CareQuality Commission

East Lancashire Hospitals NHS Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

East Lancashire Hospitals NHS Trust serves a population of 521,000. The trust has two acute sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community sites. There is noticeable deprivation in both Blackburn with Darwen and Burnley. Alcohol-related diseases and adult smoking are among the most prominent health concerns in both areas. Of the local population, 44% are non-white ethnic minorities and life expectancy is 10 years lower for men and seven years lower for women in the least deprived areas of both boroughs.

East Lancashire Hospitals NHS Trust was one of the 14 trusts reviewed as part of the Keogh Review in 2013 based on the trust having been an outlier for the previous two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). The review identified a number of concerns at the trust particularly related to the quality governance assurance systems. The review panel also identified a number of areas of good practice and dedicated staff, but there was more for the trust to do to communicate effectively to staff and share learning to ensure consistent approaches to quality improvement across the organisation, all of the time.

The trust was placed in special measures and CQC inspected the trust using the new comprehensive inspection model in July 2014. This resulted in the hospital overall being rated as Requires Improvement with improvement needed in urgent care; medical care; surgery and end of life care.

This inspection was a follow up and was conducted on 20 and 21 September 2016 and was a well-led review to follow up the focused inspection conducted on 19, 20 and 21 October 2015. We did not inspect the community sites and only reviewed four core services in October 2015 in order to review the progress of the trust since coming out of special measures in July 2014. We have aggregated the ratings following this inspection with the previous ratings for the services not inspected to give a revised rating for the trust. We also looked at the governance and risk management support for the services we inspected.

Our key findings regarding the trust's response to the last inspection report and current practice were as follows:

- The trust had a clear vision, objectives, values, operating principles and improvement priorities. These had been arrived at using a bottom up process and all staff we spoke with were engaged in the strategic direction of the trust, its vision, demonstrated the values and were dedicated to achieving the best care for patients.

- The hospital services were supported by strong governance processes' including well managed risk registers feeding in to the board, ensuring a robust overview of the risks within the hospital. However, there was ongoing work to enhance the Board Assurance Framework and risk management in the trust, where we found areas that required improvement. Staff demonstrated their involvement in the solutions to the risks identified which had developed staff ownership of risk and solution and was enhancing achievement.

- The trust's 'Harm free care' strategy, had improved the way they dealt with and learnt from incidents. The strategy included actions such as completing rapid reviews of serious incidents, referral to a panel for discussion and sharing outcomes in senior meetings. We saw evidence of learning and change to practice from incidents and how this learning was shared across the service and trust wide.

- The Emergency Department/Urgent Care Centre had introduced a number of quality innovations that have improved patient experience, patient care, patient safety and patient outcomes. Some of the initiatives that had been introduced included the introduction of a Mental Health Triage Tool and Observation Policy; Rapid Assessment review; Introduction of a Sepsis Nurse Lead; Creation of a Dementia friendly environment and review and development of the Paediatric Emergency Department.

- Following the results of an audit in 2014, improvements were required to improve the care of patients with sepsis. Following the improvements,

Summary of findings

the emergency department (ED) was now the second best provider regionally for the treatment of neutropenic sepsis, with 80% of patients receiving antibiotics within the hour.

- The hospital had consistently achieved better than the England average in respect of the 18 weeks target from referral to treatment. Surgical procedures were sometimes cancelled at short notice but systems were in place to ensure patients were rescheduled within 28 days of the cancellation.

- Nurse staffing in ED, medical and surgical departments had improved since the last inspection. Although there was a reliance on agency staff; nurses had been recruited but they were not yet in post.

- The trust employed an Intensive Home Care Team who provided support to the ED and facilitated early discharges of patients from hospital. Established links with local GPs who provided medical support, if required, were available.

- Cleanliness and hygiene throughout the trust was of a high standard.

- There was a full bereavement service available at the hospital which was well received by users although it was noted not to be as well utilised by the ethnic minority groups. Work was underway with the local religious leaders to review this.

- Staff were caring, kind and respectful to patients and involved them in their own care. Improvements had been made in the monitoring of patients to identify if their condition was deteriorating which included revised systems for obtaining prompt medical assistance.

- Staff were proud of the work they did; they worked well together and supported each other when the services were under pressure. The trust ranked in the top 100 places to work in the NHS in an external health journal. Staff and patients told us they felt well engaged with and their views were valued.

- Staff explained that the last few years had been difficult but the stability of the current board and executive team contributed greatly to the culture of continuous improvement.

- Leadership across the departments 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.

However,

- The risk management strategy was last approved in August 2016 included the risk management roles, responsibilities and processes. However, it did not clearly articulate where the trust saw its risk management processes at the beginning of the strategy and where it aimed to be at the end.

- The risk descriptions on the Board Assurance Framework (BAF) were poor, describing only the condition with no detail on the cause of the risk or consequences. As a result of this, some actions were broad with no leads or timescales. Controls, assurances and gaps in both were comprehensively described within the framework.

- The WRES data showed that black and ethnic minority staff (BME) were employed in higher proportions in lower pay bands (1 to 4) within the trust. BME staff were highly underrepresented in senior management roles.

- The risks associated with the use of a separate prescribing document for medicines delivered via a pump were raised with the trust at the time of the inspection. They took immediate action to address our concerns.

- The emergency department continued to find the four hour wait target challenging. Over the winter months last year there were 1644 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.

- There was no designated area for patients not requiring an overnight stay, but who needed to undergo a period of observation or await test results. These areas can 'contribute to patient safety, are highly efficient in terms of providing short term and ambulatory care, reduce admissions, and have been shown to improve crowding. Currently, staff admitted these patients to the Acute Medical Unit (AMU) which the trust had doubled in number of beds from 40 to 80 to improve flow out of the ED.

Summary of findings

- The audit of assessment of mental health patients in the ED (2014/15) showed there remained room for improvement particularly in the assessment and recording of a patient's mental state which was only assessed and recorded in 30% of cases. The ED worked closely with a neighbouring trust in providing care for patients with mental health needs which was provided in a timely way 24 hours a day, seven days a week when required.

- Medical staff recruitment in some areas remained a challenge; the ED department relied on locum staff to fill gaps, actions were being taken to develop doctors internally to reduce the need to recruit from outside the trust.

- The results from data collected as part of national audits into the outcomes for patients with some clinical conditions showed the hospital was performing worse than the National average. Work was ongoing to improve these outcomes however this was not completed at the time of the inspection.

- The training and development of staff was below the trust's target for nurses within the medical services.

