
<td>82%</td>
</tr>
<tr>
<td>January</td>
<td>193.2</td>
<td>150.0</td>
<td>78%</td>
</tr>
<tr>
<td>February</td>
<td>193.2</td>
<td>150.9</td>
<td>78%</td>
</tr>
<tr>
<td>March</td>
<td>193.2</td>
<td>151.3</td>
<td>78%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 15.3% in medicine, which is higher than trust’s target of 5%.

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

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 33.1% in medicine, which is
higher than the trust target of 12%. There is a notable peak in turnover in September 2017, which could be due student staff moving department.

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

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 0.9% in medicine, which is lower than the trust’s target of 3.75%.

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

Locum and agency staff usage

The trust provided us with locum and agency staff usage at trust level for all grades of medical staff during the period of October 2017 to August 2018:

- Agency medical shifts 6128
- Bank medical shifts 5130

Staffing skill mix

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

Staffing skill mix for the 169 whole time equivalent staff working in medicine at East Lancashire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>17%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (March 2018)
Records

The service used both electronic systems and paper-based records for patient care. We checked fourteen patient records during our inspection and found information relevant to care and treatment was documented and recorded. However, the information was not all in the same place and this meant staff had to look in different places to find all the information needed.

The patients’ risk assessments were recorded on the electronic record system and paper records were kept for observation charts, prescription records, nursing and medical assessments. We found two sets of notes out of the 14 we reviewed where the risk assessment was missing. Both had been completed but not printed out and placed into the patients’ notes. The risk assessments were not accessible on the electronic system once the patient was discharged. A ward manager expressed concern for accessing the information when investigating incidents and on one occasion had to contact the IT department for assistance to view the assessment record.

Paper-based patient records were stored in trolleys or locked cabinets on wards near the nurses’ station which improved maintaining confidentiality of records in communal areas found on the previous inspection. Electronic records were accessed at computer terminals. We saw a mobile computer terminal used on a consultant ward round which provided mobile access to the electronic record to record patient information in real time.

At the time of inspection, the trust was in the process of procuring an electronic patient record system with an approximate implementation plan of eighteen months and anticipated roll out for May 2020. The system would enable all records to be held electronically.

Medicines

There were systems and processes in place to ensure the proper and safe use of medicines. However, the medicine management arrangement for assurance of these processes was not fully embedded.

The trust had identified two areas of concern within the nursing assurance performance framework; there was low uptake for the trust’s online medicines management training package and there were inconsistent documentation reasons for medicine omissions.

In seventeen drug charts we reviewed we found evidence of allergy status, pharmacy annotation, venous thrombosis embolism assessments, medicine reconciliation and charts were signed and dated. Two of the seventeen records had missed doses with no documented reason for omission.

In response to action we said that service must take in our last inspection the pharmacy team on the acute medical assessment ward visited A&E daily to stock check. This identified any patients’ own medicines which may have been left in the department on admission and these were returned to the patient on the ward or retained in the pharmacy department for seven days for collection or disposal.

The previous inspection report found the service should consider how medicine storage fridge temperatures could be accurately recorded and action taken where they were not within correct range. We found no area inspected this time had robust monitoring of fridge temperatures. For example, on the acute medical assessment ward we found the fridge temperature had been recorded as 0.3 degrees centigrade and no action had been documented for the low temperature. At the time of inspection, the efficiency of the medication was not affected as it was identified the temperature recorded had been transcribed incorrectly 0.3 instead of 3.
The service managed controlled drugs well in every area except ward C7. We found controlled drugs stored appropriately and balances checked with two signatures. However, on ward C7 we found most of the requisitions were not signed for “collected by” and “received by”. We found a bottle of acetone in an unlocked sundries cupboard and some opened oral liquid bottles were not annotated with an opening date.

Post inspection the service provided evidence for the collection and receipt of controlled drugs using an alternative document and standard operating procedures for the process in place at the time of inspection.

**Incidents**

Staff we spoke with were aware of how to report an incident and the type of incidents that could happen on a medical ward. Staff were mostly confident in reporting these to senior staff or report them on the electronic incident reporting system.

Incidents were reported by matrons quarterly with monthly exception reports to the integrated care group division. Investigations and root cause analysis were recorded on the electronic incident reporting system. We saw an incident where a patient had fallen resulting in a fractured neck of femur. This was reported as a serious incident, a root cause analysis investigation was carried out and presented to the board. Following the investigation, a duty of candour letter was sent to the family and actions where identified for staff learning and service improvements.

There had been two never events within the integrated care group which not all staff were aware of, or the learning that had followed. A “share to care” bulletin was circulated by the trust to all staff with incident themes, outcomes and learning, which staff said they did not always have time to read.

In the medicine for elderly people department the top three incidents identified were falls, medicines relating to and violence and aggression. Learning had identified one-to-one care had not been identified for some patients and an enhanced risk assessment tool was introduced.

Concerns were raised on inspection relating to safeguarding incidents. The incidents had raised awareness of safeguarding patients and staff when patients required additional mental health support. Reflective learning had provided staff with further training and support such as communication skills when talking to patients and relatives.

**Never Events**

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

From July 2017 to June 2018, the trust reported two incidents classified as never events for medicine.

One of these incidents pertains to a misplaced nasogastric tube, which has been placed into a lung. The other relates to a biopsy being performed on the wrong patient. Both incidents occurred within 30 days of each other.
Following the never event of the misplaced nasogastric tube, the nasogastric care bundle now emphasises a restriction on x-rays to confirm replacement after 4pm.

![Graph showing incident breakdown]

Source: NHS Improvement - OBIEE NRLS STEIS (July 2017 to June 2018)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from July 2017 to June 2018.

Of these, the most common types of incident reported were:
- Slips/trips/falls meeting SI criteria with 16 (57% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with four (14% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (11% of total incidents).
- HCAI/Infection control incident meeting SI criteria with two (7% of total incidents).
- Pressure ulcer meeting SI criteria with two (7% of total incidents).
- All other categories with one (4% of total incidents).

(Source: Strategic Executive Information System (STEIS))

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, 12 falls with harm and 12 new urinary tract infections in patients with a catheter from June 2017 to June 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Lancashire Hospitals NHS Trust**

1. **Total Pressure ulcers**
   - 1 Pressure ulcers levels 2, 3 and 4
   - 2 Falls with harm levels 3 to 6
   - 3 Catheter acquired urinary tract infection level 3 only

2. **Total Falls**
   - 12 Falls with harm levels 3 to 6

3. **Total CUTIs**
   - 12 Catheter acquired urinary tract infection level 3 only

*Source: NHS Digital - Safety Thermometer*

During our inspection we observed the safety thermometer information displayed in the entrance on the wards we visited. The information was updated monthly to inform patients and visitors on the performance of the ward.

We saw improvement in the numbers of falls. Actions and learning had been identified, implemented and continued to be monitored.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment using care bundle pathways based on national guidelines and best practice.

The service had care pathways which staff followed for treatment and escalation of different conditions. For example, The national Institute for Health and Care Excellence (NICE) Quality standard [QS76] acute kidney injury. Other pathways included stroke, diabetes, alcohol detoxification pathways for patients with an alcohol dependency and a frailty pathway for patients identified with complex needs. We saw evidence of the use of the frailty pathway used to reduce the length of stay of frail patients. Additional supporting pathways were in development with the allied health professional leads to streamline the patient journey and enhance recovery.

Patients were seen daily on the ward by a consultant, observations were recorded appropriately and this was evidenced in the patients' notes.

The policies, guidelines and standard operating procedures were overseen by the divisional clinical effectiveness committee.

Nutrition and hydration

The service assessed nutrition and hydration needs of patients and made referrals to supporting therapists when required.

The trust had a food and drink strategy to enhance nutritional care. This composed of an electronic malnutrition universal screening tool, the implementation of the nasogastric tube bundle care plan and the introduction of hydration mugs. The hydration mugs had fluid volume indications which helped staff complete fluid balance charts where closer monitoring of fluid intake was needed. The strategy was under review to update its objectives in line with best practice.

The malnutrition universal screening tool (MUST) was used by nursing staff to assess the needs of the patient. All 14 patients records we viewed had this assessment completed.

Dietitians provided support and nutritional advice for patients when needed. When required, speech and language therapists performed swallowing assessments for stroke patients, prepared care plans for patients who needed feeding assistance and percutaneous endoscopic gastroscopy (PEG) tube feeding.

We saw patients had water jugs and cups at their bedside which were checked by staff morning and evening. Patients told us tea and coffee rounds took place at breakfast, dinner and late afternoon.

There was a selection of meals available for patients. Some patients told us meals could be bland at times and some patients told us the puddings were great. Red trays were used to identify patients who required help with eating and were identified by ticking a box on the food choice form.
The service provided food to patients outside of meal times when needed. A patient told us staff had gone to the kitchen to find them something to eat as they had been admitted after the evening meal. Another patient told us staff had responded to all their needs.

**Pain relief**

Pain relief was prescribed dependent on a pain score assessment recorded on the early warning score document.

We saw pain scores were recorded on the early warning scores chart for most patients. Five of the four patients we spoke with said their pain was managed with medication adequately. However, the patient who told us the pain was not manageable had been admitted with pain and had only been given paracetamol. No pain score was documented and this was escalated to the nurse looking after the patient for immediate review.

The trust’s pain team were available for advice and support for patients with more complex pain needs.

**Patient outcomes**

Patient outcomes were audited, monitored and benchmarked by the service nationally and locally in the region for comparison.

The trust had a commissioning for quality and innovation (CQUIN) goal for sepsis, which was audited. Improvements had been made and a letter of recognition had been sent to the trust for this.

The respiratory assessment unit had improved same day discharge for patients with chronic obstructive pulmonary disease exacerbation. Specialist input was provided which had increased best practice tariff achievement from 30% to 70%.

**Relative risk of readmission**

The service had actions to improve the expected risk of readmissions and were working with other trusts and community services to reduce readmissions. Some cases were due to complex cases and social needs in the area.

**Trust level**

From March 2017 to February 2018, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology, general medicine and clinical haematology had a higher than expected risk of readmission for elective admissions.
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions, whereas patients in respiratory medicine and cardiology had a higher
than expected risk of readmission for non-elective admissions

England average: 

Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (March 2017 to February 2018))

Royal Blackburn Hospital

From March 2017 to February 2018, patients at Royal Blackburn Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in general medicine had a higher than expected risk of readmission for elective admissions
- Patients in cardiology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions
Elective Admissions - Royal Blackburn Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Non-Elective Admissions - Royal Blackburn Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, Royal Blackburn Hospital achieved an overall SSNAP level of grade A in the December 2017 to March 2018 audit.

The hospital’s performance has improved noticeably from January 2016 to March 2018.

|------------------------------------------|------------|------------|------------|----------------|----------------|----------------|----------------|
Team-centred total key indicator level

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
<th>Dec 17 - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
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<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
</tr>
</tbody>
</table>

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

Overall significant improvements had been made in Sentinel Stroke National Audit Programme. An action plan was formed to continue further improvements. Two consultant stroke nurse specialist posts had been created. These nurses assisted in the thrombolysis of stroke patients who attended A&E and linked patients through to the stroke ward.

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 89.3%, which did not meet the audit minimum standard of 90%. The 2016 figure was 80.8%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 18.4%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was insert percentage. This is better than expected/within the expected range/worse than expected. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 72.1%. This is within the expected range. The 2016 figure was not significantly different from the national level.

The one year relative survival rate for the trust in 2016 is 35.9%. This is within the expected range. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Royal Blackburn Hospital

The crude proportion of patients who had a vision assessment (if applicable) was 48%. This did not meet the national aspirational standard of 100%.
The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 18%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 25%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 73%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The service had seen a reduction in the number of falls from the previous inspection. However, senior nursing leads acknowledged there was more work to do around actions for improvement following the national falls audit.

Competent staff

The service had training support in place to make sure staff had the skills, knowledge and experience to deliver effective care, support and treatment. Staff appraisal rates were high and opportunities for development were encouraged where possible. However, we found some specialised training had not been given following a policy update.

The trust had a clinical skills team to support doctors in training. Junior doctors we spoke to felt supported and had access to trainers and mentors when needed. At the time of inspection this had only been for two weeks.

Nursing staff had a band five competency book to complete as part of the nursing preceptorship. Practice nurse educators had been successful in supporting staff training on some ward areas in the division. This was in the process of embedding throughout the division. Some staff told us it had been difficult to find mentorship and support but this was improving with the appointment of the practice nurse educators. Some staff expressed concern regarding nasogastric training as none had been provided since the policy had been updated. The nutritional nurse at the time of inspection had been off sick and no training was available.

Health care assistants completed a care certificate in the first 12 weeks of their employment. This was extended to support completion or put on hold for maternity or ill health reasons. At the time of inspection there was no clear distinction between band two and band three health care assistants’ duties. Managers told us this was under review and needed clarification.

We were told there were opportunities for staff to develop and take on additional duties (clinical or managerial) with support from ward managers. Staff we spoke with told us they had received an appraisal in the last twelve months and had the opportunity to identify further training needs.

Nursing staff completed competencies specific to their role and the area they worked. Staff competency records were held locally since the nationwide IT incident. Post inspection we requested the essential training list for nursing staff and health care assistants for each speciality with completion rates. The information could not be collected centrally but the education team planned to do so in the future when the IT systems were ready to support this. We were provided with essential training lists for staff working on acute medical unit and completion rates were only given for health care assistants. The completion rates were low due to many recently employed health care assistants who were still training.
The service had processes for managing disciplinary action and we were provided with evidence of action taken following incidents raised relating to patient allegations.

Senior nursing staff told us that agency staff did not always follow trust protocols and this was evident in some of the incidents that had occurred. On inspection we asked to see local induction records for agency staff but they could not be located. Following the inspection, we requested the agency staff induction policy and local induction record but this did not show an induction for agency staff in trust policy and procedures.

**Appraisal rates**

From April 2017 to March 2018, 90% of staff within medicine received an appraisal compared to a trust target of 90%. The trust has not supplied data allowing this to be broken down by staffing group.

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

**Multidisciplinary working**

Multidisciplinary teams worked together within the service, across the trust and across other organisations to deliver effective care and treatment.

We saw staff working collaboratively to understand and meet the complexity of patients’ needs. Each morning the consultant round included a nurse, therapist, pharmacist and member of the discharge team. This meant each person’s condition and progress towards discharge was evaluated every day. We saw multidisciplinary notes in patient records which contained a coloured sticker to denote which therapist had seen the patient.

The integrated care division provided care in the community and some staff worked across sites. Matrons and senior leaders across other sites held daily conference calls at 9am to plan and review patient acuity.

Other teams within the hospital, portering staff, pathology, diagnostic imaging, safeguarding team, bereavement team and specialist nurses, supported patient care when needed. Medical staff told us the pathology lab would phone significant abnormal blood results which was helpful.

Patients were also signposted to other agency support from other organisations including dementia, Alzheimer’s, stroke and therapeutic assistant practitioners. One patient had a scan appointment at another hospital and transport was arranged for the patient to attend the appointment.

**Seven-day services**

Doctors, nurses and health care assistants provided patient care seven days a week. Therapists routinely supported care Monday to Friday on general medical wards and at weekends on wards providing care for older people. Diabetes support was available seven days a week.

The stroke ward had started to trial an additional band six specialist stroke nurse working at night, to support seven day working service.
Other services such as pharmacy, porters and diagnostic services were also available when needed.

Consultant led Sunday morning discharges had begun to improve access and flow within the division.

**Health promotion**

The trust had a smoking cessation service where patients who smoked could receive support and advise on stopping smoking. Patients who were referred were given advice and offered nicotine replacement therapy.

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

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

The Mental Capacity Act and deprivation of liberty training is included in the safeguarding training for the trust.

Staff understood how to assess whether a patient had the capacity to make decisions about their care and how to seek advice and support when in doubt.

We saw discussion of mental capacity for a patient during a safety huddle. It was acknowledged that the patient had capacity but had not consented to treatment.

The trust had a safeguarding team who supported staff to make deprivation of liberty applications to local authorities.

We saw evidence where patients with dementia were identified and the dementia lead nurse was contacted to support patient care and advise staff. Some staff we spoke with were unclear about the process of mental capacity and deprivation of liberty but knew where to gain support and advice. However, other staff told us how a patient with mental health support needs were provided at the trust until a mental health bed became available.

**Is the service caring?**

**Compassionate care**

Staff were caring and supported patients treating them with dignity and respect. Patient feedback supported a compassionate approach to care.

Every ward we visited had received compliments from patients and relatives regarding the care and treatment given. We saw thank you cards displayed on medical wards which were very positive about the care and treatment they had been given. We asked patients on the wards about their care and treatment, some comments included “excellent care”, “the staff are great”, “staff are very caring and treated me with much respect” and “the matron made time to meet me and my wife”.


We saw call bells answered promptly and curtains drawn to provide dignity and respect when needed. Staff told us on the stoke ward they celebrated birthdays, wedding anniversaries and other significant occasions for patients if they were on the ward.

The trust had a bereavement team that supported patients and relatives when they were on the end of life care pathway. Staff told us extra support and training in communication skills was provided so they were confident in speaking to patients and family members.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 56% which was better than the England average of 25% from July 2017 to June 2018.

**Friends and family Test – Response rate between July 2017 to June 2018 by site**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACUTE MEDICAL UNIT A (INPATIENT)</td>
<td>2215</td>
<td>68%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>ACUTE MEDICAL UNIT B (INPATIENT)</td>
<td>1650</td>
<td>54%</td>
<td>56%</td>
<td>56%</td>
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<tr>
<td>IT8 RH</td>
<td>796</td>
<td>52%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>C6 RH</td>
<td>510</td>
<td>43%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>D3 RH Diabetes</td>
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<td>79%</td>
<td>56%</td>
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</tr>
<tr>
<td>T10 RH</td>
<td>479</td>
<td>68%</td>
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<tr>
<td>C9 RH</td>
<td>438</td>
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<tr>
<td>Ward D1</td>
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<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>C3 RH</td>
<td>379</td>
<td>50%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>C4 RH</td>
<td>347</td>
<td>51%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>C8 RH</td>
<td>341</td>
<td>56%</td>
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<td>56%</td>
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<tr>
<td>ASU (ACUTE STROKE UNIT)</td>
<td>329</td>
<td>49%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>CCL (Coronary Care Unit) RH</td>
<td>310</td>
<td>61%</td>
<td>56%</td>
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</tr>
<tr>
<td>C2 RH</td>
<td>299</td>
<td>37%</td>
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</tr>
<tr>
<td>C7 RH</td>
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<td>56%</td>
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</tr>
<tr>
<td>E4 RH</td>
<td>288</td>
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<td>56%</td>
</tr>
<tr>
<td>C5 RH</td>
<td>256</td>
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<td>56%</td>
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</tr>
<tr>
<td>C1 RH</td>
<td>192</td>
<td>45%</td>
<td>56%</td>
<td>56%</td>
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<tr>
<td>Ward 16 RH (Complex Discharges)</td>
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</tr>
<tr>
<td>D1 RH</td>
<td>143</td>
<td>75%</td>
<td>56%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Key

- **Highest score to lowest score**
- **100%**
- **50%**
- **1%**

1 The total response exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

2 Sorted by total response.

3 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.

(Source: NHS England Friends and Family Test)
Emotional support

We saw positive examples of staff providing emotional support to patients. However, staff told us due to staffing pressures they could not always provide the support they wanted.

We saw positive interactions between all grades of staff and patients. On the cardiology ward we saw a nurse providing reassurance when explaining how to take medication when they were home and what the medicine was for.

We saw a patient moved to a bed following initial triage on acute medical assessment B. The staff nurse explained to the elderly patient what would happen to make them more comfortable and reassured the patient’s relative the doctor would know where they were and would see them soon.

The trust had specialist nurses and spiritual leaders available to provide emotional support to patients and advise staff when psychological assessments were considered.

Understanding and involvement of patients and those close to them

Patients and those close to them told us they were involved in making decisions about their care. We saw documented discussions in patients notes which supported this.

A relative told us how they were allowed family time whenever they needed before the patient was transferred to a hospice. Visiting times on wards were between 10am and 10pm which allowed patients relatives to visit throughout the day.

Relatives and patients told us the doctors would explain and answer questions about care, treatment and investigations. However, on occasion this was the following day as the consultant was on another ward round.

On the wards we visited, we saw quiet rooms where nursing and medical staff could sit and talk in private to patients’ relatives. These rooms were light and spacious and provided a comfortable and safe space for talking.

Service planning and delivery to meet the needs of the local people

The trust planned services and delivery in the hospital and community to meet the needs of the local people.

The integrated care group provided local services for medicine for older people, stroke, cardiology, digestive diseases, respiratory disorders, diabetes and endocrinology. These were delivered on specialist wards with additional general medical wards. Patient referrals were made to other organisations for care and treatment where appropriate.

The acute medical assessment ward B was designated for GP referral admissions and had a separate reception and nurse triage room. The acute medical assessment ward A had extended pharmacy support to enable patients to be discharged rapidly.
The trust was part of an integrated care partnership to deliver the frailty strategy for Pennine and Lancashire. The partnership represented all the health and care organisations including local councils, voluntary, community and faith sector services. It focused on striving to achieve the best outcomes for the local people and making a positive difference to their lives. The new model of care aimed to put control of health and wellbeing to the local people so they could remain healthy for as long as possible. If the local people became ill the model aimed to ensure the local people received the right level of support within their home or local area.

**Average length of stay**

**Trust Level**

From April 2017 to March 2018 the average length of stay for medical elective patients at the trust was 6.8 days, which is higher than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.5 days, which is higher than the England average of 6.4 days.

Average length of stay for elective patients in general medicine and gastroenterology is lower than the England average. The average length of stay for elective patients in cardiology is higher than the England average, being double the England average.

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

![Bar chart showing average length of stay for elective patients in different specialties.](image)

Note: Top three specialties for specific trust based on count of activity.

With non-elective specialities, performance is much closer to the England average, with only respiratory medicine being lower than the England average.

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

![Bar chart showing average length of stay for non-elective patients in different specialties.](image)

Note: Top three specialties for specific trust based on count of activity.
Royal Blackburn Hospital

From April 2017 to March 2018 the average length of stay for medical elective patients at Royal Blackburn Hospital was 7.0 days, which is higher than England average of 6.0 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.4 days.

Elective Average Length of Stay - Royal Blackburn Hospital

For non-elective specialities, performance is close to the England average apart from respiratory medicine which is lower than the England average.

Non-Elective Average Length of Stay - Royal Blackburn Hospital

Meeting people’s individual needs

The service took account of patients’ individual needs and worked toward meeting those needs.

On the stoke ward representatives from a national stroke charity visited the ward on a Monday to provide information and leaflets to patients. To support patients a stroke choir had been set up and performed concerts. This supported patients with speech confidence.

Patient status boards were seen on the medical wards we visited. They detailed the patient’s bed number, additional notes, diet, mobility, investigation status, consultant review and discharge information at a glance with numbers and symbols. The symbols included a butterfly for dementia needs, raindrop for monitoring fluid input and output, a cutlery symbol for patients with dietary and feeding needs and a leaf for patients at risk of a fall.
The trust used a hospital passport for patients with learning disabilities or living with dementia to identify preferences and additional needs. This included information about the patients’ daily routines, likes and dislikes and individual preferences.

The trust provided a translation service for patients who did not speak English as a first language. The top five languages for the interpretation service was Urdu, Punjabi, Polish, Gujarati and Bengali.

We saw a patient who had been referred to hospital for an urgent blood transfusion. Usually blood transfusions were planned and given on another ward, but due to clinical symptoms arrangements were made for the transfusion to be given on the acute medical assessment ward B.

**Access and flow**

People could access care and treatment but this was not always in a timely manner as patients waited for beds. There were high numbers of bed moves at night due to discharges that occurred towards the end of the day and ‘bay flips’ to prevent mixed sex breaches.

We attended a bed managers’ meeting and saw how capacity and flow issues were handled on a day to day basis. These meetings updated the matrons on the breaches in the emergency department, bed shortages and flow issues, to agree actions or escalate decisions to more senior managers.

The trust had policies to support access and flow such as “Guidance for the safe transfer of adult patients” which covered the decision to transfer, role of the flow team, infection control, transfers out of hours and to other sites. Sometimes speciality beds were not available for patients and they were admitted to other areas. We saw a patient on a medical ward waiting for a stroke bed, although he had been reviewed by the stroke consultant within twelve hours of admission, which was documented in the patient record.

We were told, generally, the same pattern occurred where patients on the wards were discharged later in the day which resulted in bed moves at night. This was evident with high numbers of bed moves at night on the acute medical assessment wards A and B. From the last inspection the acute medical assessment units purpose was still to reduce the number of unnecessary admissions to the medical wards but capacity and demand had increased. One consultant told us there was sometimes “terrible flow” as the beds were not readily available on the wards.

The trust had a discharge team to facilitate earlier discharges on the ward by chasing outstanding prescriptions, blood tests and medicines. Feedback from medical staff on one of the general medicine wards said this worked well and enabled them more time to spend seeing patients. However, more complex cases for discharge took longer.
Referral to treatment (percentage within 18 weeks) - admitted performance

The trust’s performance is similar to the England average, dipping to approximately 80% from October to December 2017, before improving to meet the England average.

(Source: NHS England)

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

One specialty was 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>Thoracic Medicine</td>
<td>100%</td>
<td>93.0%</td>
</tr>
</tbody>
</table>

Three specialties were 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>Rheumatology</td>
<td>93.5%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>25%</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Following the inspection, we requested information about the geriatric medicine referral time to treatment. The trust provided data from September 2017 to August 2018, except for June 2018 at 98.96%, the referral time to treatment within 18 weeks was 100%.

Patient moving wards at night

From May 2017 to April 2018 there were 7,158 patient moving wards at night within medicine. We were informed on inspection this was due to discharges that occurred later in the afternoon/evening and bay flips when needed to prevent mixed sex breeches. This is when a single sex bay was changed from male to female or female to male.

Post inspection the trust provided additional information. In the time period reported there were 38,212 in-patient transfers of which 7,158 were at night and this equated to 19% of the total bed moves. This included moves from the urgent and emergency department to the acute medical units.
Medical Outliers

Following the inspection, we requested information about the number of medical outliers for the previous three months, June, July and August 2018. This ranged from two to twenty-eight per day for the three-month period. The service had eight designated medical beds on ward C22 for medical outliers which equated to an average of five medical outliers per day during the three month period.

The Trust had a medical outlier plan which included arrangements to ensure every medical outlier was reviewed every day, had a named medical consultant and team responsible for their care and that cover. Medical outliers were identified on the trust’s electronic patient information system and communicated, with a daily outlier list collated and circulated each morning by the patient flow team.

Learning from complaints and concerns

The integrated care group division treated concerns and complaints seriously, investigated them and lessons learned from them helped to improve the service.

The matrons and ward managers were actively concerned with addressing complaints locally. Staff told us how they would escalate any complaint immediately to a senior nurse or matron if they could not resolve the issue. This approach had seen positive results in the reduction of complaints received. For example, the digestive disease department had received complaints around complex and long-term care where continuity of consultant care was not maintained. Following this feedback, the consultant rotas on the wards was extended from weekly to fortnightly to provide the continuity of care for patients. Last year there were 16 reported level four complaints compared to two at the time of inspection.

Summary of complaints

From April 2017 to March 2018 there were 111 complaints about medical care. Of these, the vast majority occurred at the Royal Blackburn Hospital with 106 complaints. The trust took an average of 73 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be resolved within 50 days.

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

The number of compliments received were displayed on the information board at the entrance of each ward. On ward had received 51 compliments for August 2018. Some wards also displayed thank you cards from patients and relatives.

Is the service well-led?

Leadership

There was a clear leadership structure in place, from ward to board, which centred on providing high-quality person-centred care.
The integrated care group division was overseen by a divisional medical director, divisional director of nursing and divisional general manager. The integrated care group was subdivided into four areas: nursing for emergency pathway with acute medical assessment wards; nursing for community; nursing for acute with cardiology, digestive, respiratory, diabetes speciality wards; and, medicine for older people wards, stroke ward and community hospitals. Each subdivision had a clinical director, business manager, assistant business manager and matron or matrons.

The divisional leaders were from diverse backgrounds who had the skills, knowledge and experience to lead the service. They understood the challenges of the service and were passionate about providing sustainable, safe care and treatment.

Ward managers and matrons were visible on the wards and staff generally felt supported. Concerns were raised by ward managers and matrons in relation to staffing, where staff were moved from one area to another. Three ward managers told us they had not always agreed with the senior leaders’ decisions and had challenged decisions made, but they respected working relationships.

We were informed the matrons were visible on the wards and were supportive, but staff had not seen more senior leadership visit on the wards.

Vision and strategy

The trust had a clear vision “To be widely recognised for providing safe, personal and effective care”. There was a clear divisional vision to deliver this as an integrated model of care for community and hospital services.

Strategic development plans for the service included the providing safe staffing with an ageing workforce and population. This included providing mental health support by working with clinical commissioning groups and the local NHS mental health trust.

The vision of care was focused on pursuing integrated pathways and identify other commercial opportunities. Staff we spoke to were aware of the local service vision and strategy within the ward and some knew the trust vision and strategy from the booklet provided by the trust to support them during a care quality commission inspection.

Culture

Staff were committed to delivering high-quality and sustainable care within the service.

We found generally staff on the ward felt they were doing the best they could with the resources available.

Staff felt proud to work for the trust in delivering the care to patients. We found staff satisfaction was mixed and there were pockets of staff who did not always feel actively engaged and empowered to deliver the service as they would like due to operational constraints.

The divisional leaders said they continued to foster an open culture, rather than a culture of blame. We were told there had been a historical blame culture that had not been helpful. It was acknowledged that a cultural change would take a long time for staff perception to change.
Some staff felt they were moved too frequently between wards with the use of the safe staffing acuity tool. Senior managers had given some staff the opportunity to attend the acuity meetings and assist in staff resource planning to understand and see how the acuity tool was used.

**Governance**

The service had division and corporate committees to monitor performance and quality. These committees identified risks and enabled escalation, from ward to board, within the integrated care group.

The divisional core committees consisted of the serious incident review group, clinical effectiveness, education board and patient safety and risk and patient experience committees. The divisional safety and risk committee sub-groups included the mortality steering group, health and safety, medicine safety and optimisation group, venous thromboembolism committee, risk assurance meeting, infection prevention and control and the policy council. All committees fed into the corporate assurance structure committees with directorate and trust support and challenge.

Staff were clear about their roles and responsibilities and senior leaders understood their accountability.

**Management of risk, issues and performance**

The division identified risks and issues and measured performance to make improvements to the services.

Each speciality ward identified their own risks and issues but performance was measured as a division. Common risks included staffing and incidents such as falls, suboptimal care, violence and aggression. These risks were identified on the service risk register. Measures were taken to mitigate staffing risks with a divisional recruitment drive, skill mix review and the use of bank and agency staff. From the previous inspection staffing was identified as a risk but this was now recognised as a national risk. Where possible a member of staff would stay in a bay where patients had high acuity. The division recognised having the staffing skill mix to support patients was key to preventing incidents.

The nursing assessment performance framework accreditation scheme was used to manage ward performance. All staff we spoke with were aware of the performance scheme and were positive about it. Silver wards were proud of their achievement and were asked to support struggling wards where improvement was needed. At the time of inspection there were five red wards and seven amber wards.

External clinical audits and internal audits were used to measure performance and the division had seen improvements. Action plans identified areas for improvement.

**Information management**
The trust and division collected information using electronic and manual records to analyse and manage information to support its activities.

Staff training records were held locally using a paper based system. Staff told us this was laborious and plans were in place to put the records onto an electronic system.

Incidents were reported on an electronic system that identified serious incidents and escalated to divisional and board leads.

Staff could access information on the trust intranet, such as policies, procedure and care bundle pathways.

Information quality and records management for the trust was assessed using the information governance toolkit. It was scored at 81% for 2017 to 2018. The toolkit has radically changed for 2018 to 2019 to reflect the increased emphasis on cyber security and the trust aimed to continue improvements.

The divisional leads used information including audits, performance dashboards, staffing figures, complaints and patient feedback to monitor and were reviewed in meetings to determine actions for improvement.

**Engagement**

The service engaged well with those who used services, the public and external partners to support high-quality sustainable services. However, there were limited opportunities for staff engagement due to the service delivery demands.

The division was actively engaged with external organisations to develop the service and patient experience. Patient engagement was improving with the service development of home first. Senior leaders told us they had recognised the importance of involving patients much earlier in the process of developing services. A friends and family test survey template had been adjusted to enable access for patients with learning disabilities and feedback for this was in the early stages.

The division used a “you said, we did” scheme where staff, patients and relatives could give feedback. These were displayed on the entrance to each ward on the ward information and performance board. We saw on ward C4 there was a “you said” that they did not provide good mouth care with a “we did” to provide bespoke training for all staff and individualised training.

Senior leaders said they looked for more opportunities to engage with staff. Staff told us there had been a consultation to change the shift pattern to long working days. Most staff had chosen one option, but the trust implemented the other option. Some staff felt they were not listened to.

There were opportunities for staff the feedback with a trust annual survey and feedback Fridays. The CQC staff National Survey 2017 showed the integrated care group was the most improved division in the trust. However, this included services outside medical care and the data was not broken down into core service level.

**Learning, continuous improvement and innovation**

The service had a strong focus on continuous learning, improvement and innovation. The leaders looked for innovative roles and different ways of working to deliver the care services.
Continuous learning was a high priority and was encouraged across the division. There were opportunities for staff development for all grades.

Several improvement innovations had been implemented within the integrated care division. Some of these included Red2Green, which was first implemented by Ward B4 in August 2017. Days where no recovery-enhancing treatment was given were classified as red days, whereas days that added value and moved a patient closer to discharge were green days. Multidisciplinary teams across the trust worked together to improve the patient experience and reduce the length of time people spend in hospital.

‘#EndPJparalysis’ is a national campaign the trust has implemented which focused on encouraging patients to be more mobile by changing out of their pyjamas into day-time clothes. This was to aid patient recovery and reduce muscle wastage.

The service had a dedicated ward pharmacy workforce transformation and quality improvement project. This initiative was to improve accurate medicines reconciliations by having a pharmacist and pharmacy technician dedicated to a single ward Monday to Friday. This has seen patients getting better faster, leaving hospital sooner and a reduction in re-admission rates.

The diabetes directorate won a successful bid last year from NHS England to enhance the trust’s diabetes inpatient specialist nursing service and diabetes foot service across the trust. Additional staff were successfully appointed by October 2017. This made several improvements to the service a) A comprehensive staff training programme for diabetes care and management, b) A reduction in response times for assessment and waiting times in line with national institute for health and care excellence (NICE) guidance and c) Seven-day service provision.

The service had made other improvement initiatives which were not seen during our inspection such as, home first, safer and integrated care pathways including cardiology and hepatobiliary.

The division was working with another trust to develop a lung disease pathway and allied health professionals to deliver patient therapy pathways.
The trust’s services include vascular, general surgery, urology, orthopaedics, ENT, maxillofacial surgery, colorectal and hepatobiliary across the two sites. The trust has 12 surgical wards, with 227 inpatient beds.

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

The trust had 43,652 surgical admissions from February 2017 to January 2018. Emergency admissions accounted for 11,101 (25.4%), 27,759 (63.6%) were day case, and the remaining 4,792 (10.9%) were elective.

(Source: Hospital Episode Statistics)

The surgical services at Royal Blackburn Hospital are managed by the surgery and anaesthesia division, who also manage surgery and anaesthesia services at Burnley General Hospital. The division includes the operating theatres, the surgical wards, the surgical triage unit and the pre-operative assessment clinic.

The Care Quality Commission carried out an unannounced inspection between 4 and 6 September 2018, that is staff did not know we were coming, to enable us to observe routine activity. During this inspection we visited surgical wards C22 (urology and head and neck), B20 (vascular), C14A general surgery, B22 and B24 (orthopaedics), surgical triage unit, pre-operative assessment clinic, the surgical admissions and the day case unit.

We spoke to 13 patients and relatives. We also spoke with 41 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, dieticians, pharmacists, domestics, ward clerks, housekeepers and nursing agency staff.

We observed care and treatment and looked at 16 patient care records. We reviewed comments from staff focus groups, patient feedback cards and we looked at the service performance data.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, organisational or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.
Mandatory training completion rates

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 at trust level for staff in surgery is shown below.

The trust has not included any staffing group data with their training return, so the data cannot be broken down into the nursing and medical staff groups.

