

East Lancashire Hospitals NHS Trust

Burnley General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent care centre	Requires improvement	
Medical care	Good	
Surgery	Good	
Maternity and family planning	Good	
Services for children and young people	Good	
End of life care	Requires improvement	
Outpatients	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

Burnley General Hospital is one of seven hospitals and care centres that form East Lancashire Hospitals NHS Trust. It specialises in planned (elective) treatment and has 291 beds. The hospital includes an Urgent Care Centre (UCC) for treatment of minor injuries and illnesses. It does not include an Accident and Emergency (A&E) department or supporting facilities such as intensive care. These services are provided from the Royal Blackburn Hospital.

We carried out a comprehensive inspection because East Lancashire Hospitals NHS Trust had been flagged as high-risk on the Care Quality Commission (CQC) intelligent monitoring system which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. The inspection took place on 30 April, 1 and 2 May 2014.

Overall, Burnley General Hospital requires improvement. We rated it as 'good' for caring for patients and providing effective care. It requires improvement in providing safe care, being responsive to patients' needs and for being well-led.

Our key findings were as follows:

- Staff were caring, compassionate and respectful and maintained patients' privacy and dignity.
- The hospital was clean and well maintained. Staff were seen to be adhering to the "bare below the elbow" policy, washing their hands regularly, and hand gel was readily available. Infection control rates were similar to that of other hospitals.
- Some patients did not understand the purpose of the UCC. This meant that sometimes patients who attended the department did so inappropriately and required transfer to a centre that was fully equipped and staffed to meet their needs. Sometimes transfers were not responsive enough which could delay treatment and put patients at risk.
- The trust had undertaken much work to improve its mortality rate — currently slightly above the expected range.
- Performance against access target in the Urgent Care Centre was consistently good, however, some patients who required mental health assessment or admission to a specialist service waited too long in the department which was not resourced to meet their needs.
- Care on the medical wards was safe, effective, caring, responsive and well-led. Staffing levels in the wards had improved over the last 12 months, however, there remained some vacancies for qualified staff.
- Patients' nutritional needs were appropriately assessed and a suitable diet provided. Although not unanimous, the majority of patients said the food was good.
- Surgery was effective but the routine checking of theatre equipment lists was not undertaken which posed a risk to patients.
- Theatres were not utilised to their full capacity, with a number of empty lists every week.
- Patient privacy and dignity was at risk of being compromised as male and female patients, as well as children, were all waiting together in the theatre reception area.
- Maternity services provided safe and effective care. Maternity services had improved the normal birth rates, reduced caesarean section rates and increased birthing choices for women; they had received an award for this.
- Surgery was effective but the routine checking of theatre equipment lists was not undertaken which posed a risk to patients.
- Care for children and young people was safe, effective, caring, responsive and well-led.
- Patients received safe and effective care end of life care from ward staff and a specialist palliative care team. However, this specialist care team was only available Monday to Friday from 9am to 5pm. Outside of these hours, support was provided from the local hospice.
- There was a limited bereavement service available. The trust recognised this and was aiming to recruit to this service.
- A new strategy for end of life care had been drafted. At the time of the inspection, this had yet to be approved and therefore new ways of working were not yet embedded into practice.

Summary of findings

- Patients in outpatients were treated with dignity and respect by caring staff who worked to maintain their safety. However, clinics were sometimes cancelled at short notice and frequently ran late.
- Patients attending outpatients expressed difficulties with the car parking arrangements. The demand for spaces was high and often resulted in a long walk to the appropriate clinic.
- Staff were very positive about the current leadership of the trust. They felt the culture was more open and honest and felt supported in raising concerns and reporting incidents.

We saw several areas of outstanding practice including:

- East Lancashire Hospitals NHS Trust's maternity services were awarded the Royal College of Midwives' Mothercare Maternity Service of the Year award for their 'innovative work to improve maternity services, promote normal births and facilitate staff engagement activities'. The award also recognised their work in reducing caesarean section rates and increasing birth choices for women.
- The breast and gynaecology ward was very well designed. The early pregnancy unit, ultrasound scanning suite and gynaecology theatres were all in close proximity and purpose-built, with staff having input into the planning of the building. This created an outstanding setting to facilitate a responsive service for outpatients visiting the early pregnancy unit and inpatients staying on the ward. For example, patients were actively encouraged to attend the assessment area if they experienced any post-operative complications so they could be seen by a gynaecologist quickly rather than having to attend A&E at Royal Blackburn Hospital.

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

Importantly, the trust must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled and experienced staff employed in the Urgent Care Centre (UCC) at all times to care for very unwell children.
- Ensure that acutely unwell patients who attend the UCC, and require emergency or urgent transfer to the Royal Blackburn Hospital or other centres, receive the appropriate response.
- Ensure that people who attend urgent care with mental health needs receive prompt, effective, personalised support from appropriately trained staff to meet their needs.
- Ensure that there is an appropriately resourced bereavement service available.
- Take action to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time.
- Ensure that instruments are checked and accounted for before and after each procedure and that there is documentary evidence to support this.

In addition the trust should:

- Consider improving the management of theatre activity to increase patient flow.
- Review the layout of the theatre reception area to maintain the privacy and dignity of all patients.
- Take action to finalise the strategy for end of life care and ensure this is embedded in practice.
- Consider the appropriateness of the lack of lifting equipment should a person fall or collapse and be unable to lift themselves in the UCC.
- Work to improve the number of staff in the UCC attending mandatory training.
- Assess the frequency of the review of local risk registers.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating

Why have we given this rating?

Urgent care centre

Requires improvement



Safety required improvement. Some patients did not understand the purpose of the UCC. This meant that sometimes patients who attended the department did so inappropriately and required transfer to a centre that was fully equipped and staffed to meet their needs. Sometimes transfers were not responsive enough which could delay treatment and put patients at risk.

Within the unit patient safety was a priority and risks to patients were identified and managed. There were mostly good outcomes for patients. We found staff to be compassionate and caring and patients we spoke with during our visit were positive in their feedback about staff. However, we also received some negative feedback about the arrangements in place to transport patients requiring further treatment or admission to Royal Blackburn Hospital. Performance against access targets was consistently good, however, some patients who required a mental health assessment or admission to a mental health bed waited too long in the centre, which was not staffed to meet their particular needs.

Staff were engaged, enthusiastic and proud of the service they provided. The leadership of the unit requires improvement. Whilst staff felt well-supported and worked effectively as a cohesive team the high issues with the identity and purpose of the unit have not yet been sufficiently addressed. The hospital needed to work more effectively with the ambulance service and the provider of mental health services to improve the responsiveness of their services.

Medical care

Good



Overall, we found that Burnley General Hospital was providing medical care that was safe, effective, caring, responsive and well-led. The trust had recently combined its medicine and community divisions to form an integrated care group, the head of which was a GP. The aim was to improve the links between acute care and community care. Staff told us that there had been significant improvements in

Summary of findings

the culture of the trust within the last 12 months. Staff reported a more open and honest culture where they felt supported to raise concerns and report incidents.

Ward environments were clean and well maintained. Staff followed infection control procedures and patients reported they were happy with the cleanliness levels on the wards. Multidisciplinary working was well established and there were good working relationships with community services. We found the hospital provided a responsive service to meet people's needs and there were clear discharge arrangements in place across all the wards we visited.

Nursing and allied health staff confirmed that they were largely covering seven-day service requirements among themselves by increasing extended hours and working overtime. However, there were concerns that this was not a sustainable approach. There was an ongoing recruitment campaign to address staff shortages and the trust had introduced flexible working arrangements, but staff sickness levels for all the wards we visited were still above the trust average.

Surgery

Good



Safety in surgery services required improvement. Theatre staff did not complete the documentation for the theatre equipment lists. Instruments should be checked and accounted for before and after each procedure to ensure they are not missing or left inside a patient.