- Despite the duty of candour processes being in place, there were occasions where the 10-day timescale was not met by the trust.

- Within the root cause analysis investigations that were reviewed we observed that a one-line summary of the incident was recorded as opposed to a true root cause.

- A number of wards fell below 80% fill rate for registered nurses. However, the wards were sufficiently staffed during the night. Staffing throughout the medical and surgical services, together with the neonatal intensive care unit services had been identified as an issue for the trust and actions had been implemented to manage the risk.

- Within the root cause analysis investigations that were reviewed we observed that a one-line summary of the incident was recorded as opposed to a true root cause.

We saw several areas of outstanding practice including:

- Several examples of innovation across the surgical division, including robotic surgery, theatre open days to break down barriers between community and operating theatres and the use of social media.

- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.

- A band 3 member of staff from theatres ran a painting competition for children and young people who had learning difficulties and medical conditions. The resulting art work was displayed in the patients' waiting area. This innovation was looking at working closely with these young people and easing their anxiety about undergoing surgery.

- Each ward and theatre area held weekly staff meetings called 'Feedback Fridays.' These meetings were a two way process and covered all significant governance issues pertinent for their area, including lessons learned from incidents and complaints, the risk register for their individual areas and feedback from matron and governance meetings.

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

Importantly, the trust must:

- The trust must review the duty of candour implementation and adhere to the 10-day timescale for all incidents.

Additionally, the trust should:

- The trust should continue to work towards reducing the time taken to investigate and close a complaint to ensure they meet the trust target.

- Root cause analysis reviews should contain a true root cause of the incident as opposed to a one-line summary.

- The 10-day timescale for duty of candour processes should be adhered to.

Summary of findings

- Fill rates for registered nurse staffing should not fall below the recommended staffing requirements. The trust should continue to prioritise the recruitment and retention of nursing staff.

- Continue to review the Board Assurance Framework (BAF) to ensure it is more robust and fully reflects the supporting information behind each strategic risk, including action plans with timescales for completion.

- Review the work force equality standards data for the trust and continue to implement the action plan for improvements within this area.

Address the shoulds and musts for the locations

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to East Lancashire Hospitals NHS Trust

East Lancashire Hospitals NHS Trust was one of the 14 trusts reviewed as part of the Keogh Review in 2013 based on the trust having been an outlier for the previous two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR).

The review identified a number of concerns at the Trust particularly related to the quality governance assurance systems. The review panel also identified a number of areas of good practice and dedicated staff, but there was more for the Trust to do to communicate effectively to staff and share learning to ensure consistent approaches to quality improvement across the organisation, all of the time.

The trust was placed in special measures and CQC inspected the trust using the new comprehensive inspection model in July 2014. This resulted in the hospital overall being rated as Requires Improvement with improvement needed in urgent care; medical care; surgery and end of life care.

A follow up inspection was conducted on 19, 20 and 21 October 2015 with good progress being demonstrated and both the Royal Blackburn and Burnley General hospitals being rated as good overall. However as the trust level review was not conducted at that time this could not be reflected in the trust's overall rating. Therefore it was agreed that a trust level review would be undertaken. This was conducted on 20 and 21 September 2016.

Our inspection team

Our inspection team was led by:

Inspection Managers: Nicola Kemp and Lorraine Bolam, Care Quality Commission

The team included two CQC inspectors, an assistant inspector and a governance specialist.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well led?

Before visiting, we reviewed a range of information we held as well as up dated information provided by the trust. We carried out an announced inspection visit of the trust on 20 and 21 September 2016. We conducted interviews with the executive team members and non-executive members and reviewed policies, governance and risk management processes and tested those processes.

What people who use the trust's services say

The trust had a poor performance in the 2014/15 Cancer Patient Experience Survey (CPES) with 17 of the 34

measures scoring in the bottom 20% of trusts. Several of these indicators were related to staff communication with patients and providing adequate and understandable information.

Summary of findings

The 2016 patient-led assessments of the care environment (PLACE) scores for the trust were similar to the England average and all had improved since 2015. Scores for food showed the greatest improvement, from 75% to 82% in 2016, but were also the area with the greatest difference to the England average, which scored 88% for both 2015 and 2016.

Between August 2015 and July 2016, the trust had a consistently better NHS Friends and Family Test recommendation rate than the England average. Response rates for the trust were also better than the England average for the entirety of the time period.

Facts and data about this trust

East Lancashire Hospitals NHS Trust serves a population of 521,000. The trust has two acute sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community sites. There is noticeable deprivation in both Blackburn with Darwen and Burnley. Alcohol-related diseases and adult smoking are among the most prominent health concerns in both areas. Of the local population, 44% are non-white ethnic minorities and life expectancy is 10 years lower for men and seven years lower for women in the least deprived areas of both boroughs.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Good** 🟢

Are services at this trust safe?

Summary

We rated the trust as 'Good' overall for safe. This was because;

- The trust had processes in place for monitoring compliance against the duty of candour regulatory requirements.
- Safeguarding children training uptake was at 88%, which was better than the trust target of 85%.
- The trust's incident reporting ratio was better than the average for all acute trusts.
- We reviewed three investigation reports for never events. All of the reports demonstrated the use of root cause analysis techniques with a comprehensive timeline, identification of care and service delivery factors, contributory factors, good practice, conclusion, root cause and recommendations. All of the reports were accompanied by an action plan with evidence required for completion and timescales clearly stated.

- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection.
- Rates of Meticillin-resistant Staphylococcus aureus (MRSA) were generally better than the England average with the exception of December 2015 when one case was reported.

However:

- Despite the duty of candour processes being in place, there were occasions where the 10-day timescale was not met by the trust.
- Within the root cause analysis investigations that were reviewed we observed that a one-line summary of the incident was recorded as opposed to a true root cause.

- A number of wards fell below 80% fill rate for registered nurses. However, the wards were sufficiently staffed during the night. Staffing throughout the medical and surgical services, together with the neonatal intensive care unit services had been identified as an issue for the trust and actions had been implemented to manage the risk.

Duty of Candour

- The trust had processes in place for monitoring compliance against the duty of candour regulatory requirements. 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.

- A daily update report was provided to the Medical Director on incidents where moderate harm or above had been caused to a patient, along with the status on duty of candour. In addition to this, weekly meetings were held with the divisional governance leads.

- However, despite the processes being in place, there were still occasions where the 10-day timescale was not met by the trust. In the July 2016 Serious Incident Report, it was reported that two out of 39 incidents where duty of candour applied had not met the 10-day timeframe. There was no explanation within the report for why this had not been met and whether the duty of candour progress had still been initiated. The report also identified that this was an improvement from the previous report. The Medical Director identified this delay was often due to difficulty in determining an appropriate clinician to have the initial discussion with the patient or their family, for example where there was a multidisciplinary team involved in the care.