The trust set a target of 90% for completion of mandatory training.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>1,588</td>
<td>1,633</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1,573</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>1,573</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>1,556</td>
<td>1,633</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>1,571</td>
<td>1,652</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>1,534</td>
<td>1,633</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent</td>
<td>1,517</td>
<td>1,633</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>1,201</td>
<td>1,334</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>1,427</td>
<td>1,633</td>
<td>87%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff in the surgery core service exceeded the trust’s 90% completion rate target eight of the nine mandatory training modules.

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

The Blackburn surgical division followed the trust mandatory training policy. This was based on a training needs analysis which determined which training, staff, were required to undertake based on their roles and responsibilities. Staff 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 courses were undertaken electronically via the trust ‘learning hub’ which also provided access to other training and course bookings. Some training such as life support training required attendance in person in a classroom.

During our inspection we sampled a number of wards and areas and found that ward and theatre managers kept a record and monitored their team’s compliance with mandatory training. We found that any pockets of non-compliance were largely amongst staff members who were on long term sick absences. The trust had a good system for alerting individuals and managers when mandatory training was due.

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.
**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 at trust level for staff in medicine is shown below.

The trust has not included any staffing group data with their training return, so the data cannot be broken down into the nursing and medical staff groups.

<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
<td>1,574</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>1,567</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Staff in the surgery core service exceeded the trust’s 90% completion rate target for both of the safeguarding training modules.

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

A safeguarding policy was in place which was in date and accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a vulnerable adult or young person and they understood the correct process to follow. Safeguarding vulnerable adults and safeguarding children and young persons was included in the hospital mandatory training programme.

Each ward had a safeguarding ‘link nurse’ who could support staff with any concerns and whom was a point of contact for advice and training. The trust had a safeguarding team which included specialist safeguarding practitioners as well as other safeguarding specialists. The trust safeguarding team was available during core hours for staff to contact should they have any safeguarding queries or concerns.

Paediatric surgery was undertaken in theatres. Children were put on designated paediatric only theatre lists to ensure the appropriate resources could be provided such as paediatric trained nurses and those with level three safeguarding training. Although some unplanned emergency paediatric surgery was undertaken as necessary.

The division treated young people aged 16 and 17 years on the adult surgical wards. If they had a concern about safeguarding they would consult the paediatric ward where there were nurses trained to level three and four. They also had access to the child safeguarding team who could advise them accordingly.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
An infection prevention and control policy was in place and we found staff were aware of this policy. There was an infection prevention and control team in the hospital with infection control specialist nurses and a designated lead link nurse for infection prevention and control on each ward. These were available as a point of contact for advice, guidance and training.

We observed that clinical and surgical areas appeared visibly clean. Cleaning rotas were in place and these were audited regularly. Infection prevention and control formed part of the ward audit programme and was undertaken monthly. Any areas of concern were recleaned, rechecked and issues rectified.

We observed that staff working in clinical and surgical areas were compliant with the trust uniform policy and arms 'bare below the elbow' practice. Alcohol gel points and hand washing sinks were available around the clinical areas for the use of staff, patients and visitors. There was good access to hand gels and handwashing facilities for staff at the point of care and we observed these to be utilised as appropriate by staff and visitors. There were posters on the entrance to wards advising visitors and staff to cleanse their hands.

During our inspection we observed that staff cleansed their hands between patient contact and before and after performing care interventions. Staff on wards used personal protective equipment, such as gloves and aprons as appropriate. Staff in theatres followed infection prevention precautions and wore appropriate theatre attire in designated areas.

Those patients who were subject to isolation precautions due to infection or at risk of infection were cared for in single side rooms. Appropriate signage and access to personal protective equipment was in place and doors were closed. Instructions were provided to inform visitors and staff of the need to follow certain precautions. There was a risk assessment and standard operating procedure in place for patients with tracheostomy or laryngostomy which allowed for their doors to remain open for safety reasons as they were unable to shout for help if needed.

The latest surgical site infection annual audit report was published December 2017, which is the latest published data and covered the period April 2016 to March 2017. The trust recorded six surgical site infections for hip replacements, from 273 operations. This was higher (worse) than the England average. The trust recorded no surgical site infections for knee surgery from 398 operations, this was lower (better) than the England average. The division also audited surgical site infections as part of the Getting It Right First Time (GIRFT) programme. This was designed to improve the quality of care across the wider NHS by reducing unwarranted variations.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

In the operating theatres staff told us they had access to the equipment and instruments they needed to undertake their roles. The division used single-use, sterile instruments as appropriate. The single use instruments we saw were within the manufacturers’ expiry dates.

The service had arrangements for the cleaning and sterilisation of reusable surgical instruments which were undertaken on site by the theatre sterile services unit. We were advised that there was an efficient turnaround of equipment and an urgent service was also available. Within theatres there was a robust process for ensuring clean and dirty items were segregated to reduce the risk of any cross contamination.
Waste and clinical specimens were handled and disposed of in a way that kept people safe. Staff used the correct system to handle, sort and store different types of waste and these were labelled appropriately.

Resuscitation equipment was checked in line with trust policy. Trolleys were sealed and a record was usually kept of unique seal reference numbers, except for one ward where there was no place on the checklist to record the seal number. This was highlighted and rectified at the time of inspection. During the inspection a sample of items contained within the trolleys were checked and were in all but one trolley found to be in a useable condition and within the manufacturers’ expiry dates. On one ward both sets of defibrillator pads were out of date, this was raised with staff and rectified at the time.

Medical and clinical equipment was serviced and tested regularly. The medical engineering department provided maintenance and engineering services to the hospital and was responsible for the periodic servicing and maintenance of trust equipment. Most of the equipment we checked had been serviced and checked appropriately, however we found that all anaesthetic machines in the division were outside of their service dates. The division were aware of this and explained that this was due to an issue with the manufacturer and parts were on order. The service provided evidence from the manufacturer who stated the machines remained safe for use. Operating theatres had their air circulation annual checks completed in April 2018; these found the systems to be compliant and met minimum requirements.

Bariatric equipment was available to the wards and theatres if required. Operating theatre tables were suitable for use by bariatric patients and were labelled accordingly. During our inspection, we found items subject to the ‘control of substances hazardous to health’ regulations were stored securely and appropriately.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The division used a recognised ‘track and trigger’ scoring system for recognising acutely ill and deteriorating patients. They used an early warning system to identify patients who were most at risk of deterioration and aid the escalation of their care. The patient’s observations and vital signs produced a score, which correlated with certain actions such as urgent medical attention or greater frequency of observations. During the inspection a sample of charts were checked and we saw these had been escalated as appropriate. Staff we spoke with were familiar with the triggers and what action to take.

An acute care team was available 24 hours a day, seven days a week. The team responded to clinical emergencies and those patients requiring immediate attention or triggering an urgent response on their early warning score, due to their clinical observations. The acute care team also provided a ‘step down’ service to monitor patients who had transferred from the critical care area to a regular ward to ensure they were not at risk of relapse or deterioration.

Patients’ risk during surgery was assessed at pre-operative clinic which was a nurse led service. The assessment nurses took the patient’s past medical history, undertook a clinical examination and determined if any further tests or information was needed prior to surgery. The pre-operative clinic also had some designated anaesthetist led appointments for those patients who were potentially at greater risk and who needed a consultation with an anaesthetist prior to their
surgery. The pre-operative team initiated enhanced recovery protocols for relevant procedures and educated patients on the programme and what they needed to do. The pre-operative clinic also assessed patients for their mental health needs and any phobias or anxiety.

A patient’s risk of developing complications or experiencing harm during their treatment was assessed on admission to the wards and clinical areas and was reviewed at regular intervals thereafter. During our inspection we saw that assessments were carried out for nutritional needs, risk of falls and mobility, venous thromboembolism (VTE), manual handling, skin integrity and risk of pressure ulcers and dementia screening. These individualised risk assessments were completed and reviewed regularly. A patient’s risk was also highlighted at handover and printed on handover sheets to aid staff awareness.

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.

There was a trust medical and nurse lead for sepsis who were available for advice and support and who had delivered a series of awareness training sessions to surgical staff. A sepsis care bundle was in place and sepsis screening was aligned to the early warning observations recording tool. Compliance was audited regularly using the sepsis care bundle measurement audit, this was reported to the divisional clinical effectiveness leads and was reported to be improving. Cases which have not met the required standard were incident reported and were monitored through governance systems.

The service reported compliance with sepsis on a trust wide level and reported that 100% patients were screened and 91% of inpatients with possible sepsis received intravenous antibiotics within one hour. An audit of the sepsis bundle from January to March 2018 produced an overall composite score of 87.4% which was an improvement on previous results.

There was an audit of antibiotic administration for surgical patients with suspected sepsis, this revealed some delays and some inconsistencies in antibiotic administration. An action plan was produced with plans for education sessions and circulation of awareness material. There is to be a further audit to test for improvement.

Staff we spoke with appeared to be familiar with sepsis and could describe what they needed to do, however, a pharmacist we spoke described that ideally antibiotics should be administered within 24 hours rather than the recommended one hour.

Theatres had reported several serious incidents around safe surgery and as a response has strengthened processes in theatres. During our inspection we observed the operating theatres processes around the National Patient Safety Agency (NPSA) ‘five steps to safer surgery’ and the completion of the World Health Organisation (WHO) checklist. We observed good practice in conducting the checks and the team used a white board to assist their recording of elements of the surgical safety checklist. They had also devised a process called ‘10,000 feet’, this was a process by which any member of staff could call for a pause in procedures if they felt there was a concern about patient safety. The 10,000 feet initiative received external recognition when it won a patient safety award in 2018.

The operating theatres team had an ‘audit day’ whereby the theatres team had a day set aside where no surgical activity was carried out to undertake audits and internal reviews of performance, training and improvement initiatives for staff.

During our unannounced inspection, it was evident that the surgical division had implemented their own ‘Local Safety Standards for Invasive Procedures’ (LocSSIPs) based on the ‘National Safety
Standards for Invasive Procedures’ (NatSSIPs). This was a directive by the National Patient Safety Agency (NPSA) which instructed hospitals to implement plans to standardise processes and improve the safety of higher risk invasive procedures. They also had a designated trust lead in place for these.

**Nurse staffing**

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust has reported their staffing numbers below for the period April 2017 and March 2018.

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>687.5</td>
<td>644.1</td>
<td>94%</td>
</tr>
<tr>
<td>May</td>
<td>700.4</td>
<td>649.3</td>
<td>93%</td>
</tr>
<tr>
<td>June</td>
<td>709.6</td>
<td>642.1</td>
<td>90%</td>
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<tr>
<td>July</td>
<td>707.6</td>
<td>638.2</td>
<td>90%</td>
</tr>
<tr>
<td>August</td>
<td>708.7</td>
<td>635.9</td>
<td>90%</td>
</tr>
<tr>
<td>September</td>
<td>683.9</td>
<td>659.9</td>
<td>96%</td>
</tr>
<tr>
<td>October</td>
<td>683.9</td>
<td>661.8</td>
<td>97%</td>
</tr>
<tr>
<td>November</td>
<td>683.9</td>
<td>657.3</td>
<td>96%</td>
</tr>
<tr>
<td>December</td>
<td>683.9</td>
<td>649.1</td>
<td>95%</td>
</tr>
<tr>
<td>January</td>
<td>712.2</td>
<td>643.3</td>
<td>90%</td>
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<tr>
<td>February</td>
<td>714.4</td>
<td>637.1</td>
<td>89%</td>
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<tr>
<td>March</td>
<td>712.7</td>
<td>633.5</td>
<td>89%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8,388.8</strong></td>
<td><strong>7,751.4</strong></td>
<td><strong>92%</strong></td>
</tr>
</tbody>
</table>

The nurse staffing fill rates were between 89% and 97% from April 2017 to March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 7.6% in surgery.

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

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 7.8% in surgery.

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

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 5.2% in surgery; higher than the trust target rate of 3.8%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
During our inspection we found that the wards had sufficient staff on duty to protect patients from avoidable harm. We also found that there was sufficient flexibility in the system to allow for the accommodation of an unpredictable event such as staff sickness or the care of a patient with higher acuity levels than planned for. As ward managers and ward coordinators were supernumerary, they could assist staff when unexpected events occurred.

During our inspection we found that nursing vacancy levels on wards were low and new staff had just started or were about to start in post to fill vacancies. Ward managers reported that vacancies attracted good numbers of candidates and that positions on the surgical wards were popular with students. They reported that students who had undertaken placements on the wards very often sought permanent positions.

The division undertook professional judgement assessments which considered the numbers of nurses and care staff needed on wards. Ward managers could bid for extra staff based on the individual needs on their wards. We saw that staffing levels had been increased as a result and this had a positive impact on the running of the wards. Staff we spoke with were satisfied with the numbers on duty and felt this enabled them to undertake their roles to a high standard.

An exception to this was seen on the day surgery ward. We found that this area was often used as an escalation area to care for patients overnight when there were no beds on the surgical triage unit or other wards in the hospital. This area was not staffed overnight so additional staff had to be called in to care for the patients placed here overnight. This was usually staff from other wards and agency or bank staff. This added additional strain on nursing and care staff resources and caused staff to feel they were compromising patient care when this happened. We were advised this also impacted on the care they could provide for day surgery patients who may experience delays or cancellations in care and treatment due to staffing issues. We saw that this escalation area was used 12 days during the period 22 May to 2 September 2018. There had been four incidents reported around staffing and there had been one complaint from a patient who felt the facilities were not appropriate and that, because of staffing, they did not receive pain relief in a timely way.

**Bank and agency staff usage**

The surgery division used an increasing number of bank and agency staff over the six months prior to the inspection. Most additional staff were from the trust ‘bank’ supply, that is the trust’s own staff who wish to work additional hours for pay. The advantage of this is that they are more familiar with the trust practices, policies and procedures. We saw during our inspection that agency staff received an induction when they came to work in the surgery division, that on the whole agency staff had worked on the wards before and that where possible agency staff were block booked.

Figures provided by the division showed that on average 11 agency staff and 37 bank staff per day were used across the division which included wards and operating theatres.

<table>
<thead>
<tr>
<th>Month</th>
<th>Agency</th>
<th>Bank</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-18</td>
<td>287</td>
<td>1361</td>
<td>1648</td>
</tr>
<tr>
<td>Apr-18</td>
<td>322</td>
<td>991</td>
<td>1313</td>
</tr>
<tr>
<td>May-18</td>
<td>331</td>
<td>982</td>
<td>1313</td>
</tr>
<tr>
<td>Jun-18</td>
<td>318</td>
<td>1076</td>
<td>1394</td>
</tr>
<tr>
<td>Jul-18</td>
<td>328</td>
<td>1263</td>
<td>1591</td>
</tr>
<tr>
<td>Aug-18</td>
<td>416</td>
<td>1136</td>
<td>1552</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2002</td>
<td>6809</td>
<td>8811</td>
</tr>
</tbody>
</table>
Theatres Staffing

The service had enough theatres staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

During our inspection we found that there were sufficient staff in theatres to protect patients from avoidable harm. Operating theatres were staffed in line with Association for Perioperative Practice (AFPP) minimum standards. There was enough flexibility in the system to ensure that the department could maintain safe staffing levels in the event of unforeseen events such as operations overrunning, out of hours events and sickness.

Operating theatres used agency and bank staff to fill any gaps in duty rosters. Agency theatre staff were block booked for extended periods to offer continuity and familiar staff.

Surgical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust has reported their staffing numbers below for the period April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Month (2017 - 2018)</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE</th>
<th>Fill Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>225.2</td>
<td>223.1</td>
<td>99%</td>
</tr>
<tr>
<td>May</td>
<td>227.2</td>
<td>223.7</td>
<td>98%</td>
</tr>
<tr>
<td>June</td>
<td>228.5</td>
<td>221.9</td>
<td>97%</td>
</tr>
<tr>
<td>July</td>
<td>228.5</td>
<td>220.9</td>
<td>97%</td>
</tr>
<tr>
<td>August</td>
<td>227.3</td>
<td>229.3</td>
<td>101%</td>
</tr>
<tr>
<td>September</td>
<td>227.3</td>
<td>231.8</td>
<td>102%</td>
</tr>
<tr>
<td>October</td>
<td>227.3</td>
<td>231.8</td>
<td>102%</td>
</tr>
<tr>
<td>November</td>
<td>227.3</td>
<td>233.8</td>
<td>103%</td>
</tr>
<tr>
<td>December</td>
<td>227.3</td>
<td>236.8</td>
<td>104%</td>
</tr>
<tr>
<td>January</td>
<td>229.9</td>
<td>236.8</td>
<td>103%</td>
</tr>
<tr>
<td>February</td>
<td>230.2</td>
<td>234.1</td>
<td>102%</td>
</tr>
<tr>
<td>March</td>
<td>229.2</td>
<td>233.1</td>
<td>102%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>2735.2</strong></td>
<td><strong>2757.3</strong></td>
<td><strong>101%</strong></td>
</tr>
</tbody>
</table>

The medical staffing fill rates were between 98% and 104% from April 2017 to March 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of -0.8% in surgery, which could indicate an over establishment of staff.

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

From April 2017 to March 2018, the trust reported a turnover rate of 19% in surgery;

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

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 1.3% in surgery, lower than the trust target rate of 3.8%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

Staffing skill mix

From March 2018 to March 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at East Lancashire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>18%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

*(Source: NHS Digital Workforce Statistics)*

During our inspection we were told that surgical staffing was good and the service was a location of choice for doctors seeking a varied and stimulating learning environment. Managers told us they were always able to secure good quality candidates to posts. Junior doctors staffing was supplemented by advanced nurse practitioners (ANPs) which were present on every ward we visited and associate physicians (AP) who had recently been recruited to some wards.

Consultant ward rounds were undertaken daily with ward rounds being undertaken at weekends for new patients and those for whom a review was requested. During our inspection we found surgical staffing was adequate. 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 the training programme was good, there were plenty of opportunities for development and learning.

**Records**

Staff kept detailed records of patients’ care and treatment. Records were up-to-date; however, we saw some contained illegible entries, loose leaves and they were not stored in a way which prevented unauthorised access.

Patient records were in paper form with certain elements such as risk assessments being recorded electronically. There were three different places where paper patient records were kept, a ‘nursing’ end of bed folder for observation charts, risk assessments and prescription charts, a ‘current episode’ folder for current diagnostic results and documentation of ongoing care and a ‘buff’ patient folder that contained all other patient records including historic records. The collective records contained all relevant information.

We saw that within a small number of records there were entries which were illegible, including two consent forms and there were four records which contained loose leaves, there is therefore a risk these unattached pages could become separated and lost.

We also found that patient records were stored in mobile trolleys but they were not locked, this meant that the security of these documents could not be guaranteed as records may be accessed by unauthorised individuals.

Clinicians in the service also had access to clinical portal which allowed access to records kept by other local acute NHS hospital records such as discharge letters and details of accident and emergency attendances and GP records.

**Medicines**

The service followed best practice when prescribing, giving, recording medicines. Patients received the right medication at the right dose at the right time. However, we found the recording of medicines refrigerators was not robust.

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 reviewed records that demonstrated that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection we also checked a sample 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 were not prescribed.

We found that medicines requiring cool storage were kept in medicines refrigerators. However, we found the recording of temperatures of those refrigerators was not being undertaken in a way which established if the refrigerator had been out of appropriate temperature range and so it was not known if the medicines remained safe to use. Furthermore, there was no recording of ambient room temperatures, therefore no assurance that medicines had not been exposed to extreme temperatures above 25°C, which may have affected their effectiveness.
Prescriptions charts checked were generally satisfactory, however, on one chart there was no end or review date and no indication for the antibiotic prescription. There was a medicines self-administration policy in place which was in date and accessible to staff. This was in keeping with best practice guidance. During our inspection we did not see anyone who was self-administering their own medications.

When a patient was being discharged they were referred to their local community pharmacy. This enabled better support, counselling and understanding of their medicines and a better relationship with their community pharmacist.

**Incidents**

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. When things went wrong, staff apologised and gave patients honest information and suitable support.

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.

Staff we spoke with were familiar with the types of incidents that should be reported, such as patient safety incidents, staffing issues and equipment failures. We saw evidence that incidents and associated risks in the surgery 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. We also saw that incidents experienced in other teams and divisions were shared across the surgery division for them to learn from also. For example, staff were familiar with an incident on critical care involving oxygen and air outlets.

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.

Managers in the surgery division participated in serious incident review panels. These meetings were used to highlight and discuss incidents in a timely and open way. This meeting sought to respond quickly to recent incidents to share concerns, discuss ways of dealing with incidents, ways to reduce risks to other patients and to reduce the chance of reoccurrence in other areas of the hospital.

We reviewed a sample of investigations relating to serious incidents, we found each was investigated in an open and candid way and that key issues were identified. Each report contained evidence of actions taken to prevent future incidents and there was identification of lessons to be shared, together with an action plan. There was evidence that 72-hour rapid reviews had taken place to identify any immediate issues. A family liaison officer was appointed whenever a serious incident occurred.
**Never Events**

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

The surgery division report six never events between April 2017 and July 2018.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 April 2017</td>
<td>Wrong Site Surgery, Vocal Cord</td>
</tr>
<tr>
<td>12 April 2017</td>
<td>Wrong Site Surgery, Abscess</td>
</tr>
<tr>
<td>18 July 2017</td>
<td>Retained foreign object post procedure, gall bladder</td>
</tr>
<tr>
<td>6 October 20/17</td>
<td>Wrong Site Surgery, Varicose Veins</td>
</tr>
<tr>
<td>11 October 2017</td>
<td>Wrong Site Surgery, Biopsy</td>
</tr>
<tr>
<td>12 March 2018</td>
<td>Wrong Site Block</td>
</tr>
</tbody>
</table>

The trust implemented an action plan and a series of measures to reduce or eliminate the chances of repeated never events. Most were attributable to failures within the safer surgery processes. Education and awareness raising activities, the launch of enhancements to the safer surgery processes had been implemented.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from July 2017 to June 2018.

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

- Pressure ulcer meeting SI criteria with four (25% of total incidents).
- Slips/trips/falls meeting SI criteria with three (19% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (19% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (13% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (13% of total incidents).
- All other categories with two (13% of total incidents).

(Source: Strategic Executive Information System (STEIS))
Safety Thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this 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 three new pressure ulcers, eight falls with harm and five new catheter urinary tract infections from June 2017 to June 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at East Lancashire Hospitals NHS Trust

1 Pressure ulcers (3)

2 Falls (8)

3 Catheter urinary tract infections (5)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

The surgical division reported 98.9% harm free care from August 2017 to July 2018. This was much better than the England average. The division reported five cases of Clostridium difficile infection and one case of methicillin-resistant Staphylococcus aureus infection.

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 and were often the topic of feedback Friday discussions.

Risk assessments for pressure ulcers, falls and venous thromboembolism 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, venous thromboembolism prophylaxis or implementing a falls care plan. The division participated in the trust falls reduction programme and ‘steady on’ initiatives to help reduce patients falls. The division reported compliance with venous thromboembolism assessment completion was 99.5% for the period July 2017 to June 2018.

**Is the service effective?**

### Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

National Institute for Health and Care Excellence (NICE), 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. The clinical effectiveness committee and divisional management group reviewed and actioned any changes. Any deviation or planned departure from the guidance such as that deemed ‘relevant but not implemented’ was risk assessed, barriers to implementation ascertained and these were agreed through governance committees and documented accordingly. Where relevant this was reported to the divisional risk register.

Divisional management undertook ongoing reviews of the compliance and reported back centrally. Care pathways and care bundles such as fractured neck of femur, revascularisation surgery, abdominal surgery such as colectomy and stoma surgery reflected National Institute for Health and Care Excellence guidance and were followed by surgical teams. These had been reviewed and corresponded with latest guidance.

The division used technology and equipment to enhance the delivery of effective care and treatment. They used the latest surgical robot for certain procedures which improved outcomes for patients.

The division followed best practice in relation to the pre-operative assessment processes; this ensured patient risk was identified and minimised as much as possible. It also aimed to optimise patients for surgery to provide the best possible outcomes.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of psychiatric liaison staff employed by the local NHS mental health trust. The psychiatric liaison service worked 24 hours a day, 7 days a week with patients of all ages who required mental health input.

The service carried out a range 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 ‘Forward Measurement Plan 2018-19’ was in place which was the audit programme for the division.
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.

The patient’s records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition. We observed that those deemed at risk were highlighted on their records and that risk assessments were reviewed at appropriate intervals. We found patients on food charts and fluid balance charts had these completed and updated 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.

Surgical wards had access to a dietician during core hours who could provide advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. We saw that dieticians were readily available on wards and reviewed patients with identified issues.

The wards also 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.

Speech and language therapists were available during core hours, they could assess if it was safe for patients to eat. Outside these times, there were protocols to obtain urgent swallowing assessments. There were also policies and procedures around the use of naso-gastric tubes, including which staff could insert, what the ‘safe to use’ criteria were and initial feeding regimes.

There were mixed feelings from patients about the quality and choice of food and that was provided, some stated it was unpalatable and the choice was limited, others stated it was okay. Some wards had ‘hydration stations’ on the wards where patients and relatives had access to hot drinks, snacks and nutritional supplements. Patient led assessments of the care environment found that food scores were 81% for ward food, this is worse than the England average score of 87% for 2018.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain on most wards but we found delays in doing this on the surgical triage ward. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Surgical wards and theatres recovery areas assessed pain as part of the early warning score system, the measurement of pain levels was recorded alongside clinical observations on the patients’ chart. On the whole patients reported good attention and responses by staff to their pain levels, however, we found one patient in the surgical triage unit who had attended following a referral from her GP but had not been assessed for pain, nor given any pain relief since her arrival four hours earlier. This was raised with staff who acted on the information swiftly.

Staff also had access to a dedicated pain team with specialist pain control nurses within core working hours. Out of hours and at weekends, pain advice could be sought from the on-call anaesthetist. We saw evidence that the pain team was well utilised and that where pain relieve was difficult to achieve a pain team review was requested.
Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Relative risk of readmission

Royal Blackburn Hospital

From March 2017 to February 2018, all surgery patients at Royal Blackburn Hospital had a higher expected risk of readmission for elective admissions when compared to the England average. This was most notable in the urology specialty.

Elective Admissions - Royal Blackburn Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

The division explained that a contributing factor to the statistics was because routine, low risk elective surgery was undertaken at Burnley and only higher risk and more complex procedures were undertaken at Blackburn. For this cohort of patients, it was more likely they would have complications, slower recovery times, increased lengths of stay and greater prospects of readmission. Comparisons to the general population therefore were not accurate.

The division had undertaken some analysis on readmission rates. They stated that they had uncovered that this was specifically due to two procedures namely circumcision and ear surgery that had very high readmission rates which impacted on the overall readmission statistics. They reported that in all other areas readmission rates were in line with England averages. They were working on understanding why these specialities had such high rates and would take steps to improve these.

All surgery patients at Royal Blackburn Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Non-Elective Admissions - *Royal Blackburn Hospital*

Notes: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

*(Source: Hospital Episode Statistics)*

Readmission rates for non-elective unplanned procedures was much better than the England average for all specialities with fewer readmissions than expected.

**National Hip Fracture Audit**

In the 2017 National Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.2% which was within the expected range. The 2016 figure was 6.3%.

The proportion of patients having surgery on the day of or day after admission was 69.0%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 72.5%.

The perioperative medical assessment rate was 96.3%, which failed to meet the national standard of 100%. This was within the middle 50% trusts. The 2016 figure was 94.9%.

The proportion of patients not developing pressure ulcers was 97.4%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 98.1%.

The length of stay was 24.9 days, which falls within the middle 50% of trusts. The 2016 figure was 23.8 days.

*(Source: National Hip Fracture Database 2017)*

<table>
<thead>
<tr>
<th>2017 National Hip Fracture Audit Results</th>
<th>Royal Blackburn Hospital</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to orthopaedic ward within 4 hours</td>
<td>39.8</td>
<td>39.7</td>
</tr>
<tr>
<td>Mental test score recorded on admission</td>
<td>99.6</td>
<td>94.8</td>
</tr>
<tr>
<td>Perioperative medical assessment</td>
<td>96.3</td>
<td>88.7</td>
</tr>
<tr>
<td>Physiotherapy assessment by the day after surgery</td>
<td>99.1</td>
<td>94.5</td>
</tr>
<tr>
<td>Mobilised out of bed by the day after surgery</td>
<td>87.3</td>
<td>79.0</td>
</tr>
<tr>
<td>Nutritional risk assessment</td>
<td>95.2</td>
<td>93.8</td>
</tr>
</tbody>
</table>
The hip fracture audit showed that the service performed better or comparable to England averages in the 2017 publication. The service reported that there had been a significant improvement which would be seen when the 2018 report was published. The surgical division had created a specialist hip fracture nurse specialist to facilitate the flow of patients with hip fractures through the service and to ensure better compliance with measurements of best practice in the treatment of hip fractures. Since the introduction of this role, the length of stay for patients with hip fractures had reduced, patients’ surgery was undertaken in a timelier way and more patients were had input from an orthogeriatrician.

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, 91.3% 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 2016 figure was 81.3%.

The risk-adjusted 90-day post-operative mortality rate was 3.3% which was within the expected range. The 2016 figure was 4.1%.

The risk-adjusted 2-year post-operative mortality rate was 20.2% which was within the expected range. The 2016 figure was 22.8%.

The risk-adjusted 30-day unplanned readmission rate was 8.8% which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 64.1% which was worse than expected. The 2016 figure was 59.8%.

*(Source: National Bowel Cancer Audit)*
National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% for Abdominal Aortic Aneurysms. The 2016 figure was 0%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 22 days, which is worse than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 3.8%. This was within the expected range.

(Source: National Vascular Registry)

Following the inspection, the trust told us that its latest measurement for April–June 18 was 11.5 days median and for July–September 18 was 13 days median from symptom to surgery. The trust told us the vascular directorate had invested significant effort into improving this measure and had seen a vast sustainable improvement in time to treatment.

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the trust achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 211 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 155 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 131 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 88 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 211 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
The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 the performance on groin hernias was about the same as the England average.

For Varicose Veins, the performance was about the same as the England average.

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

For Knee replacements the performance was better than as the England average.

(Source: NHS Digital)

**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.

**Appraisal rates**

From April 2017 to March 2018, 90% of staff within surgery at the trust received an appraisal. This compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Numbers Required</th>
<th>Numbers completed</th>
<th>Percentage Completed</th>
<th>Trust Target (95%) Met?</th>
</tr>
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<tbody>
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<td>Acute Pain</td>
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<tr>
<td>435</td>
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<td>435</td>
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<td>Gen Surg Advance Nurse Prac</td>
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<td>5111</td>
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<td>Percentage Completed</td>
<td>Trust Target (95%) Met?</td>
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<tr>
<td>435</td>
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<td>Vascular Medical Secs</td>
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<td>Surgery</td>
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<td>Vascular Spec Nurse</td>
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<td>Theatre Stores and Proc</td>
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<td>Ward C18A</td>
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<td>Surgery</td>
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<td>Ward C14A</td>
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<td>Surgery</td>
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<td>Ward C18B</td>
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<td>Surgery</td>
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<td>Trust Target (95%) Met?</td>
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<td>435[5189]RBTH Ophthalmology Outpatients</td>
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<td>7</td>
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<td>Surgery</td>
<td>23</td>
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<td>Surgery</td>
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<td>6</td>
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<tr>
<td>435[5519]Elective Admissions</td>
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<td>Surgery &amp; Anaesthetics</td>
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<td>435[4325]Acute Care Team</td>
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<tr>
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<td>7</td>
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<td>23</td>
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<td>3</td>
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<td>Surgery</td>
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<td>Surgery</td>
<td>2</td>
<td>1</td>
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<tr>
<td>435[5370]Ortho Dir Mgmt</td>
<td>ELHT</td>
<td>Surgery</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>435[5121]Urology Medical Staff</td>
<td>ELHT</td>
<td>Surgery</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

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

During our inspection we sampled appraisal compliance rates on the surgical wards and found most staff were up to date with appraisals, the exceptions being those who were on long term sick or maternity leave. Ward managers had a good system to monitor when their staff were due an appraisal. They reported that there were sometimes delays in the trust system being updated.
Nursing staff told us they felt there were opportunities for professional development within the division such as additional training course and learning new skills.

The junior doctors we spoke with during our inspection and those who participated in focus groups told us they felt supported by senior colleagues and that they had access to the advice and guidance they required from senior surgeons and consultants. Junior doctors said the surgery division at Blackburn provided a good training environment and provided opportunities to learn a range of skills. They stated they would recommended it as a place to work to other doctors and surgeons. Managers within the surgery division said they had no issues attracting junior doctors to the division due to the wide range of training opportunities that were provided and as the service was a busy but supportive environment.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The surgical division encompassed a range of disciplines who worked closely together to meet patients’ needs. Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care.

During our inspection we spoke with a range of staff from different specialisms and grades who told us that the multidisciplinary team relationship was good and the team worked well together. They stated they felt supported as part of a team and were involved in planning and delivering patients’ care and treatment.

An integrated therapy team comprised of occupational therapists, physiotherapists, dieticians and speech and language therapists. These teams worked together aiming to prevent unnecessary hospital admission and to support early safe discharge. During our inspection we saw that they worked with patients to facilitate patients’ rehabilitation following surgery, assessing patients’ needs, assisting and teaching them to use equipment aids and mobilise. We saw that a range of disciplines were debriefed and updated following ward rounds.

There was access to a wide range of specialist staff such as stoma care, palliative care, tissue viability specialists, which could be requested for advice and input. Occupational therapists worked collaboratively with the intensive home support service, social services and local authority staff to organise ongoing and community care for patients being discharged.

Ward pharmacists were involved in the planning and care of patients and were integral to the ward team. They provided facilitated medicines reconciliations for inpatients and organised medicines patients were to take home with them.

Seven-day services

Some specialisms had consultant led ward rounds at a weekend. However, some ward rounds only reviewed new patients and those for whom a review was requested, such as poorly patients.

Urgent diagnostic procedures and laboratory tests were available at the weekends. Processes were in place so ensure that urgent requests were undertaken and reported on in a timely way.
Physiotherapy services were present on the wards at weekends and provided assessments and consultations. An occupational therapist was on site Saturdays and Sundays from 8.30am to 4.30pm, they were accessible for surgical patients in particular for first day post-operative mobilisation and discharges home. Some specialist services such as dietitians, and some specialist nurses were not available at weekends. For some specialist services such as speech and language and the pain team, an urgent referral protocol was in place to enable urgent assessments to be carried out by alternative professionals such as advanced nurse practitioners and anaesthetists.

Pharmacists were available daily during core hours and operated an out of hours on call service outside of these hours.

The service had an emergency theatre for urgent and emergency procedures which was available and staffed 24 hours a day, seven days a week. This reflected The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2007): Emergency Admissions: A journey in the right direction? And Royal College of Surgeons (RCS) (2011): Emergency Surgery, Standards for unscheduled surgical care guidance.

**Health Promotion**

The surgical division had access to smoking cessation, alcohol advice and other health promotion advice. A referral could be made for patients who agreed to help to give up smoking or alcohol reduction.

The pre-operative assessment nurse provided health promotion advice as required to enable patients to be in the best health for their surgery. This included advice around venous thromboembolism and medicines advice about their planned surgery.

Staff in the division were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. The trust had the highest rate of flu vaccine take up in the country at 92.3%.

A range of leaflets were available on health promotion such as weight loss, healthy eating and smoking cessation and condition specific advice was provided in leaflets and posters which were located 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**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Mental Capacity Act and Deprivation of Liberty training completion

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.
<table>
<thead>
<tr>
<th>Course Title</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Percentage trained</th>
<th>Trust target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children</td>
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<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>1,567</td>
<td>1,633</td>
<td>96%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

The trust had a consent policy in place which had been reviewed and updated regularly and was in keeping with current guidance. This was accessible to staff electronically.

A Mental Capacity Act and Deprivation of Liberty Safeguards policy was in place, up to date and accessible to staff. This was in keeping with best practice guidance. Staff received training in this area as part of the mandatory training programme. 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 their movement and 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. Staff we spoke with could describe the circumstances which might warrant the implementation of these policies and what they needed to do. They could describe the mental capacity assessment and best interest decisions.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

During our inspection we observed that staff demonstrated a very kind and caring approach to their patients and families. We overhead several exchanges between staff and patients and found that these were respectful, supportive and positive. Cubicle curtains were drawn around the bedsides and single room doors were closed whilst patient care was taking place to protect the privacy and dignity of patients. Staff sought permission from patients before entering rooms and closed curtains.

Patients we spoke with were very positive about the caring nature of staff. They stated they were treated with dignity and respect. One patient told us, “I was very embarrassed about not being able to look after myself properly…. the staff were very understanding and supportive…. they washed my hair for me and it made me feel so much better”. Another patient said, “This was the most positive experience I have ever had in hospital”.