Patient safety was monitored and incidents were investigated to assist learning and to improve care. Medicines and records were appropriately stored. The majority of staff received mandatory training, including safeguarding training. There was a sufficient number of staff with the right skills mix in place. The environment facilitated safe care, following infection control procedures.

Procedures and treatments within surgical services followed national clinical guidelines. Patients spoke positively about their care and treatment at the hospital.

Due to the lack of segregation, patients' privacy and dignity were not always afforded, as male and female patients, often wearing theatre gowns, were waiting together in the theatre reception area.

Summary of findings

Maternity and family planning

Good



The maternity and family planning services were found to be safe and effective, with caring staff. The service was responsive to the needs of the local population, providing a mix of standalone birth centres, an alongside birth centre (both of which are midwife-led) and obstetric-led birthing options for women. The service was also found to be well-led. There were established governance processes in place. Staff received feedback from incidents and there was evidence of learning as a result.

Services for children and young people

Good



Children, young people and neonates (newborn infants) received safe and effective care from appropriately trained and competent staff. We saw that staff treated patients with dignity and respect, showing compassion and empathy to them and their families or carers.

Staff were positive about working in the family care division of the trust and told us they felt supported and valued in their roles. Parents and carers were satisfied with the care and treatment delivered to their children and told us they felt included and involved.

The environment was clean, bright and airy with sufficient equipment to deliver the necessary treatments. Toys were available in waiting and treatment areas. However, on the neonatal intensive care unit NICU, there were no facilities for parents/carers to have a hot drink or sit on the ward away from the cot side. There was a refurbished waiting area outside of the unit which provided seating, toys and a cold water fountain.

The care and treatment provided to children and young people was based on national guidelines and directives. Policies and procedures were reviewed regularly and updated as necessary. The care and treatment was audited to monitor quality and effectiveness and, as a result action had been taken to improve the service.

Staff were provided with regular and appropriate training and an annual performance development review. There was no process for staff to receive formal supervision throughout the year but, during our discussions with staff, we were told the managers were approachable and provided support when required.

Summary of findings

Services for children and young people were caring. Patients and their families/carers were treated with dignity and respect. Surveys took place to gather feedback from patients and their families/carers. Interpreter services were available when required.

End of life care

Requires improvement



Care for patients at the end of life was supported by a consultant-led, specialist, palliative care team. Staff followed end of life care pathways that were in line with national guidelines and staff used care pathways effectively. Staff were clearly motivated and committed to meeting patients' different needs at the end of life and they were involved in developing their own systems and projects to help achieve this.

Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents. The palliative care team staff were clear about their roles and benefitted from good leadership. We observed that care was given by supportive and compassionate staff.

Relatives of patients who received end of life care spoke positively about the care and treatment patients received and they told us their relatives were treated with dignity and that their privacy was respected. The relatives of patients, nurses and doctors spoke positively about the service provided from the specialist team.

However, we found that shortfalls in the hospital bereavement service impacted on the quality of service provided to grieving relatives. The strategy for end of life had been revised and was in draft format and therefore this was not yet embedded in practice.

Outpatients

Good



Patients were treated with dignity and respect by caring staff. Patients spoke positively about their care and felt they had been involved in decisions about their care. Staffing numbers and skills mix met the needs of the service. There was a clear process for reporting and investigating incidents. Themes and trends were identified and action taken to minimise risks. The outpatients departments we visited were clean and well-maintained.

Patients and staff told us that clinics were sometimes cancelled at short notice and we found that clinics frequently ran late. Patients spoke of the anxiety and inconvenience this caused them. Staff were auditing this and were considering ways to

Summary of findings

address it. Changes to the patients' ambulance transport services had caused confusion for staff, resulting in them not knowing which patients had transport arranged. Patients could wait for long periods for transport if their appointment was late. There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other. Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients.

Requires improvement

Burnley General Hospital

Detailed findings

Services we looked at:

Urgent care; Medical care (including older people's care); Surgery; Maternity and family planning; Services for children and young people; End of life care; Outpatients

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Detailed findings

Background to Burnley General Hospital

Burnley General Hospital is part of East Lancashire Hospitals NHS Trust. The trust was established in 2003 and is a major acute trust located in Lancashire. In addition to this hospital the trust comprises another acute hospital, community hospital sites with inpatient beds at Pendle Community Hospital, Accrington Victoria Hospital and Clitheroe Community Hospital, as well as the full range of adult community services. Community services were not included in this inspection.

Burnley General Hospital has 267 beds.

In 2013 the trust overall was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the medical director for NHS England) as part of the Keogh Mortality Review in July 2013. After that review, the trust entered special measures because of the following concerns: the governance systems were not providing the expected level of assurance to the board and escalation of risks and clinical issues was inconsistent; imbalance in capacity and demand across Royal Blackburn Hospital and Burnley General Hospital sites; lack of understanding of patient flow; clinical concerns not being addressed; complaints procedure was poor and lacked a compassionate approach; in some areas the staffing levels were insufficient to meet the basic needs of patients; and more nursing leadership, direction and support was required.

The trust is not a foundation trust – its application was put on hold following the Keogh Mortality Review.

Burnley is a district in Lancashire. The 2010 Indices of Deprivation showed that Burnley was the 11th most deprived local authority (out of 326 local authorities). Between 2007 and 2010 the deprivation score for Burnley increased, meaning that the level of deprivation worsened. Census data shows that Burnley has a decreasing population and a lower than England average proportion of Black, Asian and minority ethnic residents. Life expectancy is 13.7 years lower for men and 6.3 years lower for women in the most deprived areas of Burnley than in the least-deprived areas of the country.

There is a fair distribution of men and women in the population, with the highest proportion in the age group 40 to 49, similar to the England average.

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a high-risk trust according to our new intelligent monitoring model and to follow up on actions since the Keogh Mortality Review.

The inspection team inspected the following seven core services at Burnley General Hospital:

- Urgent Care Centre (the full range of Accident and Emergency services was not provided).
- Medical care (including older people's care)
- Surgery
- Maternity
- Children's care
- End of life care
- Outpatients

Our inspection team

Our inspection team was led by:

Chair: Edward Baker, Deputy Chief Inspector, CQC

Head of Hospital Inspections: Mary Cridge, CQC

The team included CQC inspectors and a variety of specialists: medical director, general manager, student

nurse, executive director of workforce planner, occupational therapist, GP, experts by experience, associate director of corporate governance, clinical lead for paediatrics, consultant anaesthetist, midwife, director of nursing, professor of cardiac studies and a junior doctor.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information and asked other organisations to share what they knew about the hospital. This included the two local clinical commissioning groups, NHS Trust Development Authority, General Medical Council, Nursing and Midwifery Council and the Royal Colleges.

We held two listening events in Burnley and Blackburn on 29 April 2014, where people shared their views and experiences of Burnley General Hospital and Royal Blackburn Hospital. Over 80 people attended the two events. Some people who were unable to attend the events shared their experiences by email or telephone.

We carried out an announced inspection on 1 and 2 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with patients and staff from across most of the hospital. We observed how people were being cared for, talked with carers and or family members and reviewed patients' records of their care and treatment.

Facts and data about Burnley General Hospital

Burnley General Hospital is a 263-bed hospital which specialises in planned (elective) care. Overall the trust – East Lancashire Hospitals NHS Trust – has 7,223 staff providing healthcare services mainly to the residents of East Lancashire and Blackburn with Darwen which have a combined population of around 530,000. The population of East Lancashire is around 382,000.

In 2012/13 the trust had over 9,771 inpatient admissions, 45,153 day cases, 469,449 outpatients attendances (both new and follow-up) and 177,901 attendances at emergency and urgent care.

The trust has delivered financial surpluses for the all the years from 2007/08 to 2012/13. In 2012/13 this surplus was around £4.7 million. A surplus is predicted for 2013/14 and the trust has delivered cost improvement savings of £16.2million.