- We requested evidence to demonstrate compliance with the duty of candour requirements. The trust provided us with a 'duty of candour day six report'. This spreadsheet recorded if apologies or explanations had been given to the patient, letters sent and if the letters had been uploaded to the risk management system. We reviewed some letters that were sent out apologising to patients and informing them of the trust's investigation into their care.

Safeguarding

- Policies and procedures were accessible to staff on the trust intranet for safeguarding vulnerable adults and children. There was a safeguarding strategy in place

- There was a Head of Safeguarding in post and staff we spoke with knew how to access the safeguarding service for advice and information.

- The trust had commissioned at independent review of its safeguarding arrangements during 2015 to ensure they were fulfilling their statutory safeguarding duties. The review led to the trust securing additional resources and an expansion and restructure of the safeguarding team.

Summary of findings

- Staff received training in safeguarding children and vulnerable adults. Mandatory training included the following: safeguarding vulnerable adults, safeguarding children, the Mental Capacity Act 2005 and Deprivation of Liberties safeguards.
- The trust had a safeguarding team who worked Monday to Friday 9am and 5pm. An emergency duty team was accessible to staff outside of these hours. A safeguarding nurse worked within the paediatric ED team to ensure links between these teams.
- The paediatric team had links with social services, for referring concerns or seeking advice. Staff we spoke with knew how to identify suspected abuse and confirmed they were familiar with the referral process to social services if they had concerns that an adult or child was at risk of abuse.
- There were approximately 150 safeguarding champions throughout the trust. They supported staff and patients through the safeguarding system and since their development the number of alerts had increased.
- The trust had revised the safeguarding children face to face training courses at levels one, two and three to ensure they were more interactive. This was in response to participant feedback. The training compliance figures were monitored at monthly nursing and midwifery forums, within divisional performance meetings and at quarterly internal safeguarding boards.
- Safeguarding children training uptake was at 88%, which was better than the trust target of 85%.

Incidents

- The trust's incident reporting ratio was 44.18 incidents per 1000 bed days, which was better than the average for all acute trusts. The percentage of 'no harm' incidents reported at the trust was significantly better than the average for all acute trusts at 90.4% compared to 75.1% whilst the proportion of incidents resulting in severe harm or death was in line with national averages. However, there could be delays at the trust in uploading the incidents to the National Reporting and Learning System (NRLS), with a median of 108 days in the last published data, compared to a median of 37 for all acute trusts.
- There had been five reported never events between July 2015 and June 2016, with one determined as not being a never event following investigation. Two of these related to retained swabs, two wrong site and one misplaced naso-gastric tube. The board were informed of the actions taken in response to the investigation findings from the never events and subsequent audit results to check compliance and outcomes against these

actions. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

- The Medical Director told us the investigation process for never events changed in the trust for the last never event. This was to improve the timeliness of the investigation and include the wider team in reviewing the timeline and undertaking the root cause analysis. This panel meeting was undertaken within 14 days of the incident and included all the staff in theatre who had been involved in the incident. We were told this was a really positive meeting with the lead consultant openly reflecting on what he could have done differently. The meeting resulted in immediate learning and actions being disseminated across all theatres in the trust within 14 days before the investigation report was formally completed. We were told this would be the process adopted for any future never events that occurred.

- We reviewed three investigation reports for the never events. All of the reports demonstrated the use of root cause analysis techniques with a comprehensive timeline, identification of care and service delivery factors, contributory factors, good practice, conclusion, root cause and recommendations. However, the root cause recorded was often a one-line summary of the incident as opposed to a true root cause. For example, failure to follow policy was recorded as the root cause as opposed to human factors. All of the reports were accompanied by an action plan with evidence required for completion and timescales clearly stated.

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.

- Safety Thermometer information for the trust showed that between August 2015 and August 2016, there were seven pressure ulcers, 21 falls with harm and 16 Catheter urinary tract infections. The trust did not submit any safety thermometer data in October 2015.

Staffing

- The trust used recognised and validated tools to determine the required levels of nursing staff.
- We reviewed staffing data between April 2016 and August 2016 and found there were areas that were not staffed with sufficient

Summary of findings

numbers of suitably qualified nurses during the day. A number of wards fell below 80% fill rate for registered nurses. However, the wards were sufficiently staffed during the night. Staffing throughout the medical and surgical services, together with the neonatal intensive care unit services had been identified as an issue for the trust.

- Any shortfalls in nurse staffing were generally filled with overtime, bank or agency staff.
- At the time of our inspection, we found some areas were still experiencing issues with capacity and ability to manage the wards with the correct staff mix. There were 221 nurse vacancies across the trust. However, there was a comprehensive recruitment programme in place to fill the vacancies within the services. Additionally, daily meetings to discuss staffing levels were held to ensure there was a good allocation of staff on the wards.
- The trust had introduced a red flag system with criteria for staff to raise issues, such as ward staffing.
- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection. However, there were still 38 medical vacancies across the trust.
- There were generally low levels of locum use, with substantive staff preferring to work additional hours to fill any gaps in rotas.
- The medical staffing skill mix was sufficient when compared with the England average. Consultants made up 37% of the medical workforce at the trust which was similar to the England average of 42%. There were slightly less registrar group doctors who made up 33% of the medical workforce compared with the England average of 36%. Of the medical workforce, 20% were made up of junior doctors, which was higher than the England average of 14%.

Cleanliness, infection control and hygiene

- Rates of Methicillin-resistant Staphylococcus aureus (MRSA) were generally better than the England average with the exception of December 2015 when one case was reported.
- Clostridium difficile (C.diff) prevalence rates were also better than the England average for the majority of the time period, August 2015 to July 2016. However, rates had been increasing since April 2016 and the trust was subsequently worse than the England average.
- Rates of Methicillin-susceptible staphylococcus aureus (MSSA) had improved over the same time period, fluctuating around the England average from October 2015 and being below the average in July 2016.