Emotional support

Staff provided emotional support to patients to minimise their distress.
During our inspection, we saw that staff supported the emotional needs of patients. Staff provided reassurance and showed a kind approach to patients who were admitted for surgery and those who were anxious and nervous. They demonstrated empathy, explaining the processes and procedures to try to help them feel less anxious. A patient told us, “they held my hand all the way through…. they were brilliant”.

There was emotional support from Macmillan nurses and other specialist nurses such as stoma nurses for some patients who had received bad news such as a cancer diagnosis or who were having certain life changing surgery. However, we found that patients who were undergoing amputations including major amputations of limbs, did not have access to any counselling services.

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 for patients to visit theatres, gain support from specialist nurses such as the learning disabilities specialist nurse. Measures and adjustments could be put in place 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. There was also a bereavement suite and bereavement nurses to offer wrap around support and advice for those who had lost a loved one at the hospital.

The service also promoted the emotional wellbeing of patients through pet therapy. During our inspection we saw a dog visiting the ward areas. The dog walked around the ward areas and patients could pet the dog. This has been found to have a beneficial effect on wellbeing and was very well received by patients.

**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.

The patients and relatives we spoke with told us members of staff encouraged patients to participate in discussions about care and treatment. They said they were given time to express their views and wishes and felt they were listened to. This is supported by what we saw and heard on inspection. We found staff to be approachable, accommodating and considerate to patients wishes. We saw that staff gave patients the opportunity for discussion and sufficient time to have their questions answered.

Patients told us they received clear and comprehensive information verbally and in letters and leaflets provided to them, the received this in way they understood. They felt the information enable them to make informed choices and they felt involved in their care plans.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

The surgical division recognised the needs of the local population and used various sources of data such as public engagement and the use of local data and statistics to design and plan the
services provided. They used patient and community representatives to provide input into service planning and design. They also worked with local clinical commissioning groups and the healthcare community to determine service provision often working in partnership to achieve this.

The facilities and premises within the surgery division were suitable for the services that were being delivered. For instance, the surgical assessment and day surgery unit had been designed with thought towards the best practice guidance for these units, such as; a patient collection and drop off point close to the entrance and ready access to operating theatres.

The surgical triage unit provided access to surgical services directly from GP for ambulatory patients, thus reducing the need for such patients to pass through the accident and emergency department. However, we found that the patients we saw seated in the waiting area had not had an initial review or triage, which they would have received had they attended the accident and emergency or urgent care departments which set a minimum time in which attending patients should receive a triage or an initial assessment of their risk and needs. We found that trust standard operating policy around triage was not clear as to whether this applied GP referred patients. This posed a risk that staff did not have accurate picture of the needs of the patients in the waiting area and were not sighted on potential risk of deterioration or immediate needs. During our inspection we identified a patient in severe pain whose pain had not been recognised therefore had received no pain relief for four hours and another patient who had waited for five hours who was diabetic, had not eaten or taken their medications who was experiencing low blood sugars.

Following the inspection, we received evidence that the standard operating procedures around the surgical triage unit had been revised and this stated that GP referred patient should be reviewed by a nurse within 30 minutes of arrival, be reviewed by a junior doctor, advanced nurse practitioner or physicians associate within one hour and be reviewed by a consultant or middle grade surgeon within two hours.

**Average length of stay**

**Royal Blackburn Hospital - elective patients**

From April 2017 to March 2018 the length of stay for all elective patients at the Royal Blackburn Hospital exceeded the England average. Vascular surgery had a lower average length of stay than the England average.

**Elective Average Length of Stay - Royal Blackburn Hospital**

![Average Length of Stay Graph]

*Note: Top three specialties for specific site based on count of activity.*

**Royal Blackburn Hospital - non-elective patients**

From April 2017 to March 2018 the length of stay for non-elective patients at the Royal Blackburn Hospital exceeded the England average in all specialisms, except in vascular surgery where the
performance was slightly better than the England average.

Non-Elective Average Length of Stay - Royal Blackburn Hospital

![Average Length of Stay Chart]

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

The average length of stay for patients was on the whole higher than the England average. The division explained that a contributing factor to the statistics was because routine, low risk elective surgery was undertaken at Burnley and higher risk and more complex procedures were undertaken at Blackburn. For this cohort of patients, it was more likely they would have complications and slower recovery times leading to increased lengths of stay. They also stated that this may be due to the local populations health generally as they experienced poorer health generally and had more complex medical conditions than other areas in England.

The division had done some project work both internally and with an external consultant on areas where they could improve their access and flow, including reducing lengths of stay. This was a work in progress.

Meeting people’s individual needs

The service took account of patients’ individual needs.

A specialist learning disabilities and autism nurse was available and very proactive within the surgery division, staff knew her name and could describe instances of her making reasonable adjustments to facilitate the care of patients.

A delirium bundle was in place on surgical wards which helped staff to diagnose and implement treatment for patients living with dementia. The service adopted the dementia butterfly scheme to sensitively identify those living with known or suspected dementia or similar symptoms. The service also used an amended version of the ‘this is me’ scheme which they called ‘reach out to me’, this was a document describing a patient’s, background like and dislikes, preferences to enable staff to better understand the patient’s needs.

Surgical wards followed the ‘John’s campaign’ which enabled the families and carers of those living with dementia to participate in their care whilst they were in hospital and enabled them to have open visiting hours to stay with their loved one as they wished. Staff provided patients with ‘twiddle muffs’ which had been made by local charity, these were devices designed to occupy and stimulate those living with dementia.

The trust ran monthly dementia cafes were patients, relatives and visitors could gain advice and information. We saw that patient were screened for delirium as part of their admission process and provided delirium advice leaflets to give information and advice around delirium, to help with understanding of and thus prevention of further episodes.
The surgery division had access to a garden which was a pleasant outdoor space, staff told us they identified those patients who might need time away from the hospital environment, such as long-term inpatients or those who were feeling down, to enable them to get some fresh air and change of scenery.

Most areas were suitable for patients using wheelchairs. There were wheelchair accessible toilets available around the hospital and in wards.

There were processes in place for people who needed translation and interpretation services. We saw that advice leaflets and information stated that they were available in other languages. We did not see any stock copies of leaflets in any of the more common language spoken by members of the local community.

There was access to mental health support from another local NHS service provider if patients required a review and assessment, however, staff did say the response to requests for review were not available in a timely way.

A family liaison officer was appointed by the trust whenever a serious incident occurred. The family liaison officer was a point of contact and support for the patient and family and could guide them through the process of investigation and information gathering.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Access to the surgery division services were through different routes. Through the accident and emergency and urgent care centres and through routine or urgent GP referrals. Non-urgent consultations take place in outpatient clinics and referred for surgery as required.

Urgent cases went to the surgical triage unit which placed patients into speciality beds. They accepted patients who potentially required surgery and placed them in the appropriate speciality beds, approximately 50% of these patients were assessed and discharged back home to await further tests, return for surgery at a later date or were treated in another way.

The service used the complex discharge team and the intensive home support service for complex discharges to enable patients with ongoing needs to return home safely. The home first initiative involved discussion and planning with patients for discharge early in the process and involved carers and relatives also. Patients returned home with the home first team who could assess and make some adaptations to the patient’s home environment there and then. They would also assess if the patient was safe and could manage, if they could not the patient was able to return to the same ward and bed which had been kept ‘open’ for them.

Operating theatres utilisation at Blackburn during the period September 2017 to August 2018, was generally good with an average figure of 78%, The division was undertaking work to improve theatre. Utilising theatres well is important as this can reduce the number of cancelled operations, improves referral to treatment times and improves flow through the department which increases efficiency.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Theatres Utilisation Sep 2017 – Aug 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>84%</td>
</tr>
<tr>
<td>Vascular</td>
<td>81%</td>
</tr>
<tr>
<td>Urology</td>
<td>79%</td>
</tr>
</tbody>
</table>
Referral to treatment times were mixed, some specialties were better and some were worse than the England average. The trust was aware of the lengths of time patients waited for treatment and had plans in place to identify ways to improve performance.

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

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was similar to the England average. The most notable departure from the average being a 7% dip below the average in October 2017.

(Source: NHS England)

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

Three specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>78.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.8%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>67.6%</td>
<td>60.4%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>67.7%</td>
<td>76.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>60.3%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>50.0%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>
Following the inspection, the trust told us it continued to work on improving access and referral to treatment times, although had achieved the target for incomplete pathways since December 2017.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The trust performed better than the England average for the entire reporting period, with the percentage of patients whose operation was cancelled and were not being treated within 28 days which was consistently below 5%.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - East Lancashire Hospitals NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days]

**Cancelled Operations as a percentage of elective admissions - East Lancashire Hospitals NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions]

Over the two years, the cancelled operations, as a percentage of elective admissions, at the trust showed a worse performance than the England average. In both 2016/17 and 2017/18, the trust’s performance worsened from quarter 3 to quarter 4. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

Between September 2017 and August 2018, the surgery division (including both sites) cancelled 2155 operations on the day of surgery, 1121 were due to issues outside of the control of the hospital such as patients failing to attend or the patient being unfit for surgery. The remaining 1034
cancellations were due to issues such as a lack of beds, staff or equipment, administration errors and running out of time.

The service was looking at ways to improve the efficiency of theatres such as preventing delayed starts for operations, which resulted in overruns and potential cancellations of patients later on the list. The division reported some recent improvements which were seen in August 2018 statistics provided during the inspection.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust had an in-date complaints policy which was accessible to staff and in line with best practice recommendations. The staff we spoke with understood the process and could advise patients and relatives on how to make a complaint or raise a concern. During our inspection we observed posters and leaflets displayed in patient and public areas which provided information on how to make a complaint. Details were also provided for the trust’s customer relations team and patient experience team who supported patients to raise concerns. How to complain was also described on the trust internet and social media sites.

Complaints were managed by the customer relations team who followed the policy regarding acknowledgement of complaints and complaint response times. Input from matrons, ward managers and relevant staff was sought during the investigation to gather information on the concerns raised. We reviewed a sample of complaint responses and found that these appeared appropriate. Letters advised complainants about the Parliamentary and Health Service Ombudsman if they felt their complaint was not resolved to their satisfaction.

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, an information leaflet for maxillofacial reconstructive surgery was issued to patients to explain possible complications. We saw that information about complaints was discussed at team meetings, divisional quality and safety teams and patient experience group meetings and minutes were recorded. Trends and recurring themes were examined and that learning was implemented and shared. Patient stories were shared at meetings and patients presented them at board meetings to highlight their experiences.

We were advised that there had been recent improvements in the timeframes taken to respond and resolve complaints, this was due to changes in the sign off process to streamline the process and weekly monitoring and discussion of complaints by joint teams to ensure complaints were progressing in a timely way.

**Summary of complaints**

From April 2017 to March 2018 there were 52 complaints about surgical care. The trust took an average of 75 days to investigate and close complaints. This is not in line with their complaints policy which states complaints should be resolved within 50 days.

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

**Number of compliments made to the trust**
The trust has stated that their data does not include a ‘compliments log’, which is used internally to harvest compliments at a ward level and publishes them on the trust’s intranet.

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

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Managers of the surgery and anaesthesia division appeared skilled and knowledgeable and capable of leading the division effectively. The senior management team were passionate about their service and very enthusiastic to drive forward changes and improvements. They were keen to enhance the experience of working in the service for staff and to better utilise resources for the benefit of the local population.

The team were keen to express that they were a ‘committee’ of leaders, all with a voice and role of equal and respected value to the collective team. This approach appeared to work well for the service and the team worked well together with the ethos of getting things done. There were some interim managers in post, but this, far from bringing a negative aspect; served to bring a fresh and creative input into the ‘committee’. There appeared to be effective dynamics and good working relationships. This empowered individuals to take forward initiatives, which received the support of the collective team and they had over the previous year implemented strategies to makes some improvements in areas such as culture, safety and performance within the division. This was a work in progress, but achievements had been made.

On reviewing quality strategy improvement documents and speaking to managers it appeared that leaders were sighted on the challenges facing the surgery division. The managers had undertaken a lot of work in understanding the cultural issues in theatres and had implemented an improvement strategy. This was expanded to improve cultural issues within the wider division and had yielded some results.

However, staff on the wards and departments told us they very rarely saw the senior divisional or trust managers, other than the individuals who were actively engaged in surgical procedures within theatres. They told us that they had not seen senior managers and trust executives engage in walk arounds.

On the whole, staff on wards and theatres spoke very highly of their managers stating they were supportive, present and led by example. There were some issues in the surgical assessment and day surgery unit, but divisional managers were aware of the issues and were working on plans to improve these issues.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
The trust had a set of visions and values which were adopted throughout the surgery division. The trust values of safe, personal and effective were displayed throughout the department and on all literature, templates and forms staff used. Staff we spoke with were generally able to describe what these were.

The division had its own role within trust strategy, this largely focussed around the improving the experience for staff, thus improving staff retention and reducing sickness. They also dedicated a lot of time and effort to improving the safety culture and in particular, preventing further ‘never events’ and reducing the number of serious incidents in the division. The two had been identified as being interrelated.

The division was also looking at ways to improve referral to treatment times, reduce cancelled operations and improve operating theatre utilisation. They were in an assessment phase and were looking at ways to improve performance, they had visited other organisation to look at ways they have structured services. An action plan was a work in progress.

The division was also looking at ways to ensure sustainability of services and were involved in the regional transformation project. They were considering partnership working and collaboration in the regional healthcare economy to ensure they could compete and be sustainable.

Culture

Managers across the service were working towards achieving a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Divisional managers acknowledged that morale within the department and particularly in theatres had been poor and this was reflected in the results of the most recent staff survey results. They told us they had developed an ‘improving together’ plan with staff to address this and believed for the first-time staff were being consulted and involved in solutions. They felt this had already brought positive changes. They had not, however, tested this through any interim internal staff survey, to ascertain if their strategies were having any effect.

Staff we spoke with gave mixed feedback on the culture of the service. Most staff were very happy and positive about their work and said they were supported by ward and theatre managers to provide good care and to develop and progress in their role. Many said they enjoyed their work, were proud of the trust and the care they delivered to patients.

Smaller numbers found there were pressures in resources and the demands placed on them caused them stress and a necessity to compromise the care they could provide. Some staff said they felt empowered to speak up, suggest improvements and had confidence that these would be acted upon, but a small minority said they felt it was pointless as nothing had been done or would be done.

Some staff in the surgical assessment and day surgery unit expressed concern over their ability to provide a good service due to the area being a designated escalation area. When being used as an escalation area staff felt care was compromised as staffing the area adequately was a challenge. They also felt the environment was not appropriate for inpatients and their visitors.

During our inspection staff informed us about reports of discrimination and bullying within theatres and amongst surgical staff, we referred these to the trust.
A freedom to speak up guardian was in place and staff we spoke with were aware of this role and how to contact them. The guardian worked alongside the trust’s senior leadership team to ensure staff had the capability to speak up effectively and were supported appropriately if they had concerns regarding patient care.

**Governance**

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was evidence of good clinical governance procedures and quality measurement processes. These ensured risks were identified and escalated through a series different committees and steering groups to trust and executive level.

The surgery division had divisional governance and quality and safety meetings. These discussed issues pertinent to the division such as the divisional risk register, complaints, clinical audits, clinical effectiveness, serious incidents, patient experience and morbidity and mortality. Where necessary these would be shared with other divisions and the trust senior executive teams.

There was evidence that there was sharing of information with and from committees and groups down to staff on the ground. There were ward level and divisional meetings which shared performance, quality and safety information with staff, there was evidence of share information and learning in a timely way. Minutes from these meetings were recorded and shared.

**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 surgery division had a ‘risk register’ which highlighted areas of risk to the running of the service. This register comprised of 446 individual risks, 28 of these scored a risk rating of 10 or above. These included risks such as staffing, lack of speciality doctors and failures in divisional performance. Surgical division risks were also captured on the trust wide risk register. Each item on the register was allocated to a department but did not include the name of the individual with designated responsibility of the risk, nor review dates or how long the item had been on the risk register and whether progress had been made on those risks.

Each ward also had their risk registers, they were effective in identifying local issues and focussing attention on those.

Nursing assessment performance framework was the ward accreditation scheme in operation at Blackburn. All staff we spoke with were familiar with the scheme and were positive in their views about it. It sought to measure performance, standardise methods and reduce variation between wards.

The division was aware of its position regarding referral to treatment times and monitored these by speciality. These were discussed in regular performance meetings with divisional managers. Each speciality had an ongoing plan to address any underperformance in referral to treatment times, these were based on short term actions and longer term transformational change. Some examples included the development of ear, nose and throat nurse specialists, reconfiguring services and
reviewing job plans. There was also work with the clinical commissioning group colleagues to understand future demand.

The service was working through a theatre productivity and efficiency programme which had seen some positive improvements in performance. This programme was ongoing and plans were in place to continue to build on the progress made, these included launching new events such as ‘lean’ initiatives to seek further improvements in performance and culture in theatres.

A serious incident review group reviewed serious incidents in a timely way and assessed any immediate actions that could be implemented pending the full root cause analysis investigation.

**Information management**

The division collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust and division managed and used information well to support its work. Where these were electronic they used secure systems with security safeguards. There was satisfactory access to terminals and mobile computers to enable staff to access the systems.

Staff had access to the trust intranet which provided a range of internal and external resource materials to assist staff in their day-to-day tasks. Staff also used the system to access training and development information and courses. The used the electronic system to request diagnostics, specialist nurse and speciality referrals such as tissue viability and dieticians.

Ward and department managers had access to various information sources such as staffing and human resources information, equipment and stock information and audit results and performance dashboards to enable them to manage the day-to-day running of their services and offer areas for improvement. The theatres dashboard highlighted details of cancelled operations and theatres utilisation to advise managers of the current performance and support decision making. There were also reports to aid the facilitation of patients with cancer though the pathways.

The trust business intelligence service developed reports to review system management and quality of performance such as nursing assessment performance framework results. The service told us they were working with information technology designers to enhance the use of such systems.

The trust had a ‘share point’ site where useful information could be found such as policies, standard operating procedures and policies. The trust was attempting to achieve a ‘three clicks’ system whereby any information could be found within their intranet system in a maximum of three clicks. Clinicians had access to clinical portal which allowed access to records kept by other local acute NHS hospital records and GP records.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The surgery division was an active member of the local sustainability and transformation plan or integrated care system, they discussed strategies for closer working and alignment of services. The division participated in the North-West surgery and theatre networks, sharing good practice and developments and formulated cross site care bundles.
The service visited other health care providers to see what aspects of care delivery they could use within their own service.

The service worked in partnership with the local authority on initiatives such as ‘steady on’, a falls improvement reduction programme. They worked with local charities on initiatives to make sure patients being discharged from hospital had food and provisions for when they returned home. The service had facilitated collaborative programmes of work within the community such as an initiative to treat patients with deep vein thrombosis in the community in partnership with local GPs thus preventing the need for a hospital admission. They also worked with partners in an integrated ophthalmology service, and had undertaken a sustainability scoping exercise around urology service provision with other local NHS providers.

Staff from the head and neck ward provided tracheostomy training packages to local nursing homes. This assisted in ensuring patients with tracheostomies were safer and that nursing staff could identify emerging issues at an earlier stage.

The division engaged with local patient groups and service user groups such as the learning disabilities and autism group. They sought feedback from service users via patient engagement events entitled ‘what matters to you’.

There was also opportunity for members of the public to ask the chief executive questions or raise concerns via “Kevin’s Website”.

The service connected with local ‘surgery’ specific groups such as stoma support groups to gain feedback from those who had used the service and get a sense of the needs and concerns of such patients. The monthly dementia café sought to engage and educate patients, families and members of the public around living with dementia. The division worked with the local football club to promote prostate health and cancer awareness for men watching football matches.

The division issued bereavement letters to families to ask if they wanted to come into the hospital and discuss the care of their loved one and have any questions answered.

The division used a ‘you said we did’ scheme for staff to canvas opinion and ideas on what could be done better and where improvements could be made. Staff suggested that the operating theatres start an hour earlier and that this would improve delays to theatre lists as patients and staff would be ready to start the theatre lists on time. Staff guardians were appointed to support staff to raise issues and offer suggestions.

The division was trialling ‘reverse mentoring’ where senior staff shadowed junior staff to gain insight and perspective on their challenges.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service was one of the first in the region to fund and acquire one of the latest state of the art surgical robots. This enabled more accurate, less invasive procedures from which patients experienced better outcomes; greater success and improved recovery times.

The ‘Share 2 Care’ magazine initiative was created to improve greater knowledge of learning from incidents and drive continuous improvement. Staff were familiar and supportive of this publication.
The surgery division participated in ‘feedback Fridays’. This was an initiative to help improve the safety culture within the service. Ward managers assessed their five-key safety, risk and performance issues with their areas and this was raised and discussed in an open forum on Fridays. The issues were posted on staff notice boards so they knew which issues would be raised during the next session.

The division adopted a scheme entitled ‘refer to pharmacy’, they used this for almost every patient who was discharged from the surgery division. The scheme ensured that information about the patients’ inpatient stay and procedure, their prescription and medication needs were shared with the patients’ local pharmacy on discharge. This enabled community pharmacists a better understanding of their patients’ needs, so they could better tailor their service to meet those needs. Analysis of this scheme had shown an improvement in medication adherence and thus improved outcomes for patients, such as better quality of life and a reduction in readmissions as patients were enabled to be well for longer and be ‘healthy at home’. This system was developed by the trust and had been adopted in other areas. It had also been recognised by nomination in several innovation awards both locally and nationally.

The trust appointed a family liaison officer for those affected by a serious incident. They could guide the patient and family and provide support and information.

The service used the trust’s ward accreditation scheme, the nursing assessment performance framework scheme. Wards were awarded red, amber and green status depending on their performance, if they achieved three green ratings on the run they were given silver status and staff were given pins for their uniform and a plaque to display on the ward. The vascular ward (B20) was the first ward to achieve this status.

‘Going the extra mile’ or GEM awards were awarded to staff following nominations from peers for the work they had done and achievements in their role. Clinical effectiveness awards were also given out to staff. The awards were presented at an annual trust awards evening which celebrated trust successes. A number of staff from the surgery division had won awards.

The trust has signed up to the ‘vital signs’ programme through NHS Improvement. This was an initiative in which seven trusts came together as a network to share best practice around ‘lean methodology’, a system which aims to improve the quality of patient care; improve safety; eliminate delays and reduce lengths of stay. There was a divisional transformation team who supported the implementation of change and encouraged continuous improvement. The team had been part of the restructuring of the surgical services when the elective centre at Burnley General Hospital was established.
Community health services

Community health services for adults

Facts and data about this service

The trust provides adult community nursing services, predominantly in East Lancashire. This includes district nursing, treatment rooms, integrated neighbourhood team co-ordinators, and a range of specialist nursing services including tissue viability, lymphedema, lower limb, vascular, bladder and bowel service, diabetes integrated service, palliative and end of life care, respiratory and heart failure services.

The trust provided allied health professional services across the health economy, including all trust divisions and primary care. Provision included acute, sub-acute, and rehabilitation inpatient services, intermediate care, community and domiciliary services. The trust's allied health professionals also provide a large range of outpatient clinics across all localities, including the Integrated Musculo-skeletal, Pain Management and Rheumatology services, (IMPReS), Fast Physio and Occupational Health and wellbeing services.

Integrated neighbourhood team co-ordinators: provide a case management approach, based in the neighbourhoods and works closely with primary care although linking with all other health/social and voluntary services within the community.

Intermediate care allocation team (ICAT): A team of social workers, nurses, therapists and co-ordinators who can commission care and work together to support the patient at home. It provides a single point of access to health and social care professionals throughout East Lancashire, offering direct access to Intermediate care resources provided by the NHS, the county council and the voluntary sector.

Intensive Home Support Service: integrated with the intermediate care allocation team, a team of clinical/non-clinical staff including nursing therapy and social care staff. They respond to a referral within two hours providing rapid access to sub-acute and crisis care needs, thus preventing a hospital admission.

Podiatry: provides intervention to patients with long term conditions for example, diabetes, biomechanical problems, patients who require nail surgery and patients presenting with acute foot/ankle problems.

District nursing (24-hour provision): works across all nine neighbourhoods within East Lancashire with registered and non-registered nurses to meet patients' needs of the neighbourhood population, including some staff with specialist practitioner qualification in district nursing.

Lymphedema service: provides for cancer and non-cancerous lymphedema, providing specialist assessment and care.

Lower limb vascular service: a triage, specialist assessment management and treatment service for people with established or suspected peripheral arterial disease, acute and critical ischaemia or those with tissue viability problems.
Tissue viability: provides specialist wound management, clinical support and training programmes within East Lancashire acute hospital and community including care and nursing homes.

Bladder and bowel: specialist nurse-led service for individuals experiencing bladder and bowel incontinence chronic bladder and bowel conditions.

Domiciliary phlebotomy: Provision of routine domiciliary phlebotomy service to patients in their own home.

Integrated therapy service: comprises occupational therapy and physiotherapy works across Pennine Lancashire with teams based in the six localities. The Blackburn with Darwen team is a physiotherapy-only commissioned service. These services include in-reach into residential rehab units at Springfield, Castleford and Olive House, and input into the reablement service. The occupational therapy service in East Lancashire provides specialist assessments to Lancashire county council social services via an S75 agreement. The East Lancashire community therapy teams are commissioned to provide a service over seven days, and work 8.00am to 8.00pm, Monday to Friday. The trust’s stroke rehabilitation therapy team is based at Pendle Community Hospital in Nelson and is available for all stroke patients who have suffered an acute event and the rehabilitation can be provided up to twelve weeks.

These community teams support patients in East Lancashire who live in their own homes, and residential and nursing care settings. The trust provides integrated care to meet the needs of the patient and prevent unnecessary hospital admissions. The geographical areas covered encompass Hyndburn, Ribblesdale, Burnley, Pendle and Rossendale.

(Source: Routine Provider Information Request (RPIR) Community – Context tab)

Our inspection was short notice announced (staff knew we were coming) to ensure that everyone we needed to talk to was available and was part of the CQC new methodology for inspection. During our inspection we visited five of the community base locations these were Accorn Health Centre, Accrington Victoria Hospital, St Peters Health Centre Burnley, Bacup Primary Health Centre and Rossendale Primary Care Centre.

We visited three district nursing teams, the lymphedema and lower limb vascular team, two locality treatment rooms, the integrated respiratory team, the integrated home support service, the intermediate care allocation team, podiatry teams in two localities and the integrated physiotherapy and musculoskeletal team.

We spoke with eleven nurses, four allied health professionals, five service leads, three matrons, four team leaders, three administration staff, one podiatry assistant and ten patients.

We observed seven home visits with district nursing teams and three clinic appointments in the treatment rooms. We reviewed ten patient’s records.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.
The mandatory training covered key skills which included conflict resolution, equality, diversity and human rights, fire safety, health and safety welfare, infection prevention and control, information governance, preventing radicalisation, safeguarding adults level one, safeguarding children level one, safer handling theory and basic life support. We were told that Mental Capacity Act 2005 and Deprivation of liberty safeguards training were covered as part of the safeguarding adults and children level one training.

District nurses had additional clinical skill training which was completed annually this included syringe driver training and hand hygiene training. We reviewed six staff members training records and these had all been completed.

The training was delivered by a mixture of face-to-face sessions and e-learning modules. Staff members training completion was recorded on their individual learning hub profile and stored on an electronic system.

The electronic system provided staff members and their team leads with email reminders 90 days before their mandatory training became out of date. Team leaders told us this assisted them to plan time for staff to complete the training. The data fed into a monthly report which was monitored by the assistant director of nursing and matrons. We saw that this information was fed back to staff in their monthly team meetings and displayed on notice boards in team areas. The district nursing teams had some of their own trainers for some of the practical core skills training such as basic life support and syringe driver training.

### Mandatory Training completion

#### Nursing staff

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Current Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support</td>
<td>93%</td>
</tr>
<tr>
<td>Conflict Resolution L1</td>
<td>99%</td>
</tr>
<tr>
<td>Equality, Diversity &amp; Human Rights</td>
<td>99%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>99%</td>
</tr>
<tr>
<td>Health, Safety &amp; Welfare L1</td>
<td>99%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control L1</td>
<td>99%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>97%</td>
</tr>
<tr>
<td>Prevent (Preventing Radicalisation)</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding Adults L1</td>
<td>99%</td>
</tr>
<tr>
<td>Safeguarding Children L1</td>
<td>98%</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>99%</td>
</tr>
</tbody>
</table>

**Note:**

Safeguarding Adults training includes MCA/DoLS training

(Source: the trust: additional data request)

The service had a target of 95% completion for mandatory training, this was being met in all areas except basic life support for nursing and support staff.

#### Medical and dental staff

The trust told us they did not employ medical or dental staff for this core service.
Allied health professionals

(Source: the trust: additional data request)

The basic life support training was below the trust target of 95%. The trust told us this was due to access to the training for the podiatry team who were clinic based, we were told there was a plan to provide bespoke sessions to staff in the health centres to achieve the competency.

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.

Staff received safeguarding training as part of their induction and training was refreshed every year. Staff knew how to recognise a safeguarding concern and how to make a referral. Staff gave us examples of recent referrals which they had made. The integrated neighbourhood team gave us an example of a safeguarding case they were involved with as part of the multidisciplinary team approach. We were told this involved a social worker, care agencies, the wellbeing service and the patient, they described a positive outcome for the patient.

The service was an adult service, however the trust provided data which showed that some of the teams provided care and treatment to children. The data showed that in the last twelve months eight children were treated by district nurses, 107 children were treated in treatment rooms and 450 children were treated by the bladder and bowel service.

We were concerned that the data provided as part of our additional data request showed that only one nurse in the service had received safeguarding children level three training and this did not meet with national guidance. Following the inspection, the trust provided data to demonstrate that within the bladder and bowel service the senior band six and seven nurses had received safeguarding level 3 training. There were six staff across the service who had received the training. The trust had identified that Clitheroe hospital treatment rooms was the clinic where children were treated, the band five nurses who worked at Clitheroe health centre had received the safeguarding children level three training.

The staff we spoke with had access to the contact details for the trust’s safeguarding team and we were told that staff contacted the team for advice if they suspected a potential safeguarding issue. There was a safeguarding link nurse in place for the service.

There was an electronic form for staff to complete to refer a safeguarding concern, staff said they received an email response once this had been received by the safeguarding team.
The service used an electronic patient record system. The system was also used by other community healthcare services such as general practitioners. The system displayed an alert on the patient’s record if a previous safeguarding concern had been raised so staff were aware.

Safeguarding Training completion

Nursing staff

<table>
<thead>
<tr>
<th>DR264 (following DR1)</th>
<th>SGC Level 1</th>
<th>SGC Level 2</th>
<th>SGC Level 3</th>
<th>SGA Level 1</th>
<th>SGA Level 2</th>
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<td>83</td>
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<tr>
<td>No of Staff Non-Compliant</td>
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<td>412</td>
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<td>100</td>
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(Source: the trust: additional data request)

Allied health professional staff

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<th>DR264 (following DR92)</th>
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<th>SGC Level 3</th>
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<tbody>
<tr>
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<tr>
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<tr>
<td>Total No of Staff</td>
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<td>236</td>
<td>268</td>
<td>228</td>
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<tr>
<td>Percentage Compliant</td>
<td>94</td>
<td>96</td>
<td>97</td>
<td>96</td>
<td>97</td>
</tr>
</tbody>
</table>

(Source: the trust: additional data request)

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 organisational.

Each authority has its 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 made 363 new referrals from April 2017 to March 2018. Below is a breakdown of the referrals by month, also included are safeguarding alerts and referrals raised for advice/support.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide - Safeguarding Alerts raised by ELHT</td>
<td>42</td>
<td>40</td>
<td>53</td>
<td>63</td>
<td>41</td>
<td>38</td>
<td>46</td>
<td>49</td>
<td>51</td>
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Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves and equipment clean. They used control measures to prevent the spread of infection.

Infection rates were displayed in all the areas we visited these were recorded on the ‘safety at a glance’ notice boards and infection rates were low. There was an infection control link nurse available to community teams to escalate concerns and obtain advice relating to infection prevention and control.

The link nurse delivered aseptic non-touch technique and hand hygiene training to staff on an annual basis. Completion of the training was recorded on staff electronic training records and reported to the infection prevention and control team. The data was recorded on the infection control dashboard.

In the health centres and clinics, we visited we saw that there was personal protective equipment available to staff, such as disposable aprons and gloves. There was alcohol gel, detergent wipes and soap available for appropriate hand washing and decontamination of equipment.

We observed staff using the appropriate personal protective equipment and decontaminating their hands during patient home visits and during clinics. We observed patients attending clinics in the treatment rooms and saw staff using detergent wipes to decontaminate the treatment bed between patients.

Podiatry and district nursing teams had sterile equipment pouches made up for certain procedures. In the district nursing teams, we saw this for peripherally inserted central catheter line care, these were known as ‘PICC pockets’ and urinary catheter packs. They provided a sealed sterile single use pack for each patient. This was in line with National Institute for Health and Care Excellence guidance.

We observed district nursing staff who were undertaking a home visit providing education to a patient about catheter care to prevent infection. The nurse also provided the patient with a hand hygiene leaflet which outlined effective handwashing techniques.

The infection control team carried out monthly audits of the service at team level, this was reported on the infection control dashboard. The data was presented at the divisional patient safety, risk and patient experience meeting on a two-month basis. The audit covered a number of areas such as hand hygiene, catheter care, infection rates, wound care and training. The audit data provided...
by the trust covered November 2017 to June 2018, we saw an improved picture in the results particularly in May and June 2018 in which community services were at 100% compliance.

All clinical areas we visited were visibly clean and tidy. The clinic and treatment rooms contained daily cleaning schedules which outlined areas to be cleaned on a daily, weekly and monthly basis. In some areas we saw these had been completed, however, we reviewed the cleaning schedules in two areas which had not been consistently completed. These were the podiatry clinic rooms at Bacup Health Centre and the pulmonary rehabilitation treatment rooms at St Peters’ Health Centre in Burnley. We found gaps ranging from two days to twenty-two days within a month period. Following the inspection the trust provided information to confirm that the clinic rooms were closed on the days where we had identified gaps.

In the podiatry clinic rooms at Bacup Health Centre we observed the mobile workstations looked aging and not visibly clean. They had removeable glass tops which staff told us made them difficult to clean. Staff also highlighted to us that they reported infection control risks, however, these were not always actioned in a timely manner due to the arrangements for the maintenance of certain equipment. We were shown an example of a treatment chair which had been reported due to a tear in the covering. This had been reported two months prior to our inspection and had not yet been fixed.

Environment and equipment

The service had suitable premises and access to equipment and generally maintained them well.

The service provided care and treatment in clinics which were in a variety of premises and locations. These were a made up of health centres, GP surgeries and community hospitals around the East Lancashire area. In the locations we visited the design, maintenance and use of the facilities was appropriate for the care and treatment provided. The buildings were modern, spacious, accessible and kept people safe.

Treatment and clinic rooms were visibly clean and tidy and surfaces and floors were smooth and easy to clean. There was access to dressings and sundries which staff needed in lockable cupboards. There were sharps bins and clinical waste bins available in all rooms. Treatment rooms were equipped with a telephone and computer for staff to use.

We observed appropriate management of waste and specimens. District nurse teams had sharps bins which they used for home visits. We observed these being used in patients’ homes for the safe removal and disposal of sharps. The bins were returned to the base at the end of the shift.

In the areas we visited we observed appropriate waste segregation. We saw specimens being transferred from patients’ homes in a designated red box which was returned to a specified area at the base location for collection.

District nursing teams had ‘grab bags’ set up with essential equipment and sundries needed. The bags had a checklist of items which were contained. If staff needed additional items outside of this for specific procedures there were pre-made packs and additional sundries available to obtain from the clean utility rooms at the base locations. It was the responsibility of the nursing staff who had used items from the bag to restock them at the end of each shift. Senior nursing staff told us the bag was introduced to ensure staff had what they needed to undertake their role and to reduce waste from carrying unnecessary stock in vehicles.
Staff told us that they generally had all the equipment they needed and that there were limited issues accessing equipment. Specialist equipment for use in patients’ homes was accessible and appropriate and there was an emergency out of hours service for equipment needs.

Stock rooms were well stocked with equipment and sundries. The management and rotation of stock was assigned to different job roles in different areas and teams. We checked a range of equipment and sundries stored in different areas and these were stored appropriately.

Electrical equipment and equipment which required calibration was managed by the medical engineering department for the trust. We saw that the integrated home support service had a spreadsheet on the shared computer drive which detailed all equipment held by their department with staff allocated to each piece of equipment so they could monitor and plan calibration and re-testing. We checked a range of equipment across community services which required testing and calibrating, the majority were inside the date period.