Between October and December 2013 bed occupancy for the trust was 81.7%. This is below the England average (85.9%) and below the level of 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital. This overall trust figure hides the fact that the percentage was significantly higher at Royal Blackburn Hospital and lower at Burnley General Hospital, reflecting that Burnley provides elective care.

There have been a significant number of changes at board level in the last nine months. The chair joined in March 2014. There is currently an interim chief executive who started in January 2014, an acting medical director who started in February 2014, an interim director of human resources who started in November 2013 and an interim director of operations who started in April 2014. The chief nurse is a substantive post holder having commenced in January 2014. The deputy chief executive and finance director, and the director of service development commenced in 2009.

CQC inspection history

East Lancashire Hospitals NHS Trust has had a total of 11 inspections since registration. Three of these have been in Burnley General Hospital. In March 2012 a themed inspection was undertaken specifically looking at services for the termination of pregnancy and the outcomes inspected were met. In September 2012 a routine inspection was undertaken and all the outcomes inspected were met. A further inspection was undertaken in November 2013 in response to concerns that had arisen. At this inspection two outcomes were found to be met – those relating to the care and welfare of people using the service and staffing –however, the assessment and monitoring of the quality of the service provision was not met and a compliance action was issued.

Detailed findings

Our ratings for this hospital







Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent care centre	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Maternity and family planning	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	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both the urgent care centre and outpatients.

Urgent care centre

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

The Urgent Care Centre (UCC) at Burnley General Hospital was re-designated in 2007 from an Accident and Emergency (A&E) Department. The centre's operational policy (November 2013) described its aim as "to provide a 24-hour walk-in service for patients presenting with minor injuries and illness".

The centre was open 24 hours a day, seven days a week, and 365 days a year. The UCC saw nearly 51,000 patients in 2013, averaging about 135 to 140 attendances per day. The centre moved into a purpose-built, new building in January 2014. Out-of-hours GPs were co-located in the centre from 8pm to 8am.

There were 14 consultation/treatment rooms, of which four were used by GPs. There was a separate children's area, with its own waiting room. As a UCC, there were not have full resuscitation facilities available but it was equipped with resuscitation equipment, including an automated defibrillator and heart monitoring equipment. When the centre was designated a UCC, it was anticipated that most patients attending would self-present. However, some patients were brought to the centre by ambulance. There was strict criteria used by the ambulance service to ensure that only appropriate patients are taken there. Patients who self-presented with life-threatening conditions which cannot be treated there were transferred by ambulance to the Royal Blackburn Hospital. The trust also contracted with a local ambulance service to provide an intermediate ambulance service to transfer stable patients to Royal Blackburn.

Summary of findings

Safety requires improvement. Some patients did not understand the purpose of the UCC. This meant that sometimes patients who attended the department did so inappropriately and required transfer to a centre that was fully equipped and staffed to meet their needs. Sometimes transfers were not responsive enough which could delay treatment and put patients at risk.

There were mostly good outcomes for patients. We found staff to be compassionate and caring and patients we spoke with during our visit were positive in their feedback about staff. However, we also received some negative feedback about the arrangements in place to transport patients requiring further treatment or admission to Royal Blackburn Hospital.

Performance against access targets was consistently good, however, some patients who required a mental health assessment or admission to a mental health bed waited too long in the centre, which was not staffed to meet their particular needs.

Staff were engaged, enthusiastic and proud of the service they provided. The leadership of the centre requires improvement. Whilst staff felt well-supported and worked effectively as a cohesive team the significant issues with the identity and purpose of the centre have not yet been sufficiently addressed. The hospital needed to work more effectively with the ambulance service and the provider of mental health services to improve the responsiveness of their services.

Urgent care centre

Are urgent care centre services safe?

Requires improvement



There was a risk-aware culture in the centre and a willingness to learn from mistakes. Safety incidents were thoroughly investigated and openly discussed. Staff were able to describe incident reporting procedures.

Some patients did not understand the purpose of the UCC. This meant that sometimes patients who attended the department did so inappropriately and required transfer to a centre that was fully equipped and staffed to meet their needs. Sometimes transfers were not responsive enough which could delay treatment and put patients at risk.

There were insufficient numbers of suitably qualified, skilled and experienced staff employed at all times to care for very unwell children.

Incidents

- The number of serious incidents reported in A&E/UCC trust-wide was in line with expected for the size of the trust.
- The staff we spoke with told us they were encouraged to report incidents and received direct feedback.
- Feedback was provided to staff at regular 'share to care' meetings and monthly formal governance meetings. We were told that delayed ambulance transfers and delayed mental health assessments were always reported as untoward incidents.

Safety thermometer

- Performance against national Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections) standards was regularly discussed at 'share to care' and governance meetings and was displayed in the centre for staff and patients to see. It was reported that there had been no recent infections or pressure ulcers in the centre. One recent fall had been reported.

Cleanliness, infection control and hygiene

- During our visit we found the centre was clean and tidy. In the 2013/14 patient satisfaction survey, 97.74% of respondents said the centre was clean.

- Hand-washing facilities were readily available and we saw staff regularly wash their hands and use hand gel between seeing patients.
- 'Bare below the elbow' policies were adhered to and staff wore suitable protective clothing, such as aprons and gloves when necessary.
- Cleaning schedules were displayed on noticeboards for the public to see. It was also reported that recent spot audits of hand hygiene and cleanliness of equipment (commodes) had scored 100%.

Environment and equipment

- The centre was light, spacious and well laid out. Staff told us that most of the time it was large enough to accommodate the number of patients attending the unit. Treatment rooms were spacious and had partly opaque glass doors to allow for privacy and safe observation. One treatment room had been equipped with a trolley and seating which could accommodate bariatric patients. We noted, however, that there was no lifting equipment, such as hoists. The matron told us this equipment had not been provided because the centre was designed to accommodate ambulant patients. In the event of a fall or sudden collapse, a lack of suitable equipment placed staff and patients at risk.
- The x-ray department was situated in adjacent building and was easily accessible.
- There was a secure room used to accommodate patients with mental health problems who had been assessed as being at risk of harming themselves or others. This was monitored by CCTV and was equipped with a panic alarm. The room was free of any items of furniture or equipment which could pose a ligature risk.
- The centre was adequately equipped and there were systems in place to ensure that the centre was fully equipped and stocked and that equipment was clean and fit for purpose. There were checklists in use for daily checks of resuscitation trolleys. We checked these records and they were complete and the resuscitation trolley was fully equipped and fit for purpose.
- There were suitable security arrangements in the centre. Security staff were employed within the centre, 24 hours a day, seven days a week, with personnel rotating every two hours. They were visible when we visited and staff told us they were always accessible and responsive. There was limited access to certain areas within the centre, such as the treatment room, and reception staff were able to lock down certain areas of the centre in the

Urgent care centre

event of a security incident. There was a nurse call system and a tannoy system at the nurses' station so that patients and/or staff could summon assistance. Staff were provided with personal alarms which would summon security staff.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where necessary. Fridge temperatures were correct.

Records

- All patients' records were in paper format and all healthcare professionals documented care and treatment using the same document.
- The records we looked at were clear and easy to follow. They recorded appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan.
- There was a records audit in progress at the time of our visit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our visit we saw that patients' consent had been appropriately and correctly obtained. Most interventions in the centre required informal or verbal consent. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people who lacked capacity to consent to care and treatment. They told us, for example, they may speak with relatives, carers or the patient's GP. The trust told us that Mental Capacity Act 2005 training was available, although this was not mandatory for all staff. There was therefore a risk that practice may be inconsistent. An overview of the Act was covered at induction training and within safeguarding training, both of which were mandatory for all staff.

Safeguarding

- Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was access to patients' previous attendance history and to the child risk register.
- The centre used a child risk assessment tool to identify any concerns regarding child welfare.

- It was noted in the governance meeting minutes in March 2014 that all consultant and middle grade doctors had completed level 3 (advanced) safeguarding training. Records for other roles were not available.