Summary of findings

Are services at this trust effective?   **Good** ●

Summary

We rated the trust as 'Good' overall for effective. This was because;

- Care and treatment was underpinned by policies and procedures, which were evidenced based.
- Assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- There was effective use of clinical audit to monitor and improve performance. Where audits highlighted areas for improvement the trust developed, implemented and monitored robust action plans to secure improvement.
- Mortality and morbidity reviews were held monthly. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence.
- Good multidisciplinary working was evident in all areas visited.
- Monthly multidisciplinary governance and quality meetings were held led by the clinical lead for each speciality, referred to as 'share to care' meetings.
- The trust had a clear transformational plan, working with internal and external partners, to improve outcomes for patients. There were set objectives and goals identified.
- Staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS) and when and how an application should be made. DoLS are part of the Mental Capacity Act (2005). They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity.

However:

- The readmission rates for emergency readmissions within 28 days of discharge were worse than the national average for paediatric readmissions. There was an action plan in place to address this
- There was a lack of physiotherapy in some wards and departments. Some patients and staff were concerned that the reduction in physiotherapy provision had a negative effect on the rehabilitation of patients and increased their length of stay.

Summary of findings

- In the Rakehead unit the self-contained residential area allocated for the use of patients who had completed their treatment was awaiting refurbishment and had been out of use for six months. This meant patients were not getting the opportunity to be supported in their independence.

Evidence based care and treatment

- Care and treatment was underpinned by policies and procedures, which were evidenced based.
- Assessment tools, care bundles and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Clinical pathways were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards.
- Patient outcomes were, in the main, in line with or better than the England average.
- There was effective use of clinical audit to monitor and improve performance. Where audits highlighted areas for improvement the trust developed, implemented and monitored robust action plans to secure improvement.
- Enhanced recovery pathways were used in a number of surgical specialities, such as colorectal and breast surgery. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery. The trust's strategic plan 2014-2019 included objectives to implement enhanced recovery pathways across further surgical procedures
- Standard Operating Procedures such as procedures for particular staff to come and care for patients with mental health needs were in place.
- Local audits were undertaken on a monthly basis. These included use of the child risk assessment tool, the modified early warning score (MEWS) system and the aseptic non touch technique.

Patient outcomes

- Mortality and morbidity reviews were held monthly in services. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence. The trust mortality steering group also met on a monthly basis and had oversight of these reviews to ensure these were robust and identify improvement plans.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and

Summary of findings

transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of one would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. In June 2016, the trust's score was within the expected range.

- The trust had a clear transformational plan, working with internal and external partners, to improve outcomes for patients. There were set objectives and goals identified. For example, emergency care pathways, community service development and stroke service development. Regular updates were discussed at trust board meetings.

- Patient reported outcomes measures (PROMs) data between April 2015 and March 2016 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was were better than the England average. The proportion of patients with worsening outcomes was also lower than the England average.

- The readmission rates for emergency readmissions within 28 days of discharge were similar to the national average. However were worse than the national average for paediatric readmissions. The trust believed this was due to the trust's 'open door policy' for this age group. There was an action plan in place to address this.

- There was a lack of physiotherapy in some wards and departments. There were eighteen hours provided on the wards and each patient in the Rakehead rehabilitation unit received physiotherapy a maximum of three times per week. Some patients and staff were concerned that the reduction in physiotherapy provision had a negative effect on the rehabilitation of patients and increased their length of stay.

- In the Rakehead unit there was a self-contained residential area allocated for the use of patients who had completed their treatment and were having rehabilitation to return home. This was awaiting refurbishment and had been out of use for six months. This meant patients were not getting the opportunity to be supported in their independence as part of their rehabilitation before they returned home.

Summary of findings

- In the hip fracture audit 2014 the trust scored better than the England average for nine of the 10 indicators. However, the hip fracture audit data showed the hospital was worse than the England average for the mean total length of stay. We were told that this was directly related to the fact that community rehabilitation facilities sit within the trust.
- In the bowel cancer audit the trust was worse than the England average for patients being seen by a clinical nurse specialist and also for discussion at a multidisciplinary team meeting. However the lung cancer audit results for 2014 showed that the trust was preforming better than the England average with 99% of patients receiving computerised tomography (CT) scan before bronchoscopy compared to 91% nationally.
- The rate of readmission following surgery was worse than the England average. The higher areas for risk of readmission were both urology and vascular surgery which were both worse than the England average for elective admissions.

Multidisciplinary working

- Multidisciplinary teamwork was very well established including work undertaken with local communities and the local authority. Team working focused on the securing good outcomes for patients.
- Monthly multidisciplinary governance and quality meetings were held led by the clinical lead for each speciality, referred to as 'share to care' meetings.
- Discharge letters were sent electronically to the patient's GP and district nurse, if appropriate, following discharge home. We reviewed a selection of discharge letters; we found there were a number of abbreviations which potentially would not be understood by the district nursing team.
- There were good links and inter-trust working with other neighbouring trusts. Examples of good inter-trust working were given across vascular surgery, paediatrics and the hepato-pancreatic-biliary service. Consultant surgeons told us they had a good history of working together with other trusts across Lancashire and worked within the Lancashire and South Cumbria network.
- Within end of life care, there were two multi-disciplinary team meetings (MDT) every week. All new patients were discussed at these meetings. Advice to other healthcare professionals on palliative care was provided to improve the quality of the care for patients. The meetings were used to co-ordinate the patient's pathway and to signpost to other staff or teams as appropriate. They were also used to provide information to patients and carers.

Summary of findings

- Blackburn emergency department (ED) and Burnley urgent care centre staff worked in partnership to ensure patients received care at the correct location. Patients requiring emergency care were transferred from Burnley urgent care centre to Blackburn ED. The local ambulance service NHS trust provided the resource for transfers but staff were managed by the trust. Between July and October 2015 the ambulance transferred between two and 11 patients daily.
- The ED had links with the local ambulance service who would assist with ambulance admissions, attend bed management meetings to assist managing patient flow into the department.
- The Intensive Home Care Team worked with a range of disciplines to provide care for patients being discharged from hospital. These included; physiotherapists and occupational therapists, dieticians, podiatrists and social services.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS) and when and how an application should be made. They reported good support from the safeguarding team and the trust lead for mental capacity and DoLS which included support resources and training materials on the wards.
- Staff had received training in the Mental Capacity Act as part of their induction.
- There was a mental capacity act and Deprivation of Liberty safeguards lead who worked full time in the trust.

Are services at this trust caring?
Summary

Good ●

We rated the trust as good for being caring. This was because:

- Patients were complimentary about the staff describing them as helpful, caring and kind. On the wards patients told us their call bells were answered promptly.
- The results of the NHS Friends and Family test were consistently high for patients who would recommend the hospital.
- Patients had access to various means of emotional support and were given the information they required both verbally and in writing.
- All staff we observed were caring, professional and friendly. Patients were involved in their care and treatment and

encouraged to ask questions. We saw patients were supported emotionally before, during and immediately after their procedure. Patients were positive about the way staff had cared for them.