However, in the pulmonary rehabilitation department at St Peters health centre in Burnley we found a range of equipment which had stickers indicating that it had not been calibrated within the specified timescales and were showing up to seven years outside of the calibration date. We raised this with the service leads as a concern. We were told that the stickers to indicate when the equipment was recalibrated were in place but not visible. As the stickers were not visible this meant that staff could not be assured that the equipment was calibrated and ready for use. We reviewed the medical engineering records for the testing and calibration of equipment, weighing scales calibration was not included on the database.

We reviewed the medical engineering equipment maintenance database for the community locations we visited. We found that there were 59 pieces of equipment which were outside of their re-testing date. We found that at St Peters Health Centre 48 out of 189 items of equipment were outside of their re-testing date. The medical engineering department carried out an annual audit for the maintenance of equipment. We saw that the audit did not cover community locations. We were not assured that there was an adequate process in place for the maintenance of equipment in community locations. There was a risk that equipment was not fit for use.

Staff had access to bariatric equipment for patients with additional needs. The service told us there was no issues with accessing this type of equipment. However, the lymphedema team had identified access to bariatric equipment was a problem. We saw this was recorded on the local risk register and risk assessments were in use to mitigate the risk to patients’ and staff.

**Assessing and responding to patient risk**

The service assessed patient risk and prioritised patients’ needs in an emergency and patients were being re-assessed within the timescales scheduled. However, the electronic patient record did not flag high risk patients.

Patient referrals were triaged by senior staff in community teams. There were pathways in place during the triage process to identify the level of patient risk and clinical need, this determined how quickly patients would be seen, we saw the Intensive home support team used a red flag system. The triage process also identified if patients needed to be referred to a different and more appropriate service.

We saw evidence that patient risk assessments were undertaken as part of the patient’s first visit and follow up visits with the district nursing teams. These were completed on the electronic patient
record system and stored electronically, they could be accessed by other community staff with access privileges. Risk assessments covered pressure ulcers, falls, patient mobility and nutrition and were in line with standard operating procedures and national guidance.

We reviewed ten patient records and saw evidence that initial risk assessments had been undertaken and care plans had been initiated to mitigate patient risk, this included the provision of pressure relieving equipment. Re-assessment of patient risk was scheduled by nursing staff on the electronic system, this was based on clinical judgement. We saw that re-assessments had been undertaken within the specified timescale. There was no guidance or pathways in place for staff which stated re-assessment timescales. Staff told they based re-assessments on clinical judgement or if there were changes in the patient’s condition, and this was reflected in the policies for the service.

We reviewed the pressure ulcer policy which stated that pressure assessments should be completed as a maximum of every three months for low risk patients and those at higher risk would be re-assessed based on the clinical judgement of nursing staff. The trust had introduced a pressure ulcer collaborative in 2014. The data for the district nursing teams had shown a decrease in the amount of acquired pressure damage. Between March 2017 and August 2018, the data for acquired pressure damage remained at a consistent level.

Whilst safety performance was not an issue. Team leaders told us the lack of guidance and pathways for re-assessments, was a concern for the band four and band three staff who were not clinically trained and were unable to make clinical judgements. It was also highlighted that the risk assessment templates on the electronic record did not flag if a patient was at risk once their assessment score was inputted. The team leader at Bacup Health centre had developed and delivered training for these staff groups on pressure ulcer assessments, Waterlow scores and nutritional assessments. The training was based on the use of Waterlow scores, the malnutrition universal screening tool, NICE guidance and trust procedures. The training helped staff identify who was at risk and what action should be taken.

Safety huddles were undertaken across the community services, the timing and frequency of these varied. The district nursing teams had a daily safety huddle which was recorded on standardised templates, this was in use across all of the teams. We observed a safety huddle, this involved discussions about patient visits which had been undertaken that day, staff shared patient issues and risk. This was an opportunity for senior nursing staff to cascade essential information to the team.

Staff identified and responded to changing risks to patients appropriately. District nursing team leaders reviewed staffing daily against the acuity of the patients on their team’s case load and identified capacity within the team. This meant they could allocate unplanned visits to nursing staff. We observed a patient being prioritised due to a blocked catheter. The intensive home support service visited patients with a need for clinical intervention within two hours, this included patients with an exacerbation of chronic obstructive pulmonary disease.

Staff were aware of how to recognise deteriorating patients and the service had a ‘recognising a deteriorating patient’ pathway in place. This provided a flow chart of actions for staff to follow which included referral to other services or calling an ambulance.

Podiatry staff had close links with the trust acute based diabetic foot team for urgent advice and referrals into the hospital.
The intensive home support and intermediate care allocation teams had developed and introduced ‘community early warning scores’ this was to help staff identify deteriorating patients and ensure appropriate consistent action. However, non-nursing staff raised concerns that they had not received sepsis training.

**Staffing**

While there were gaps in staffing, the service took action to ensure there were sufficient staff in the right area to meet patients’ needs. Staff did have the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

District nursing teams were split into neighbourhoods, there were nine in total across the East Lancashire area. Team leaders reviewed district nurse caseloads monthly to consider the number of patients and review their acuity, this was to ensure care was adequate to meet the patients’ needs. Caseloads varied between the neighbourhood teams. Team leaders told us that nurses had an average caseload of 20-40 patients, this worked out at an average of eleven patient visits per day, per staff member.

The team leaders of each the district nursing team undertook a situation report (SITREP) approach to reviewing capacity each morning, this fed into the twice daily matrons meeting. The situation report looked at staffing numbers on shift, the acuity of the patients, planned visits for that day and new referrals. This meant that matrons could identify where staff could be moved between teams to provide safe staffing.

We reviewed the fill rates for district nursing staff between April 2018 and August 2018, the average percentage of shifts covered was 94.7%.

Senior nurses told us the staffing establishment was adequate for the case load, however, the shortfall in actual staffing compared to the planned staffing was a struggle. The matron told us that senior band 6 and band 7 nurses had been added to the rota to ensure patient visits we met. Despite this staff felt that their caseloads were manageable and they had time to spend with patients.

**Planned v Actual and Vacancies**

![Planned V Actual Staffing and Vacancies](image-url)
The staffing data provided by the trust showed that vacancies across the community teams were high. Between April 2018 and July 2018, the average vacant posts for registered nurses was 19.9, for support staff 6.69 and for allied health professionals was 9.65. The allied health professional team with the highest vacancy numbers was the integrated therapy teams. Senior staff told us that there was a national shortage of both registered nurses and allied health professionals and so they were considering ways of using staff skill mix differently.

We were told that the opportunities for progression within the therapy teams was limited. Senior nursing staff told us that nursing staff had left the organisation due to high vacancies and the additional pressure this brought. However, the district nursing team had recently recruited five qualified nurses who were due to start in September 2018.

High staff vacancies were included on the divisional risk register, despite the shortages referral times were in line with the trust targets. The incidents in the Burnley district nursing team showed there were 15 incidents reported related to staffing, however, these were no harm incidents. Staff were encouraged to report staffing shortages as incidents.

### Turnover

Between August 2017 and July 2018, the turnover rate reported for nursing and midwifery staff was 7.84%, for additional clinical services was 1.71% and for allied health professionals was 12.32%. The turnover rates for community adult’s services were above the trust target of 5%. Teams were considering ways to improve staff retention.
Turnover (FTE and %)  
01/08/17 - 31/07/18

Sickness

(RPIR) – Sickness tab

Sickness (%)  
01/08/17 - 31/07/18

Sickness Absence Rate % (FTE)  
01/08/17-31/07/18

(Source: the trust, additional data request)

Sickness rates were discussed at individual team meetings and were reported as part of the assistant director of nursing report, which was reviewed at matron level. We discussed sickness
rates with different teams who had identified the causes. There were actions in place to address and improve these.

**Nursing and allied health professional – Bank and Agency usage**

(Source: the trust, additional data request)

**Bank / Agency (FTE)**
01/09/17 - 31/09/18

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<th>Staff Type</th>
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<th>Dec 17</th>
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<th>Mar 18</th>
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<th>Aug 18</th>
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*Only AHP used in cost centre:
R198 - Musculoskeletal Gpws Services
R128 - Integrated Community Therapy Team
No AHP usage in R153 Podiatry

Comments:

No medical locums used in AHP in the community

(Source: the trust, additional data request)

We were told that district nursing teams had a high use of bank staff but did not use agency staff, bank nurses were either part of the team or had been working permanently for the team. They therefore understood the service and knew the patients. The data provided by the trust showed that between April and July 2018 the average use of bank nursing staff was 204 shifts per month. The service was actively trying to recruit to reduce this.

Therapy teams had a high agency usage and between April and July 2018 they reported an average usage of 29 shifts per month, this was to support vacancy rates. We were told that bank and agency staff underwent the same local induction and training as permanent staff to ensure patient safety.

The trust told us the service did not employ any medical staff.
Suspensions and supervisions

The trust has recorded seven supervisions for staff within community adults, with one of these supervisions resulting in a dismissal in April 2018.

(Source: Routine Provider Information Request (RPIR) – Suspensions and Supervisions tab)

Quality of records

The service kept up to date records of patient care and treatment and records were available to access across multidisciplinary community teams. The electronic record system had been newly introduced in April 2018, and at the time of our inspection the service had not developed a process to audit records and monitor quality.

The service used primarily electronic records on a computerised system which had been recently introduced in April 2018. Staff accessed the system using electronic devices in patients’ homes and computers based in clinics. Records were legible and contained relevant patient information. The electronic system meant that notes were time and date stamped automatically with user’s name attached to each entry.

The electronic system was shared with the wider community health service and staff could access GP and other healthcare professional records. Staff told us this enabled them to obtain more background information about patients including current medication and current and past medical conditions.

Risk assessments and care plans were recorded on electronic templates in the patient records, they provided prompts for tasks to be completed. The system had been in place for four months at the time of our inspection. Staff highlighted that some patients’ records had not yet been scanned and uploaded to the system prior to April 2018, this made it difficult to go back to historic notes, we saw evidence of this during our inspection. Paper records which had not yet been scanned onto the system were stored in team base offices.

Records completed during home visits were a mixture of electronic and paper based. Staff updated them after each episode of patient care whilst in the patient’s home. We saw good documentation of patients’ records including assessments, observations, allergy status and care plans. Wound charts and body maps were completed on paper notes which were kept in the patients’ home, there was no template available on the electronic patient record system to document these. Staff documented these as a file note, this did not always provide comparative detail to the paper records kept in the patients’ home. We brought this to the attention of senior nursing staff. We requested a copy of the policy and process for this, the service did not have any guidance on this.

We reviewed records across the multidisciplinary community teams we visited and we saw good documentation of comprehensive care plans which were clear and regularly reviewed. We saw completed risk assessments with associated care plans and referrals as a result, including documented interactions with patients.

We were told that the service had not yet developed an audit process to monitor the completion of patient records, since the introduction of the electronic system in April 2018. We were told this was because the record keeping policy did not support the way information was recorded on the electronic patient record. The clinical record steering group was undertaking work to update the
record keeping policy and develop an audit tool which included electronic patient records. Matrons confirmed there was no interim measure in place to monitor the quality of records, we were told that the system could produce a report of fields which had not been completed on templates. This was not being used as an interim monitoring process.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Community nursing staff held stock of medication in base locations. Medicines were managed stored and transported safely and securely. Medicines were stored in clean utility rooms and were kept in locked cabinets. The keys were stored within the room in a key coded safe which staff in the team had access to.

The district nursing team appointed a medicines champion who was responsible for managing the stock of medication including a weekly stock and date check. Medication orders were sent to the hospital pharmacy at Blackburn in a green sealed bag.

Medication held in the department was recorded on medication logs, stock had to be booked out of the log when it was removed from the cupboard for use. We checked the medication stock and found that medicines were within the manufacturers’ expiry dates, intact and there were no discrepancies between the actual stock and that recorded in the log. However, in one of the district nursing bases we found two boxes of syringes which had passed their expiry dates, we brought this to the attention of the staff who removed them immediately.

Matrons carried out a medicines management audit every three months. We reviewed the audit results published in May 2018 and saw mixed compliance percentages across the teams. The average compliance percentage across the nine teams was 84.9% which was not in-line with the aspirational 100%. We saw that an action plan for improvement had been implemented across the service and individual teams had action plans specific to their areas. Matrons were monitoring the progress of team action plans.

Cool bags were available for the transportation of vaccines which needed to be stored at a lower temperature, however, staff said they did not transport and administer many vaccinations. There was no room temperature monitoring in place where medicines were stored.

District nursing teams had patient group directions in place for the administration of adrenaline injection, lidocaine with chlorhexidine gluconate gel, sodium citrate micro enema, chlorphenamine syrup and tablets, aspirin dispersible tablets and vaccinations for influenza, typhoid and measles, mumps and rubella. This authorised them to administer prescription only medication from their own assessment without a written prescription. We reviewed the copies of the patient group directions forms which provided administration guidance. They were in date and had been signed and authorised by the appropriate senior staff.

Nursing staff administered intravenous antibiotics in patients’ homes, these were supplied by the outpatient parenteral antimicrobial therapy team for the trust. We saw evidence that patients received a microbiologist review and this was documented on paper records in the patients’ home. We observed the administration of intravenous antibiotics in a patient’s home, there were two nurses present in line with standard operating procedures. We observed pre-dose checks including documentation checks, allergy checks and observations. The two nurses then carried out
medication checks and we saw that administration records were signed and countersigned appropriately.

The service did not hold controlled drugs. Controlled drugs were supplied by community pharmacies and stored in patients’ homes. District nursing staff had authorisation to destroy injectable controlled drugs in patients’ homes, when they had passed away. We saw evidence of the authorisation form which had been signed by the chief pharmacist of the trust, however, this was dated 2015. Nurses had the appropriate kits to denature the controlled drugs which were then given to patients’ families to be returned to the community pharmacy. We reviewed the policy for this process which was in date and specified in detail the steps nursing staff should take during this process.

There was a number of community nursing and podiatry staff across the service who had undertaken non-medical prescriber training and could prescribe a number of medicines. This reduced delay in the supply and administration of medication.

**Safety performance**

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

The service reported their safety figures monthly as part of the assistant director of nursing reports and performance was reviewed at divisional level. The information was displayed in departments and we saw evidence of this on the ‘safety at a glance’ boards. The information covered pressure ulcers, catheter acquired urinary tract infections and falls which had been reported monthly.

We were told that the performance was discussed with staff in monthly team meetings and staff were given the opportunity to share ideas for improvement.

**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. When things went wrong, staff apologised and gave patients honest information and suitable support.

The trust used an online incident reporting system which was accessible on trust computers. There was a positive culture around the reporting of incidents. Staff were encouraged to report incidents regardless of the level of harm. Staff gave us examples of incidents which they had reported and told us they received feedback following the submission of incidents, this was either face-to-face or by email.

Incidents were reviewed at a local level and discussed at divisional meetings. Incidents which meet the Serious Incident Framework 2015 underwent a root cause analysis investigation. These were then presented at a corporate level to the serious incident requiring investigation panel. Incidents were included as part of the monthly assistant director of nursing report which was sent to all team leaders.
Staff were made aware of incidents which had been reported through the monthly team meetings and we saw the top five incidents displayed in the areas we visited, as part of the ‘safety at a glance’ boards.

Lessons learned from incidents was shared with staff in a number of different ways including safety huddles and monthly team meetings. The trust distributed a share to care bulletin once a month which shared incidents and lessons learnt across the trust including those in the acute and community services. There was a weekly bulletin distributed to staff by email this contained shared learning which needed to be sent to staff in between the share to care bulletins.

Staff told us if they were involved in an incident they would receive a de-brief and have additional support put in place following that.

Themes from incidents were monitored at divisional level. The trust risk register was integrated into the incident reporting system, this enabled incidents to be linked to risks on the risk register. This enabled the monitoring of themes and frequency of incidents. Senior nursing staff told us that pressure ulcers had been identified as an area of concern trust wide. As a result, there had been a focus on making improvements. Tissue viability nurses had provided training across the trust this has resulted in a 15% reduction in pressure ulcers. The community teams had been involved in a pressure ulcer collaborative, district nursing teams had worked with nursing homes to improve the management across the community. A staff member created a poster campaign which was distributed to homes in the local area called ‘want to keep your bottom peachy?’ to raise awareness and improve selfcare.

**Never Events**

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

From March 2017 to February 2018, the trust reported no incidents classified as never events within community adults.

(Source: NHS Improvement - STEIS (March 2017 February 2018))

**Serious Incidents**

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).

From April 2017 to March 2018 trust staff in this core service reported no serious incidents, with the trust not supplying any data for serious incidents at any community site.

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

**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.
From April 2017 to March 2018, the trust has provided one prevention of future death reports in relation to an incident that occurred within the trust in March 2016. A falls prevention group was formed which bought in a range of measures including the development of a risk assessment tool to help negate future incidents.

(Source: Routine Provider Information Request (RPIR) – P86 – Prevention of future death reports)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Care was provided in line with national guidance from the National Institute of Health Care Excellence guidance, best practice and professional standards. Standard operating procedures and patient assessments were designed in line with national guidance examples of what we saw were pressure area assessments using Waterlow scores, national early warning scores and malnutrition universal screening tool.

District nursing staff involved in treating patients at the end of their lives attended the end of life care team meetings in line with the gold standard framework and were aware of standards for end of life care.

Updates in guidance was reflected in policies and procedures and staff were made aware of these through team meetings. The trust had a Clinical Audit Manager who ensured that new and updated National Institute for Health Care Excellence guidance and Quality Standards were distributed to service leads. It was their responsibility to undertake a baseline assessment. The service leads were responsible for providing an update to the clinical audit manager.

Nutrition and hydration

The service assessed and monitored patients’ nutritional needs effectively. New patient assessments took into account patients’ lifestyle and cultural preferences these were recorded on the patients’ record.

Patients nutritional needs were assessed using the malnutrition universal screening tool. We saw evidence of patients being referred to dieticians and speech and language teams as a result of being identified as high risk. Nutritional assessments were re-visited if there were changes in the patient’s condition.

The trust undertook nursing assessment and performance framework inspections of different teams. The assessment reviewed how nursing staff assessed, documented and reviewed nutrition and hydration. The trust told us that there had been no issues identified with this in community nursing teams. There was currently no nutrition and hydration audits in place, the service told us this would be part of the new record keeping audit which was under development.
Pain relief

Pain was assessed and reviewed during patient interactions and formed part of the initial patient assessment.

Podiatry teams told us of the benefits of having non-medical prescribers in the team, meant that analgesia could be prescribed for patients in a timely manner.

The integrated physiotherapy and musculoskeletal team provided a pain management service. There were weekly pain management clinics held at the Rossendale Primary Health Care Centre. The district nursing service did not undertake audits relating to the assessment and monitoring of pain relief. We were told that pain relief had not been identified as an area of concern.

Patient outcomes

The service monitored the effectiveness of care and treatment and findings to improve them. They compared local results with those of other services to learn from them.

The service had an audit forward plan for the next year. The plan included details of which teams were contributing to national and internal audits.

The integrated pulmonary rehabilitation team contributed data to the National Asthma and COPD Audit. The data for the trust from February 2017 showed improvements in the indicators for patients being reviewed within 24 hours and a reduction in re-admissions for patients with chronic obstructive pulmonary disease, and mortality rates had marginally improved. The service lead told us the results were positive but recognised that improvements needed to be ongoing. It had been identified that the trust had the third highest asthma admissions in the UK, in response the department was working towards improving reviews for asthmatic patients.

The intensive home support service monitored patient outcomes through internal audit, this looked at the numbers of deflected admissions and supported discharges which they reported as 2483 for 2017. They also reported an 80% reduction in a cohort of patients attending the emergency department, who had been referred to their services from the respiratory assessment unit. The service was working towards achieving the commissioning for quality and innovation national (CQUIN) goal 11 which looked at patient involvement in their care. They were also contributing to the national audit for intermediate care.

The integrated neighbourhood team provided a co-ordinator role for the health and social care needs of patients. The team measured patient outcomes through patient stories and case studies, the feedback of the service had been good. We were told that their aim was to reduce inappropriate GP attendances and unnecessary GP referrals to additional services. The team felt they were achieving this however they were not recording and monitoring this data.

The lymphoedema team initiated participation in an audit with the national institute for health care research the audit and benchmarked the trust against Manchester trusts. The initial audit took place in 2016, as part of the audit process there was a supported follow on project. There was a multidisciplinary approach to the project which included a range of community teams including lymphoedema nurses, district nurses, treatment room nurses and podiatry. The aim was to assist the service to improve leg ulcer management in the community.
The lymphoedema service lead told us that the initial data showed the trust performed well and comparative to the other trusts involved. The service identified in the results that there were improvements to be made and re-audit data was showing an improvement. The team told us there was still work progressing and that re-audits were due in October 2018. The project linked in well with the national leg matters campaign.

**Audits – changes to working practices**

The trust has not broken down their audit data by core service, so data can only be presented for the entirety of all community core services. The trust completed three audits in relation to community. These audits were listed under community services:

- Hand Hygiene and ANTT
- Urinary Incontinence in Women
- Bladder & Bowel Service - Bedwetting in Under 19’s

(Source: Routine Provider Information Request (RPIR) – Audits – Changes to working practices tab)

**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.

Staff training and appraisal records were recorded on their individual learning hub on an electronic system, this was accessible through the trust intranet page. Team leaders could use the system to monitor staff training and appraisal compliance.

The district nursing team had developed a training competency framework and workbook. This was used for new starters and bank staff and was part of their local induction. Staff were allocated a mentor who was a senior nurse. Staff worked through the competencies with their mentor and were signed off once completed. Staff were unable to undertake home visits if they had not been signed off as competent in their roles.

The district nursing teams had specific training some needed to be completed annually and others less frequently. We found there was an inconsistent approach to this across the teams. In some areas they were completing all of the competencies annually. We reviewed the annual competencies of staff and found they had been completed.

The service provided a preceptorship program for newly qualified nurses and there was a practice educator to support staff through training.

Staff were given time to attend internal and external training to support the requirements of their role. Staff told us that there was funding available for them to do so. There were opportunities for staff to expand their scope through more specialized training. There were staff members in the lymphoedema team who had been trained in lymphatic massage by a National cancer charity. Staff told us they were given time to attend the two-yearly update training for this.

Nursing staff were seconded to undertake the specialist community practitioner course there were spaces available annually for this. Staff told us they had attended the course and some had been seconded for the next year cohort. Qualified nurses said they could attended external courses particularly for leg ulcer management and end of life care.
There were staff in the integrated home support service and district nursing teams who were working through the advanced clinical skills course. They told us they were supported by mentors for prescribing practice.

As part of the improving leg ulcer management in community nursing project. The lymphoedema team had provided a program of training to different staff groups and specialties across the trust. We were told they had provided palliative care training for dealing with swelling in patients who are at the end of their lives to community nursing teams and community end of life teams. They had delivered leg ulcer management training to podiatry, district nursing teams and nurses providing care in the treatment rooms.

Staff working in treatment rooms had attended leg ulcer training at a local university. The vascular team provided annual training updates following the initial training. However, staff told us this was dependent on staffing within the vascular team.

The different teams had arrangements in place for regular one-to-one sessions. We were told this was to support staff in their roles and identify training needs. The trust had a one-to-one template in place to guide and record discussions.

Clinical Supervision

The trust has not provided their clinical supervision rates. The trust has made the following comments around clinical supervision:

The trust has databases for medical clinical supervisors and nurse mentors. Working in conjunction with Health Education England North (previously Health Education England North West) we have never been required to collect this information. Our education teams do not have a problem with allocating clinical supervisors or trainees reporting lack of clinical supervision. As a trust we are working towards multi-professional clinical supervision in our clinical workforce as we transform our clinical teams and include new roles.

(Source: Routine Provider Information Request (RPIR) – Clinical Supervision tab)

The service provided clinical supervision for staff members. The frequency varied between teams. We were told that the physiotherapists working in the integrated physiotherapy and musculoskeletal teams were given supervision time each week this was either with their team leader or the extended scope practitioner.

We saw a supervision record template in place in the integrated home support service. It provided a comprehensive and guided discussion template. It took a holistic approach ranging from wellbeing to case studies, good practice and complaints and compliments.

Appraisal rates

The service reported appraisal rates for the community adult services at 93% for nursing staff and 90% for allied health professionals. This was slightly below the trust target of 95%.

Appraisal rates for each team were reported monthly and recorded on the assistant director of nursing report. Teams leaders were responsible for monitoring the rates. We were told that if the target was not being met the team leader was required to provide an action plan and rationale for review at the matrons’ meeting.
The learning hub produced email reminders for staff and team leaders 90 days prior to appraisal due dates. Team leaders told us they used them as a prompt to ensure that staff had their appraisals arranged and completed.

**Multidisciplinary working and coordinated care pathways**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Community teams were split into localities and neighbourhoods which aligned with teams of different specialities. Teams were based in buildings that were shared with a range of other services including different trust community teams, general practitioners and social care. The patients under their care often used the range of services within these localities which encouraged cross team working, the use of a shared electronic patient record system also enabled teams to obtain and share information.

Staff had an open positive approach to cross team working and identified benefits to patient care. We saw evidence of patients being referred to other services within the community with ease. This information was stored on the patients’ record and was accessible to all teams involved in the patients’ care. Nursing staff spoke of regular interaction with general practitioners about patients under both their care, they said this was often a phone conversation.

The service had an integrated neighbourhood team that provided a single co-ordinated approach to patients’ health and social care needs. The team was based in five different localities, and each locality had a clinical co-ordinator. The co-ordinators were from a variety of health care backgrounds this included nurses, occupational therapists, physiotherapists and social workers. The clinical co-ordinators identified the multi professional team required to meet patients’ needs on an individualised basis. They facilitated a multidisciplinary team meeting on a two-weekly basis. The meetings were made up of a mixture of General practitioners and district nurses for the locality, the remainder of the team was dependant on the agencies identified to be involved in the care of each individual patient. Examples we were given were social workers, age UK, local hospices, patient carers and patient family members. Action plans were created and the individual agencies took responsibility for the completion of these.

The Integrated home support team and the intermediate care allocation team worked jointly to provide immediate clinical care and ongoing rehabilitation support for patients. The teams were made up of a mixture of nurses and therapy staff, they worked together to meet the diverse needs of patients.

The integrated physiotherapy and musculoskeletal team provided a multidisciplinary approach to patients. The team was a mixture of physiotherapists, general practitioners and extended scope practitioners. Patients were assessed and triaged to ensure that they followed the service pathway to meet their needs.

The service had a range of pathways in place to ensure that patients received the appropriate treatment for their condition.
Health promotion

Staff across the service encouraged patients to make healthy lifestyle changes and promoted ways for patients to manage their own health. This included referrals to smoking cessation services and wellbeing services.

Community teams who provided care to patients with complex long-term conditions used different ways of connecting with patients and promoting self-care. Staff facilitated support groups, provided information leaflets and used technology to connect with patients.

The lymphoedema team delivered regular talks and evening groups in the local area. The groups were to provide support to patients who were suffering with breast or gynaecological cancer and patients who were in remission. The support groups provided patients with information and support to manage issues associated with lymphoedema and to signpost these patients to services should their condition deteriorate. The team also provided a patient led follow up at Burnley General Hospital for patients who were at risk of developing lymphoedema. They provided advice on warning signs and signposted access to their services should the patient encounter any problems.

The Intensive home support service and the Integrated respiratory team encouraged patients to sign up to an application for patients with chronic obstructive pulmonary disease. The application could be added to electronic devices such as smart phones, laptops, tablets and personal computers. The service had acquired licences so the application was free for patients and it provided self-management tools. Staff told us the application contained videos with inhaler techniques, exercises and advice on how to manage breathlessness.

The integrated respiratory team facilitated a pulmonary fibrosis support group, this was held every three months at Burnley General Hospital. The support group was facilitated by a member of the admiration team who was supported by the advanced nurse practitioner.

District nursing staff had developed a campaign to raise awareness of pressure areas. It provided information to assist patients in managing their own health to prevent pressure areas. The poster encouraged activity, a balanced diet and skin checks. We were told that the posters had been distributed to local nursing and residential homes.

Nursing and allied health professional staff had access to a range of leaflets to assist patients to manage their own health. There was a mixture of leaflets in use which were created by the service and external agencies and national charities. An example of the trust leaflets, were advice about footwear for patients with diabetes and working together to prevent moisture lesions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff were aware of their responsibilities in relation to consent. We observed nursing staff obtaining consent whilst in patients’ homes and we saw documented evidence of this. The integrated neighbourhood team had built consent into the referral process and told us it was the referrer’s responsibility to obtain this from the patient prior to referral. However, they did say that when they made initial contact with patients they confirmed consent verbally. Staff told us if they
did not think a patient had capacity they would refer them to a social worker to undertake the capacity assessment.

Staff were aware of how to recognise when a patient lacked capacity and understood that patients could have fluctuating capacity linked to their acute condition. In the intensive home support service, we saw good documented evidence of a capacity assessment and best interest decision made which included the multidisciplinary team and the patient’s family.

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

Mental Capacity Act and Deprivation of Liberty training was provided as part of safeguarding adults level one training. The trust provided a completion rate for this training as 99% for nursing staff and 96% for allied health professional staff.

**Deprivation of Liberty Safeguards**

We requested information from the trust for the amount of deprivation of liberty safeguard applications made by the service in the last twelve months. The trust confirmed that there were no applications made by the service. The trust confirmed this was because in the community, patients who would require a deprivation of liberty safeguard would be receiving residential care. It would be the responsibility of the residential care provider to make the application as they would be the managing authority for the patient.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff being caring to patients and taking the time to explain in detail their care and treatment. We observed staff being sensitive to patients’ privacy and dignity and having good communication and interactions with patients.

We spoke with patients who were using the service and we saw evidence of compliments which patients had provided through feedback forms, compliments cards and the integrated physiotherapy and musculoskeletal care survey. Patients spoke highly of the health care professionals providing treatment.

A patient who was receiving nursing care at home said, “all staff are brilliant”, a patient’s relative who contacted the integrated neighbourhood team said how staff “supported their relative”, the integrated home support service received compliments which said, “you’re all angels, I don’t know what I would have done without you” and feedback for the integrated physiotherapy and musculoskeletal survey was “incredibly knowledgeable and respectful of my circumstances”.

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff understood the impact of complex long-term conditions of patients’ wellbeing, emotionally and socially. The integrated nature of community services meant that staff could refer patients to a variety of services to meet their needs. They could also refer patients to the integrated neighbourhood team who would co-ordinate social and emotional support from external agencies. Staff had access to nurses and healthcare assistants who were trained in advanced communication skills.

The multidisciplinary meetings which took place in different localities on a two-weekly basis reviewed patients’ emotional needs. The integrated neighbourhood team provided examples of patients whom they had organised emotional and psychological support for, this included referral to a local hospice for psychotherapy and day therapy and to local wellbeing services for activity and social support.

Privacy and dignity was monitored through the nursing assessment and performance framework. This was through observations of care, patient feedback, staff interviews and training records. Results of the audits were good and the trust said that this was a way to provide assurance that privacy and dignity was embedded into practice. Staff told us that if patients required a chaperone for certain procedures or intimate care this was something which they would organise for patients.

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. Staff across the service felt they had time to spend with patients and have discussions about their care and treatment.

District nurses undertook a full assessment of patients’ needs at their initial visit. Staff explained the service to patients and discussed treatment plans and care packages. We observed discussions between staff and patients which included careers and family, we saw sufficient information being discussed about care plans and treatment. We observed reviews of care plans and treatment goals.

Patients who received care in the treatment rooms told us that the nursing staff behaved professionally at all times. Patients told us that they felt they could speak to the nursing staff if there was a problem. Patients told us they had their treatment explained to them and that this often backed up with an information leaflet relating to their condition. We were also told that patients were given contact details for the service if they encountered any problems in between appointments. Patients felt they could raise concerns if necessary however the patients we spoke with, had not had a reason to do so.

The integrated neighbourhood team gave us examples of how they had supported patients and their careers through difficulties managing their care and care packages. The patient and their carer had been involved in the regular multidisciplinary meetings and the setup of care packages. The result was that the carer was empowered to become the case manager for the patient.
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.

Services were commissioned by two local care commissioning groups, some services varied due to the difference in commissioning. Staff did not feel this impacted on the care patients received.

The trust had been working with the Pennine Lancashire sustainability and transformation partnership. This was in-line with national integrated care initiative. The aims and objectives were aligned with the trust’s strategy to develop integrated care partnerships and improve the health and wellbeing of the local population, whilst reducing hospital admissions the partnership involved working in conjunction with GPs and commissioners.

Service leads were aware of local priorities and service priorities were aligned to these. It had been identified that support for patients with chronic obstructive pulmonary disease was a local priority. The intensive home support service had contacted patients under the care of local general practitioners who were diagnosed with chronic obstructive pulmonary disease. They were providing condition education for patients’ in their own home and a contact to the team in case of an exacerbation of their condition. The integrated respiratory team linked in with the service for these patients.

The Integrated respiratory team identified that the trust was the third highest in the United Kingdom for asthma admissions, the service reviewed their patient demographic and identified that 15% of their Asthma patients were under 30, female, and of Asian origin. The service has had a focus on ensuring patients attend asthma clinics annually at a minimum to help manage their condition. The service was using a national asthma charity’s tool to assist patients to monitor and manage their condition.

The service had access to a translation service for patients whose first language was not English. Staff in treatment rooms had access to a phone and the number for the service was available on the intranet.

Information leaflets were in use for various conditions, we only saw these printed in English. However, staff told us they could obtain these in other languages. On the back of some of the trust leaflets we saw instructions in different languages of how to obtain the leaflet in an alternative language or format with a number to contact.

Meeting the needs of people in vulnerable circumstances

The service took account of patients’ individual needs. We saw good examples of personalised care.

The integrated neighbourhood team provided a co-ordinator role to assess and manage the health and social care needs of patients who had been referred. Each patient was triaged and their needs identified. This meant that care plans were personalised to meet the patients’ individual needs, the involvement of other services was based on the care goals and the needs of each individual patient. They considered psychological needs, personal activity needs, financial needs, nutritional needs along with physical health needs. The clinical co-ordinator brought the range of
services together to work to meet the needs of individual patients. The co-ordinator provided a named contact for patients and their families throughout their journey.

The service used a dementia screening pathway for patients who met the criteria. There was a dementia link nurse to support staff and patients. Staff could refer patients into community services which they thought would be appropriate to support patients.

Buildings where clinics took place were designed in an accessible way. The buildings we visited were purpose built as health and social care premises there were ramps and lifts available for patients who needed them. Corridors were spacious as were clinic rooms and there were disabled facilities available. Patients who were unable to leave their homes were provided with home visits where possible. In addition to district nursing services home visits were provided by podiatry, lymphoedema teams and therapy staff.

Patients communication needs were assessed during the triage process and initial visit assessments. Whilst staff did not have access to communication aids they did have access to a learning difficulties link nurse. Staff told us that they would involve family and carers for patients who had additional needs. The integrated neighbourhood team gave us examples of patients’ who they had identified as needing communication support and said how they involved other external services to support patients’.

**Access to the right care at the right time**

People could access the service when they needed it. The service monitored referral to treatment times, cancellations and did not attend rates.

District nursing teams and the intensive home support services were provided seven days per week. The intensive home support service provided services until 10.00pm and the district nursing team provided care 24 hours a day. Clinics were available in different localities Monday to Friday in the main 8.30am until 6.00pm. The podiatry service provided clinics until 7.30pm one day a week for patients who worked. Patients who were unable to access clinics in health centres due to being house bound were provided home visits.

The intensive home support service provided patient visits within two hours of referral. We were told the two-hour target was not always met during the weekends due to less staff allocated to the team on these days, however they prioritised patients to reduce the impact of this.

There were pathways in place which encouraged community staff to identify patients in the acute hospital setting who could be treated in the community. Examples of the pathways were the home first and the intensive home support in reach pathway. The aim was to step down patient care for those with a stable condition and provide care in patients own homes away from the acute hospital setting.

**Referrals**

From April 2017 to February 2018, the trust identified 26 services in this core service which were measured on ‘referral to initial assessment’. The average days from referral to community service in this core service was 10.6.

(Source: Routine Provider Information Request (RPIR) Community – Referrals tab)
We reviewed the referral to treatment times provided by the trust. Referral to treatment times across the community services were generally less than one week. The longest waiting times we saw were for the pulmonary rehabilitation programme which had a waiting time of ten to twelve weeks. This was in line with the national target of 90 days.