Mandatory training

- The trust's report on mandatory training compliance as at February 2014 showed that 63% of A&E and UCC staff (across the trust) were up to date with mandatory training. There was a practice development nurse attached to the centre. They were unable to show us training records specific to the centre because of an administrative error which had deleted records. However, staff we spoke with told us they were well-supported with training and undertook regular refresher training.

Initial assessment and management of patients

- Patients who self-presented reported to a reception desk where they were booked in and asked to take a seat in the appropriate (adult or child) waiting room. Patients were then triaged, using the Manchester triage system. This system is a nationally recognised and commonly used system in the UK. It utilises a series of flowcharts that lead the triage nurse to a logical choice of triage category, using a five-point scale.
- Patients arriving by ambulance were brought in via a dedicated, controlled entrance.
- A child risk assessment tool was completed for all patients under the age of 16.
- Where patients presented with serious conditions which could not be treated at Burnley General Hospital, arrangements were made to transfer them to Royal Blackburn Hospital. Depending on the clinical need, this may be using their own car or public transport, a free hospital shuttle bus, intermediate ambulance or emergency ambulance transfer.
- Prior to our visit we had received two complaints from patients who had required transfer. One patient had travelled on the intermediate ambulance and did not consider that this form of transport was appropriate, given how unwell they were and the needs of the accompanying patients. A second patient complained about waiting too long for an emergency ambulance.
- The matron and the incoming and outgoing clinical directors confirmed that there were ongoing concerns about the number of transfers required and on occasions the timeliness of transfers. responsiveness to calls for emergency ambulance transfer. An analysis of

Urgent care centre

occasions when the centre had breached the four-hour target (95% of patients are admitted, transferred or discharged within four hours of their arrival in A&E) showed that, between 1 January 2014 and 30 April 2014, there were 59 occasions when patients waited in the centre for more than four hours because of delayed transport. The ambulance trust provided evidence that seven of these related to the ambulance trust.

Management of inappropriate attendance

- Despite the fact that the UCC had been in operation for seven years, there remained some lack of clarity with regard to its function and significant numbers of patients continued to attend inappropriately. The hospital had used a number of methods to engage with the public and to educate them about the function of the centre to reduce the number of inappropriate self-presenting patients. These included media campaigns and a leaflet drop to households in Burnley and surrounding areas.
- While the UCC was introduced to treat ambulant patients with minor illness or injuries, its function had, over a number of years, extended. It was increasingly accepted that a proportion of patients who summoned the ambulance service in an emergency may be suitable for conveyance to this centre. A paramedic pathfinder protocol had been developed by the North West Ambulance Service, which allowed ambulance personnel to assess the most suitable destination for their patient. The pathfinder was only applicable to UCCs that were designated 'Kite mark 1'. This means that the centre met certain minimum criteria in terms of its staffing, equipment and facilities. The Burnley General Hospital UCC was designated as such. There were a number of exclusion criteria, such as children under five, patients with acute mental health conditions and patients with chest pain not linked to trauma. There were a series of algorithms which determined the most appropriate pathway. There were two protocols, one for trauma patients and one for medical conditions. Further protocols were being developed.
- We were told that the protocols were constantly refined to ensure that they remained safe and appropriate. The matron told us that incident reports would be completed each time a patient arrived by ambulance and was deemed to be inappropriate and required treatment or admission elsewhere.
- An audit had been undertaken in March 2014 to determine whether the protocol was appropriate and being applied consistently. This had been initiated due to an increase in the number and proportion of patients arriving by ambulance at UCC.
- The audit concluded that the ambulance service had used the protocol correctly in 49 out of 50 cases so had therefore been used appropriately. In this audit it was noted that 18% of ambulance-borne patients subsequently required ongoing treatment which necessitated transfer to Royal Blackburn Hospital. When the paramedic pathfinder protocol was introduced, it was predicted that about 5% of patients brought to Burnley General Hospital by ambulance would require cross-site transfer. Data from the North West Ambulance Service had shown that, on average, about 10% of patients needing transfer. The audit highlighted that transferred patients often had complex issues that needed further investigation, intervention and monitoring, which were not currently available at the UCC at Burnley General Hospital.
- The audit report went on to say that patients transferred to Royal Blackburn were often delayed. Staff completed incident forms when delays occurred. Some delays were for many hours. There were differing views on the use of the UCC centre as a 'place of safety'. The College of Emergency Medicine's Unscheduled Care Facilities (2009) document states that these care facilities should not be deemed a place of safety by ambulance services. This conflicting interpretation was yet to be resolved between the two parties. We were told that weekly meetings took place between the two parties but these were not recorded. In the meantime, it had been recommended that a business case be prepared to extend the availability of the intermediate ambulance beyond 10.30pm and to provide equipment, drugs and staff training for patients waiting for cross-site transfer to prevent any unnecessary delays in treatment.

Management of deteriorating patients

- The trust had a policy entitled 'the deteriorating patient and recognition of the sick patient' to ensure care was proving promptly and appropriately.
- The centre used a recognised early warning tool. A 'track and trigger' system was used by staff so that they knew which vital signs should be monitored, with what frequency and, when triggers were identified, how to

Urgent care centre

escalate. There were clear directions for escalation printed on the reverse of the observation charts and staff we spoke with were aware of the appropriate action to take if patients scored higher than expected.

- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary timeframes

Nursing staffing

- We were told that nursing numbers and skills mix had recently been assessed in the UCC using a recognised staffing tool. Data provided by the trust showed that centre was fully staffed. Staff we spoke with felt that staffing levels were appropriate most of the time.

Medical staffing

- There was a consultant on duty from 9am to 4pm Monday to Friday, supported by GPs, trainees and middle grade doctors. Out-of-hours consultant cover was provided by a consultant in the A&E department in the Royal Blackburn Hospital.
- Middle grade doctors provided cover 24 hours a day, seven days a week and GPs provided some out-of-hours cover during the evening, at weekends and bank holidays.
- The hospital's risk register identified that there was "limited out-of-hours nursing or medical staff on duty out of hours – the UCC is medically staffed by lone middle grade after 02.00 – therefore inadequate staffing levels to manage critically ill".

Caring for sick children

- There was one paediatric-trained nurse in the centre. This meant that there was not an appropriately trained nurse in the centre at all times. However the children's minor injuries unit was staffed by paediatric nurses and doctors and they could be called on if required. If a sick child came in when the minor injuries unit was closed they would be transferred as an emergency to Blackburn A&E.
- The trust aimed to ensure that all nurses were trained in paediatric intermediate life support (PILS) as a minimum. Training records were not available during our inspection but we were subsequently provided with information which showed that this standard was not complied with. Seven out of 39 nurses had received recent training in PILS or advanced paediatric life support (APLS). Although all consultant staff were trained in APLS, it was acknowledged by the trust that

two out of 11 middle grade doctors (who provided cover in the absence of a consultant out of hours) were not up to date with their APLS training and there was no guarantee that locum doctors would be appropriately trained. This meant we could not be assured that there were always appropriately trained clinicians on duty to care for very unwell children.

- The hospital's risk register identified that there were "no paediatric nursing or paediatric medical staff on site out of hours, therefore possibility of inadequate staffing levels and skills to stabilise the critically ill child".

Major incident awareness and training

- Staff in the UCC were well briefed and prepared for a major incident and could describe the processes and triggers for escalation.

Are urgent care centre services effective? (for example, treatment is effective)

Not sufficient evidence to rate

There was evidence of adherence to National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine guidelines and regular audit to ensure treatment pathways were consistently followed and were effective.

Evidence-based care and treatment

- The emergency medicine directorate, of which the UCC was a part, used a combination of NICE and College of Emergency Medicine guidelines to determine the treatment they provided. Guidance was regularly discussed at governance meetings, disseminated and acted upon as appropriate. For example, in February 2014 it was noted at the directorate governance meeting that the College had produced a leaflet to be given to patients who had self-harmed or presented a risk of doing so. This was to be given out by triage nurses.
- A range of clinical care pathways had been developed in accordance with guidance produced by NICE.
- At monthly governance meetings any changes to guidance and the impact that it would have on their practice was discussed. Staff were encouraged to undertake a clinical audit to assess how well guidelines were adhered to.