- Visiting time was open on the ward to enable family members to take an active part in supporting their relatives and multi-faith facilities were available for patients and those close to them.

However;

- However in Rakehead rehabilitation centre, call bells rang for long periods of time without being answered and we observed one example of undignified practice in that unit which was brought to the attention of the trust.

Compassionate care

- The NHS Friends and Family test conducted between February 2014 and February 2015 showed the percentage of patients that would recommend the hospital to friends and family ranged between 75% and 100%. The response rates (59%) were significantly higher than the England average (37%) indicating the scores were more likely to be representative of the opinions of the patients receiving care at the trust.
- We observed many examples of compassionate care given to patients and those close to them based on individual needs. Staff provided reassurance and comfort to parents who were anxious or worried.
- We observed on a ward handover that patients were referred to as bed numbers rather than their name, to protect their identity. The ward manager explained that this was for confidentiality reasons as the handover was completed at the nurse's station where there were single rooms in close proximity.
- The trust had a bereavement care service that included the bereavement co-ordinator, the bereavement centre and the chaplaincy. This was managed by the Deputy Chief Nurse. The service had undertaken a bereavement survey, which showed, in the period July to October 2015, the service had given out 178 surveys, of these 70% were returned.

Understanding and involvement of patients and those close to them

- The individual plan of care and support for the dying person in the last days and hours of life (IPC) contained a section about the needs of carers and their understanding of the diagnosis.

Summary of findings

Carers were asked if they wanted to participate in the care of their relative so that staff could facilitate this. Concerns and fears of carers were recorded and also their own religious and spiritual needs. This was reviewed on a daily basis.

- We saw documented discussions of updates in their care and treatment with patients and their families.
- In the 2014 CQC patient survey, the trust scored seven out of ten for people feeling they were as involved as they wanted to be in decisions about their care in the ED.
- In the ED, We saw staff talking to relatives and building a rapport with them by explaining the care and treatment being given to loved ones. Relatives told us they were very satisfied with the care received.
- In Medicine, patients said they could ask any questions from the doctors and they clearly explained their care and treatment to them. One patient told us the doctor had explained in detail what was happening and why they needed the tests which had been done.
- Should patients wish to speak to a doctor they said their request was quickly responded to.
- Patients understood what was happening around their discharge from hospital or why they needed to remain in hospital.
- Patients we spoke with said they had received good information about their condition and treatment. They had also received sufficient information prior to, as well as after surgery.
- Visiting time was open on the ward to enable family members to take an active part in supporting their relatives.
- Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.

Emotional support

- Referrals were made to specialists who could provide additional emotional and social support for patients such as the drug and alcohol misuse nurses.
- Psychiatric nurses were available 24 hours per day through the mental health liaison team. They offered support and advice for patients with mental health needs.
- Nurse specialists provided specific support for patients, for example the stoma nurses following colorectal surgery resulting in a colostomy.
- Patients told us the nursing staff would answer call bells promptly, and provided good support during their stay on the ward.

Summary of findings

- The staff on the wards referred to the specialist palliative care team (SPCT) for psychological support for patients. They said that the palliative care consultants were good at speaking to patients and families.
- Wards had quiet areas available for relatives.
- The bereavement centre had information on counselling services, organ and tissue donation. A booklet called care after death was given to relatives about registration of death. Ward staff said they gave the booklet to relatives and were fully aware of bereavement services. 97% of relatives who filled in the bereavement survey said that they found the booklet easy to understand.
- There was religious and spiritual support from the chaplaincy who visited the wards frequently. Staff were aware of how to access different faith groups.
- There was bereavement support at the local hospice. This could be accessed by anybody living in the catchment area of the hospice.

Are services at this trust responsive?
Summary

We rated the trust as 'requires improvement' for being responsive. This was because:

- There was draft guidance for all nurses if a patient died out of hours and there was the need for an urgent funeral service. We were not told when this would be approved.
- Treatment was usually provided in a timely way however the trust struggled to maintain targets for the percentage of patients being discharged, admitted or transferred within four hours of arrival in the emergency department. Between July 2014 and August 2015 an average of 89% of patients were admitted, transferred or discharged within four hours.
- Between November 2014 and March 2015, there were 2134 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.

However:

- The trust had a well-developed approach to strategic planning. Services were planned to meet the needs of the local population and included national initiatives and priorities.
- Matrons held meetings twice daily to look at bed management and staffing for the day and night shifts. This ensured that the movement and flow of patients was closely monitored.

Requires improvement ●

Summary of findings

- We saw evidence that learning took place from complaints and this was shared with staff at regular meetings.
- Between November 2014 and March 2015, there were 2134 occasions when ambulance handovers took longer than 30 minutes. The department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.

Service planning and delivery to meet the needs of local people

- The trust had well developed approach to strategic planning. Services were planned to meet the needs of the local population and included national initiatives and priorities.
- The surgical triage unit had a 'hot clinic' where patients were referred to from a number of routes, including their GPs, the emergency department and specialist nurses. This unit was well utilised and well-staffed.
- There was a trauma team within the hospital who coordinated the care of patients admitted following a trauma. The team arranged beds, investigations, outpatient appointments, scans and theatres for patients as well as managing the orthopaedic outliers (orthopaedic patients that were not nursed on an orthopaedic ward due to bedding shortages). This ensured the service could better manage patients at busy times.
- Matrons held meetings twice daily to look at bed management and staffing for the day and night shifts. This ensured that the movement and flow of patients was closely monitored.
- The trust was not collecting data about the numbers of patients dying in their preferred location or patients discharged within 24 hours of death. The electronic palliative care co-ordination system (EPaCC's) would collect this data when the system was implemented in December 2015.
- There was a triage system for the assessment of patients by the specialist palliative care team (SPCT). Information about the patient would be faxed to the SPCT office. Urgent referrals would be seen within the working day, moderate referrals by the end of the next working day and non-urgent within two working days. This was audited and in the period May to July 2015 there was 100% compliance with these response times. If the patient could not be seen, telephone advice was offered.
- There was a rapid transfer discharge pathway for the dying patient in the last few hours and days of life which had a multi-disciplinary approach. This was to support the rapid, safe transfer of care to home or a care home dependent on the patient's choice. There was a tool to facilitate this; both the

pathway and the tool were being reviewed by the trust due to changes in national and local end of life care. The SPCT recognised that the pathway had trust wide educational requirements that the review would address There was a rapid transfer ambulance arrangement with a dedicated phone number that allowed a two hour response to transfer a patient in the last days of life.