Services had triage processes in place to ensure that referrals were prioritised as necessary to meet the clinical needs of patients.

We saw that the lymphoedema team had a triage pathway in place which specified when certain patient groups must be seen. The referrals were triaged by a specialist nurse who had a higher level of clinical knowledge. The triage pathway put patients into three categories these were most urgent, soon and routine. Most urgent patients were seen within five days this included patients who were at the end of their lives, soon were more urgent cases and were seen within two weeks and routine cases were to be seen within 4-6 weeks. Staff told us they were meeting these targets and that there was limited data on this.

District nursing team’s referrals were triaged by senior staff members, patients who were identified as being urgent were prioritised for same day visits. We saw evidence that a patient had been prioritised due to reporting a blocked catheter. Staff told us that if they identified that a patient needed clinical input immediately but could be treated in their own home, they would refer the patient to the intensive home support team, so that the patient would be seen within two hours. Similarly, the intensive home support team would triage patient referrals and step-down patients to alternative services such as the intermediate care allocation team and district nursing teams if they did not require a two-hour clinical response.

Services monitored ‘did not attend’ rates and patient cancellations within 24 hours of appointments. Senior staff across the service told us the rates were high. The impact on the small teams was much greater and we saw that this was recorded on the directorate risk register for the lymphoedema team. The lead nurse for the service told us that they were working towards introducing text reminders for patients. The integrated physiotherapy team had recently introduced a text message reminder service for appointments which had improved these rates.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, were shared with all staff. Complaints and compliments were reported as part of the monthly assistant director of nursing report and discussed in team meetings.

**Complaints**

From April 2017 to March 2018 Community services for adults received one complaint, which was related to the podiatry team.

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

Across the service we were told that teams received very few complaints. This was reflected in the data provided by the trust which told us one formal complaint had been received for the community adults service from April 2017 to March 2018. The trust had a dedicated complaints team called the customer relations team who were responsible for the co-ordination and investigation of complaints.
Senior staff members told us that they tried to deal with complaints at a local level to prevent them becoming formal complaints. We were given an example of a recent complaint that was made to the service which was dealt with by the team leader and prevented escalation to a formal complaint. The service learnt form the complaint and took appropriate action to prevent future similar complaints. The action included further training and support for staff.

Staff told us that if a patient raised a complaint to them, they would direct the patient to the community patient advice and liaison service. They told us that they would also inform their line manager so that follow up could happen to attempt to resolve the complaint informally.

We saw that the service had a 'you said we did' initiative in place. We saw that the district nursing team had introduced primary nursing following feedback from patients who were unhappy that they did not have the same nurse for each visit. As part of this initiative the leg cafés which were held by the lower limb vascular teams were moved from public buildings back into health centres. This was because of patient feedback and concerns about the accessibility and suitability of facilities.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The matrons and service leads for the teams were visible and based in the community with their teams. The matrons told us that they shared their time across the different locality bases so that they had direct contact with their teams.

Staff across the service told us that they felt the leaders were visible and approachable and that there was an open-door policy.

The teams had a structure to ensure that staff members had regular one-to-one meetings with their line managers. Team leaders said that these fed into each level of staff member and provided oversight of the service for the lead.

Service leads were aware of the challenges to maintaining high quality services and developing services to meet the changing needs of the population. Service leads articulated plans and identified actions for the future development of services.

The trust had a leadership development programme in place for nursing staff. This was a nine-month development course.

The integrated physiotherapy service lead had identified that a similar course would be beneficial to leaders within their service. They had undertaken work with the learning and development team to develop a leadership development course. The programme covered a range of leadership skills including coaching and managing difficult conversations. We were told this had been delivered to all the team leaders across the physiotherapy and musculoskeletal service including the administrator teams. We were told that the service was looking at creating an aspiring leaders course for the more junior team members who had leadership aspirations.

Vision and strategy
The service had a vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff, patients, and key groups representing the local community. The service had a strategy in place which was aligned to the Pennine Lancashire sustainably and transformation plan. The trust was part way through their five-year strategy. The vision of the strategy was that “in three to five years’ time, the health and social care system across Pennine Lancashire will have a fully person-centred approach, with seamless, integrated services and pathways”. The strategy aimed that patients with long term conditions would receive treatment in their own homes instead of the hospital setting to prevent avoidable admissions.

The strategy had taken into account the needs of the local population and we saw evidence within the strategy that the trust had identified the local population and estimated the needs of the future population based on this information.

We saw integrated teams that were working towards this model. The integrated home support service and the intermediate care allocation team were treating exacerbations of complex conditions and providing rehabilitation support to patients to keep them well at home.

The district nursing teams were currently undergoing a review of their services to further integrate the teams. We saw evidence of questionnaires which had been sent to patients requesting their feedback on the service and what could be done better. However, the service had identified on the risk register that the planned integration of nursing teams may not meet the target timescale due to capacity within the teams.

Staff we spoke with said they were proud to work for the trust and that they followed the values providing safe, personal and effective care to patients. Staff were aware of the focus on the integration of services.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us they were proud to work for the trust and the service and enjoyed their jobs. Staff felt that they could raise concerns and share ideas for improvement.

Staff we spoke to said that they felt connected to the organisation and did not feel isolated. Staff said there was weekly communication from the trust and podcasts from the chief executive. Staff told us that the integrated structure of their teams and the multidisciplinary working meant that they felt like they were part of a much bigger team.

However, we were told by staff in focus groups and one of the therapy service leads, that therapy staff were leaving the organisation due to limited opportunities for career progression. The service lead told us they needed to look at what they could do to create more opportunities for staff, however, financial constraints were a barrier.

The trust provided a wellbeing service for staff called the employee assist programme. This was provided by an external company but was available to staff 24 hours a day, seven day a week. The support ranged from personal including anxiety and depression, workplace, family and relationships, daily living and life events. The service was available by telephone, email, instant messaging and via a website. There were information leaflets available in staff areas.

We were told that the wellbeing team had recently provided a mindfulness session for district nurses at the Burnley hub and all staff were invited. The team leader told us that the night shift
team had identified team building as a priority. We were told that a team building session had been arranged for them later in the month.

District nursing teams had a buddy system in place for staff undertaking home visits on their own. This meant that they always had a senior nurse available as their linked contact. This was the same for staff working through the night. However, practices for monitoring the safety of lone workers varied in different teams and the services were not clear about what the lone worker policy was.

**Governance**

There was a clear reporting and governance structure in place. The services were aligned to the integrated care group division and the diagnostic and clinical support division for therapy staff. There were monthly divisional meetings in which performance, risk, incidents and complaints were reviewed.

Matrons met with the assistant director of nursing monthly to discuss the monthly report for each team. Information from these meetings was then discussed at team leader meetings and shared with staff in monthly team meetings. We saw evidence of this in meeting minutes which were stored electronically on shared drives. The performance data was displayed for staff to read on notice boards in departments.

Matrons attended a monthly clinical effectiveness meeting in which a review was undertaken of audits and changes to clinical pathways, policies and procedures. Information from this meeting was shared with the necessary staff as part of team meetings.

Serious incident reviews were undertaken as part of the serious incidents requiring investigation panel. Staff involved in undertaking root cause analysis investigations presented their findings to the panel in this meeting. We were told that once outcomes and learning were agreed this information was shared with staff in team meetings as part of learning from incidents.

Staff and managers felt that information was fed up and down the structure effectively and they were aware of information they needed to know for their roles.

The teams we spoke with told us they had monthly team meetings. However, we were told that some of the team meetings had been cancelled due to limited staffing.

**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 trust used an electronic incident reporting system to record the risk register. We saw departmental and divisional risks recorded on the register. A scoring system was used to categorise the risks identified. This identified at what level the risks would need to be reviewed and identified which register they were recorded on. An example of this was risks which scored between fifteen and twenty-five were recorded on the corporate risk register and discussed at board level.

Matrons told us that the benefit of the risk register being recorded on the incident reporting system was that it allowed incidents to be linked to the risk register. District nursing matrons told us that
the risk register was discussed at the team leader meeting on a two-monthly basis. The register was then presented at the monthly divisional meetings by the matron. We were told that the scoring of these risks was scrutinised at this meeting and amended as needed. The quality and safety committee provided oversight of the risk register.

The risk register was visible across the organisation and divisions. We reviewed the risk register and saw that the risks we were told about from senior staff were present on the register and action plans to mitigate risks were documented.

In the areas which we visited we saw that the teams displayed the top five risks and we were told this was discussed at the monthly team meetings. The risks were recorded on the departmental and divisional risk registers. An example of a risk identified was moving and handling risk due to access to bariatric equipment in the lymphoedema team. We were told to mitigate the risk to staff a separate moving and handling section had been added to patient assessment tool, to identify patients’ needs and ensure practice was safe for both practitioner and patient.

Patient Safety alerts were sent to community teams from the trust governance team using a generic email account. They were then cascaded to staff email accounts. We were told that information was then provided to staff verbally during safety huddles. The team leaders were responsible for feeding back actions which were taken because of the alert. This information was then sent to the governance team. We saw evidence of care plans and information leaflets which district nursing staff provided to patients with mouth swabs following a national patient safety alert.

The service had a performance dashboard for monitoring the performance. This looked at waiting times against targets, referrals received, internal demand and did not attend data. These were reviewed as part of the divisional meetings. The review of performance was monitored through the assistant director of nursing reports and were used to improve performance.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service recorded performance data on a dashboard. The data collected covered a variety of performance metrics. The information was used to monitor and improve services at a divisional level. The information recorded on the dashboard was presented to local commissioners to demonstrate performance against targets.

The service primarily used the electronic system for patient records. There was a sharing agreement in place for access to patient information from external healthcare providers such as general practitioners who used the system for patient records. Staff had access through personal login details and passwords.

However, the service had not developed a system for extracting data to audit the quality of information which had been inputted into the system. At the time of our inspection there was no audit process in place for the management and quality of electronic patient records.
Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service regularly collected patient feedback, through patient experience forms. These were reported monthly as part of the assistant director of nursing report and discussed in team meetings. In the July 2018 the responses the district nursing teams in Burnley received were 100% positive feedback. We saw that for July 2018 the intensive home support service had received an overall positive score of 90% and a 100% recommendation on the friends and family test.

The integrated physiotherapy and musculoskeletal service undertook an annual care survey and monitored the quality of the service through the patient feedback received. We saw the 2018 survey which showed positive results and an improvement from the previous year.

The strategy for the service was developed through consultation from a variety of stakeholders, local care providers and patients and carers. The service was working closely with local care commissioning groups and the Pennine Lancashire network to develop and integrate services further. We saw evidence of the questionnaires which had recently been circulated to patients to assist with the review of the district nursing services.

Staff engagement was good, staff had regular team meetings and were encouraged to contribute ideas for development. Staff received cascade emails from the integrated care group meetings and matrons cascaded information from divisional governance meetings into the monthly team meetings. The integrated physiotherapy team provided staff with anonymised surveys to identify what staff thought could be done better. As a result, the team had received communication training and leadership training for team leaders.

There was a staff guardian in place for staff to approach and raise concerns, staff were aware of the role.

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.

Lessons learnt and shared was an embedded practice throughout the service. Complaints and incidents were discussed in team meetings and displayed in team areas for all staff to see. The trust had a share to care bulletin which was shared across the trust monthly. Staff were aware of incidents in their teams and across the trust including the outcomes.

The services were encouraged to take part in projects and research both internally and externally. The lymphedema team had initiated involvement in the improving leg ulcer management in community nursing project. This had been developed following an audit with the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care. The aim of the project was to improve leg ulcer management in community services. The project began in September 2017 and was ongoing. Staff told us staff of different grades have received additional training as a result. There was a multidisciplinary team approach to making improvements including podiatry, treatment rooms and community nursing teams. Staff felt awareness had been
raised and the team had received more enquiries from non-specialist teams for advice on dealing with lower limb issues. The project was a standing agenda item on the team meetings for all community teams.

The integrated physiotherapy team had been involved in research for addressing shoulder pain. The team recruited the first patient to the study in the country and met the recruitment target within two months. The team had won first prize for the best debut category at the 2017 Greater Manchester Clinical Research awards.

The integrated respiratory service was in the preliminary stages of working with a local drug and alcohol service to identify how to reach out to patients under these services for better chronic pulmonary obstructive disease diagnosis and treatment. The team were in the scoping stages of how to provide joint mobile clinics to this patient group.

Staff told us they were encouraged to contribute to changes and improvements. Staff in the district nursing team told us they had put forward a poster initiative ‘want to keep your bottom peachy’ to improve pressure area management in local nursing and residential homes. Staff told us this was approved and that the posters had been distributed.

**Accreditations**

There were no accreditations associated with this core service.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)
Community inpatients

Facts and data about this service

Community inpatient services at East Lancashire Hospitals NHS Trust are based across three sites, Pendle Community Hospital, Accrington Victoria Hospital and Clitheroe Community Hospital.

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>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendle Community Hospital – Hartley Ward</td>
<td>Rehabilitation</td>
<td>24</td>
</tr>
<tr>
<td>Pendle Community Hospital – Reedyford Ward</td>
<td>Rehabilitation</td>
<td>24</td>
</tr>
<tr>
<td>Accrington Victoria Hospital – Ward 2</td>
<td>Rehabilitation</td>
<td>18</td>
</tr>
<tr>
<td>Clitheroe Community Hospital – Ribblesdale Ward</td>
<td>Rehabilitation</td>
<td>32</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Universal P2 – Sites)

Community inpatient beds, including stroke rehabilitation, are provided by the trust at Accrington Victoria Hospital, Clitheroe Community Hospital and Pendle Community Hospital. These beds are supported by a full multi-professional team including in-patient nursing, medical and AHP staff. The trust provides an Occupational Therapy and Physiotherapy service within these Community Hospitals. The trust also provides an Occupational Therapy [OT] only service to Longridge Community Hospital.

(Source: Routine Provider Information Request (RPIR) CHS CH1 – Context CHS)

Pendle Community Hospital consists of three 24-bedded wards, Marsden ward which is a specialist stroke rehabilitation ward as well as Hartley and Reedyford wards, which are both general rehabilitation wards.

Clitheroe Community Hospital has a 32-bedded rehabilitation ward called Ribblesdale whilst Accrington Victoria Hospital has ward two which is an 18-bedded female rehabilitation ward.

Community inpatient services sit under the integrated care group which includes medicine and community services.

We carried out an unannounced inspection of all three community sites on 28 to 30 August 2018. During our inspection we spoke with many members of staff including the named nurse for safeguarding, physiotherapists, registered nurses, healthcare assistants, housekeepers, complex case managers, matrons, ward managers and the falls lead for the trust. We also spoke to six patients, three relatives and observed a best interest meeting.

We reviewed 25 sets of patient records and eight incident report forms. Patients and their relatives were also spoken to about their experience.
**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills and made sure all staff were included. We saw a high level of compliance across all three community hospital sites.

**Nursing Staff**

We saw a high level of compliance across all three community hospital sites. For example, conflict resolution ranged from 97% to 100%, equality and diversity from 97% to 100%, basic life support from 80.6% to 93.9% and information governance from 94.1% to 100%.

The service provided a mixture of face to face and e-learning modules in areas such as moving and handling and equality and diversity. This meant that staff had a clear oversight of key issues such as infection prevention and safe management of important tasks such as moving and handling.

**Medical Staff**

Medical staff including, a specialty doctor, a consultant for each site and a ward doctor at each site – nine in total were fully compliant (100%) in all modules of the mandatory training programme, including safer handling, basic life support, conflict resolution, equality, diversity and human rights, health and safety awareness and infection prevention and control. The medical staff were managed by an offsite business manager.

**Safeguarding**

Staff understood how to safeguard patients from harm and abuse, they could identify different forms of abuse and knew how to make a safeguarding referral. Safeguarding training levels were high and we saw evidence of safeguarding referrals.

**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. 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.

Between April 2017 and March 2018, the trust reported a total of 616 safeguarding alerts, made 1,408 safeguarding referrals for advice and support and 363 new referrals. The trust has not provided the data in a way that allows it to be broken down by core service.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide - Safeguarding</td>
<td>42</td>
<td>40</td>
<td>53</td>
<td>63</td>
<td>41</td>
<td>38</td>
<td>46</td>
<td>49</td>
<td>51</td>
<td>79</td>
<td>56</td>
<td>58</td>
</tr>
</tbody>
</table>
Staff understood how to safeguard patients from harm and abuse, they could identify different forms of abuse and knew how to make a safeguarding referral. During our inspection we saw evidence of a safeguarding referral for a vulnerable patient with complex needs.

Training levels on how to recognise and report abuse were high, 100% of both registered nurses and health care assistants were trained in adult safeguarding level two as well as seven out of nine medical staff.

Safeguarding alerts and referrals were made to a generic email address received by an internal safeguarding team who then forwarded them to the relevant external agency – either Blackburn with Darwen or East Lancashire safeguarding teams. Records received prior to our inspection confirmed an increase in the number of safeguarding queries and alerts made throughout the trust between April 2017 and March 2018.

Training in children’s safeguarding level two was also undertaken despite the community inpatient department being an adult only service, this was in line with national intercollegiate guidance. 99% of registered nurses and 89% of healthcare assistants had completed the training.

We spoke with safeguarding champions within the service who told us they attended bi-monthly meetings where enquiries and alerts were discussed. Records confirmed that quarterly reports were provided to the Internal Safeguarding Board to ensure both local and national safeguarding standards were met.

Funding had recently been secured for an independent domestic violence advisor to be based within the safeguarding team. At the time of our inspection the trust had a peer support group called the SEE (safe, enlightened and empowered), a network where members of staff who had experienced domestic violence could share their experiences. The trust was represented on the multi-agency domestic abuse steering groups and domestic abuse strategic boards for Lancashire and Blackburn with Darwen.

We saw a policy for female genital mutilation and found that training for this sat within children’s safeguarding level 3 training. Records confirmed that 23 female genital mutilation concerns had been raised between January and December 2017, throughout the trust. However, staff within this department were trained to level two in children’s safeguarding which did not include female genital mutilation.

Prevent (a training package about the risks of radicalisation) training compliance within the service was high, 99% of registered nurses and 98% of healthcare assistants were trained. A prevent policy was also in place within the trust.
The trust was represented at the local safeguarding adults and children boards. As well as multi-agency subgroups, including the safeguarding quality assurance sub group, safeguarding adult review subgroup, the Mental Capacity Act networks, North West Prevent networks and domestic abuse forums.

The trust had also recently taken part in an external safeguarding audit.

Cleanliness, infection control and hygiene

Apart from hand hygiene, the service controlled the risk of infection. Staff kept equipment and the premises clean and used control measures to prevent the spread of infection.

Patient led assessment of the care environment (PLACE) assessments were undertaken within the service. The team included NHS and private/independent health care providers, 50 per cent of the team was made up from members of the public (known as patient assessors).

The focus of the assessments was on the environment in which care was provided, as well as non-clinical services. This included cleanliness, food, hydration, the extent to which the provision of care with privacy and dignity was supported and whether the premises were equipped to meet the needs of people with dementia against a specified range of criteria.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Cleanliness %</th>
<th>Condition Appearance and maintenance %</th>
<th>Dementia Friendly %</th>
<th>Disability %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendle Community Hospital</td>
<td>97.41%</td>
<td>92.12%</td>
<td>85.98%</td>
<td>87.04%</td>
</tr>
<tr>
<td>Accrington Victoria Hospital</td>
<td>97.92%</td>
<td>84.95%</td>
<td>77.73%</td>
<td>76.18%</td>
</tr>
<tr>
<td>Clitheroe Community Hospital</td>
<td>94.07%</td>
<td>93.48%</td>
<td>82.32%</td>
<td>82.81%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

Infection prevention and control link nurses were accessible to the community inpatient team and provided training, advice and guidance. We saw that infection prevention and control champions worked within all three sites. They were responsible for the infection control information boards we saw displayed in each of the wards.

The monthly matron audit looked at infection control such as catheter associated urinary tract infections as well as compliance in areas of aseptic hand hygiene technique, cleanliness of commodes and the condition of mattresses. We saw that action plans in response to the audits were created and undertaken for example, the aseptic hand hygiene audit in May 2018 at Accrington Victoria Hospital revealed some areas of non-compliance. An action plan was created and in the following audit, June 2018 we saw that the full compliance was achieved.

Hand hygiene results for the three months ending July 2018 were 100% compliant at Clitheroe Community Hospital, Accrington Victoria Hospital and on Hartley and Marsden ward at Pendle Community Hospital. However, compliance for Reedyford ward at Pendle Community Hospital was 75%. We observed an action plan following this low result that stated Reedyford wards infection control link nurse was on long term sick, so their priority was to identify a new infection control link nurse to ensure compliance.
We found that the audit sample was small and therefore potentially not fully representative. For example, at Pendle Community Hospital we found that on one ward between April 2018 and August 2018, 11 registered nurses, 10 health care assistants, four therapists and one member of medical staff had been audited.

During our inspection we did not witness staff washing their hands. We were told by one member of staff that she didn’t need to wash her hands after dealing with a patient suffering from diarrhoea because the patient wasn’t infectious.

Staff were arms bare below the elbow, neat, clean and tidy in line with the uniform policy and gloves and aprons were available on corridor walls within each ward.

Environment and equipment

The service did not always have suitable equipment, which was well maintained, to keep patients safe.

All three sites of the community inpatient department had differing styles of estates. For example, Ward two at Accrington Victoria Hospital was an old ‘nightingale’ style ward, it was an open layout with two large bays. Clitheroe Community Hospital was a newly built unit where all beds had on-suite bathrooms and large open plan windows. Pendle Community Hospital was a 1960’s building which had traditional style four bedded bays.

All wards on each site were secured by buzzer access.

The dedicated 24 bedded stroke rehabilitation ward at Pendle Community Hospital only had two hoists available. We were told that one had recently been broken, this left only one hoist available until a temporary replacement could be sourced from another ward. However, we did not see this raised as an incident nor added to the service’s risk register. No clear management plan was in place at the time of our inspection.

At Accrington Victoria Hospital we were told by the matron that the bath had been out of service for the last twelve months, this meant that patients used one of the two showers available instead. We were told delays in rectifying this were due to the detection of asbestos in the basement, this meant that plans originally drawn up to alter the room to a wet room had been cancelled and attempts to source a bath unsuccessful.

Linen was managed in line with trust policy and clinical waste was stored in secure areas on each of the sites. Sharps bins (where needles and glass vials were disposed of) were correctly labelled and not overfilled.

Resuscitation trolleys and equipment were available in each ward. We found these to be checked daily, adequately stocked and in date.

All wards on each site had access to an outdoor garden area. Clitheroe Community Hospital and Accrington Victoria Hospital had outdoor areas which were suitable for beds to be taken outside. This meant that less mobile patients could enjoy fresh air as well as the sights and sounds out the outdoors, this also included more mobile patients.
Assessing and responding to patient risk

The service completed risk assessments for patients and had processes for managing deteriorating patients.

The community inpatients department used an early warning scoring system. This is a system of scoring observations such as blood pressure, respiratory rate and temperature, to monitor and identify any deterioration in a patient’s condition. We saw that the scoring trigger threshold was lower than on the acute hospital sites to ensure timely action could be taken, given the geographical locations and reduced medical provision. If a patient scored a two or above a discussion with a senior nurse or member of medical staff was undertaken, as was increased monitoring of observations.

Early warning score (EWS) audit results were reviewed and for the three months ending July 2018 were 100% compliant. However, results for August 2018 demonstrated a drop to 85%. We spoke with management and observed minutes from the team meetings. We also observed an action plan following a recent incident of a deteriorating patient when the EWS score was not escalated effectively. The action plan stated that staff were to read and sign that they fully understand the trust clinical observation policy CP37; all qualified staff to sign the record keeping guidance; all staff to sign the trusts standard operating procedure (SOP) for measuring fluid status; staff to access fluid balance chart change package and complete the e-learning module on sepsis. Additional to this bespoke acute illness management sessions and training were being held. The first session to be held for staff was planned for 29 September 2018.

The service’s process for managing a deteriorating patient was to liaise with senior members of medical or nursing staff during office hours. During the night time and at weekends, the process was to liaise with the medical registrar based at Royal Blackburn Hospital via telephone. Should the patient require transfer back to the main hospital site then the local ambulance service would be contacted to transport the patient. Managers told us that the patient should bypass the accident and emergency department and go straight to the acute medical assessment ward, however due to bed shortages patients would often end up in the accident and emergency department.

Falls risk assessments were completed for each patient and actions following a fall were documented within the medical notes. Patient’s deemed to be at high risk of falls had picture of a leaf on the board above their head, this meant that staff and visitors had a visual awareness of the risk to that patient. We saw an in depth falls awareness noticeboard on the main corridor of some wards which explained to staff and visitors’ relevant information relating to falls, such as a laminated copy of the protocol, an explanation of the leaf, leaflets about ways to reduce the risk of falls and what to check for after a fall including signs and symptoms of injury.

A falls lead for the trust attended each ward once a week and reviewed all falls incident reports. Each ward had its own link nurse who supported staff in undertaking risk assessments and managing high risk patients.

Patients at risk of falls were co-located to a bay where a designated member of staff was continually based. The member of staff would not leave the bay or go behind a curtain without arranging for a second member of staff to take over the monitoring of patients. We found this was in place during our inspection and that an extra health care assistant had been brought in to cover this task on one of the wards.

Information provided by the trust showed that the mean average occurrence of falls throughout all community inpatient wards between 8pm and 8am was 42%. Staff told us the process of not leaving the bay during these shift times was extremely difficult with the number of staff on duty. To
address this a dedicated falls lead nurse was working with the service. A one-hour training package for staff had been devised and was being rolled out, this highlighted information such as how to recognise patients vulnerable to falls, definitions of falls and the management of them. A weekly review of fall assessments had been implemented within the service as had a daily review of individual care plans. If a patient scored a ‘yes’ in the falls assessment making them at risk then a multifactorial risk assessment was undertaken. This was a more in-depth assessment that considered medical factors, hearing and visual impairments and the gait and balance of the patient.

We checked five sets of patients notes and found that risk assessments were completed and recorded accurately and in line with trust policy.

**Staffing**

The service did not always have the numbers or mix of nursing staff to meet the planned staffing allocation. The service had mitigated the risk by using bank and agency staff or allocating managers to shifts.

**Safer Staffing levels**

The trust provided the following statement relating to how they are meeting the requirements for safe staffing levels of their services:

An inclusive strategic nursing and midwifery staffing review is undertaken annually and presented to Trust Board. The outputs from the reviews are articulated applying a triangulated approach to safe staffing, utilising professional judgement, data from the Allocate Safe Care tool (Shelford Model) and any idiosyncrasies such as geographical layout. Midwifery staffing is reviewed using professional judgment and Birth rate plus. The model hospital portal is used to benchmark against peers.

A proactive and pre-emptive approach to safe staffing is undertaken each day. A safe staffing huddle takes place at 10am, chaired by a Divisional Director of Nursing. The current and forecasted staffing positions are reviewed. Prior to the safety huddle there are a series of pre-safety huddle actions that take place. There is also a sequence of set actions that need to be undertaken, should a ward area be highlighted as a red or amber ward (red and amber as described by Safe care) Professional judgment as well as the acuity data from Safe care informs any decision to move staff across the organisation.

The information from the huddle is widely distributed; various touch points to update the staffing position then takes place throughout the day with either the Director of Nursing and or the Deputy Director of Nursing, with any immediate concerns escalated immediately.

The Trust has a Safe Nursing and Midwifery staffing escalation policy, a process flow sheet that details responsibilities and actions for the safe care census entry times and the various staffing touch points and safety huddles (07:30, 09:00, 10:00,13:00,16:00 and 19:30)

(Source: Routine Provider Information Request (RPIR) Universal P15 – Safer Staffing)
We saw that for Hartley ward at Pendle Community Hospital out of 62 shifts (early and late shifts) only eight shifts had a rostered band seven co-ordinator, this was because the band seven co-ordinator had been included within the registered nursing numbers due to vacancies, to ensure adequate levels of cover. A manager told us this meant that managerial duties such as incident investigation, performance management and audit completion were often delayed.

A high proportion of registered nursing shifts were covered by bank and agency staff. For example, across all three sites in July 2018, 90 shifts were filled by bank members of staff and 48 by agency staff. Managers were aware of the staffing issues and vacancies had been advertised. We were told that to manage this a weekly staffing review took place where daily staffing levels were discussed and any forecasted gaps highlighted.

Following consultation with staff, the number of health care assistants on the stroke rehabilitation ward who worked during the night had been increased from two to three. We were told this was a temporary measure until the next professional judgement panel meeting within the trust, where managers planned to put forward a business case for permanent funding.

We looked at the registered nursing rotas and we saw that overnight a band five registered nurse was the most senior level of cover within all wards. Access to clinical support was via a telephone call to the medical registrar or site manager at Royal Blackburn Hospital. Managers told us that at weekends a band six registered nurse should be rostered. However, at Pendle Community Hospital we found that between 21 July 2018 and 28 August 2018 three out of eight shifts had no band six registered nurse on one of the wards and one of the eight shifts on the other two wards also had no band six registered nurse.

We observed a daily safety huddle in which staffing numbers were discussed.

Nurse and midwifery council revalidation took place every three years. The trust had a revalidation policy supported by a dedicated e-portfolio within its learning hub which was built into the electronic staff record system where details of individual revalidation dates could be found. A monthly human resource report was sent to managers detailing upcoming dates.

**Total numbers – Planned vs Actual**

The mean average percentage of fill rates for registered nurse day shifts between July 2017 and July 2018 (inclusive) was 77.4% for Accrington Victoria Hospital, 83.7% for Clitheroe and 81.6% for Pendle Community Hospital – 77.4% Hartley, 83.9% Marsden and 83.4% Reedyford wards. For registered nurse night shifts the mean average percentage was 100% for Accrington Victoria Hospital, 99.4% Clitheroe Community Hospital and 100% for Pendle Community Hospital.

**Vacancies**

**Nurse Staffing**

Information provided by the trust showed that the vacancy rate for Nursing and Midwifery Registered staff between August 2017 and July 2018 was 15.8%. During our inspection managers told us they were aware of staffing issues which had been exacerbated by a recent change in shift start time. They were trying to recruit staff to the service by advertising nationally and holding recruitment days.

**Turnover**
Nurse Staffing

Information provided by the trust demonstrated that the turnover rate for Nursing and Midwifery Registered staff between August 2017 and July 2018 was 7.7%. Managers for the service felt that a change to shift start time had attributed to this level of turnover.

Sickness

Nursing staffing

Information provided by the trust showed that sickness rates in the service varied between zero and ten percent for all wards between August 2017 and July 2018, with the exception of the community ward at Clitheroe Community Hospital where the sickness rate was ten percent or more for ten of the months within the twelve-month period and went as high as around 24% in July 2018. Managers told us that absence management was managed in line with the trust policy and in conjunction with the human resource department. Staff could access counselling, physiotherapy, occupational health and money advice services through the trust.

Nursing – Bank and Agency Qualified nurses

Registered nursing bank staff were used by the community inpatient department on 855 occasions during a twelve-month period from August 2017 to July 2018. There was a range of 44 registered nursing bank shifts used in October 2017 to 90 shifts in July 2018.

222 registered nursing shifts were covered by agency staff. This ranged from seven registered nurse agency shifts in April 2017 to 22 shifts in July 2018.

(Source: Routine Provider Information Request (RPIR) Universal P20 – Nursing bank agency)

Medical staffing

The service was a predominantly nurse led service with minimal medical cover which consisted of consultants at each hospital and a ward doctor for each ward. General practitioners also reviewed patients within the ward at Clitheroe Community Hospital.

Suspensions and supervisions

From April 2017 to March 2018, the trust reported two suspensions related to community inpatients. One incident occurred at Accrington Victoria Hospital, with the other being at Pendle Community Hospital.

(Source: Routine Provider Information Request (RPIR) Universal P23 – Suspensions and Supervision)
Quality of records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care, although they were not always stored securely.

We looked at 20 sets of nursing records and 15 sets of medical records within the service and found that staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. We looked at both nursing and medical records and found both to be completed in line with national guidance.

Seven sets of the medical records contained do not attempt cardio-pulmonary resuscitation orders. We saw that the reasons for the decision, timescales, General Medical Council numbers, dates and documentation of discussions with the patient and relatives were recorded.

The remaining eight sets of medical records and the twenty sets of nursing records were found to be legible, dated and timed. The medical records contained information such as therapy goals, levels of mobility and evidence of medical assessments. The nursing records contained abeyance pain scores, intentional-rounding information, enhanced care scores, falls prevention care plans and skin care.

Records we reviewed confirmed that allied health professionals documented occupational health equipment and community physiotherapy requirements for patients. We also noted that consent was clearly documented for all interactions.

However, we found that record trolleys on two wards were not locked and that nursing records for patients in individual rooms were kept on bumper bars outside of the rooms. This meant that there was a risk that patient records were not secure and could be accessed by other patients or visitors on the ward.

Medicines

The service was following best practice when prescribing, giving, recording medicines. Records showed that patients had been given the right drugs at the right dose and the right time. However, it was not storing drugs appropriately and in line with best practice.

Daily drug checks were carried out across all of the community inpatient wards we visited, including controlled drugs. We reviewed documentation relating to the storage and administration of drugs which we found to be correctly accounted for and in date. We noted that the controlled drug books were legible, dated and signed.

Each of the wards we visited had drug trolleys which were securely locked and mounted to the wall. Patient’s bedside cabinets contained lockable drawers where their own medication could be stored.

We looked at the prescription charts for six patients and found allergies were clearly noted, drugs were administered in a timely way and no missed doses had occurred.

We found that drug fridge temperatures were checked and recorded daily, however at Clitheroe Community Hospital the temperatures had been consistently recorded as out of range for approximately 10 weeks. During this time the log of temperatures showed a range of eight to 24 degrees and it had been recorded and that the fridge had ‘defrosted’ on at least four occasions. This was raised to managers and immediately rectified. Drug fridge temperatures are important to maintain the effectiveness of medication.
At Pendle Community Hospital we saw that the patient group directions for staff to administer paracetamol on Hartley ward were out of date. A senior nurse told us that they were no longer used because medical staff ‘wrote up’ paracetamol routinely on the prescription charts. We found this was the case when we checked prescription charts on the ward.

We found that that fluid and food thickening powder had been left on top of the lockers near six of the beds within the stroke rehabilitation ward at Pendle Community Hospital. No risk assessment was evident on the storage of thickeners. A national patient safety alert issued on 6 February 2015, was sent out to alert staff of the risk of asphyxiation by accidental ingestion of fluid/food thickening powder. This presented a safety risk to patients who may have consumed it or been administered it by a visitor who was unaware of the dangers. We spoke with staff on the wards and discussed that access to thickening powder should be limited to appropriately trained staff.

The pharmacy department carried out regular audits of medication use and a file was kept within each ward of six weekly drug card audits.

**Safety performance**

**Safety Thermometer (July 2017 – July 2018)**

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day. For example, at “shift handover” or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

The trust reported six falls with harm from July 2017 to July 2018.

**New Pressure Ulcers**

From July 2017 to July 2018 the trust has reported no new pressure ulcers.

**Catheter & UTI**

The trust reported no new Catheter & UTI’s from July 2017 to July 2018.
Falls with Harm

Falls with Harm: patients with harm from a fall

- Falls with Harm
- Low Harm
- Moderate Harm
- Severe Harm
- Death

Patients

0 0 1 0 0 0 1 0 0 0 0 0 4
0 0 1 0 0 0 1 0 0 0 0 0 4
0 0 0 0 0 0 0 0 0 0 0 0 0
0 0 0 0 0 0 0 0 0 0 0 0 0
79 79 125 72 92 58 94 71 95 93 84 139 84
From July 2017 to July 2018, the trust recorded 1,157 cases of ‘harm free’ care.

**Incident reporting, learning and improvement**

The service managed patient safety incidents well and staff reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

During our inspection we saw that the incident reporting system for the department was electronic. It included prompts such as duty of candour which prevented the person completing the form from moving on until it had been checked to say it was undertaken, if appropriate.

We saw actions from incident investigations were identified and carried out to improve patient care. For example, since May 2018 following an incident, the department had completed a fluid intake record for all patients, this meant that the department could ensure all patients were suitably hydrated. They had not seen any acute kidney injuries since its commencement.

Themes of incidents were part of the agenda for discussion in the department weekly managers meeting. Lessons learnt were shared with staff during daily huddles, monthly staff meetings and via emails.

**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 no serious incidents (SIs)
in community health inpatient services, which met the reporting criteria, set by NHS England from April 2017 to March 2018.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From April 2017 to March 2018, the trust has reported no serious incidents within community inpatients.