Urgent care centre

Pain relief

- All patients we spoke with reported that they had been offered appropriate pain relief and this had been administered promptly. Patients' records also confirmed this.

Nutrition and hydration

- There was a kitchen in the centre where drinks and snacks could be prepared for patients and relatives.
- All of the patients we spoke with had been offered a drink.
- Patients' records confirmed that regular nutrition and hydration checks were made.

Patient outcomes

- The emergency medicine directorate participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other A&E departments. Audits included consultant sign off, renal colic, pain relief in children, vital signs in majors, fractured neck of femur, severe sepsis and septic shock. The clinical director for A&E acknowledged that the most recent College of Emergency Medicine audit results were "not good enough". However there were clear action plans indicating what improvements need to be made as a result of the audit results and performance was regularly re-audited to monitor improvements.
- Unplanned re-attendances at A&E within seven days were below the target of 5% set by the Department of Health (January to April 2014).

Competent staff

- Medical staff rotated through the UCC and A&E departments at the Royal Blackburn and therefore could access regular supervision and peer support. They told us they received weekly work-based teaching at Burnley General Hospital.
- Nursing staff told us they were well supported with training and supervision. There was a practice development nurse in the centre who worked alongside nurses. A system of peer audit review had been introduced so that clinicians were regularly assessed in a range of clinical tasks. A training needs analysis was then developed and this formed part of the annual performance development review.

Facilities

- There was a plaster room in the centre but this was not staffed by plaster technicians. Only two senior nurses were currently trained to complete plasters. This was not an appropriate or efficient use of their skills. There were plans for them to delegate training to further staff.

Multidisciplinary working

- There was input from a range of specialists. Staff told us they were mostly well supported by 'in reach' teams. There was an internal professional standards agreement in place, as recommended by the College of Emergency Medicine, which required that specialist doctors should attend the department within 30 minutes of referral.
- Physiotherapists were based in the UCC five days a week and provided first-line treatment to appropriate patients, which meant that treatment could be initiated more promptly. Such developments were designed to improve the patient experience and patient flow through the centre.
- The pharmacy department was based in the main hospital and mobile patients would be directed there to collect prescribed medicines. Staff considered it was not very accessible as it was quite a long walk, involving two flights of stairs and the service was not available out of hours. Hospital doctors could not prescribe medication to be dispensed in the community (although GPs could). This meant that some patients had to return to the hospital to collect their prescription or travel to the Royal Blackburn Hospital where opening hours were longer. A supply of frequently used medicines, such as antibiotics, was maintained in the centre which could be dispensed when the pharmacy was closed.
- The hospital had a contract with Lancashire Care NHS Foundation Trust to provide a psychiatric assessment service. Appropriately trained mental health practitioners could be contacted for advice or requested to attend the centre to assess patients. These staff also liaised with the crisis team who were responsible for the 'gatekeeping' function, i.e. finding and appropriate mental health bed for patients who required admission. Frequent delays were experienced. Monthly 'interface' meetings were held, however, we noted that these meetings had been cancelled in February, March and April 2014. Given the dissatisfaction with this service described to us by the senior staff, we were concerned that the centre was not giving this matter the necessary attention.

Urgent care centre

- Patient experience was supported through a partnership with Age UK who provided a 'safely home' transport service to patients from East Lancashire. A coordinator was based in the centre seven days a week. The service provided transport and basic home care support to patients aged over 60.
- There was evidence of partnership working with the local ambulance service. There were two ambulance liaison officers who worked in the trust's A&E and UCCs. Regular meetings took place to ensure that the two services worked cooperatively and effectively, ensuring that delays were kept to minimum. However, at the time of our visit, there were some unresolved issues with regard to the responsiveness of inter hospital transfers.

Seven-day services

- Consultants worked Monday to Friday only. Weekends were covered by middle grade doctors supported by consultants at Royal Blackburn.
- The x-ray department was open 24 hours a day, seven days a week. Patients requiring specialist scans such as computerised tomography (CT) were transferred to the Royal Blackburn.
- Pharmacy services were not available seven days a week but a pharmacist was available on call out of hours. The centre held a stock of frequently used medicines such as antibiotics, and painkillers which staff could access out of hours.
- The trust was in the process of recruiting an advanced physiotherapy practitioner and there were plans to extend the service to a seven-day service.

Are urgent care centre services caring?

Good



Patients were very positive about the welcoming, caring and compassionate staff. Patient satisfaction surveys showed similar positive feedback. The centre had received few complaints and numerous compliments from people who had used the service.

Compassionate care

- The UCC did not participate in the NHS Friends and Family Test but used its own patient satisfaction survey.

The overall satisfaction rate for the 13 months from March 2013 to March 2014 was 91.34%, although the response rate represented only a small proportion (3%) of the total number of attendances in this period.

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Comments were mostly very positive and included: "The service is brilliant; really welcoming and caring". The only negative comment we received related to a member of administrative support staff who was thought by one patient to have been rude. We passed this comment on to the matron.
- Patients commented positively about the environment, particularly the treatment rooms, which were more private than cubicles with curtains.
- Nursing staff were described as "gentle, friendly and caring". Doctors had explained things to patients in a way that they could understand. Patients and relatives commented that they had been offered cups of tea.
- Steps had been taken to ensure people's privacy and dignity. The centre had introduced a system to make the booking-in process more private. Patients queuing at reception were directed by a sign to wait behind a line to allow the other person some privacy.
- Patients required to provide a urine sample were able to place their sample in a collection hatch so that they did not have to carry this through the centre.
- We witnessed a nurse adjusting a patient's gown as they walked down the corridor as this was not properly fastened and was revealing their underwear.

Patient understanding and involvement

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- There was a range of patient information in the form of leaflets and posters. Information was available in different languages and formats.
- There was a notice displayed at reception showing the anticipated waiting times. This had been introduced following some negative patient feedback.

Emotional support

- There were adequate facilities where distressed relatives could wait or be supported by staff.

Are urgent care centre services responsive to people's needs?

Urgent care centre

(for example, to feedback?)

Requires improvement



Arrangements to manage the access and flow of patients, from arrival to discharge, were mostly effective. However, delays were experienced for patients who required transferred to the Royal Blackburn or another centre. The centre was meeting access targets. However, patients who required a mental health assessment waited too long in the UCC and were not adequately supported by suitably trained or skilled staff.

Service planning and delivery to meet the needs of local people

- The centre had an escalation policy (October 2013) which described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances where there was significant demand for services.
- Daily bed management and safe staffing meetings took place so that capacity was constantly monitored.

Access and flow

- There were effective arrangements to manage the access and flow of patients from arrival to discharge.
- The design and layout of the building was largely appropriate for the needs of people who used it. There was direct access from the car park, where there were designated disabled spaces. There was also a drop-off point. Wheelchairs were available. Patients arriving by ambulance entered via a dedicated entrance which was controlled.
- The trust scored within expectations in relation to the questions about waiting times in the NHS A&E survey.
- The centre had consistently met the national standard which required that 95% of patients waited less than four hours to be admitted, transferred or discharged.
- Patients requiring transfer to the Royal Blackburn Hospital or other centres were frequently delayed. This caused patients added distress and discomfort and affected patient flow as cubicles became blocked, causing 'knock on' delays to other patients.
- Patients attending UCC who required a mental health assessment frequently had to wait too long for this assessment to take place. Delays were also experienced in identifying a suitable bed if it was deemed that they required admission. The staff felt the service from the

mental health liaison team, which was provided by Lancashire Care NHS Foundation Trust, was not responsive enough. There was a service level agreement which required mental health practitioners to respond within one hour of a request for a mental health assessment. Staff and managers told us that this was frequently not achieved. This caused added distress to patients and put pressure on staff, particularly if the patient was agitated or displaying challenging behaviour. The trust provided us with data which showed that, between 1 January and 30 April 2014, 62 patients in A&E waited for more than four hours for a mental health assessment. This figure refers to both the Royal Blackburn and the Burnley General Hospital sites. There was regular dialogue with the trust which provided this service and it there were plans to increase the increase staff numbers from June 2014 in the A&E at Blackburn but it was no evidence as to what actions were being discussed for Burnley General Hospital.