- There was draft guidance for all nurses if a patient died out of hours and there was the need for an urgent funeral service. We were not told when this would be approved.

- There was good liaison between the cold store and the mortuary at the Royal Blackburn Hospital and transport was arranged if necessary to move patients between the sites. There were no bariatric storage facilities at Burnley hospital and so all bariatric patients were taken to the Royal Blackburn hospital.

- The chapel at Burnley hospital had stained glass and a number of statues and faith icons. In the prayer room religious texts were available. The female side of the prayer room appeared unclean and the washing facilities available were part of the toilet area.

- There was a lower uptake of end of life services from the local ethnic populations than the white British population. The clinical director was aware of this and action was planned to understand the reasons for this.

Meeting people's individual needs

- The consultants conducted home visits for patients with complex needs and applications for continuing health care were fast tracked when the patient was in the last year of life.

- Staff knew how to access interpreters for face to face contact and language line. Due to the diversity of staff in the trust many different languages were spoken, staff were used as interpreters if necessary and where appropriate. Staff could also access British Sign Language services for patients who were deaf or hard of hearing. Very few information leaflets that we saw were available in any other languages than English.

- There was a specialist nurse for patients with a nurse for patients with a learning disability and autism. Patients were flagged on the electronic patient system so the nurse was aware that they were in the hospital. They would try to visit them and was available to provide information and support to the ward staff. If a patient was a planned admission staff would work with the patient and their carers before the admission.

- There was a room in the emergency department (ED) designed to keep mental health patients safe. The room had windows which allowed monitoring to take place, fixed furniture and no

ligature points. In addition there were two exits to maintain the safety of staff. Staff agreed that although the room was fit for purpose in terms of safety it was stark, with no pictures on the walls and poor acoustics.

- The trust had a shared protocol with the local mental health NHS trust in order to provide care for patients requiring a mental health assessment. The protocol focused on the benefits of shared working for patients which included ensuring they were seen and assessed in a timely manner. It also covered training requirements and flow charts.
- The trust used a bedside alert system to notify staff of patients who had additional needs or where risks had been identified. This included patients that were at increased risk of falls, pressure ulcers, or venous thromboembolism (VTE). It also included patients that required assistance at meal times. Staff were familiar with this system.
- Computer software was available on each ward area that enabled staff to translate information into any language and print out for the patient. This ensured that information was readily available in any language.
- Theatre staff actively engaged patients with learning difficulties who were due to have an operation. The theatre ran open days where patients were invited to visit the theatres and take part in interactive sessions, such as role play key hole surgery and hand hygiene techniques. This was to relieve anxiety in these patients.
- The NHS Friends and Family test had been adapted for people living with a learning difficulty, which included pictures to make it easier to understand and complete.

Dementia

- The ED had areas designed to meet the needs of patients living with dementia. This included a triage room which had coloured walls and images of the sky showing on ceiling tiles to enhance perception. Two dementia 'champions' were employed who had specialist knowledge of dementia and could assist colleagues if required.
- Within the ED, there were a range of lead nurses to ensure patients with dementia and safeguarding needs were properly supported whilst visiting the department.
- The hospital had a dedicated dementia team to ensure the needs of dementia patients were met whilst they were using hospital services. The trust had a scheme in place for dementia patients called the butterfly scheme, where a blue butterfly is used to let staff know that the patient may require additional help because of dementia.

Summary of findings

- Wards B22 and B24 had higher levels of patients who suffered with dementia. These wards provided one to one nursing care when required and also maintained a one to four nursing bay. This was to minimise the risk of patient falls and also to reduce anxiety. Activity boxes were used in these areas that included memorabilia and historic objects to engage the patients in activities.
- The trust patient led assessment of the care environment (PLACE) showed an increased score for being dementia friendly in 2015/16 which was better than the national average.

Access and flow

- The development of the acute medical unit had increased the number of beds from 42 to 82 for patients admitted for medical assessment. These were provided on two separate units. The purpose of this unit was to reduce the number of unnecessary admissions to the medical wards by patients being treated and discharged directly from this unit. Patients could be admitted to this unit from the emergency department or directly from their GP or outpatient clinics.
- The average length of stay on the medical wards was approximately two days shorter (better) than the average for all elective and similar to the average for all non-electives.
- The department of health target for urgent care centres is to admit, transfer or discharge patients within four hours of arrival. The matron informed us that breaches rarely occurred in the urgent care centre. This was supported by figures which showed that 99% of patients in July 2015 and 98% in August 2015 were admitted transferred or discharged within four hours.
- The urgent care centre met the department of health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.
- The department of health target to commence initial assessment of patients within 15 minutes was also met in July 2015 (on average six minutes) and August 2015 (on average seven minutes).
- The trust had met the 18 week target for referral to treatment for patients and was better than the England average between 1st April 2015 and 31st March 2016.
- The average length of stay for elective and non-elective surgery was similar or better than the England average.
- Bed occupancy across the surgical division ranged between 80.5% and 86.9% for the 12 month period prior to the

inspection. The National Audit Office advises that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care acquired infections.

- Between November 2014 and March 2015 there were 2134 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.
- The department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.

Learning from complaints and concerns

- Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. Where possible complaints were dealt with at the time they occurred. The trust had introduced a scheme whereby senior staff were bleeped to attend to people wishing to make a complaint. This enabled them to deal with the matter at the time if possible.
- Complaints and compliments were shared in weekly 'share to care' meetings. The meetings were attended by a range of staff, ensuring awareness of developing trends.
- The trust had set a threshold for complaints at 0.4 per 1000 contacts. The actual ratio had continuously been significantly less than this, in line with the trust's aims. The trust had a customer service team, which combined the patient advisory liaison service (PALS) and complaints. This team reviewed all patient experience mechanisms, including compliments, to identify good practice to share along with areas for improvement. The ethos at the trust was to try to address concerns as they arose. For example, if an inpatient had any concerns they were encouraged to raise this with the ward teams and/or PALS. There was a bleep link to the PALS team to facilitate this support in a timely way.
- A weekly panel meeting was held to review all new complaints, which the Director of Nursing attended. Complaints were used to inform improvement work. At the time of the inspection, the trust was targeting end of life care, highlighting complaints in this area and sharing any learning from this. Complaints were selected at random to review if practice could have been improved; a Non-Executive Director was involved in this review. The Patient Experience Group Report presented in August 2016 detailed that 48 complaints were between 26 and 50 days overdue against the trust target of 25 days, 11 were between zero and 11 days overdue and no complaints were overdue by

50 or more days. The same report demonstrated that the average number of days taken to close a complaint was around 80. The trust was aiming to reduce this to 40 days going forward.