(Source: Routine Provider Information Request (RPIR) Universal P30 – Incidents)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Guidance for staff was clear and referenced good practice taken from national guidelines.

Policies and procedures were available on the trust intranet making them easily and readily accessible. All of the documents contained flowcharts and contact details of relevant agencies, as well as clear guidance for staff. We looked at seven policies which were, safeguarding adults, patient discharge, freedom of information, volunteers, complaints and concerns, consent and the slips, trips and falls policy; all of which were in date.

Policies and protocols referenced good practice taken from national guidelines in various organisations. Examples of this were the National Institute for Health and Care Excellence, Department of Health and the Chartered Society of Physiotherapy.

We observed that the National Institute for Health and Care Excellence guideline CG179 was followed for pressure ulcer care in conjunction with the trust policy. There were no reported pressure ulcers for the previous two years. This information was displayed on the trust dashboard and a certificate was given to each area from the tissue viability nurse congratulating the staff on their patient care.

There were three incidents of moisture lesions raised in the two months to July 2018. This had been previously highlighted and management felt they were being under-reported. An action plan was put in place and staff were encouraged to report these incidents to demonstrate themes.

We also observed that the National Institute for Health and Care Excellence guideline CG162 was followed for stroke rehabilitation in adults. Evidence was demonstrated within the care plans implemented by the physiotherapists and occupational therapists.

Patients had access to skilled therapists on admission who would then ensure a clear personalised care plan with clear outcome goals was implemented. Physiotherapists, occupational therapists, speech and language therapists delivered evidence-based interventions in order to build strength and independence, enabling patients to return to their homes or to an alternative healthcare setting.

The physiotherapists and occupational therapists at Accrington Victoria Hospital informed us that they were on the ward until 12 noon. They also had a community caseload.
Although delayed discharges were evident on one of the sites we visited. During our inspection we saw evidence of the intense planning process for patient discharge, as well as the detailed input that was given in the facilitation of the environmental visit, to promote patient independence, whilst maintaining safety.

**Nutrition and hydration (only include if specific evidence)**

Staff at all sites ensured that patients received food and drink to meet their needs and improve their health. Staff assisted patients with their menu choices if required.

Menu choices were completed two days in advance as food was not cooked on site but was delivered by a private home delivery company. All ward areas provided choices of food for individual patient’s religious and cultural preferences.

We noted that breakfast, lunch and evening meals were encouraged to be eaten in the dining rooms on the ward areas. This not only improved independence, it prevented social isolation as patients could get together and talk to each other. Mid-morning drinks and snacks were provided to patients and their relatives. Patients we spoke with informed us that if they were hungry staff would bring them snacks at other times of the day.

Three patients we spoke with at Pendle Community Hospital informed us that snacks were poor in the evening as sandwiches were not provided, unlike Royal Blackburn Hospital where these were available. This was due to meals now being provided by a private home delivery company. We spoke with the housekeeper and staff who confirmed that now meals were being provided by an outside source, choices were not as flexible.

Dieticians liaised with the housekeepers regarding supplements needed for certain patients. These were documented in the patients notes and written on a board in the dining room area. The board was a valuable aid as a reminder to staff when serving food.

We observed out of date food in the fridge on the Marsden ward at Pendle Community Hospital. The housekeeper was informed and action was taken to remove the items.

Thick and easy clear thickener was used on the Marsden ward for patients who had swallowing difficulties. Dispensing instructions were in line with the National Institute for Health and Care Excellence (NICE) guidance, bulletin 100.

We looked at five patient records and observed the use and completion of a malnutrition universal screening tool (MUST). This is a five-step tool which helps to identify adults that are malnourished, at risk of malnutrition or obese. All charts were completed correctly and in date.

Since May 2018 following a recent incident, all patients had been commenced on fluid balance charts. Since this initiative was implemented the wards have not had any acute kidney injuries (AKIs).

We observed feedback received from patients in August 2018 at Accrington Victoria Hospital which stated that food was not very appetising. We were informed that the matron and ward sister had arranged to meet with the catering manager to discuss options. Food used to be made on-site but was now delivered by a private provider and this was not as flexible for patient choice. Following the meeting a focus group was set up to discuss catering. One change had been made which was that they purchased better bread to improve the sandwiches.
We spoke with staff to ascertain how a new patient’s meal preferences were met, when their food choice was ordered prior to their arrival. We were informed that they would speak with the catering manager to ensure that the food delivered met their needs.

Staff ensured patients had a jug of their preferred drink in the morning and would re-fill this as required. We observed fluid balance requirements being discussed during morning bedside handovers and we noted that fluid balance charts were in place for every patient being discussed in the handover. In addition to this we saw that monthly audits demonstrated 100% compliance for the correct completion of fluid balance charts.

A water hydration station was in place on all the ward areas, for staff to use. This had been implemented due to the hot weather over the summer period. Although it was aimed at staff usage, patients and their families could use this facility if required.

**Pain relief**

The service did not always assess and monitor patients regularly to see if they were in pain. Patients did not always have timely pain relief, reassessment of pain or access to sufficient pain relief.

We observed that there was a numerical rating score on the early warning scoring chart. However, there was no other pain tool in place for neuropathic or cancer pain.

Three patients we spoke with confirmed that they had received pain relief as required in a timely manner. However, we reviewed five patient records at Accrington Victoria Hospital, one record had an early warning score chart that demonstrated a pain score of zero (zero = no pain); the patients’ record also had an abbey pain tool chart that demonstrated a pain score of three (three = mild pain). The records did not tally and there was no evidence that pain relief had been given or a re-assessment of pain for a further eight hours.

We were informed by a staff nurse at Pendle Community Hospital that during a night shift a patient had complained of pain and was also suffering from nausea and vomiting. The patient had received the pain relief medications that were prescribed, however, stronger pain relief or anti-sickness medications could not be prescribed and therefore the only option was to transfer the patient via ambulance to Royal Blackburn Hospital. The patient requested not to transfer and received pain medications when the junior doctor arrived the next morning.

**Patient outcomes**

All hospitals collated information about the effectiveness of care and treatment and this was shared internally and externally. The information was used to improve outcomes for patients.

The services participated in the community national audit of intermediate care, which was completed with social care and their local clinical commissioning group. Data collated included date of admission, waiting times, staffing and costings.

Management monitored the effectiveness of care and treatment through continuous national and local audits. We observed results from the sentinel stroke national audit programme (SSNAP) in which the trust’s journey had taken them from a rating of D in 2016 to a top rating of A in 2018. We were informed that community inpatients were rated B at the present time. This was an area that
the trust management and staff were very proud of and were striving to maintain and improve. We also observed results from the national falls audit, national hip fracture audit, national dementia audit and were informed that they were now involved in the national Parkinson’s audit. In addition to the documented results we observed action plans to identify areas for improvement.

There were a number of local audits, which looked at for example slips, trips and falls, early warning score (EWS), handwashing, urinary catheter care, commode cleaning, mattress and wristbands ‘this is me’ audits. All local audits were 100% compliant for the period June to August 2018 and were completed by inter-departmental areas which ensured that bias was eliminated.

We were informed by the physiotherapists and occupational therapists that the majority of patients were seen again in the community. This was good practice to ensure patient centred care, continuity of care and support was given throughout the patients care pathway. We were told by the physiotherapists that feedback from patients in the community was very positive with regards to receiving continuity of care.

Let’s Eliminate Avoidable Falls (LEAF) was a new collaborative group which had been set up and falls were a major focus for the trust. We observed that all the community inpatient wards were engaged in this new initiative. We spoke with staff who informed us that good multi-disciplinary (MDT) working was helping to achieve the ultimate goal of this collaborative, to improve patient care and keep patients safe. The leaf system had symbolically reminded patients and their families that there was a risk of falls. We compared data from 2017 to 2016 and saw that there had been an 11% reduction in falls that resulted in harm, this equated to a reduction of 187 less falls.

Monthly falls strategy meetings were held. We observed minutes and action plans from these meetings. We noted for example, that there was attendance from the falls lead nurse, physiotherapist, divisional head of surgery and anaesthetics, matron for older people and quality improvement which demonstrated a positive multi-disciplinary approach to improving care.

A falls package known as a change package had been implemented in 2015. A prompt sheet was placed into each patients’ admission documentation which prompted staff to complete. Examples of the package were red and amber leaf symbols to be displayed, signage in bathrooms, prompts for patients to use their call buzzers, footwear to be checked and blood pressure to be monitored if hypotensive. Monthly meetings were held to discuss the change package and action plans implemented. We were informed that they were not benchmarking their results against other trusts, but were in the process of speaking with trusts in other areas.

We were informed that a frailty working group had been commenced for the winter period. This was held at Royal Blackburn Hospital. A focus of the group was to encourage patients who had fallen at home not to attend accident and emergency, but to go directly to the community inpatient areas for an x-ray and plan of action.

We reviewed data which demonstrated that Marsden ward at Pendle Community Hospital was in the top three results for the trust and demonstrated excellence in the PJ paralysis initiative. We also noted that Marsden ward had received a commendation from Royal Blackburn Hospital, for the early transfer of patients who had extended stroke symptoms. By transferring patients early, it improved their outcome of recovery significantly.

**Audits – changes to working practices**

The trust has not broken down their audit data by core service, so data can only be presented for the entirety of all community core services. The trust completed three audits in relation to community. These audits were listed under community services:
Wristband audits were carried out weekly following a never event in which a patient had the wrong treatment at the Royal Blackburn Hospital site. We observed the results for three months ending July 2018 which showed 100% compliance.

**Competent staff**

The service made sure staff were competent for their roles. Appraisal rates were above or close to the trust target and staff were given opportunities to develop. The service had arrangements for revalidation and clinical supervision.

We were informed that a nurse revalidation report was sent by the human resources (HR) department monthly. We observed this and saw that all registered nurses held up to date registrations.

We reviewed the human resources report provided by the matron and saw the junior doctors were all up to date with their general medical council (GMC) registration. Supervision was given to the junior doctors by a named consultant for training and personal requirements. All were up to date with the appraisal process.

Stroke services at Pendle Community Hospital had a dedicated team of physiotherapists, occupational therapists and speech and language therapists. The group of staff rotated through acute and community services every 9 months to ensure that they kept their skills up-to-date. Staff informed us that the rotation to other areas not only increased their knowledge and skills it also had a positive impact on improving patient care.

There were three dementia link nurses at Pendle Community Hospital, one for each ward area and link nurses at Accrington Victoria Hospital and Clitheroe Community Hospital. The link nurses had an increased knowledge of dementia which they shared with staff in their area. They received training from the dementia lead nurse to ensure that they remained competent within the field. Although we did not observe competency documents to support this training we did observe team meeting minutes to corroborate that discussions had taken place. In addition to this we observed dementia and delirium care bundles that had been launched by the dementia lead nurse. Discussions were held to review individualised care plans which not only increased the competence of the link nurses but increased the knowledge of the ward staff.

There were also link nurses for diabetes, nutrition and hydration, infection control and tissue viability. We were informed by the ward managers that regular meetings took place with the specialist nurses in their fields to ensure skills were kept up-to-date, which enabled the link nurses to disseminate their knowledge to staff. In addition to this we observed that discussions had taken place in the staff appraisal files.

During the inspection, we spoke with two student nurses. Both students stated that they were welcomed onto the unit by staff and they felt that they had been supported with their learning needs.
Clinical Supervision

The trust has not provided their clinical supervision rates. The trust has made the following comments around clinical supervision:

*The Trust has databases for medical clinical supervisors and nurse mentors. Working in conjunction with HEE North (previously HEE NW) we have never been required to collect this information. Our Education teams do not have a problem with allocating clinical supervisors or trainees reporting lack of clinical supervision. As a Trust we are working towards multi-professional clinical supervision in our clinical workforce as we transform our clinical teams and include new roles.*

(Source: Routine Provider Information Request (RPIR) Universal P42 – Clinical supervision)

We were informed that at Pendle Community Hospital a journal club had been commenced for clinical supervision.

Appraisals

The trust target for appraisal completion is 90%. Between April 2017 and March 2018, the appraisal rates for community inpatients were as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of individuals required - YTD</th>
<th>Number completed – YTD</th>
<th>Percentage Completed</th>
<th>Trust Target (95%) Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>R132</td>
<td>Community Hospital Management</td>
<td>ICG</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>R141</td>
<td>CCH Ward</td>
<td>Community</td>
<td>47</td>
<td>42</td>
</tr>
<tr>
<td>R133</td>
<td>AVCH GP Ward</td>
<td>ICG</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td></td>
<td>75</td>
<td>66</td>
</tr>
</tbody>
</table>

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

We discussed the appraisal percentages with the ward matrons. They identified that percentages did not meet the target due to staff sickness and night shift workers. We were told that they were arranging appraisals for the night staff whilst we were on inspection.

Records we reviewed confirmed that both junior doctors and resident medical officers (RMO’s) were up to date with their appraisals.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. There were regular multidisciplinary team meetings and staff worked with other organisations to support the discharge of patients.

There were weekly multidisciplinary team meetings, as well as daily ‘mini’ multidisciplinary team meetings at all community inpatient sites. We observed evidence of these meetings documented on standard multidisciplinary team templates that were kept in individual patient notes.
Physiotherapists, occupational therapists and speech and language therapists undertook joint initial assessments of patients when they were transferred from the acute hospital for rehabilitation. This meant there was a clear understanding of the ability, risks and goals of the patients.

We observed staff working together as a team. We spoke with three healthcare assistants and were told that their peers and management were very supportive and that no-one in the team believed they were better than another.

There were various specialities, for example doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, social workers and other health care professionals that supported each other to provide good, safe and effective patient care.

Care was delivered using a multidisciplinary approach to all aspects of care and treatment. There were detailed, comprehensive care plans containing numerous assessments of health and well-being for all healthcare members to complete.

We were informed that there was good, collaborative working with residential rehabilitation nursing homes.

We saw that an occupational therapist had been working with the local council and housing trust to secure living accommodation for one of the patients who was nearing readiness for discharge. This meant the patient could be safely and suitably discharged and supported back into the community.

The home first initiative was a service that was helping with hospital discharges. The aim of the initiative was to prevent patients being stranded on hospital wards and reduce their length of stay. As soon as a patient no longer needed medical support in hospital, the initiative supported patients to leave hospital rather than waiting on the ward for care assessment and rehabilitation planning. The patients bed was held on the ward for three to four hours whilst the patient received the assessments and support at home or in an alternative setting of their choice. We saw records which detailed the discussions from multi-disciplinary meetings held three times per week for this initiative. They were attended by doctors, nurses, therapists and social services. We were informed by management that going forward they would be using the Neighbourhood model for their vision and strategy, with the focus on keeping people well in their communities.

We were informed that there had been seven incidents related to discharge planning. Following root cause analyses investigations of these incidents it highlighted concerns about appropriate and effective documentation. The discharge plans had been discussed with the nursing teams and a discharge checklist was now being promoted to improve this part of the patient pathway.

We were told by staff at Pendle Community Hospital that delayed discharges were occurring due to patients waiting for care packages to be set up. The waiting times varied dependent on a patient’s postcode. Staff stated that the timeliness of a care package depended on the local authority.

The management team at Accrington Victoria Hospital identified a continued problem with late discharges and length of stay. As a result, they were using the SAFER (S - Senior Review, A - All patients, F - Flow, E - Early discharge and R - Review) model of care. The data was collated monthly to ascertain if the new model was improving outcomes.

Re-enablement was a new initiative offered by Lancashire County Council. The initiative provided free carers for the first six weeks of a patient being in their own home. Patients were assessed by a social worker whilst being an inpatient. Feedback gained so far from staff and patients, was that it is a ‘fantastic collaborative service that encourages and promotes independence’.
Health promotion

The service had initiatives to promote healthy lifestyles. Tai-chi classes were held every Wednesday at Pendle Community Hospital. The exercise class not only helped with mobility and mindfulness but it assisted with skin integrity and the prevention of pressure ulcers occurring.

Various other activities, such as gardening, producing lavender bags from the garden, hand massage, nail painting and communication groups were available for patients and their relatives. This again promoted independence and enhanced the patients' well-being.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed, recorded and acted on in line with relevant legislation.

Deprivation of Liberty Safeguards

From April 2017 to March 2018 the trust reported a total of 21 DoLS applications. The trust did not provide figures as to how many of these applications were successful.

<table>
<thead>
<tr>
<th>Name of inpatient ward or unit</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendle Community Hospital</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
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<td>2</td>
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<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Clitheroe Community Hospital</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Accrington Victoria Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Universal P13 – DoLS)

The service provided mandatory training to staff which included Mental Capacity Act and Deprivation of Liberty Safeguards training. This training was incorporated in the safeguarding training. Staff we spoke with could describe their responsibilities under the Mental Capacity Act and were aware of how to access additional advice and support if they felt a patient lacked capacity to consent to care and treatment. Staff stated that they found the flowchart in the safeguarding policy a great help when required.

We observed a multidisciplinary meeting to discuss the best interests of a patient who was unable to make some decisions themselves. The staff we saw were kind and caring towards both the
patient and their relatives and explained thoroughly the purpose of the meeting, before jointly
deciding what the best interests for that patient were.

To keep patients subject to a Deprivation of Liberty Safeguard order safe, the unit had
implemented ‘bay tagging’ for those patients. This involved a staff member being present at all
times in the bay and the patients being visible to the member of staff.

Staff informed us at Pendle Community Hospital that it was a challenge to get mental health
access due to the services being provided by another trust.

An action plan was also observed for new patient admissions at risk of delirium, this followed the
National Institute for Health Care and Excellence guideline QS63.

Is the service caring?

Compassionate care

We observed staff treating patients and their families with compassion. Feedback from patients
that we spoke with at all sites confirmed that staff treated them with kindness and provided lots of
support.

Patient-Led Assessments of the Care Environment (PLACE) are self-assessments that are
undertaken by teams of NHS and private/independent health care providers. Assessment panels
include at least 50 per cent members of the public (known as patient assessors) who focus on the
environment in which care is provided, as well as the non-clinical services such as cleanliness,
food, hydration, the extent to which the provision of care with privacy and dignity is supported and
whether the premises are equipped to meet the needs of people with dementia, against a
specified range of criteria.

This data is at hospital site but not core service level.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Privacy, Dignity and Wellbeing %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendle Community Hospital</td>
<td>78.44%</td>
</tr>
<tr>
<td>Clitheroe Community Hospital</td>
<td>77.11%</td>
</tr>
<tr>
<td>Accrington Victoria Hospital</td>
<td>85.71%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

A high return rate from both the family and friends test in June and July 2018 and local patient
surveys, demonstrated that patients in general felt positive about the care they had received and
would recommend the service.

Three of the five patients we spoke with at Accrington Victoria Hospital informed us that at times in
the morning they had to wait for long periods for their hygiene needs to be met. We spoke with
staff about this and were informed that it could be due to the vast majority of patients waking up at
the same time as the morning staff came on duty. Staff would endeavour to assist patients with
mobility issues first.
Patients we spoke with at Accrington Victoria Hospital also stated that they felt squashed in their bed spaces as there was not much room to manoeuvre. However, we observed staff maintaining the patient’s privacy and dignity by utilising the curtains on each bed space and talking very softly to minimise any confidential discussions.

Staff we observed at Clitheroe Community Hospital were empathetic and caring. The atmosphere of the ward was calm and relaxed. However, we spoke with a family member who stated that although the atmosphere was good and staff were lovely they felt that they were not kept up-to-date with their loved ones’ care.

There was a staff champion at Pendle Community Hospital who identified any celebrations or issues that needed to be cascaded to staff. This worked well, for example a patient whose birthday occurred whilst they were an inpatient was surprised with a small gift and a cake. Staff we spoke with said that this role was invaluable for staff and patient morale.

**Emotional support**

Staff informed us that they understood the impact that a person’s care, treatment or condition would have on their wellbeing and they were mindful that social interaction was an important aspect in the patients care.

We were told that patients could become low in mood due to decreased mobility. Staff gave an example about a patient who had no family and felt very isolated due to a recent fall, which resulted in a fracture to the hip. Staff had empowered the patient by having regular conversations to make them feel at ease and encouraged them to eat in the dining area and not at their bedside. This resulted in the patient getting to know the other patients which opened up great conversations of memories and this had a positive impact in their rehabilitation.

In addition to this staff informed us that if they felt that the emotional support they provided did not appear adequate and they had any concerns about the patients’ psychological status they were able to refer to mental health team. However, staff at Pendle Community Hospital stated that if they recognised that the patient required more specialised help to improve their emotional wellbeing they found it difficult to refer to the mental health team as the service was sourced from another trust. In the interim they would get advice from the dementia lead nurse or the safeguarding lead for help if required.

We observed staff giving emotional support to a patient’s family as their loved one was on the end of life care pathway. The conversations we heard were compassionate and empathetic. In addition to this we observed management giving emotional support to a staff member when they had left the patients room.

We observed a best interest meeting which was sensitively dealt with. The family were involved throughout the meeting and their thoughts and feelings were taken into consideration at all times. When the meeting had finished we observed a staff member providing emotional support for the patient’s daughter who was finding it very difficult to accept that her mother was deteriorating.

**Understanding and involvement of patients and those close to them**
Staff ensured that patients and those close to them were partners in decisions about their care and treatment. Staff we observed communicated with patients during assessments in a way that patients could understand. We observed a care plan being completed and the patient and their relative were given ample opportunity to have their concerns heard and questions answered.

Every Wednesday on the Marsden ward at Pendle Community Hospital held a ‘meet your therapist’ afternoon. Families could meet up with a physiotherapist, occupational therapist or speech and language therapist to discuss goals and progress.

The home first initiative was in place to get patients home quickly and as safely as possible. Two therapists completed home assessments and identified equipment the patient needed that day. The patients bed on the ward was kept open for two hours or until the assessment was completed.

Chaplaincy services were evident on the ward. Catholic practitioners attended on a Sunday and at times Islamic practitioners would also attend. However other religious practitioners could be accessed if required.

Leaflets were available in the reception areas for patients and visitors. Examples of these were, ‘how we can use your information’, ‘a guide for patients, carers and relatives’ and ‘what is intentional rounding?’

Within the service we saw carers link leaflets which were displayed in the waiting room and in various languages. They provided information for carers on how and where to access additional support

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. The hospitals were designed with the patients in mind, and included gardens and outdoor spaces, therapy kitchens and dementia friendly areas. In all hospital patients had a view from a window within their room.

At Clitheroe Community Hospital we saw there was a designated ‘therapy kitchen’ used in conjunction with the occupational therapists and physiotherapists, where patients practiced important daily tasks such as making a cup of tea in preparation for their discharge home. We also saw here that the medical provision included general practitioners who undertook the ward round reviews. This meant that there was continuity between the patients’ hospital and community care.

Therapists worked closely across all sites. Occupational therapists and physiotherapists worked daily with patients whilst other allied health professionals including speech and language and dieticians attended twice a week. A pharmacist attended each site daily between Monday and Friday.

In all hospitals we saw that patients had a view from a window within their room, often the windows were wide aspect and patients could easily see out from their beds meaning they could be distracted from their environment.

Patients from Marsden and Reedyford ward in Pendle Community Hospital had access to Hartley ward for the community roof-top garden. This encouraged family, friends and carers to be involved
in promoting independence for the patients. It also had a big impact on the patients by being able to sit out in the fresh air. Patients we spoke to said when it had been hot over the summer period it had been lovely to not only sit out in the garden but to help with the up-keep of the lovely shrubs and plants was refreshing.

We observed that access to the rooftop garden catered for not only wheelchair access but a bed could be pushed outside so that patients who were bedbound could also benefit from the fresh air and lovely surroundings. A downstairs garden had also recently opened which was attended by patients and their relatives.

Pendle Community Hospital was a dementia friendly environment with signage and colouring evident. It also had a dedicated old-fashioned tea room. There were plans in place where staff were looking into individually enhancing the environment. A staff member who was passionate about dementia care was looking into what colours or other aids the unit could have to improve the care of patients living with dementia. Business plans were awaiting sign off from management and then Pendle Community Hospital staff were looking into how to raise funds with the help of the friends of Pendle Community Hospital.

Patients at Clitheroe Community Hospital stated that the ward was lovely and staff were fantastic. There was a designated quiet area for patients and their families with a visual display of fish for relaxation purposes. Additionally, Clitheroe Community Hospital had an outdoor garden area that catered for patients who were bedbound. A dementia corner was set up that replicated a home from the 1930’s. It had an old sideboard, fireplace, suitcase with a genre of music from the 1920’s to 1960’s and various other memorabilia.

Due to the layout of the ward, Accrington Victoria Hospital, did not have an inside quiet area. Patients could sit in the dining room which was also used as a day room if required. There was an outdoor seating area at the end of the ward which could be opened for patients at their request. There were folding doors so that patients who were bedbound could enjoy the fresh air if required.

Singers were brought in twice a year to Pendle Community Hospital by the stroke association. This brought staff, patients and their families together which promoted mindfulness and social interaction.

Portable phones were available in the ward areas for patients whose mobility was poor. This was a great source for those patients whose relatives could not visit.

Although some areas had televisions we saw that in others these were not available or in use. One patient told us that without it the days were “long”. Whilst another told us it was “quiet” with “not much happening”.

Meeting the needs of people in vulnerable circumstances

The service worked towards meeting the individual needs of patients in vulnerable circumstances. We saw a dementia friendly corner at Clitheroe Community Hospital where an old-fashioned fire place and display cabinet stood, there was also a suitcase which contained older memorabilia such as 1950’s and 1960’s books and a scrap book of the royal wedding in 1947. There was also a digital fish tank display next to a bank of seating and outside a designated quiet area.

A butterfly corner was also available on Reedyford ward which was dementia friendly. This area of the ward offered a quiet and relaxing atmosphere for patients to relax in whilst listening to music.
from the 1930’s up to 1960’s or to gain emotional support from staff. Patients we spoke to whilst sat in this corner stated that they felt part of a family when they were there and it didn’t feel like they were in a hospital setting. All patients we observed were smiling and singing to the old music. This meant that patients and relatives could utilise these areas as break from their bedside environment.

There were dementia friendly twiddle mittens in use within the service, the mittens were made from various materials and textures. They provided a distraction for patients that may have been frightened or anxious.

In response to the national dementia audit the trust had implemented some of the suggestions from the action plan provided to them, including a dementia and delirium care bundle (a set of interventions which together improve patient care) which we saw was in use within the community inpatient department.

For identifying patients who required extra support for their mobility needs a picture of a leaf was placed on their bedside board. This ensured that staff and the patients relatives were reminded that extra support was required when the patient needed to mobilise. Falling leaf posters were evident in the main corridor of the ward areas which explained their meaning and how this new initiative was reducing the number of falls.

Staff asked patients about their communication needs on admission and planned the care appropriately to ensure that any needs were met through reasonable adjustments.

Staff on the unit could accommodate different religious beliefs and ensured that patients and had these needs met.

The service had access to an interpretation service and communication boards had been made in various languages so that the patient’s needs could be identified.

### Access to the right care at the right time

#### Accessibility

The largest ethnic minority group within the trust catchment area is Indian. The trust did not provide the percentage breakdown for their catchment population.

<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>Indian</td>
</tr>
<tr>
<td>Second largest</td>
<td>Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>Other Asian</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Eastern European</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Universal P56 – Accessibility)
**Bed moves at night**

Managers told us that patients were not moved during the night unless a deteriorating condition meant a transfer to the acute hospital was required. Patients were received onto the wards with a cut off time of 9pm and discharged from the wards no later than 6pm. This was in line with trust guidance for the safe transfer of adults, no patient should be transferred unless for emergency transfer between the hours of 10pm and 7am.

**Waiting times**

The trust had made the following statement with regards waiting times:

**Physiotherapy and Occupational Therapy:**

The clinical prioritisation criteria and professional standard is to see new referrals on the wards within 24 hours Monday to Friday. At weekends any urgent or emergency new referrals are referred via a bleep to the team working and assessed and seen by that team. Non-emergency referrals at the weekend may wait until the next working day depending on the caseload of the weekend team.

Monday to Friday there are bi- daily team meetings where the workload is distributed between the team to ensure all new, emergency and priority patients are seen, this has been in place for over 12 months.

**Speech & Language Therapy:**

As per our professional bodies guidelines (RCSLT) we aim to see newly referred patients within 2 working days. Over the past 12 months we seldom breach this target (i.e. new referrals tend to be seen within 24-48 hours Mon-Fri). Occasionally patients will breach this target. This tends to be in relation to annual leave/staff sickness/non-clinical commitments.

A speech and language therapist was employed at Pendle Community Hospital three days a week with a speech and language assistant three days a week. However, there was no cover when on annual leave or off sick.

**Dietetics:**

We aim to see all urgent referrals (no nutrition/very limited nutritional intake or alternative feeding) within 24 hours (1 working day). All other referrals are prioritised daily within each dietitian’s caseload which includes all review patients. All community hospitals are visited at least once per week. Breach rates are recorded monthly. All patients discharged before being seen are sent an opt-in outpatient letter.

**Orthotics:**

All referrals into the Orthotics department are triaged daily (with the exception of weekend). Referrals are clinically prioritised by emergency e.g., spinal/cervical/hip orthoses. Non-emergency referrals would be shoe raise or footwear. In the period January - March 2018, 82% of referrals seen were triaged, supplied and discharged from the service the same day.
Information provided to us following our inspection demonstrated an increase of one whole time equivalent member of staff within the stroke service. This meant that patients on Marsden ward had access to a speech and language therapist for five days a week. However, cover for absences was not guaranteed.

**Bed occupancy**

The trust provided information regarding average bed occupancies from April 2017 to March 2018:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Location</th>
<th>Average bed occupancy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVH2</td>
<td>Accrington Victoria Hospital</td>
<td>95.6</td>
</tr>
<tr>
<td>Ribblesdale</td>
<td>Clitheroe Community Hospital</td>
<td>95.4</td>
</tr>
<tr>
<td>Marsden</td>
<td>Pendle Community Hospital</td>
<td>96.9</td>
</tr>
<tr>
<td>Hartley</td>
<td>Pendle Community Hospital</td>
<td>96.6</td>
</tr>
<tr>
<td>Reedyford</td>
<td>Pendle Community Hospital</td>
<td>94.4</td>
</tr>
<tr>
<td><strong>Core Service Average</strong></td>
<td></td>
<td><strong>95.8</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) Community CHS6 – Bed occ & LOS)*

**Average length of stay data**

The trust provided information for average length of stay from April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Location</th>
<th>Average length of stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVH2</td>
<td>Accrington Victoria Hospital</td>
<td>18.7</td>
</tr>
<tr>
<td>Ribblesdale</td>
<td>Clitheroe Community Hospital</td>
<td>22.4</td>
</tr>
<tr>
<td>Marsden</td>
<td>Pendle Community Hospital</td>
<td>34.1</td>
</tr>
<tr>
<td>Hartley</td>
<td>Pendle Community Hospital</td>
<td>24.9</td>
</tr>
<tr>
<td>Reedyford</td>
<td>Pendle Community Hospital</td>
<td>29.2</td>
</tr>
<tr>
<td><strong>Core Service Average</strong></td>
<td></td>
<td><strong>25.8</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) Community CHS6 – Bed occ & LOS)*

**Referrals**

The trust did not provide any information on the time of referral to treatment in relation to community health inpatient services.

*(Source: Routine Provider Information Request (RPIR) Community CHS9 – Referrals)*
People could access the service when they needed it. The service had a ‘step up’ capacity for patients as a preferred place of end of life care as well as the ‘step down’ facility from the acute hospital site.

A home first initiative had been implemented and meant that some patients were able to be discharged directly to their place of residence where community services and equipment would be obtained in the same day. When a patient was discharged from the community hospital their bed would be ‘held’ for three to four hours so that they could return directly to the ward without needing to access the system at the beginning again.

The unit had access to diagnostic services such as X Ray on a Tuesday. If an X Ray was required outside of these times the patient would be transferred to the main hospital site in Blackburn.

The service worked closely with community services to provide integrated pathways for patients and to coordinate care and treatment for patients moving out of the service and back into community services.

Patients were transferred to the acute service if their condition deteriorated. Staff worked well with other teams such as social services or community equipment providers. Sometimes though delays with social packages of care or equipment meant that patients could not be discharged when they were ready.

**Delayed discharges**

The trust has reported their delayed discharge rates from April 2017 to March 2018:

<table>
<thead>
<tr>
<th>Team/ward/unit</th>
<th>Total discharges over 12 months</th>
<th>Total delayed discharges over 12 months</th>
<th>% Delayed Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 2 AVH</td>
<td>248</td>
<td>89</td>
<td>36%</td>
</tr>
<tr>
<td>Hartley</td>
<td>277</td>
<td>96</td>
<td>35%</td>
</tr>
<tr>
<td>Marsden</td>
<td>185</td>
<td>76</td>
<td>41%</td>
</tr>
<tr>
<td>Reedyford</td>
<td>227</td>
<td>89</td>
<td>39%</td>
</tr>
<tr>
<td>Ribblesdale</td>
<td>397</td>
<td>115</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1334</strong></td>
<td><strong>465</strong></td>
<td><strong>35%</strong></td>
</tr>
</tbody>
</table>
We were informed by the physiotherapists at Accrington Victoria Hospital that there were delayed patient discharges due to the complex care manager sharing their time between Accrington Victoria Hospital and Clitheroe Community Hospital. Although it was positive to have a complex case manager, it was currently having a negative effect on patient care due to the manager not being on site as often as required. The physiotherapists and occupational therapists were having to complete forms that the complex care manager could do in half the time. Due to the extra administration added to their current roles, time was being taken away from patient contact.

We were also informed by ward managers that delayed discharges were also occurring due to patients being admitted to the wards who were not rehabilitation patients and were waiting on social care packages. Management were raising this issue with senior management on a regular basis. During the inspection we saw no documented evidence of these discussions taking place but were assured that it was being highlighted.

**Learning from complaints and concerns**

**Complaints**

We reviewed two complaints received by the service ranging between April 2017 and March 2018. The complaints were recorded as related to ‘aspect of clinical treatment. Both complaints were dealt with in line with trust policy which included weekly contact with the complainant and written explanation of events with an apology. A root cause analysis of an incident and actions identified from it, we observed were discussed at a ward meeting.

**Compliments**

From April 2017 to March 2018 the trust recorded three compliments about the community inpatients department. The trust has stated that their data does not include a ‘compliments log’,

(Source: Routine Provider Information Request (RPIR) Universal P58 –Delayed Discharges)
which is used internally to harvest compliments at a ward level and publishes them on the trusts intranet.

We observed letters and cards in all areas complimenting the staff for their compassion and empathy.

(Source: Routine Provider Information Request (RPIR) Universal P62 –Compliments)

Is the service well-led?

Leadership

The service had managers at all levels which were visible, knowledgeable and had the right skills to manage the service.

Managers were developed within their roles by a mixture of both coaching and mentoring. Staff we spoke with were always able to identify who their line manager was, spoke positively about them and felt they were both visible and approachable. Staff also spoke highly of the band six team leaders and felt they offered both the support and supervision required.

Due to gaps in staffing managers had been included within the staffing numbers and therapist team members had been without first line management for an extended period. Although recruitment gaps had been identified and active attempts at recruitment ongoing, managers told us there was an expectation to complete all of their required tasks despite a lack of dedicated time.

Vision and strategy

The service had a clear vision and strategy which focused on the right care at the right time in the right place.

This included a frailty programme for patients who were unable to be discharged and electronic patient reporting software. Work had already begun in this area for example, a value stream analysis had been undertaken as well as an end to end pathway which ‘mapped’ each step of the patient journey. This meant that areas for improvement could easily be identified.

Posters clearly displaying the vision of the trust, which was to provide ‘safe, personal and effective care’ were displayed in each of the hospital sites. Staff understood the vision and could tell us what it was.

During out inspection we observed the values of the trust being demonstrated, staff acted respectfully, put the patients first and promoted positive change. For example, at the multidisciplinary meeting conducted by first line managers there was a focus on the patient ‘holistically’ and considered their individual needs.

Culture

Staff were positive about their roles and the team working around them. Staff felt supported, valued and included in the daily running of the wards.

We saw an emphasis on staff wellbeing. Hydration station rooms available where staff had access to water throughout their shifts to help them remain hydrated.
Acting on violence and aggression was a key priority for the service and remained on the risk register. Actions had been developed in response to concerns raised via both the staff survey and the online incident reporting tool. These included extra security patrols, posters highlighting the service’s response to acts of aggression and increased staff training on handling/de-escalation. 98% of staff had completed conflict resolution training within the service.

An ‘open and honesty’ policy was available for all staff on the trust intranet and incorporated duty of candour. Training however, was part of the induction for new staff only. Staff we spoke with knew what actions they should take in relation to duty of candour and the online incident reporting tool had a duty of candour prompt. A monthly record audit checked for the correct completion of patient records including duty of candour and the monthly nursing assessment performance frameworks audits also included duty of candour.