- The target to achieve ambulance handover within 15 minutes was achieved. Ambulance liaison officers had been employed to work in the A&E and UCCs at Royal Blackburn and Burnley General Hospital to help to reduce delays.
- The trust had a clear escalation policy which described the steps it would take when demand caused pressure on capacity. Staff we spoke with were familiar with this policy and were very clear about the importance of the whole trust and other agencies working together.

Meeting people's individual needs

- We saw some evidence that the needs of vulnerable groups were catered for. There were nurse 'champions' designated to support, and provide guidance to other staff to support, people with dementia, depression or alcohol dependency.
- Age UK provided a service between 9am and 5pm, seven days a week. This included advice, transport and home support.
- There was a separate paediatrics area with its own waiting area. There was a baby-changing facility but we noted that there were no children's toilets. We also noted that artwork within the paediatrics area was not age appropriate and there were few toys in the waiting room.

Urgent care centre

- There was little support for people with mental health needs. A mental health liaison service was available but did not have the capacity to provide anything more than telephone advice and to undertake mental health assessments.
- Patients awaiting assessment or awaiting a mental health admission were often left for a long period in an unsuitable environment and without adequate support. Patients who were assessed as being at risk of harming themselves or others were accommodated in a secure room. This was sparsely furnished and was a cold and unwelcoming environment. The matron agreed with us that this room was neither comfortable nor welcoming. They told us the room was used on a regular (about weekly) basis and, on occasions, patients may be confined in this space for many hours. We were told of a recent incident where a patient was kept in this room for around 11 hours waiting for a suitable hospital bed to be found. They were monitored by nursing, support and security staff for their own safety but the centre did not have the capacity or the skills to deal with patients who were experiencing a mental health crisis.
- Translation and interpreter services were available for people whose first language was not English. Patient information was available in a range of languages and formats.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. Patients who wished to complain were encouraged to speak with a senior member of staff. If their concerns remained unresolved they would be directed to the Patient Advice and Liaison Service (PALS). This service was publicised in the centre. If they still had concerns following this, they would be advised to make a formal complaint.
- Complaints were investigated by the lead consultant and/or the relevant matron. There were weekly divisional complaints meetings. Patients and/or relatives were contacted and invited to speak personally with the person investigating their complaint.
- Complaint themes and lessons learned were discussed at regular 'share to care' meetings and governance meetings.
- The centre captured patient feedback using questionnaires. A report for the period March 2013 to March 2014 showed that 399 responses had been received. This represented a response rate of about 3%.

The report showed the best and the worst performing areas but there was no in-depth analysis provided. We did see examples, however, where the centre had acted on negative feedback. These included improving signage to the centre and introducing a hearing loop and microphone system at reception to improve communication.

Are urgent care centre services well-led?

Requires improvement



The centre had experienced significant change over the last 12 months, with changes in management, clinical leadership, working practices and a move into a new building. The management team were proud of the fact that staff had demonstrated flexibility and had adapted to and embraced change, while delivering a service under increasing pressure.

We spoke with eight staff, from a range of clinical and non-clinical backgrounds. Staff were engaged, enthusiastic and motivated. They all spoke positively about the changes in the centre because they could see that they had resulted in real benefits to patient care. There was a real sense of pride about the improvements that had been achieved and a sense of optimism for the future.

However the unresolved issues relating to inappropriate patient and ambulance attendances in a unit that has been open since 2007 meant that the leadership of the service requires improvement.

Vision and strategy for this service

- The trust's vision was visible throughout the centre. A strapline, 'safe, personal and effective' was included on trust letterheads, patient information and staff badges. Staff had 'signed up' to this vision and were able to describe what it meant to them.
- Staff were clear about what their centre did well and where it could improve. Their views mirrored those of the management team.

Urgent care centre

Governance, risk management and quality measurement

- Regular governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.
- The centre maintained a risk register which fed into the divisional and ultimately, the trust-wide risk register. This was regularly reviewed.

Leadership of service

- The directorate was managed by a triumvirate, including a clinical lead (A&E consultant) matron and a directorate manager. The matron was newly appointed in an acting capacity although was an existing member of staff. The clinical lead, although an existing consultant took over as clinical lead on 1 May 2014. The previous post holder had undertaken the role for some years and was remaining in the directorate. The team worked cohesively and cooperatively and were respected by staff.

Culture within the service

- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- All of the staff we spoke with spoke positively about the open culture in which they were encouraged to speak up if they had concerns about patient care.
- Managers were visible and accessible and led by example. Staff spoke positively about their presence and the support they provided.
- Staff were enthusiastic and engaged. Two staff members enthused about the team spirit in the centre and greatly improved morale. They told us they were happy to come to work.

- Staff felt supported professionally, with opportunities for learning and peer support.

Public and staff engagement

- Staff were well-informed, engaged and involved. There were weekly 'share to care' meetings which staff told us were well attended by all grades of staff. There were used for information sharing and allowed staff opportunities to raise concerns or make suggestions about how the service or their working experience could be improved.
- There was information displayed within the centre to inform patients how the centre was performing, including results of monthly patient surveys. There was a 'You said, we did' display in the waiting area which described improvements the centre had made in response to patient feedback.
- We were told that the trust had used various methods to communicate with its public stakeholders to educate them about function of the service. These included media campaigns and a leaflet drop to households in Burnley and surrounding areas.

Innovation, improvement and sustainability

- Staff were encouraged and empowered to make improvements. We heard that staff working in the paediatrics section were liaising with their colleagues in the Royal Blackburn department to improve the artwork in the centre to make it more 'child friendly'.
- The physiotherapy service was one of a few UCCs in the country which operated a 'first contact' service, which meant that they could commence triage directly following patient triage, thus improving efficiency and patient experience. Staff were encouraged to develop new patient pathways; there were plans to work with orthopaedics to reduce attendances at fracture clinics.

Medical care (including older people's care)

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

Information about the service

East Lancashire NHS Hospitals Trust serves a population of about 521,400 and in 2012/13 it was estimated that there were 128,665 inpatient episodes. Burnley General Hospital provides a range of general and specialist medicine services along with a full range of diagnostic – e.g. magnetic resonance imaging (MRI), computerised tomography (CT) scanning – and support services to people across East Lancashire. The hospital is an East Lancashire Hospitals NHS Trust site which specialises in planned (elective) treatment.

During our inspection we visited all medical wards at Burnley General Hospital. These were Wards 16 (medical step down), 23 (general medicine), 28 (planned admissions) and Rakehead Rehabilitation Centre which specialised in neurological rehabilitation.

We visited the wards over one working day. We spoke with eight patients and three relatives and received information from our listening events and from people who contacted us to tell us about their experiences. We also spoke directly to staff, including nurses, matrons, allied health professionals, consultants and ward managers. In addition, we held focus groups for allied health professionals, consultants, junior doctors, student nurses and healthcare assistants, nurses and midwives.

We observed how care and treatment was provided and looked at care records. Prior to our inspection, we reviewed performance information about the trust and information from the trust.

Summary of findings

Overall we found that Burnley General Hospital was providing medical care that was safe, effective, caring, responsive and well-led. The trust had recently combined its medicine and community divisions to form an integrated care group, the head of which was a GP. The aim was to improve the links between acute care and community care. Staff told us that there had been significant improvements in the culture of the trust within the last 12 months. They reported a more open and honest culture where they felt supported to raise concerns and report incidents.