- Face to face meetings were routinely offered as part of the complaints process. Trends were also monitored via the weekly meeting. We were told that this monitoring had highlighted that complaints around 'staff attitude' had significantly reduced.

Are services at this trust well-led?   **Good** ●

Summary

We rated the trust as 'good' for being well-led. This was because:

- The trust had a vision and strategy with clear aims and objectives. The trust vision was to be widely recognised as a provider of safe, personal and effective care. We saw this was very evident within practice in the divisions.
- The trust was proactive in addressing whistleblowing concerns raised.
- The staff Friends and Family test was sent out to all members of staff in the trust. There was an upward trend of the number of staff who would recommend the trust as a place to work to their friends or family.
- The Board Assurance Framework (BAF) had six strategic risks which were aligned to the organisation's strategic objectives. It included initial, current and tolerance risk scores for each risk, demonstrating that the board had considered it's tolerance for each risk and knew where it would likely be by the end of the financial year.

However:

- The risk descriptions on the Board Assurance Framework (BAF) were poor, describing only the condition with no detail on the cause of the risk or consequences. As a result of this, actions were broad with no leads or timescales. Controls, assurances and gaps in both were comprehensively described within the framework.
- The WRES data showed that black and ethnic minority staff (BME) were employed in higher proportions in lower pay bands (1 to 4) within the trust. BME staff were highly underrepresented in senior management roles.

Leadership of the trust

Summary of findings

- Leadership across the departments 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.
- There was a newly formed management team for medicine services. The Deputy Chief Nurse for the integrated care group had been in post for 12 months, the divisional director for six months and the group manager for six weeks. This team acknowledged that whilst many improvements had taken place there was more to do in order to embed them in practice and make further improvements in patient care.
- There was a band 7 leadership and development programme. Nurses at this level said they felt the trust had invested in them and they had benefitted from internal and external presentations to develop their leadership skills.
- The matrons who managed wards at more than one trust site organised their working so that they visited all sites they were responsible for on at least a weekly basis. Staff at the Royal Blackburn site said they saw their matrons regularly and could contact them should they need to do so.
- There was a monthly open forum with the director of nursing which the ward managers could attend. This was an informal meeting to discuss any issues and concerns or ideas they might have.
- There were monthly formal meetings for ward managers where learning from complaints and incidents were discussed along with trust and clinical developments and changes.
- The meeting held for band seven nurses was now run by two band 7 nurses and not a manager of a higher band. This had resulted in ownership of challenges on the wards and making the necessary changes.
- We heard of examples of staff feeling comfortable with raising concerns with a trust director and where this had been acted upon. We also heard of positive achievements being highlighted with the board and an example of where a staff member received an award, which was presented to her by the chief executive at a ward handover.

Vision and strategy

- The trust had a vision and strategy with clear aims and objectives. The trust vision was to be widely recognised as a provider of safe, personal and effective care. We saw this was very evident within practice in the divisions.

Summary of findings

- The strategy for each division was aligned with the trust's operational development strategy and staff were aware of the trust's vision and values. Work that was completed within the divisions was centred on this vision.
- The trust vision was displayed in all areas that we visited. All staff were very knowledgeable on the trust's strategy on how they should achieve this vision and we observed they were very focused on delivering it. We found that staff understood organizational values and demonstrated behaviours that underpinned them.

Governance, risk management and quality measurement

- The Quality Committee was the Board Committee with responsibility for risk management, patient safety and quality. An update report was provided from each board committee, including the Quality Committee, to the trust board at each meeting. These update reports summarised any risks, issues or information the committee decided required escalation.
- The risk management strategy was last approved in August 2016. This document included the risk management roles, responsibilities and processes. Although it incorporated some broad risk management objectives, it did not clearly articulate where the trust saw its risk management processes at the beginning of the strategy and where it aimed to be at the end.
- The Board Assurance Framework (BAF) had six strategic risks which were aligned to the organisation's strategic objectives. It included initial, current and tolerance risk scores for each risk, demonstrating that the board had considered it's tolerance for each risk and knew where it would likely be by the end of the financial year. The risk descriptions were poor, describing only the condition with no detail on the cause of the risk or consequences. As a result of this, some actions were broad with no leads or timescales. Controls, assurances and gaps in both were comprehensively described within the framework. We discussed this with the Medical Director who confirmed that this was a reasonably new Board Assurance Framework and the trust had plans to develop supporting information behind each strategic risk, including action plans with timescales for completion.
- The paper that the board received in July 2016 to support the BAF discussed any changes in risk rating along with progress in actions taken. The report provided a useful overview for the board members. One of the actions for further improvement in risk management processes was the alignment of the strategic risks to the board committees and the corporate risk register.

Summary of findings

- The corporate risk register comprised risks rated 15 or above and was reported to the trust board. At the July 2016 board meeting there were six risks included on the register. The risks all had three risk ratings; initial, current and target demonstrating the trust had determined the level of risk it was willing to accept. The risk descriptions did not include the condition, cause and consequence of all risks. The cause was not identified in any of the risks on this register or the Board Assurance Framework, which could make mitigating and reducing risks challenging. The consequence was referred to in terms of financial consequences for the risks around nursing and medical staffing shortages. The impact to patient safety or experience was not described as part of these risks, despite the risks included being around staffing levels, meeting the 18-week referral to treatment time, stroke outcomes and the ward environment. This was not reflective of our interviews with the executive team. All members of the executive team clearly articulated future plans, potential risks to patients and how these risks were being managed.

- Clear links to divisional risk registers were recorded in the document. The actions were noted to be broad with no timescales. There was a column for recording open actions or comments and this largely stated 'due review'. None of the six risk ratings had changed since the previous paper to the board. The board minutes only recorded that the paper was presented and noted with no evidence of challenge around the management of the risks or static risk ratings. The Medical Director told us that this challenge did happen at board but more so at the quality committee and the finance and performance committee. It was acknowledged that the minutes had not captured this.

Culture within the trust

- The staff Friends and Family test was sent out to all members of staff in the trust. There was an upward trend of the number of staff who would recommend the trust as a place to work to their friends or family. Between April and June 2016, 72% of staff identified they would recommend the trust as a place to work, compared to 67% between January and March 2016.