An employee of the month initiative was in place at Pendle Community Hospital which was supported by a local charity who provided a gift for the chosen member of staff. However, this was not replicated across all other sites.

Students we spoke with told us they enjoyed working in the service and planned to return when they qualified.

Governance

There was a clear governance structure within the service which included divisional associate nursing and medical directors, divisional directors of nursing, medicine and general managers who linked in with the executive team via the relevant leads.

The associate director of nursing met weekly with the service’s matrons to identify and address issues and a directorate meeting that included both clinical and business managers took place monthly. This meant that information could be fed both up and cascading down in a timely and efficient way.

Care to share meetings followed the daily safety huddle meetings. This gave staff the opportunity to share how and why incidents occurred and the route cause analyses investigations following these incidents. It gave staff the opportunity to share ideas and thoughts which helped to enhance patient centred care.

Important information was shared with staff members via the monthly team meetings. Minutes of the meeting were emailed to all staff and placed in a folder in the staff room so that all staff had access to them.

Staff were clear about their roles and responsibilities in providing a quality service that met the patients’ needs.

Up to date policies and procedures were in place to guide all staff in the provision of safe care and treatment for patients.

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. Risks were monitored through risk registers and risk meetings. There was a programme of audit and performance monitoring through the ward accreditation scheme.
The service had a locally held risk register which held 99 risks as well as a divisional one. The two registers did not appear aligned and risks on the service register dated back to 2010. A number of risks – 46, had been created in 2013 whilst 10 had been on the register since 2011. Some of the risks were repeated such as moving and handling, slips trips and falls and violence and aggression.

A monthly corporate risk assurance meeting took place and a corporate risk register report was produced. Whilst it listed controls in place these were not specific or designated to anyone.

There appeared to be a disparity between the acute and community sites’ understanding of the acuity of patients suitable for care within the service. Incidents where unsuitable categories of patients had been transferred had been correctly escalated to managers via the internal incident reporting tool. However, this was not identified as a risk on the directorate risk register for community hospitals and no clear action plan had been introduced in response.

We were told that the recruitment of registered nurses was a challenge within the service which resulted in some managers being included within the nursing establishment. However, we did not see evidence of this included on the risk register nor a robust recruitment strategy to address this issue. Managers told us that the trust permanently advertised for staff and sent them to an area of highest demand.

Assurance structures within the service included local audits, divisional and trust wide audits such as the ward accreditation scheme, the nursing assessment performance framework, and risk assessments. Monthly team meetings, divisional meetings and steering groups such as the mortality steering group and audit committee meetings demonstrated action plans and learning.

We reviewed the minutes of the safety and risk committee sub group meetings such as the medicines safety and optimisation committee and the audit committee. Patient safety, controlled drug use, clinical audit and information governance were discussed.

**Information management**

There were standardised quality information boards across the community inpatient sites which provided current quality data such as staffing levels and safety performance. Information on falls and dementia was displayed also across each site.

Ward-level dashboards were available for review and contained information about falls, pressure ulcers, catheter acquired urine infections and venous thromboembolism.

Both nursing and medical patient records were hand written as were prescription charts.

There were computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers for staff to access information.

**Engagement**

The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The matrons in the service held open door surgeries for patients, relatives and staff. These were held three times a month.
We also saw that the trust listened to patients, an example of this was at Accrington Victoria Hospital where a recent change in food provision had left some patients dissatisfied with the quality of their food. Listening events were held and the chef of the private catering company was invited to attend the ward and speak with patients. As a result, alterations were made to the menu, for example the bread was changed and patients fed back that they enjoyed the food much more as a result.

A red bag scheme with pre-packed personal items such as existing medication, clothes, toiletries and next of kin details had been implemented within the wards in conjunction with local nursing homes. This meant that patients were suitably prepared with their own familiar items if they needed to be admitted to hospital.

A patient representative had been part of the value stream analysis work which was undertaken to ‘map’ the entire patient journey as part of the frailty pathway redesign.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The service was involved in improvement initiatives.

A consultant physician from the service was the commissioned lead of a national programme aimed at improving the safety of older people and had organised an international conference aimed at this.

Early Warning Score charts had been adapted within the community inpatient setting so that a deteriorating patient could be escalated earlier to the main hospital site. This was an agreed action following a recent incident whereby a patient had to be transferred to the acute sector. The escalation score had been reduced from four to three. All staff were aware of this and flowcharts were pinned to the medical record trolleys to ensure that the new process was uppermost in the minds of all staff.

A pilot of ‘#EndPJParalysis’ (an NHS initiative to promote a speedy recovery by getting patients out of bed and dressed) had been undertaken at Accrington Victoria Hospital and as a result had been adopted by the entire department. For many wearing pyjamas reinforces feeling unwell and can prevent a speedy recovery. One of the most valuable resources is a patients’ time and getting people up and dressed is a vital step in ensuring that they do not spend any longer than is clinically necessary in hospital.
Community end of life care

Facts and data about this service

End of life care is provided in patients own homes and residential care settings by the district nurses, supported by specialist nurses trained in specialist palliative care.

The specialist palliative care service provides a team of qualified health care professionals, who have post registration experience and recognised qualifications in palliative care. The service works alongside consultants in specialist palliative medicine working in the trust’s hospitals and independent hospices. They provide symptom management advice and ensure appropriate spiritual; emotional and psychological support is given to palliative care patients their families and carers.

The staff attend primary care Gold Standard Framework meetings, supporting the use of national standards and best practice documents, preferred priorities of care and advanced care planning. They provide an education package to all health care professionals including doctors. The service has a pivotal role as patient assessors and specialist advisors assessing and giving specialist symptom advice, and supporting other services in primary care and the trust’s hospitals.

The service works across the end of life pathway and covers patients who may be an inpatient, and oversees their care as they transfer back home. They have links and networks with local hospices, and attend Gold Standard Framework and multidisciplinary team meetings.

The trust has a service level agreement with Pendleside Hospice to provide physiotherapy.

(Source: Routine Provider Information Request (RPIR) CHS context)

End of Life networks

Hospices: Pendleside Hospice, East Lancashire Hospice, and Rossendale Hospice.

Networks: Pennine Lancashire Palliative and End of Life Health and Well-being Improvement Partnership, Lancashire & South Cumbria Palliative and EoLC Advisory Group (part of the North-West Coast Strategic Clinical Network)

Partnerships: Specialist Palliative Care Services at Airedale (shared patients at eastern side of East Lancashire Clinical Commission Group) with annual meetings to share developments and to look at any ways of improving liaison and joint working from community and hospice perspectives.

(Source: Routine Provider Information Request (RPIR) CHS EoLC Networks)
Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training modules included: basic life support; conflict resolution; equality diversity and Human Rights; first safety; health, safety and welfare; infection prevention and control; information governance, PREVENT (preventing radicalisation); safeguarding adults and children; and safe handling theory.

Mandatory training was at 96% for all staff in the community palliative care team. The electronic system indicated when staff needed to update their mandatory training.

Some training was on line and other training was face to face.

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.

The community palliative care team had completed level three training in safeguarding for children and young people and safeguarding training for adults. The training included the Mental Capacity Act and Deprivation of Liberty Safeguards.

We spoke with a safeguarding nurse from the trust on the Ribblesdale ward at Clitheroe Community Hospital. They told us they visited community hospitals and clinics to support staff at these locations. The nurse told us they had good relationships with senior social workers in the local authority.

The nurse gave an example of a recent incident where ward staff were concerned about the way a patient’s relative spoke with them. The safeguarding team had raised an alert about the patient.

The community palliative care team discussed a safeguarding incident as part of the safety huddle and how the matter had been addressed. The incident was about a patient who was left on their own despite assurances that this would not happen. The patient was being transferred to a nursing home as staff felt that it was unsafe that they were left alone.

The district nurses had safeguarding link nurses who attended safeguarding meetings every three months and fed back to the team. The nurses said that they worked closely with colleagues in the local authority and had support from the trust’s safeguarding team.

One of the district nursing teams told us about an emergency best interests meeting for a patient whose carers had refused to enter the patient’s home due to safety issues and the environment in the property. The team worked with social workers to keep the patient safe.

Cleanliness, infection control and hygiene

The service controlled infection risk well.
We saw that all the community palliative care staff had completed the infection control module of their mandatory training.

Clitheroe Community Hospital was visibly clean and tidy. We saw that personal protective equipment was available and that staff used it. We saw that equipment had “I am clean stickers”.

The majority of palliative and end of life care was delivered in patient’s homes and personal protective equipment was taken by district nurses and other health professionals for use in the patient’s homes, this included sharps boxes. We observed that this was used during the visits we made to patient’s homes.

Environment and equipment

The environment at Clitheroe Community Hospital was light, airy and spacious. There was a community in-patient ward, Ribblesdale, that accepted patients at the end of life which we visited as part of the inspection.

There was a trust syringe driver policy and staff at Clitheroe Community Hospital said that there were always syringe drivers available for patients. There was a syringe driver checklist in place for staff. Staff at the community clinic said that the district nurses did the safety checks on the syringe drivers before they went out to patients and on return they were cleaned and the service date was checked.

There had been an audit of the safe and effective use of syringe pumps used for palliative care patients in January 2018. The audit included 13 community patients and showed that pumps were routinely used safely in line with policy and guidance. There were some recommendations from the audit and an action plan was in place.

District nurses told us that they could access community equipment as appropriate and that the service was improving. There was also an out of hours service for emergency equipment needs.

Assessing and responding to patient risk

The service identified and managed patient risk well, there were systems in place to protect patients. One of the palliative care nurses was allocated to triage all the referrals into the service every day. Referrals were received by phone, email or letter and were categorised by need and risk.

The electronic record system allowed the triage nurse to review the calendars of all the staff in the team giving an overview of the workload. The nurses had between 25 and 30 patients in their caseloads and the complexity of patients could be reviewed by the lead palliative care nurse.

We saw at the multidisciplinary team meeting that patient risk was identified. A patient who was at risk of spinal cord compression was identified by the consultant and referred to appropriate services. A patient who was at risk of neutropenic sepsis had been admitted to the hospital for treatment.

At the multidisciplinary team meeting (MDT) we saw that evidence of that the MDT reviewed risk, such as the route of administration of the medicines and deterioration of patients and took action to assess and mitigate the risks.
End of life patients at Clitheroe Community Hospital were reviewed as appropriate by GPs, Monday to Friday and plans for patients were put in place for the weekend. At weekends and out of hours staff could contact the hospice or specialist palliative care helpline for advice or help about patients at the end of life.

We saw that risk assessments had been completed for pressure ulcers and falls as appropriate. Clitheroe Community Hospital used early warning scores to identify deteriorating patients and could speak with a registrar on the acute medical unit at the acute hospital if necessary. Patients could be transferred by emergency ambulance to the main site if necessary. Bay tagging was available as necessary for patients at risk of falls.

There were alerts on the electronic patient record and all paper records for patient allergies.

**Staffing**

There were three band seven care nurses and 6.4 whole time equivalent band six nurses in the community palliative care team. There was administrative support for the team.

At the time of the inspection one member of staff was due to go on maternity leave, this vacancy had been covered by a secondment of a district nurse into the team.

If the service was very busy, nurses from the palliative care team in the hospital would support the team in the community. The service did not use bank or agency staff.

There were three palliative care consultants that supported the palliative care team in the hospital and the community, including the hospices. There had been a vacancy in the team for a number of years but the consultants divided the work and covered this vacancy. The service was not on the rotation risk for registrars and the consultants told us that this was being considered and could attract doctors into the service.

Medical cover at Clitheroe Community Hospital was provided by the local GP practice from 8am to 6pm, Monday to Friday. Nursing staff could be rotated between hospital sites depending on the acuity of the ward. Sometimes the ward used bank or agency staff to cover nursing staffing shortages on the ward.

**Quality of records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Records for community staff were electronic and were available to staff on hand held devices. With appropriate permission from patients, staff could access information from the GPs. Staff told us that being able to view the whole patient record was useful and had improved patient safety and reduced duplication. There were some paper records that were kept in patient’s homes including authorisations for medicines and paper copies of ‘do not attempt cardio pulmonary resuscitation’ documentation.
We saw that the documentation of multidisciplinary team meeting outcomes was the responsibility of the person who had referred the patient to the meeting. They updated the electronic record system and the patient care record. We saw these had been completed.

In Clitheroe Community Hospital, we reviewed two records for patients at the end of life. They were in order, signed dated and legible and the care plans had been fully completed. Records were stored in locked trolleys.

**Medicines**

The service prescribed, gave and recorded medicines well. Patients received the right medicines at the right dose at the right time.

There were guidelines for anticipatory medicines for the management of symptoms in the last days of life. These had recently been updated at the time of the inspection. All of the band seven palliative care nurses were nurse prescribers as were some of the band sixes. It was hoped that all of the team would become nurse prescribers. The team said that the ability to prescribe for patients at the end of life was invaluable and had improved outcomes for patients.

We saw competency records for one of the nurse prescribers. Their medical practitioner support was one of the end of life consultants. The trust had a non-medical prescribing lead and there were regular forums and updates for non-medical prescribers.

We saw records in patient’s homes that showed that medicines were sometimes reviewed daily for dose and the route of administration. This ensured good symptom management for patients.

GPs completed prescriptions for community patients and patients discharged from hospital were discharged with the appropriate medicines. Nurses told us that they could speak with NHS111 or the helpline at the hospice if there were any discrepancies or issues with medicines out of hours.

We saw prescriptions in two home visits were clear and legible, signed and dated. There were clear administration records and records of medicines delivery to the patient’s home. Syringe driver records, prescriptions and checklists were also in order.

We saw sometimes patient’s prescriptions were changed by the palliative care nurses as they did not meet clinical practice guidelines. We saw a patient’s medicines were changed as the patient had stage four chronic kidney disease and the medicines prescribed were inappropriate for this patient.

Nurse prescribing courses for district nurses were available and the first cohort of nurses were due to begin the course in September 2018. The band four district nurses were trained as second checkers for end of life medicines. Palliative care medicines were stored at the patient’s house and risk assessments were carried out by the district nurses on the storage and availability of these medicines. A drug safe could be provided if there were young children in the house or if the medicines needed to be kept away from other residents in the household.

There were patient group directions for certain medicines that the district nurses could prescribe. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription so that patients have safe and timely access to the medicines they need. There were standard operating procedures available for the use of these medicines.
We saw at Clitheroe Community Hospital that medicines were available for end of life care including medicines for analgesia, sedation, nausea and vomiting, secretions and breathlessness. Medicines were obtained from the pharmacy at the main acute hospital and there were deliveries twice a day, although anything required urgently could be sent over in a taxi. Non-stock medicines could be sourced on the same day by the ward if necessary.

**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. When things went wrong, staff apologised and gave patients honest information and suitable support.

The trust had an electronic system for the reporting of incidents. Staff were confident to report incidents and said that they received feedback from incidents.

We saw that the community palliative care team went through a safety huddle following the triage meeting. The agenda included incidents, complaints, any risks or safeguarding concerns.

The district nurses had weekly safety meetings and safety issues were cascaded to staff by email if they were not present at the meetings. All high-risk patients were discussed every week.

The district nurses had quality and safety boards with information and actions for staff.

The district nursing teams described how they had made changes following incidents. This had included that the health care assistants make no more than three visits to a patient without a review.

From April 2017 to March 2018, the trust reported no incidents classified as never events within community end of life care.

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.

*(Source: NHS Improvement - STEIS (April 2017 to March 2018))*

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 services for community end of life care, which met the reporting criteria, set by NHS England between April 2017 and March 2018.

*(Source: NHS Improvement - STEIS (April 2017 to March 2018))*

From April 2017 to March 2018 trust staff in this core service did not report any serious incidents in community end of life care. The trust has not reported any serious incidents in any community core service.

*(Source: Routine Provider Information Request (RPIR) – Incidents tab)*
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The trust used guidelines from the National Institute of Health and Care Excellence (NICE), “End of Life Care for Adults” (Quality Standard 13) and “Care of Dying Adults in the last days of life” (NICE guidelines 31). They were also using “Strong Opioids for Pain Relief” (NICE guidelines CG140) and the “Five priorities for care of the person- one chance to get it right” (June 2014) Leadership Alliance.

Updates on NICE guidance were disseminated through the specialist care directorate meetings. We saw that guidance had been updated in the care of the dying policy.

We saw at the multidisciplinary care meeting and in care records that symptom management corresponded to these guidelines.

Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care. Each patient that we reviewed had an individual care plan and we saw that these had been completed appropriately by those involved in end of life care. There was training for staff on advanced care planning.

The health economy involved in end of life care were part of the Gold Standard Framework which provides evidence based training to all who provide end of life care.

Nutrition and hydration

In the records we saw at Clitheroe Community Hospital we saw malnutrition universal screening tool charts had been completed and this was evidenced in the patient’s records.

Nausea and vomiting were discussed as part of the triage process for patients and those patients who were unable to eat and drink or with continued vomiting were triaged as urgent.

At Clitheroe Community Hospital meals were cooked on site. The chef told us that they could respond to patient’s food requests if they didn’t want what was available on the menu. We saw patients had requested alternatives and had received them.

Pain relief

Pain was managed well for all patients and the staff involved in end of life care responded quickly and effectively to referrals for pain management. Pain management was discussed at the multidisciplinary team meeting and as part of the triage process for referrals to the community palliative care team.

Patients were encouraged to keep a pain diary to support their pain management.
The trust used the Abbey pain scale for patients with impaired cognitive function. The templates were part of the electronic record system. We saw the community palliative nurse used these in the pain management of a patient with a learning disability.

We saw that at Clitheroe Community Hospital pain control was regularly reviewed and documented by the specialist palliative care team.

Following a telephone call, we saw that a district nurse responded quickly to a call from a patient’s carers to say the patient’s percutaneous endoscopic gastrostomy tube was blocked and so could not receive their analgesia and other medicines.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They collected and compared local results with those of other services to learn from them.

The national end of life audit was last completed in 2016 but the trust completed their own audit for the period July 2017 to March 2018. This was a retrospective case note audit and was conducted by one of the palliative care consultants. Case notes were audited across the trust but at least ten case notes from community patients were audited every three months, in total 33 case notes had been reviewed from community services. The audit showed in the community patients were recognised as dying much earlier than in other hospital divisions and that 79% of appropriate patients in the community had a conversation about do not attempt cardio pulmonary resuscitation orders. The community palliative care team had seen 73% of appropriate patients in the community. There were recommendations and actions from the audit which were monitored through the end of life care strategy group.

We saw at the multidisciplinary team meeting that preferred place of care and death discussions had taken place with the patients. There was an example of a patient being discharged very quickly from the hospice to the community who had passed away soon after the discharge.

There were regular reviews of end of life patients at the Clitheroe Community Hospital by the specialist palliative care team and each patient was reviewed daily by the GP. We saw end of life care plans had been completed and were in place. Discussions had taken place regarding the preferred place of care and death and discussions with district nurses and the palliative care team were documented. Regular discussions with family members were documented about patient care and management in all but one of the plans we reviewed.

Assessments by the specialist palliative care team were clear in the records with green stickers and the intervention by the team was printed in red and pasted into the patient record. The care plans were well evidenced and the telephone number of the team and the advice line number were part of the record.

There was an audit calendar for palliative care across the trust. Some of the audits were national audits while others were local audits. The progress of the audit was recorded.

We saw mouth care was evidenced in patient records and was included in the health care assistant training.
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. We saw the appraisal rate for the community palliative care team was 95%. There was a culture of continuous training and development for all staff that were involved in the care of patients at the end of life and ongoing evaluation of training to improve uptake and content.

NICE Quality Standard QS13 End of Life Care for Adults contains Quality Statement 15, which recognises that health and social care workers need to have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers. The service provided training and support for all staff who were involved in care at the end of life.

The consultants provided clinical supervision to the palliative care team. There were structured sessions and discussions about patient scans and clinical discussions regarding patients and complex symptom management. The consultants were also available to provide support on an informal basis if necessary. Consultants would undertake joint visits to patients if necessary and one of the consultants was allocated to the community.

The district nurses told us that the palliative care team, including the consultants, were always available to give advice and support if necessary.

There was an end of life care facilitator and a large part of their role was education. There was a wide range of training available for staff including junior doctors, GPs, district nurses, health care assistants and hospice staff. Staff from care homes and nursing homes could also access education.

There was a specialist education core steering group who oversaw training across the health economy. The group produced an annual report which reviewed how much training had been delivered and what changes had been made to training packages to make them more accessible and to increase uptake.

Training sessions included symptom control, advanced care planning and difficult conversations, care of the dying patient, and palliative care for health care assistants. The training was on a rolling programme.

There were frequent Gold Standard Framework meetings with the palliative care team, district nurses and the GPs. Staff said these were invaluable for training of those involved in care at the end of life.

There was a competency pack for band five district nurses for end of life care. We saw the pack included referrals to other services, assessments and completing documentation, using a syringe driver and an awareness of the stages of end of life. We saw these had been completed and signed off.

The training for syringe drivers was undertaken every year. The trust used a ‘train the trainer’ model to deliver the training. Part of the training was online and there was also a practical element.

We spoke with a band five nurse at Clitheroe Community Hospital, they told us how they would acquire a syringe driver and set it up, how they would support care at end of life and how to find the care plans and how they would contact the specialist care team and the consultant for out of hours advice if necessary.
Multidisciplinary working and coordinated care pathways

Staff, teams and services worked collaboratively to deliver joined-up care to people who used services. There was robust integrated working between the community teams and acute hospitals, primary care, hospices, residential and nursing homes across the health economy. We saw that this worked well in the delivery of care to the patients. Staff told us they had faith in each other’s services.

There was a GP lead in the community to support palliative and end of life care and the consultants said that this very much supported integrated care delivery.

The community palliative care team worked extremely well with the three palliative care consultants, there was a consultant presence in the community to support staff and patients. The district nurse teams had close links to the palliative care nurses. Staff said they worked closely together to support patients.

We attended a multi-disciplinary team meeting for community patients at Pendleside Hospice. The meeting was well attended with representation from the community palliative care nurses, hospital palliative care nurses, medicines management, day services for patients at end of life, hospice staff, physiotherapy, a palliative care consultant, chaplaincy representation and a patient representative. The meeting was structured and succinct with examples of excellent working across disciplines. Comprehensive information was available about the patients discussed at the meeting. The meeting discussed patients who were symptomatic, new patients and recent deaths and was completed in a timely fashion.

The palliative care nurses undertook joint visits with specialist nurses for conditions including heart failure, chronic obstructive pulmonary disease and various neurological conditions. The specialist nurses provided expertise in the clinical condition of the patient while the palliative care team provided expertise in end of life care.

The community palliative care team could refer patients to a variety of services including, occupational therapy, speech and language therapy, dietetics and physiotherapy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The Pennine Lancashire palliative and end of life care model stated that all discussions with patients and carers should follow the principles of the Mental Capacity Act.

District nurses told us that they had discussions with patients about do not attempt cardio pulmonary resuscitation orders but that these were completed by the patient’s GP. All the decisions were recorded electronically but a paper copy was also available in the patient’s home. This was kept in a lilac folder and any health care professional, including ambulance staff, would be aware of it.
We saw that do not attempt cardio pulmonary resuscitation records had been completed at Clitheroe Community Hospital. In one of the records the GP had signed the record in the community and this had been reviewed by the consultant when the patient came into hospital.

We visited two patients in their homes and we saw that in both cases the do not attempt cardio pulmonary resuscitation order had been fully completed and discussed with the patient.

A safeguarding nurse we spoke with said that they supported ward staff with applications for Deprivation of Liberty Safeguards.

The district nurses told us about a patient who was subject to Deprivation of Liberty Safeguards but had challenged if following discharge to home from a nursing home. The nurse described the best interests meetings that had been held with the patient.

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

We saw that all members of the community palliative care team had completed the training for the Mental Capacity Act and Deprivation of Liberty Safeguard training as part of their safeguarding training.

**Is the service caring?**

**Compassionate care**

Patients were treated with compassionate care by all team members involved in their care. We saw care was holistic and patient centred with strong support for families and carers.

We observed the care of a patient in their own home at the end of their life. The carer had contacted the district nurse team to say that the patient had deteriorated significantly overnight. The district nurses had already planned a visit to the patient. The carer and the district nurse carried out personal care for the patient and it was evident that the patient was extremely well cared for, they were settled, comfortable and there was no agitation or distress and no evidence of pain. The district nurse carried out a thorough assessment of the patient’s needs and was kind and compassionate, it was evident that they knew the family. The communication skills of the nurse were exemplary during this difficult period and their explanations to the family were excellent. It was appropriate, unrushed, clear and concise and there was time given to the family to ask any questions. Spiritual care was addressed. Upon leaving the patient the district nurse said that they were available to come back at any time. The nurse returned to the patient after they had passed away to remove records and medicines as appropriate. They also provided bereavement information to the family.

The family were extremely complimentary about the district nursing team, everything was in place and had been discussed with the family to ensure that preferred place of death was achieved. The symptom management plan was excellent and fully completed.

We saw that privacy and dignity was maintained at the Clitheroe Community Hospital and curtains were drawn when appropriate. Patients at end of life could choose whether they wanted a single room or to be in a bay at the hospital.
Emotional support

Staff provided strong emotional support to patients to minimise their distress. Staff, including health care assistants, were trained in advanced communication skills, and were equipped to deal with difficult conversations. One of the nurses told us that patients often had conversations with the health care assistants as they provided much of the care.

We saw that patients who needed emotional support for their condition were identified at the multidisciplinary team meeting and the triage meetings and anxiety and depression were discussed. Staff could then agree the level of service that was needed to support the patients. Psychological support, of different levels was available for patients and there were two psychologists to support this. This was done for every patient and was an integral part of the needs of the patient.

We heard staff from the palliative care team talking to patients on the phone, they were kind to the patients and ascertained how they were feeling and could support them.

There was a spiritual care representative at the multidisciplinary team meetings. The training for health care assistants included spirituality and communication skills to enable them to care for patients at the end of their lives and to support their relatives and carers.

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. Care was holistic and carers and family members were involved in the delivery of the care.

We saw the social assessments of families and support mechanisms were discussed as part of the multidisciplinary team meeting.

Psychological support was considered as part of the triage process for all patients and those patients or carers with the greatest need were triaged as urgent referrals. Family issues and how carers were coping were discussed for each patient.

Relatives could stay with patients at end of life at Clitheroe Community Hospital and there were beds available for them if necessary. Refreshments and shower facilities were provided and car parking was free.

A patient told us that they thought that they were at end of life and discussions about their prognosis were done in a caring and compassionate manner. The patient described the communication as excellent and all relevant members of the family were involved, with the patient’s permission. This patient told us that the support from the district nurses, the community palliative care team and the hospice at home team had been exceptional. Both the patient and the family said that they had nothing but praise for the care and management of the patient. This care had enabled the patient to remain at home for most of the time, apart from a short spell at the hospice. The patient had changed their preferred place of care/death because of this support.

We saw three complement cards that the district nurse teams had received from patient’s relatives. One of them described “the amazing work you have done for my mum in helping her stay as comfortable and pain free to the end” another says “thank-you for the extraordinary care
you gave to my husband and you made what felt at times an overwhelming situation calm.” One card described the positive impact the nurses have had on the patient’s mum.

The hospice at home service was available for patients who were about to die imminently, there was also a sitting service to support carers and patients.

The palliative care team and the district nursing teams sent cards to bereaved relatives and if they requested a visit the teams would try to visit relatives.

Staff had access to bereavement teams to support relatives and carers and there was a family support team located at one of the hospices.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided services in a way that met the needs of local people. Services were commissioned by the two local care commissioning groups.

The district nursing service that delivered the majority of care for patients at the end of life was from 7.30am to 10pm. There was a night service based at Burnley General Hospital and there was telephone handover to the district nursing teams in the morning. The night service was briefed about patients at the end of life as appropriate. The district nurse teams supported care homes to deliver end of life care.

The community palliative care team operated between 9 am and 5pm Monday to Friday and were based at Accrington Victoria Hospital. They were supported by a full-time administrator. There were on average between 130 and 150 referrals to the team every month though in July 2018 there had been 179 referrals.

Clitheroe Community Hospital was a community hospital with a 32-bedded ward (Ribblesdale). This had four bays of four beds and 16 single rooms. All the beds had an en-suite toilet and a sink for hand washing. There was plenty of patient bed space in each bay.

There was a spacious day room with dining tables and activities for patients took place in the day room. There was a large balcony off the day room with furniture so that patients could sit outside they wanted to, beds could be wheeled out onto the balcony. The hospital was used as a step-up unit from community services and a step-down facility from acute care and took patients at end of life if appropriate. Transport services were available between trust sites.

The GPs who worked at the hospital, from Monday to Friday, could certify deaths and some of the nursing staff were trained to certify deaths. There was a cold store with two fridges so that relatives did not have to travel to the mortuary at the main acute site at Blackburn to receive a death certificate.

The fridge temperatures were checked regularly by the porters and patients retained their wrist bands as a means of identification. There was a lift from the ward to the cold store on the ground floor and porters would move patients at times when there was little activity on the ground floor.
Meeting the needs of people in vulnerable circumstances

The service took account of patients’ individual needs and worked to support vulnerable people appropriately.

There was a frail and elderly nursing team who would complete do not attempt cardio pulmonary resuscitation forms as part of advanced care planning, these teams were part of primary care services and worked with the district nurses and the community palliative care team. District nursing teams and the community palliative care team supported care homes and residential homes in the locality.

There were neighbourhood team co-ordinators who looked at complex cases and complex discharges. They worked with GPs, community services and adult social care and had access to social care records. They had multidisciplinary meetings every two weeks and provided a wraparound service with more co-ordinated care that avoided duplication. Staff said that this service would support their patients if necessary.

At Clitheroe Community Hospital patients who could be, were up and dressed and encouraged to eat their meals in the day area. The unit was dementia friendly with large numbers and appropriate signage on doors. There were patient activities available in the day room.

There was a large black minority ethnic population in the area. Work was being undertaken as some of these groups did not access care at the end of life and their expectations of end of life care were very different. The team were working with a local imam to explore some of these issues.

The palliative care nurses described how they could access interpreters for patients. The interpreters met the nurses at the patient’s home. Female interpreters could be requested by the patient. Interpreters were always used for the difficult conversations though families told staff that it should be they who translated for the patient. The nurses explained to patients why interpreters were needed. Once an interpreter was booked staff sent an email to their manager to make them aware of the booking.

The district nursing team had produced cards and pictures in different languages to facilitate communication.

Because of the geography of the area carers were sometimes reluctant to travel to some outlying locations. In these circumstances the clinical commissioning group had paid travelling expenses to carers or the district nurses had provided personal care to patients.

The nurses gave an example of a patient who had received private treatment and had been discharged from a hospital out of area. The patient was very close to end of life and their relative had contacted the district nursing service early in the morning for support. By lunchtime services had been put in place by the palliative care team, the district nurses, the GP and hospice at home to support the patient to die at home as they wished.

The trust was part of a pilot for personal health budgets for patients at end of life. The project was supported by NHS England and the trust was one of five in the country who were involved in the project. Personal health budgets can give patients more choice about who provides their care, where their care is received and their preferred place of death. People eligible for NHS continuing healthcare funding under the fast track pathway have a legal right to a personal healthcare budget. Ten patients were part of the first cohort and staff told us how one patient in particular had benefitted from the funding. The patient had employed a personal assistant to meet their care
needs at times that were agreeable to the patient. The patient had seen an improvement in their mental and physical health so much so that they undertook some treatment that they had previously declined as the support was in place for them following surgery. The nurses said that this had reduced unscheduled visits, reduced hospital admissions and there were cost savings. The patient said that they had got their life back. The pilot was ongoing with five patients in the current cohort.

We saw that the community palliative care team had received a referral for a patient with a learning disability. The patient was triaged as needing an assessment within three days due to their communication difficulties. Staff said that they would always prioritise patients with additional communication needs.

**Access to the right care at the right time**

People could access the services available for end of life care when they needed to. There was a triage system for the community palliative care team. There was a triage tool for the prioritising and assessment of all community referrals to the service. If the patient was symptomatic they required assessment within three working days, a symptomatic patient who didn’t require urgent intervention was seen within three to five working days and non-urgent assessments were seen within five to 10 working days.

The team tried to allocate patients into geographical areas to reduce travel. The palliative care team could work from community clinics without coming back to their base, they said this helped to develop their relationships with district nurse teams.

At the beginning of the year the team had some staffing issues leading to non-urgent patients having to wait up to four weeks for a visit. The team worked with the district nurses and the patients and would re-prioritise patients as necessary. At the time of the inspection there was no waiting list for patients.

There was an out of hours hospice line for advice and triage for complex patients for all those involved in end of life care.

We saw that a patient had been discharged from the hospice to the community very quickly as this was their preferred place of care at end of life. The district nurses had supported the discharge to allow this to happen.

**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.

Although the service received few complaints we saw how complaints were used for service improvement and that changes had been made to services following patient complaints.

From April 2017 to March 2018 there were no complaints about community end of life care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Compliments and complaints relating to end of life care were presented at the end of life steering group. From April 2017 to March 2018 there were three compliments received relating to end of life care in a community setting – two relating to Ribblesdale Ward at Clitheroe Hospital and one relating to the district nursing team at St Peters Health Centre.

Is the service well-led?

Leadership

The service had managers and staff at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The three palliative care consultants each took a lead for a different part of end of life care, they met every month and provided the leadership of the service across the health economy, supported by the GP lead. The consultants were supported by the palliative care nurses in acute and community settings who provided leadership in end of life care to other health professionals. Nursing staff told us that there was strong leadership from the two matrons and from the deputy director of nursing for community services. A member of staff told us that there was positive nursing leadership which was nurturing and supportive, they said that the trust was looking at the development of future leaders. There was a nursing and midwifery development programme that lasted for nine months. Two members of staff who had attended had said it was very good and that the courses were accessible.

One of the district nurses told us that their manager was always available and very approachable.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. End of life care priorities had been identified and an action plan for the service had been developed for 2018 to 2019. Learning from complaints was used to improve services. The priorities included care of the dying patient, a competent and skilled workforce, bereavement support and co-ordinated, collaborative and accessible end of life care. There was a bereavement care strategy for 2016 to 2019 for the trust that included community services.

The lead consultant articulated a strong vision for the service which included the delivery of a seven-day service, though this would be dependent on the filling of the consultant vacancy. The consultant described how they would take up and increase their input into non-malignant diseases including motor neurone disease, stroke, heart failure, dementia and frailty.
The consultant was keen to continue the triage of patients in community services, every day, Monday to Friday, as this model worked well for the identification of those who needed the service most.

Staff described a clear direction for the service and felt that they were part of the delivery of the vision.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The culture of the service was very open and staff said it was a really good place to work.

One of the community palliative team nurses had only recently started to work for the trust. They had nothing but praise for the trust and the team.

Staff told us that they felt part of the trust and that senior managers visited community sites on “back to the floor Friday”. They said that communication from the trust was good.

**Governance**

The service used a systematic approach to the continual improvement of the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The community end of life service was part of the community services, palliative care and complex case management directorate. There was a palliative care lead nurse.

The Gold Standard Framework (GSF) provided validated quality improvement training programmes in end of life care in different settings. The GSF improves the identification of patients at the end of life, improves advanced care planning, reduces the need for hospitalisation and improves co-ordination of care.

There were senior nurse meetings with the assistant director of nursing for community and these were attended by senior nurses from community services. Information about patient safety was cascaded through this meeting and then down to staff members in the community. The nurses said that there were good lines of communication between the hospital and the community.

The end of life care priorities included the development of robust governance for the provision of end of life care.

We saw that policies were developed across all organisations involved in end of life care and then these polices went through the appropriate governance meetings for sign off by each organisation involved in end of life care. The new syringe driver policy and care of the dying policy had been developed in this way.

We saw that guidance had been updated in the care of the dying policy.

**Management of risk, issues and performance**
The service had effective systems for identifying risks and there was planning to eliminate or reduce them.

There was a current risk register for palliative care across the trust, most risks were low with some medium risks. All had a review date, some were health and safety risks and others were service specific.

There were palliative specialist care directorate meetings which were held every month. These were well attended and there was a fixed agenda. We saw the minutes of meetings from May, June and July 2018. Agenda items included incidents and feedback, a review of the risk register, complaints and compliments, effective care, policy updates and updates on guidance from the National Institute for Health and Care Excellence and medicines management.