Ward environments were clean and well-maintained. Staff followed infection control procedures and patients reported they were happy with the cleanliness levels on the wards. Multidisciplinary working was well-established and there were good working relationships with community services. We found the hospital provided a responsive service to meet people's needs and there were clear discharge arrangements in place across all the wards we visited.

Nursing and allied health staff confirmed that they were largely covering seven-day service requirements among them by increasing extended hours and working overtime. However, there were concerns that this was not a sustainable approach. There was on an ongoing recruitment campaign to address staff shortages and the trust had introduced flexible working arrangements, but staff sickness levels for all the wards we visited were still above the trust average.

Medical care (including older people's care)

Are medical care services safe?

Good



Overall we found ward environments were clean and well-maintained. Staff followed infection control procedures and patients reported they were happy with the cleanliness levels on the wards.

Staff told us they were confident in reporting incidents and felt there had been a change in culture which now meant that reporting of incidents was encouraged. There was evidence that learning from incidents took place and this learning was shared with staff through weekly meetings.

In the past year the trust had undertaken a major recruitment campaign to increase numbers of staff. Despite this, we found there were still qualified staff vacancies on some of the wards we visited. Overall, nursing staff reported an improvement in staffing levels in the last 12 months.

Incidents

- No Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) had been reported in medicine between December 2012 and January 2014. This was within expectations compared to trusts of a similar size. The trust reported an expected number of incidents in total. However, they were identified as being at risk for under-reporting incidents resulting in death or severe harm. Between March 2013 and February 2014, there were no patient deaths reported for Burnley General Hospital.
- Incidents were reported via an electronic form and could be reported by any member of staff. A copy of the form was sent to the person in charge of the area where the incident occurred. Incidents were then allocated to the appropriate person for investigation if required.
- Medical staff, nursing staff and allied health professional staff were all clear on how to report an incident. Staff reported that there had been a significant change in culture in the last 12 months which meant that reporting of incidents was now actively encouraged.
- Some staff commented that they did not always get individual feedback on incidents they had reported.

However, minutes for the weekly meetings called 'share to care' and weekly multidisciplinary ward meetings demonstrated that learning from incidents and any identified themes were reported back to staff.

- All serious incidents were fully investigated. Allied health professionals told us they were actively involved in any serious incident reviews and that investigations were a multidisciplinary effort.
- All serious incidents were also taken to the Serious Incident Requiring Investigation Panel (SIRI). This panel was chaired by a non-executive and it aimed to improve the standard of investigation and reporting.
- All mortality incidents were fully investigated and minutes from the weekly 'share to care' meetings and weekly multidisciplinary ward meetings show mortality reviews were discussed.
- Mortality reports were then reviewed at monthly divisional management and quality board (medical division) meetings to identify learning or action required across the division.

Safety thermometer

The NHS Safety Thermometer is a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections.

- For new pressure ulcers (hospital acquired) and new urinary tract infections the trust performed well below the England average for the entire year in 2013 for all patients and patients aged over 70.
- For new venous thromboembolisms (VTEs or blood clots) the trust's figures were above the England average for five months of the year, primarily in June 2013 when the number of VTEs increased above the average by 3.5%. However, from November 2013 to January 2014 the trust performed in line with the national average.
- Overall the trust performed below the England average for falls with harm for all patients and patients aged over 70, except in the period from July 2013 to September 2013.
- However, the majority of incidents resulting in moderate or severe harm occurring in the medicine division were in relation to falls and hospital acquired pressure ulcers. The medicine division across the trust reported 16 falls with moderate harm between April 2013 and March 2014. This was an overall reduction of 50% from 2012/13 when the division had reported 31 incidents and was a greater improvement than the

Medical care (including older people's care)

trust's planned reduction of 15%. However, the number of incidents of hospital-acquired pressure ulcers reported by the medicine division had increased from 12 to 15 (grade 3) and from 3 to 7 (grade 4). There had been a decrease in grade 2 pressure ulcers from 64 to 38 reported incidents.

- The trust's Safety Thermometer 'harm-free care' report for February 2014 stated that, to reduce the number of pressure ulcer incidents, all harms require a root cause analysis to be undertaken by the ward manager, with support from the matron. Grade 2 and 3 pressure ulcers are to be presented to the divisional deputy chief nurse and any grade 3 or 4 pressure ulcers will be presented to the chief nurse or deputy chief nurse. The SIRI panel were also reviewing all pressure ulcer incidents. Minutes from the divisional management and governance board meeting February 2014 noted it was unclear where checking at a divisional level was taking place. It was agreed that this work should be undertaken at directorate level with the governance board made aware of progress and issues to support the process.
- On every medical ward we visited there was a 'How are we doing?' board clearly displayed. It included the 'safety cross' which showed the number of days since a fall, a pressure ulcer, MRSA and Clostridium difficile (C. difficile) incident. It also showed their recent performance in the NHS Friends and Family Test.
- Results from the Safety Thermometer were discussed during weekly ward meetings with learning cascaded via the weekly 'share to care' meetings.

Cleanliness, infection control and hygiene

- The wards we visited were clean and there was adequate supply of personal protective equipment such as gloves and aprons. Staff were seen to be adhering to the "bare below the elbows" policy and used protective equipment appropriately.
- Staff washed their hands regularly and hand gel was available at the end of each patient's bed, and we observed staff using it before and after patient contact.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- Audits were undertaken monthly on hand hygiene, aseptic non-touch technique and high-impact

interventions (key clinical procedures or care processes that can reduce the risk of infection). The divisional overall average for high-impact intervention compliance was 99.84%. The divisional average for hand hygiene was 98%. Action plans were in place where issues had been identified and learning was communicated to staff via weekly 'share to care' meetings and weekly ward meetings.

- An annual Patient-led assessment of the care environment (known as PLACE) was conducted in June 2013. The assessment gave the Blackburn General Hospital 92.77% for cleanliness. The trust's infection control monthly reports show that action plans were in place to address issues in identified areas.
- All of the patients we spoke with told us they were happy with the levels of cleanliness on their ward.

Environment and equipment

- All the wards we visited were in a good state of repair and there was sufficient equipment available.
- Equipment (such as hoists) was cleaned regularly by staff and maintained appropriately by the manufacturer.
- On Ward 28 there was a dedicated, lockable equipment storage room where electrical diagnostic and treatment equipment could be stored securely after cleaning. The room had additional plug sockets so that equipment could be charged overnight and at weekends when not in use.
- Resuscitation equipment was available on each ward and records showed equipment was checked daily.

Medicines

- Medication errors per 1,000 were within statistically acceptable limits. There had been no medication errors resulting in serious harm from April 2013 to Mar 2014 within the medicine division.
- Medicines were stored correctly in locked cupboards, trolleys or fridges where necessary. Each patient had a prescription chart which was reviewed regularly by a consultant and pharmacist.

Records

- All notes on the medical wards were in paper format. Generally, we found notes to be well maintained.
- Risk assessments for VTEs, falls, pressure ulcers and malnutrition were completed on admission and were updated throughout a patient's stay.

Medical care (including older people's care)

- Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were in place for patients where indicated. Forms had been completed by a consultant and there was evidence that decisions had been discussed with the patient and their relatives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with on the wards were able to explain processes in place for obtaining consent and they demonstrated a clear understanding of deprivation of liberty safeguard protocols.
- Training on the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards was included as part of the core mandatory training. Compliance with training was discussed during the divisional management and governance meetings. Minutes from these meetings state that all non-compliant staff had received correspondence about this by 31 March 2014.
- Additional modules were available as part of the safeguarding training, however, staff awareness that this training was available was found to be limited.
- Where patients were able to provide informed consent, we saw consent forms were completed containing information about the potential risks and intended benefits. The consent forms we viewed had been signed and dated by the patient and the treating consultant.

Safeguarding

- The trust provided four training modules around safeguarding, the first of which was part of the core mandatory training for all staff. Staff completion of mandatory safeguarding training varied across the wards we visited and was largely affected by the number of new staff that had been recruited.
- Staff we spoke with were able to describe when they would make a safeguarding referral and the process they would follow. Staff were particularly aware of possible issues that may arise due to the nature of some of the conditions patients in the area presented with.
- The wards also had access to a safeguarding lead. Any concerns regarding safeguarding could be escalated to the lead for advice and support.