- There was a comprehensive whistleblowing policy in place and we saw evidence that the trust were responsive with concerns raised by staff under the policy. An example of this was within the neonatal intensive care unit, where executive leads held a 'big conversation' meeting following a concern raised by staff members under the whistleblowing policy. An action plan was developed and improvements were made.

Summary of findings

Equalities and Diversity – including Workforce Race Equality Standard

- There was current equality and diversity strategy in place within the trust for 2015 to 2019.
- It is a requirement within the national contract for trusts to publish their results for the Workforce Race Equality Standard (WRES). The WRES data for 1st April 2015 to 31st March 2016 was publically available on the trust website.
- The WRES data showed that black and ethnic minority staff (BME) were employed in higher proportions in lower pay bands (1 to 4) within the trust. BME staff were highly underrepresented in senior management roles. There are no board members from a BME background within the trust. However a non-executive director had been recruited and was due to commence in role imminently.
- There had been a reduction in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the 12 months prior to our inspection, which had been reduced from 32% to 21%.
- There has been a reduction in the percentage of BME staff experiencing harassment, bullying or abuse from staff in the 12 months prior to our inspection, which had reduced from 31% to 25%.
- Fewer BME staff believed the trust provided equal opportunities for career progression or promotion compared to the previous year, which had reduced from 73% to 71%.
- In the 12 months prior to our inspection, there had been a 4% reduction in BME staff personally experiencing discrimination at work from their manager/team leader or other colleagues, which was reduced from 18% to 14%.
- A comprehensive action plan had been written in response to the WRES data which demonstrated actions to address outcomes including Diverse Leaders of Tomorrow, Leadership Development Programme, core mandatory training, equality and diversity training, personal development reviews, appraisals, DVD & workbook, Investors in People accreditation, learning and operational development bulletin, NHS staff survey; local NHS workforce data and surveys; information on the take-up and evaluation of local training and development opportunities. It also included staff survey results, staff friends and family test results, 'big conversations', focus groups, Back to the Floor visits.
- The poor WRES report outcomes were recorded and reviewed as part of the Human Resources risk register. The trust had conducted a '5 year look back' into the WRES data to enable them to gather a clear focus on equality in the trust.

Summary of findings

- The Chief Executive told us that a paper was due to be reviewed at the board meeting in October 2016 regarding actions to be taken to improve the situation and an external review had been commissioned by the trust. A 'big conversation' was scheduled for December 2016, led by the Chief Executive and the independent reviewer. Additionally the staff survey had a particular focus on BME, the results of which were not finalised at the time of the inspection.

Fit and Proper Persons

- Personnel files were reviewed to assess compliance against the fit and proper persons review requirements. The trust had a robust process for checking candidates prior to appointment and on an annual basis thereafter. No areas of non-compliance were identified.

Public engagement

- The trust was actively seeking the views of patients and their relatives by asking them to complete the NHS Friends and Family test, which they had adapted to ask patients additional questions to help shape future improvements. The results of this test were displayed on prominent noticeboards on all wards across the division. There was also a new initiative for patients to complete this test following discharge by being sent a text message to their mobile telephone.
- Theatres were actively working with the local community with initiatives such as theatre open days and working with local high schools.
- Theatres were using a blog on the trust's internet site where they encouraged the general public to post their views and suggestions on any issues or new ideas they wish to raise. This blog was reviewed and found to be very interactive with staff responding to posts from the public.
- There was a patient experience group and a patient experience survey was undertaken every month. Five patients were invited to participate. We saw the results for August and September 2015. There was 100% satisfaction from participants.
- There were two patient representatives who were members of the end of life care strategy and operational group. This showed that the patients had a voice at the highest level.
- There were monthly focus group meetings at Rakehead unit to obtain patient and relatives views and suggestions. Recent changes as a result of this were a review of the menu and the availability of the table tennis equipment.

Staff engagement

Summary of findings

- The trust NHS staff satisfaction responses were in the highest 20% (best) in 13 key findings. This compared to five key findings being in the highest 20% in the 2014 survey.
- The trust was proactive in addressing whistleblowing concerns raised by staff and we saw examples of this in practice.

Innovation, improvement and sustainability

- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.
- A band 3 member of staff from theatres ran a painting competition for children and young people who had learning difficulties and medical conditions. The resulting art work was displayed in the patients' waiting area. This innovation was looking at working closely with these young people and easing their anxiety about undergoing surgery.
- As part of the on-going recruitment drive, staff from theatres were going into local high schools for careers evenings to help raise the profile of working in theatres and for the trust.
- The ward manager of theatres had developed a blog on the trust's internet site to reach out to the public. This was a very interactive page where patients, staff and the public were encouraged to write about their experiences.
- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.

Overview of ratings

Our ratings for Royal Blackburn Hospital

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

Overview of ratings

Our ratings for Burnley General Hospital

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

Our ratings for East Lancashire Hospitals NHS Trust

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

Notes

Outstanding practice and areas for improvement

Outstanding practice

- Several examples of innovation across the surgical division, including robotic surgery, theatre open days to break down barriers between community and operating theatres and the use of social media.

- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.

- A band 3 member of staff from theatres ran a painting competition for children and young people who had learning difficulties and medical conditions. The resulting art work was displayed in the patients' waiting area. This innovation was looking at working closely with these young people and easing their anxiety about undergoing surgery.

- Each ward and theatre area held weekly staff meetings called 'Feedback Fridays.' These meetings were a two way process and covered all significant governance issues pertinent for their area, including lessons learned from incidents and complaints, the risk register for their individual areas and feedback from matron and governance meetings.

Areas for improvement

Action the trust MUST take to improve

- The trust must review the duty of candour implementation and adhere to the 10-day timescale for all incidents.

Action the trust SHOULD take to improve

- The trust should continue to work towards reducing the time taken to investigate and close a complaint to ensure they meet the trust target.

- Root cause analysis reviews should contain a true root cause of the incident as opposed to a one-line summary.

- Fill rates for registered nurse staffing should not fall below the recommended staffing requirements. The trust should continue to prioritise the recruitment and retention of nursing staff.

- Continue to review the Board Assurance Framework (BAF) to ensure it is more robust and fully reflects the supporting information behind each strategic risk, including action plans with timescales for completion.

- Review the work force equality standards data for the trust and continue to implement the action plan for improvements within this area.

- Address the shoulds and musts for the locations.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour
	Regulation 20: Duty of Candour
	How the regulation was not being met:
	In the July 2016 Serious Incident Report, it was reported that two out of 39 incidents where duty of candour applied had not met the 10-day timeframe for the regulation to be applied.
	Regulation 20 (2)

Enforcement actions

Action we have told the provider to take

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

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here....