We saw in the minutes of the meeting from July 2018 that the Gosport report and the findings and the implications for the service had been reviewed and discussed by the team.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The staff on the Ribblesdale ward at Clitheroe Community Hospital told us that they had been affected by the cyber-attack last year and had learned lessons from the incident.

Patient consent was obtained for shared record access to records held by the GP at the first palliative care appointment.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

We attended an event “Towards the end of life workshop” during the inspection that was organised by the local clinical commissioning group. It was one of a series of workshops as part of a service review by the clinical commissioning group and was facilitated by the end of life transformation team. The aim of the workshop was to identify improvement opportunities for the service. The workshop was attended by a wide range of stakeholders including the palliative care consultants, palliative care nurses, GP’s, nursing home managers, district nurses, hospice staff and patient representatives. These workshops were a series to improve end of life care.

There was a community staff survey undertaken by the trust and we saw that an action plan had been developed to support the findings.

The end of life care facilitator had done some work with the community district nursing teams following a heavy caseload of end of life patients. A debrief was undertaken and mindfulness was explored.

We saw that in the minutes of the directorate meetings that staff had an awareness of the staff guardian.
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 community palliative care team worked in truly multi-disciplinary way with all partners and stakeholders in end of life care to care for patients at the end of their lives and to support their relatives and carers. There was a culture of continuous learning in the team and in those teams supporting end of life care to try to improve services and deliver care at the right time and in the right place for patients.

The personalised individual budgets for patients at the end of life pilot was innovative and had improved outcomes for patients and impacted on service delivery with less interventions from health professionals.
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>Burnley General Hospital</td>
<td>East Lancashire Child and Adolescent Service (ELCAS)</td>
<td>-</td>
<td>Mixed</td>
</tr>
</tbody>
</table>

Is the service safe?

Safe and clean environment

The East Lancashire Child and Adolescent Service was located at Burnley General Hospital. The premises were situated on the ground floor and separated from adult services.

Patient access to the service was through a locked door controlled by reception staff that led to a large waiting area. The service had a large reception and waiting area, consulting rooms, a large room available for group sessions, a family therapy suite and a separate intensive support unit.

The reception and waiting area was well-lit, equipped with appropriate furniture and was maintained to a good standard. All areas were visibly clean and tidy. Cleaning records were up to date and demonstrated that the premises were cleaned regularly.

A patient led assessment of the care environment was undertaken in April 2018 and was up to date. This was a comprehensive assessment that assessed the quality of the care environment and demonstrated there were no concerns.

The consulting rooms were equipped with the necessary equipment to carry out height and weight monitoring.

Consulting rooms were not fitted with alarms and staff did not carry personal alarms when they were in an appointment. Staff managed the risk of not having alarms by ensuring the consulting rooms closest to the reception area were used, undertaking thorough risk assessments of people who used the service and where appropriate they could have an extra member of staff in the room. Although there had been no incidents where alarms had been needed, a request from the service to the provider had been made to purchase alarms for the service.

Staff were seen to adhere to infection control principles, washing their hands and wearing aprons at meal times when serving lunch in the intensive support unit.

A weekly health and safety checklist was completed and up to date, fully completed records were seen on inspection. This detailed areas around fire exits being clear, extinguishers present, fridge
temperatures being checked and taps run for three minutes in line with the trust’s infection control policy.

Checks were in place to ensure the premises were continuously risk assessed. Staff had completed an up to date ligature risk assessment of the intensive support unit identifying all the ligature risks. There was a trust policy in place to guide and support staff in completing this assessment. Staff were aware of the ligature risks and these were documented on the service risk register. Staff mitigated ligature risk by a member of staff always being with a patient, by completing comprehensive risk assessments and knowing their patients well.

Safe staffing

The service had an establishment of 78.31 whole time equivalent staff. This included a head of service/clinical director and an operational lead. There were five consultant psychiatrists and nursing staff including mental health, learning disability and paediatric nurses. Other professions included social workers, occupational therapists, psychologists, cognitive behavioural therapists, parenting staff and a counsellor. Other therapists including art and family therapists were part of the service as well as a fully established administrative team.

The service had one vacant post for a staff grade doctor although they were considering changing this to a consultant psychiatrist post as an investment into the service. The service had one vacancy for a full-time band 5 post in the intensive support unit out to advert at the time of inspection.

Due to effective management of staff and caseloads there had been no use of bank or agency qualified nursing staff or medical locums over the last 12 months in this service.

Staff working within the service had undergone a disclosure and barring check before they commenced work with the trust and three yearly update checks were on a rolling programme.

Each team within the service had a band 7 team co-ordinator who had oversight of caseloads for the rest of the team. Caseloads were reviewed formally each month. If a member of staff was absent, the band 7 would review their caseload the same day and allocate work to an appropriate member of staff using a risk based approach.

The turnover rate for this core service was 11.8% between August 2017 and July 2018 and this was reflective of staff rotating onto the improving access to psychological therapies programme and returning to post.

The sickness rate for this core service was 6.6% between August 2017 and July 2018.

Staff reported having manageable caseloads. Caseloads for named keyworkers ranged from 12-64 and this varied due to the complexities of some cases over others and the frequency of appointments needed. Management had good oversight of caseloads and staff told us that individual caseloads were discussed and reviewed in supervision.

Staff told us that cover arrangements were managed well and arranged within the team immediately to ensure continuity of care to those who used the service.

The service operated a duty system referred to as the “hot rota”, this consisted of a duty consultant, duty manager and duty practitioner available during the opening hours of the service. This ensured rapid access to a psychiatrist for those with an urgent need. A duty manager and
duty practitioner were also available for support and/or advice 24 hours a day, 365 days of the year.

**Mandatory training**

The compliance for mandatory and statutory training courses at 31 March 2018 was 96%. Of the training courses listed all achieved the trust target.

**Key:**

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service %</th>
<th>Trust target %</th>
<th>Trust wide mandatory/ statutory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>98%</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>98%</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>98%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>97%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>97%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Safer Handling Theory</td>
<td>96%</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Prevent</td>
<td>96%</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>95%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Children</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>90%</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Core Service Total %</strong></td>
<td>96%</td>
<td></td>
<td>94%</td>
</tr>
</tbody>
</table>

At the time of inspection, the mandatory training rates had increased from the above figure of 96% to 99% compliance.

**Assessing and managing risk to patients and staff**

**Assessment of patient risk**

We looked at nine sets of care records. All had a risk assessment completed and were up to date.

Risk assessments were undertaken on referral into the service and included assessment of risk to self and to others. These risk assessments were updated and reviewed regularly. Our observations during the inspection evidenced that staff were continuously risk assessing when undertaking appointments with patients and discussing patients in multidisciplinary team meetings.

Staff continuously monitored patient risk and patients were risk assessed at either high, medium or low risk. Although patient risk assessment was ongoing throughout treatment there was also a robust system in place to ensure high risk patients had their risk assessment completed every four weeks, medium risk was updated every eight weeks and low risk patients were updated every 12 weeks.
Staffing levels and skill mix within the service was very good and caseloads were reviewed regularly to ensure patients were kept safe.

**Management of patient risk**

On acceptance into the service a parent/carer pack was sent out to the family that included local and national links to support services. Patients and their families were encouraged to contact the service directly if their personal situation changed or if there were increasing concerns. The information sent to the family on acceptance to the service was also sent to the patient’s GP and other agencies such as education if appropriate.

Staff working in the intensive support unit had received a 12-hour training course in de-escalation and breakaway techniques from a nationally recognised programme. Community staff had also received a shorter six-hour training course.

High risk complex cases were discussed at the multidisciplinary team meetings where they were reviewed weekly to ensure ongoing monitoring.

Staff within the service recognised and responded to changes in risks of patients who used the service. They knew how to respond to patients whose mental health had deteriorated and who needed further assessment.

**Safeguarding**

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.

The trust had a named nurse for safeguarding of children who was based within the same corridor as the team. Staff had a good working relationship with the safeguarding department. In the period from September 2017 to September 2018 there had been 212 contacts between the service and the safeguarding team.

Safeguarding supervision was provided by the trust’s safeguarding team and in the last 12 months there had been 85 sessions held.

Safeguarding training was part of the mandatory training package provided by the trust and at the time of inspection, 100% of staff had received this training. All professionally qualified staff were trained at level 3 and all administrative staff trained at level 2.

Staff had a good understanding of safeguarding and knew when and how to make a safeguarding referral. Fifty-nine safeguarding referrals were made in the last 12 months by the service. Staff attended safeguarding meetings for patients on their caseloads.

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 organisational.

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 service had a named consultant that was the lead for safeguarding and child protection and managers from the service attended the trust internal safeguarding board meeting held quarterly.

The trust had submitted details of six external case reviews commenced or published in the last 12 months that related to this core service.

<table>
<thead>
<tr>
<th>Recommendation(s)</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure ELCAS are informed of all children under their care who attend the Emergency Department, Urgent Care Centres or Minor Injury Unit.</td>
<td>08.11.17 in discussion with Informatics to provide daily report to ELCAS where an ELCAS patient has attended ED/MIU/UCC. Process to be agreed and finalised. - ongoing work.</td>
</tr>
<tr>
<td>To review current referral pathways for children with alcohol or drug misuse, and to include criteria for ELCAS referral within those pathways</td>
<td>SOP for drug and alcohol misuse in place. 25.04.18 discussed with ELCAS operational lead and pathway to be devised for ELCAS to be added to SOP and shared with ELCAS staff. - ongoing work stream</td>
</tr>
<tr>
<td>To ensure that where ELCAS identify children as being at risk of CSE that appropriate action is taken to safeguard the child.</td>
<td>ELHT's CSE policy shared at ELCAS's Quality Safety Board including the Spotting the Signs Tool. This policy has now been updated and shared accordingly.</td>
</tr>
<tr>
<td>Strengthen safeguarding supervision for ELCAS from ELHT Safeguarding team.</td>
<td>ELCAS staff will have regular planned supervision to bring cases where there is risk of CSE and/or CSA, as well as other safeguarding risks.</td>
</tr>
<tr>
<td></td>
<td>SMART and Child-centred Safeguarding plans will be agreed, in keeping with the LSCB's Risk Sensible Model. To ensure that all ELCAS practitioners are able to access planned, reflective safeguarding supervision - a programme of planned Group ELCAS safeguarding supervision has now been agreed and is being implemented.</td>
</tr>
<tr>
<td>Child Sexual Abuse / Child Sexual Exploitation risk indicators will be highlighted in ELCAS patient records.</td>
<td>The new electronic record system (IAPTUS) has been introduced and provides up to date risk information as soon as it is inputted by ELCAS clinician. This is dependent on appropriate information sharing by other agencies or where a risk has been identified by ELCAS. Risk information such as previous CSA / CSE or other risk indicators around this will be able to be clearly noted to enable clinicians to develop robust risk management plans.</td>
</tr>
<tr>
<td>ELHT Safeguarding Team share information with key clinicians involved with individual children</td>
<td>Discussed at Team Meeting – Any safeguarding concern with a child who is currently open to a Consultant Paediatrician or ELCAS must be shared with the Lead Clinician</td>
</tr>
</tbody>
</table>
Staff access to essential information

The service used an electronic records system which had been introduced within the last 12 months. Staff also had paper records that preceded this date which were stored securely on site and which staff could access at any time.

Staff had laptops with secure internet access and a mobile phone ensuring they could access the information they needed to assess, plan and deliver care and treatment in a timely way.

A digital dictation device was available for staff to use.

There was a dedicated business intelligence support role in post and this was recognised as good practice by the NHS Benchmarking 2017 report as having dedicated IT support for the service.

Medicines management

Medication was not dispensed from the service. Prescriptions were provided by the five consultants and the service had two nurse prescribers. Repeat prescriptions were provided by GPs following a letter being sent from the consultant as part of a shared care agreement.

The intensive support team had a medicines cabinet if patients on the unit brought in prescribed medication to be taken throughout the day. This was stored in accordance with the trust medicines management policy. The medicines cabinet was checked monthly by the pharmacy department.

Track record on safety

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified. Between 1 April 2017 and 31 March 2018 there were no STEIS incidents reported by this core service.

We asked the trust to provide us with the number of serious incidents from the past 12 months. No serious incidents recorded by the trust incident reporting system were reported in relation to this core service.

Reporting incidents and learning from when things go wrong

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.

In the last two years, there have been no ‘prevention of future death’ reports sent to the trust which related to this core service.

There was a trust incident policy in place and staff reported incidents on an electronic system. Openness and transparency about safety was encouraged and staff understood their role in reporting incidents.
Lessons learnt from incidents were communicated within the service through a variety of means including team meetings, email and where appropriate in one to one meetings with staff members.

Following an incident staff had access to a de-brief session and this could be done as a group session or one to one.

Staff gave us examples of how the safeguarding team had supported them and how they attended serious multi-agency case reviews as part of their learning and development.

Staff had a good understanding of the duty of candour and had access to the trust policy. The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have or could have potentially led to significant harm.

Is the service effective?

Assessment of needs and planning of care

We reviewed 9 sets of care records. All care records demonstrated that an initial assessment, risk assessment and care plan had been completed and these were updated regularly. Patients were matched with a member of staff who had the skills and experience to meet their needs following initial assessment.

We observed a clinical outpatient appointment and physical health, diet, sleep, side effects of medication were discussed.

Care records demonstrated that care plans were shared with patients, families/carers and other relevant agencies such as the GP. Care plans that we reviewed included patient’s goals and wishes.

Best practice in treatment and care

Patients had access to a wide range of therapies to meet their individual needs including support groups Staff provided care and treatment in line with National Institute of Health and Care Excellence guidance.

Any new or updated guidance was received by the trust’s governance department and fed into the monthly quality and safety board that managers from the service attended. This information was then disseminated to the staff in the team meetings.

We observed a support group for young people who self-harmed. This was attended by two members of qualified staff and four young people. These groups consisted of 10 weekly sessions however; if it was felt a longer duration was suitable for the young person, they could attend whilst it continued to be beneficial and were encouraged to do so. The group was based on a framework that integrated cognitive behavioural therapy, group psychotherapy, interpersonal therapy and child development theory. Outcome tools were used to audit the effectiveness of these groups and included a mood and feelings questionnaire, suicidal ideation questionnaire, Health of the Nations Outcome Scales for Children, children’s global assessment scale and a strengths and difficulties
questionnaire. Data provided by the trust demonstrated there had been an improvement in symptoms of depression and suicidal ideation following participation in the group.

Whilst on inspection we observed a family therapy session and spoke with members of the family who had taken part in this session. The feedback we received was positive, with the family reporting that the sessions were benefiting them as a family and the individual patient.

This core service participated in four clinical audits as part of their clinical audit programme 2017 – 2018.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
<th>Key actions following the audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>QNCC standards for CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
<td>Royal College</td>
<td>29/09/2017</td>
<td>The audit will be submitted to the QNCC as evidence of progress in this area. Re-audit to assess the pattern of risk review in sessions over a longer period of time. Care Plan documentation to be developed to incorporate a risk review.</td>
<td></td>
</tr>
<tr>
<td>How effectively does the Primary Mental Health Team complete routine outcome measures?</td>
<td>Child and Adolescent Mental Health Services</td>
<td>Departmental/Trust</td>
<td>13/06/2017</td>
<td>Final clinic appointments to be planned 15 weeks after referral (as opposed to 16 weeks) ADHD team to implement use of the spreadsheet and complete data accordingly Completion of the Audit Report To re-audit the pathway in a further 12 months (commencing from September 1st, 2017)</td>
<td></td>
</tr>
<tr>
<td>Clinical Audit of the ADHD Pathway in East Lancashire Children and Adolescents Service</td>
<td>Child and Adolescent Mental Health Services</td>
<td>NICE</td>
<td>05/12/2017</td>
<td>IAPTUS introduced and the standard is that all cases will have ROMS. ROMS group up and running</td>
<td></td>
</tr>
<tr>
<td>Audit of the Collection of Routine Outcome Measures by the Primary Care Team</td>
<td>Child and Adolescent Mental Health Services</td>
<td>National Strategy</td>
<td>05/01/2018</td>
<td>RCADS to be implemented as a session-by-session outcome measure to replace the GBO due to its higher rate collection by the team, displayed by the current audit. Outcome measures should be collected routinely, session by</td>
<td></td>
</tr>
</tbody>
</table>
The service had a named consultant who led on audits and there was a routine outcome measurement scales working group in place at the service. A wide variety of outcome measuring tools were used to assess how patients were at the start, middle and end of their treatment.

Staff actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking and peer review were proactively pursued, including participation in approved accredited schemes.

The service provided input to the East Lancashire and Blackburn with Darwen youth offending teams and staff provided consultation, assessment, interventions and training. This meant that young people open to the youth offending team could have prioritised access to a senior practitioner and psychiatrist. During the inspection we observed a session held at a local police station. Police gave excellent examples of some of the positive outcomes this joint working had led to. An example was given about the police and health worker conducting a joint visit to a young person who engaged positively with both services and was directed away from criminal behaviour.

Staff within the service had taken part in the children and young people's improving access to psychological therapies programme. This was a service transformation programme delivered by NHS England that aimed to improve existing emotional wellbeing services for children and young people.

**Skilled staff to deliver care**

The service was delivered by three teams covering Burnley and Pendle, Hyndburn and Ribble Valley and Blackburn with Darwen. The service was led by a head of service and an operational lead.

There were five consultant psychiatrists, nursing staff including mental health, learning disability and paediatric nurses. Other professions included social workers, occupational therapists, psychologists, cognitive behavioural therapists, parenting staff and a counsellor. Other therapists including art and family therapists were part of the service as well as a fully established administrative team. There was also a full-time business intelligence lead in post.
The continuing development of the staff’s skills, competence and knowledge was recognised as being integral to ensuring high quality care was delivered. Staff were proactively supported and encouraged to acquire new skills and share best practice. We spoke with staff that had been supported to attend the children and young people’s improving access to psychological therapies programme and complete a Master’s degree in cognitive behavioural therapy. They said they had been fully supported in doing this both by having the course funded and being given adequate time to complete the course.

The team had a highly skilled workforce who were experienced and qualified in a range of therapies including cognitive behavioural therapy, eye movement desensitization therapy, art psychotherapy, family therapy, play therapy, interpersonal counselling and systemic therapy.

Staff received a 2-day corporate trust induction when they commenced employment and received a bespoke induction to the service which was tailored for their specific job role. This included opportunities to shadow staff members, spend time with other services and create a job plan to provide opportunities to develop.

Staff during the inspection told us they felt supported in their roles and were encouraged in further development.

The trust’s target rate for appraisal compliance was 90% for non-medical staff and 95% for medical staff. As at 31 March 2018, the overall appraisal rates for staff within teams relating to East Lancashire Child and Adolescent Service was 93%. Due to the format in which the data was provided it is not possible to provide figures separately for medical and non-medical staff.

<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELCAS East Lancs Team Comm</td>
<td>31</td>
<td>27</td>
<td>87%</td>
</tr>
<tr>
<td>ELCAS Intensive Supp Team BGTH</td>
<td>11</td>
<td>10</td>
<td>91%</td>
</tr>
<tr>
<td>ELCAS Admin BGTH</td>
<td>10</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>ELCAS New ways of Working</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>ELCAS Primary MH Workers</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>ELCAS Bwd Team Comm</td>
<td>11</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>69</strong></td>
<td><strong>64</strong></td>
<td><strong>93%</strong></td>
</tr>
<tr>
<td><strong>Trust wide</strong></td>
<td><strong>7268</strong></td>
<td><strong>6621</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>

At the time of inspection, the appraisal rate had increased from 93% to 94%. Staff received an annual appraisal in the first month of the financial year to identify the skill mix of the team, identify any training gaps and ensure that any courses staff wanted to attend could be applied in time to start within the academic year. This meant that the learning needs of staff were identified and areas of interest were encouraged. Managers then gave staff opportunities to develop their skills and knowledge.

The Trust had a clear supervision policy in place. One hundred percent of mental health practitioners, therapists, clinical managers and medical staff received clinical, caseload, peer group, special interest and therapy specific supervision.
The service supported the work conducted by the paediatric diabetes team for the trust. The service received funding to provide 0.6 wholetime equivalent of a band 7 registered mental health nurse and 1.05 wholetime equivalent of a clinical psychologist to carry out the annual psychological reviews ensuring that the service met the paediatric diabetes best practice tariff. The service provided the supervision for these staff members.

**Multidisciplinary and interagency team work**

The service held weekly multidisciplinary team meetings to discuss new referrals, review cases and it gave staff an opportunity to discuss more complex cases. These meetings were attended by the whole staff team including the team co-ordinator and a consultant.

We observed a weekly referrals meeting for the Burnley and Pendle team. This was attended by three consultants, the operational lead and a medical secretary. All cases were discussed and risk assessed based on clinical presentation.

Monthly senior team meetings were held and these were attended by the consultant, senior staff and the band 7 team co-ordinators.

Staff and local services were committed to working collaboratively and they had found innovative ways to deliver more joined up care to people using this service. A liaison service pilot was underway at the time of inspection and we observed an early intervention team consultation with the local police in which 12 police officers attended. This was an initial pilot focused on case discussions, prevention work, psycho-education and group supervision to support the police in improving their knowledge around mental and emotional health of young people on the fringe of offending.

If a patient from the service was admitted to a Tier 4 service (in-patient unit), staff from the service kept in touch with the inpatient unit by visiting the unit to attend meetings and keeping in touch with the patient.

Staff had been involved in the training of staff working in the accident and emergency department to increase their knowledge and understanding of mental health and promote the service and encourage staff to contact them if support and advice was required.

A local partnership was set up between the trust and Blackburn with Darwen Borough council to provide emotional health and support to the local authority. This team was made up of two clinical psychologists, two mental health practitioners, a play therapist and a fostering support worker. A variety of therapies were offered including play therapy, foster care consultation and attachment based therapy.

Members of the management team within this service were part of the children’s partnership board in which bi-monthly meetings were held by Blackburn and Darwen local council which were chaired by the director of children’s services. The purpose of these meetings was to ensure care and services to children and young people was joined up. Membership of the board included the police, faith groups, public health and local sexual health services amongst others.

The service had close links with other agencies including local schools, GP surgeries, local authorities and the youth offending team.
Adherence to the Mental Health Act and the Mental Health Act Code of Practice

No information was provided on the proportion of the workforce which had received training in the Mental Health Act.

Mental Health Act training was not provided by the trust. The trust was not registered to provide care or treatment for patients detained under the Mental Health Act (MHA) 1983.

Staff we spoke to were not clear on how the Mental Health Act related to the patients that used their service, however they felt they could raise any concerns with the consultants within the service.

The consultants within the service were all section 12 approved. This meant they were medically qualified doctors who were trained and qualified in the application of the Mental Health Act 1983.

At the time of the inspection, there were no patients under a community treatment order and we were told by staff that these were extremely rare.

Staff in the service had access to a safeguarding team and mental health liaison team within the trust if they required information relating to the Mental Health Act.

Managers we spoke to had raised the lack of Mental Health Act training with the director of nursing and medical director of the trust to look at working on a training package that could be rolled out across the trust.

Good practice in applying the Mental Capacity Act

No information was provided on the proportion of the workforce which had received training in the Mental Capacity Act.

The Mental Capacity Act 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make some or all decisions for themselves and is designed to protect those people.

The service was commissioned to provide services for children up to age of 16.

Mental Capacity Act training was completed as part of the safeguarding modules of the mandatory training provided by the trust. The clinical staff had received level 3 training and the administrative staff received level 2 training.

Staff we spoke to had a good understanding of the principles of consent when working with children and young people, supporting decision making and included parents and carers in this process. Gillick competencies training was also included as part of the safeguarding level 3 training and staff gave examples of this in practice. Gillick competencies are used to determine if a person under the age of 16 has the intelligence, understanding and competence to consent to treatment themselves.
Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with five young people who used the service and 10 parents and carers. The patients we spoke to said the staff were supportive and helpful. Patients reported staff were approachable and that they felt safe in the service.

Feedback from people who used the service was positive about the way staff treated them. People felt staff went the extra mile for them and above and beyond their expectations. Patients we spoke to felt staff were respectful and polite.

Staff recognised and respected the totality of patient’s needs. They took patients personal, cultural, social and religious needs into account and found innovative ways to meet them.

Staff on the intensive support unit were kind and respectful to the young people who were using the service. We observed staff and patients eating their meals together and engaging in conversation over lunch-time. Warm, friendly interactions were observed between staff and patients.

One of the patients we spoke to felt they were listened to and that staff on the unit could tell when they were feeling low in mood. A parent told us they were very grateful for the service and felt it was amazing with quick appointments and was a very responsive service.

Involvement in care

Involvement of patients

Participation groups for patients were held monthly in the evening so children and young people could attend and it did not impact on their education. These groups were for people who had used or were currently using the service. A member of the team from each of the three areas covered by the service were participation champions and they helped in the recruiting and engagement of this group.

Staff in the intensive support unit to offer patients choices around what activities they wanted to complete and who they would like to do those with. Patients were supported and encouraged in the choices they made.

Patients we spoke to told us that they had received information about their diagnosis and medication and were offered choices in their treatment.

Patients were involved in their care, expectations and goals were recorded in care records of both patients and parents/carers.

Patients told us that they had been consulted when the service wanted to introduce a permanent student to work on the unit. They were asked their views and to check they felt comfortable with this.
Patients designed the leaflet that was given out to describe the service and the participation group. At the time of inspection, they were also involved in designing the information given out about measuring outcomes of treatment. Patients were given questionnaires to rate the care they had received at the service and were actively encouraged to complete these.

**Involvement of families and carers**

Families and carers were given the opportunity to talk openly and receive support around the patients’ needs and appointments were offered to them separately to allow them this time. A local survey response report taken between 1 July 2018 and 31 July 2018 showed that parent and family members felt that the staff who had seen their child had listened to them as carers. Ninety three percent rated this was certainly true of the service and 98% of the parents/carers stated they were treated well by the people who had seen their child. Carers we spoke to on inspection told us they felt involved in the patients’ care and the consultants were “first class”. One parent told us that they were fully supported when their child received support from the service, that they also received support for themselves and were helped in attending school to raise awareness of their child’s current issues.

**Is the service responsive?**

**Access and waiting times**

The service was commissioned to accept referrals and provide a mental health service for children and young people up until their 16th birthday who were experiencing a range of severe and complex difficulties with their mental health. If a patient was still receiving a treatment programme after their 16th birthday, they remained with the service until either their treatment programme or therapy had ended or their care transferred over to adult services. The service utilised the choice and partnership approach model to manage referrals and case management. The model was based on collaboration with the patient, identifying strengths and the development of a shared formulation of care. The service had a clear criteria for which patients would be offered a service. Most referrals went into the service from GP’s, paediatricians, education and children’s social care. The average wait for a patient from referral to assessment over the period from September 2017 to August 2018 was 3.6 weeks and the average wait from referral to treatment time within the same period was 6.9 weeks. The service operated 7 days a week, offering appointments between the hours of 8am – 8pm Monday to Friday and 9am – 5pm Saturdays and Sundays. Appointments were offered in a variety of settings including the service within the hospital, GP surgeries, patient’s homes, schools, children’s centres etc meaning people could access services and appointments in a way and at a time that suited them.
The intensive support unit was used as a step up and step down from Tier 4 in-patient psychiatric services. The unit offered a package of care that incorporated both health and education and offered 12 places at any one time. The unit was open Monday to Friday 8.30am to 4.30pm.

Same day access to a consultant psychiatrist and a senior clinician was available from the service due to the on-call system in place meaning the service could see urgent referrals quickly.

The service had an out of hours care pathway for patients who presented at the accident and emergency department in crisis and could offer advice and consultation to staff. This service provision ran 365 days per year.

The service provided a self-harm team that consisted of two members of staff per day on a rota system. This meant that a quick response could be given to patients who had presented at the accident and emergency department who had self-harmed and they could attend the paediatric ward for those children that had been admitted providing a prompt assessment of their needs. Patients were seen by the next working day and a detailed self-harm assessment was undertaken in line with National Institute of Health Care Excellence guidance.

The service had a policy to guide staff if patients did not attend their appointments that was up to date. Staff had the ability to send text message reminders to patients and they tried to engage with the patient to establish the cause of non-attendance and worked with them to prevent future non-attendance. This included being flexible on where appointments were held and the time of appointments.

There were good arrangements in place for transitioning patients between the service and adult mental health services. These included monthly meetings held between the team and adult services and the process of transition commenced six months prior to the young person’s 16th birthday. We saw from records and in speaking to people who used the service that transition plans were in place and discussed in depth. Evening clinics were also held at the service to meet the needs of the older adolescents.

**The facilities promote comfort, dignity and privacy**

The service had a range of rooms available to see patients in that were comfortable, clean and furnished with appropriate furniture. During the inspection, the service was being decorated as part of a redesign project. The patients who used this service were actively involved in this redesign of the service. This project included the flooring being replaced throughout and new furniture including bean bags, tub chairs and coffee tables. The waiting area and all consultation rooms were also due to be repainted.

There were rooms available for consultations, a group room and a family therapy suite.

Staff had consulted with the children and young people who used the service to improve the facilities and they had requested their own art work to be displayed throughout the corridors. This could clearly be seen throughout the service.

**Patients’ engagement with the wider community**

The intensive support unit at the service provided children and young people the opportunity to continue their education whilst receiving the support by having two classrooms on site. Prior to
attendance, the patients were allocated a key teacher and teaching assistant provided by the local authority. Their role was to liaise with the patient’s main stream school to access and support educational needs.

We saw from care records that patients who had presented with issues around their sexuality and gender were signposted to local and national services for additional support.

### Meeting the needs of all people who use the service

The service was accessible to patients with physical disabilities, with the service being provided over one ground floor level. Toilets were accessible with appropriate hand rails.

Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care.

Patient leaflets were available throughout the service and were available in a variety of languages on request.

There were two parenting practitioners in the service who were trained to deliver a parenting course called incredible years. Both were due to deliver a bi-lingual course for the first time to meet the needs of parents/carers where English was not their first language and who were of south Asian heritage.

The service used an interpretation service that was different to the main service used by the trust. The chosen service had been sourced as the staff had received mental health training.

Patients who accessed this service had their care tailored to their individual needs and preferences.

### Listening to and learning from concerns and complaints

The service received two complaints within the last 12 months and these were being dealt with by the operational lead and were ongoing at the time of the inspection.

The service provided information on how to make a complaint when entering the service and this included information about the trust’s patient advice and liaison service who helped patients to resolve problems. Information was presented on a notice board in the waiting area that detailed how to make a complaint and where to seek support to do so. There was also information displayed informing people that a manager was always available to speak to if they had a concern.

Patients, parents and carers told us they would feel comfortable to make a complaint.

Staff told us that when complaints were made, the management team shared feedback which was displayed on a notice board for staff to see and these were also discussed as part of the weekly share to care meetings.
Is the service well led?

Leadership

The managers within the service were experienced and competent and had many years’ experience of working within the service. Managers were supported to develop their own skills with one completing a Master’s degree in professional practice. Staff told us the service managers leadership was compassionate, inclusive and effective and they were highly respected amongst the workforce.

The management demonstrated their passion and enthusiasm for the service and they demonstrated high levels of experience and capability of delivering excellent and sustainable care.

The staff we spoke to told us that the managers were visible and approachable. Staff told us they loved working in the service, that their roles were diverse and they had lots of opportunities to work in a creative way with young people. Staff were proud to work in the service and there was strong collaboration, team working and support across the teams with a focus on improving services and quality of care.

Vision and strategy

The trust’s vision of being recognised as providing safe, personal and effective care was embedded in the work being carried out within this service. Staff had a good understanding of the trust’s vision and values.

The values were embedded in the services multidisciplinary team meeting called share to care. This meeting had a focus around safe, personal and effective care and feedback and learning was shared in these meetings.

Culture

Managers were clear about the trust policies and guidance in relation to managing staff performance issues and followed these in practice.

The culture in the team was positive on inspection and staff told us they were happy in their roles. We observed a clinical team meeting and staff were organising a welcome sign for a new member of staff. Staff were keen to promote their roles and were attending a careers fair to promote mental health nursing. Staff also recently attended an event at Blackburn Cathedral and took cupcakes with pictures of brains on to promote mental health awareness. Staff had a real passion for the work they undertook.

Managers had an inspired shared purpose and strove to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff and a strong collaboration, teamwork and support structure was in place to focus on improving service quality and continuing to thrive.

There were processes in place to support the positive well-being of staff including the Trust provision of gym facilities, counselling service, mindfulness, yoga session and a cycle to work scheme.
There was a low level of complaints and a high level of satisfaction of the patients who used this service.

During the reporting period there was one case where a staff member was placed under supervision. No staff were moved to a different team or suspended.

<table>
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<th>Team name</th>
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<tr>
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<td>1</td>
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</table>

Managers were clear about the trust policies and guidance in relation to managing staff performance issues and followed these in practice.

**Governance**

A systematic approach was taken to work with other organisations to improve care outcomes and tackle health inequalities. This included a local partnership set up between the trust and Blackburn with Darwen Borough council to provide emotional health and support to the local authority.

Systems were in place to monitor staff mandatory training and annual appraisals. Compliance rates were 99% and 94% respectively.

Governance and performance management arrangements were proactively reviewed and reflected best practice. A full-time business intelligence role was in place to support this and information reported to management was analysed to ensure that key areas could be escalated to the appropriate level or fed back to the team to encourage learning.

Patients were assessed and treated in line with national guidance and outcomes were effectively monitored.

There was a clear framework to support the shared care team meetings that incorporated the trust values. Learning from incidents and complaints and sharing learning was embedded within these meetings.

Due to having a business intelligence role integrated into the team, managers had full access to data on the services performance, for example waiting times, mandatory training and outcomes from audits.

**Management of risk, issues and performance**

The trust provided their board assurance framework, which detailed any risk scoring 15 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. The four strategic ambitions outlined by the trust relating to this core service were as follows:

1. Put safety at the heart of everything we do
2. Invest in and develop our workforce
3. Work with key stakeholders to develop effective partnerships
4. Encourage innovation and pathway reform and deliver best practice
The trust provided a document detailing their 18 highest profile risks. Each of these had a current risk score of 15 or higher. None related directly to this core service.

The service had a team risk register. A risk register relates to potential risks to patients or staff. Managers informed us they could add to this register and this was fed into the trust overall risk register.

The service had plans in place and policies for emergencies such as adverse weather. Due to many clinics being available to work from and all staff having access to a laptop with 4G internet connection and mobile telephones, they could be flexible with appointments to ensure continuity of the service by offering telephone appointments where appropriate.

**Information management**

An electronic system was in place which had been introduced within the last 12 months. Some information was still held in paper format and these documents were kept in a secure location and were available to staff when they were needed.

There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making and improvement across the service.

Managers had access to information that supported them within their roles such as mandatory training rates and information on the performance of the service.

Staff made notifications to external agencies as needed and were confident in doing so.

**Engagement**

Patients and carers had the opportunity to give feedback on the service and were actively encouraged to do so. There were consistently high levels of constructive engagement with people who used the services.

Services were developed with the full participation of those who used them and the service proactively addressed challenges to meet the needs of the population. We were given an example of bi-lingual staff delivering parenting courses to the south Asian community as they were unable to participate due to the language barrier.

Members of the management team attended regular stakeholder engagement meetings. A children and young people's emotional health and well-being board was chaired by one of the local clinical commissioning groups which had representation from stakeholders including business intelligence, health education England, police, religious groups and the service was an active member.

The service was taking a leadership role to proactively address challenges and meet the needs of the population. The head of the service was the current vice chair of a clinical reference group that brought clinicians together to look at the clinical robustness of decisions made at the health and well-being board. This was attended by paediatricians, psychiatrists, accident and emergency practitioners and GPs.
There were consistently high levels of constructive engagement with staff, people who used the service and stakeholders.

The leaflet that detailed the service was designed by patients of the service and they were currently designing one around outcome measures.

**Learning, continuous improvement and innovation**

NHS trusts can participate in many accreditation schemes whereby the services they provide are reviewed and a decision is made if 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 to continue to be accredited.

The service had been accredited by the Quality Network for Community Child and Adolescent Mental Health Services. The service was currently one of seven CAMHS services in the country to be accredited with this.

The service was the Improving Access to Psychological Therapies lead for the Improving Access to Psychological Therapies partnership across East Lancashire and Blackburn with Darwen.

The service had joined up with the University of Central Lancashire to deliver a six-month rotation placement as part of their General Practitioners programme. This started six months ago and due to its success, the service had further placements allocated up until 2020. The service had developed close links with the university and participated in joined up research projects.

The service was recognised in the NHS benchmarking report as having good practice by having accreditation with the quality network for community child and adolescent mental health services, dedicated IT support, low sickness levels, expansion of the Assist self-harm group and a seven day a week responsive service.