Mandatory training

- The trust provided core mandatory training to all permanent staff. Overall core mandatory training compliance for the medical division across the trust was

81% (by location, Burnley General Hospital was 78% compliant). However, this figure did not include bank, temporary or fixed-term contract staff, staff with long-term sickness, staff on adoption/maternity leave, foundation year 1 and 2 staff. It is therefore difficult to gain a clear picture of the actual number of staff working at the trust who had received up-to-date mandatory training.

Management of deteriorating patients

- The medical wards at Burnley General Hospital used an early warning score system that was used throughout the trust to alert staff if a patient's condition was deteriorating. As part of the observation chart, the expected escalation process was displayed.
- From the records we reviewed, each patient had an early warning score and pain score assessment completed daily, and at regular intervals throughout the day if required.
- We found that, where indicated, patients were referred to a consultant for a review, in line with escalation protocols.

Nursing staffing

- The trust told us they had undertaken a staffing review using recognised staffing acuity tools and guidance (the Telford method, promoted by Dr Keith Hurst).
- In the past year, the trust had undertaken a major recruitment campaign to increase numbers of nursing staff. As a result, a number of newly qualified band 5 nurses had been recruited, along with a number of nurses from overseas.
- In the NHS Staff Survey 2013, the trust was in the top 20% for staff working extra hours.
- Minutes from the trust integrated performance report, April 2014 highlighted that the trust continued to experience high levels of bank (overtime) and agency spend, with 23% of spend on middle grade doctors, and a further 25% on qualified bank and agency nurses.
- We were told that, in addition to the recruitment campaign, the trust had also introduced flexible working for staff to support those who did not wish to retire but who wanted to work part-time hours.
- Sickness rates for all of the wards we visited were above trust average, though it was not clear from the information provided how this was distributed across qualified and healthcare assistant staff. In general terms, the trust had undertaken a recruitment drive to improve staffing levels and so reduce strain on staff. The trust

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also had a 'Fast Physio' service which aimed to support workers with occupational health issues. Since establishing the service, there had been a 5% reduction in musculoskeletal injuries. However, it was not clear what action was being taken specifically to address the issue of staff sickness.

- Overall, the nursing staff we spoke with reported an improvement in staffing levels in the last 12 months.

Medical staffing

- Medical staffing depended on the speciality of the ward.
- The head of the integrated care group and the chief of medicine told us that the level of seven-day service provided by medical and senior medical staff was something they felt the medicine division did well. However, they also told us that a shortage in medical staffing was the main concern in the medicine division.
- Ward 28 was a nurse-led unit with telephone support from the ambulatory care centre at the Royal Blackburn Hospital if required. On-call support was largely provided by locum medical staff which has caused problems, particularly in terms of advance prescription of medicines for patients with long-term conditions. Locums also did not have access to the relevant electronic systems which had caused delays in booking investigations. For example, the ward could not follow the relevant policy for a patient with an unprovoked (none of the identified risks) deep vein thrombosis (DVT) because the locum on call could not access the system.

Major incident awareness and training

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investigations. For example, the ward could not follow the relevant policy for a patient with an unprovoked (none of the identified risks) deep vein thrombosis (DVT) because the locum on call could not access the system.

Are medical care services effective?

Good



Care was provided in line with national best practice guidelines and the trust had participated in a range of clinical audits. Multidisciplinary working was well-established and there were good working relationships with community services. We found the wards functioned well as an interface between hospital and the community to enable effective care and discharge.

No issues were highlighted regarding lack of availability of services out of hours. Nursing and allied health staff confirmed that they were largely covering seven-day service requirements among them by increasing extended hours and working overtime. However, there were concerns that this was not a sustainable approach.

Evidence-based care and treatment

- Best practice guidelines were utilised throughout the medicine division in the trust to standardise care. For example, NICE guidelines were used on Ward 28 for blood transfusion reaction protocols and Advancing Quality standards were used in the management of stroke.
- Policies and protocols referenced research and best practice guidance. Care pathways and 'care bundles' had been introduced to standardise care and improve compliance with best practice guidelines and quality standards.
- The trust had participated in all of the clinical audits for which it was eligible in the 2012/13 period.
- According to the trusts clinical audit annual report in 2012, the medicine division completed 80 out of a possible 140 projects (with a further 43 classed as ongoing) of which 43 were clinical audits.
- From the report it is not possible to see how many Burnley General Hospital participated in specifically. The report shows that 95% of audit action plans had been received from the medicine division. The report also shows the recommendations made following the audits. For example, a recommendation from the Community

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Hospitals Audit: Pressure ulcer management and pressure-relieving devices, was "to share the results of this questionnaire with all staff, service managers and commissioners for information and consideration on service delivery". However, it was not clear whether this occurred, what action was taken at ward level or how this was followed up.

Pain relief

- Each patient had an early warning score and pain score assessment completed daily and at regular intervals throughout the day if required.
- We found that, where indicated, patients were referred to a consultant for a pain relief review in line with escalation protocols.

Nutrition and hydration

- A malnutrition universal screening tool was completed for each patient on admission and was reviewed regularly. Where indicated, patients identified as being at risk of malnutrition were referred to the dietician for further assessment.
- Dietitians' assessments were completed where required and clear care plans were in place for staff to follow as a result. The dietary assessment charts and fluid balance charts we reviewed were completed appropriately.
- Snack menus were available for patients identified as being at risk from malnutrition and we found these menus were being used appropriately.
- The majority of patients we spoke with during our inspection and at our listening events told us that the food at Burnley General Hospital was good.
- We found that the red tray system was in use on most of the wards we visited. This system uses a red tray to deliver food to patients who require additional support during meal times. We observed staff assisting patients with their meals in a calm and respectful manner.

Patient outcomes

- Not accessible for this site.

Competent staff

- According to the trust integrated performance report for April 2014, medical staff appraisal rates were satisfactory: 90% of consultants and 76% of non-consultant grade doctors had had an appraisal in the last 12 months; 91% of consultants had an up-to-date job plan at the end of 2013.
- Nursing staff reported that they received an annual appraisal. They also told us they received informal

supervision when required. We found appraisals for 2014 had been booked, though we noted the timeframe for completion was narrow. For example, on one ward, we were told they were due to be completed by the end of June 2014. It was not clear how staff could be given time to prepare for the appraisal to ensure the process was meaningful and contributed to professional development.

- Newly qualified nurses reported that they received a 12-month preceptorship training period.

Multidisciplinary working

- Multidisciplinary working was well established on the medical wards at Burnley General Hospital. We were particularly impressed by the level of effective multidisciplinary working at the Rakehead Rehabilitation Centre. Comprehensive multidisciplinary risk assessments were carried out prior to admission onto the unit; there were weekly multidisciplinary ward rounds and monthly multidisciplinary meetings to ensure an integrated approach to care and treatment.
- Allied health professionals at Burnley General Hospital told us there was good communication and cross-site working between Burnley General and Royal Blackburn hospitals.
- There were well-established links with community services. We found the wards functioned well as an interface between hospital and the community to enable effective care and discharge.
- A mental health liaison team was based at Royal Blackburn Hospital but was provided by Lancashire Care NHS Foundation Trust. There were good links with this team across the wards but most notably on the Rakehead Rehabilitation Centre. However, staff reported that it could sometimes take three to four days for the team to respond to a referral.

Seven-day services

- Medical staffing depended on the speciality of the ward. For example, there were two consultant ward rounds per week plus support from a clinical fellow permanently on Ward 16, while Ward 23 had consultant support throughout the week, plus additional support from two newly appointed clinical fellows. In addition, there was out-of-hours, on-call consultant support if required. Weekly multidisciplinary ward rounds took place on all wards. The staff we spoke with felt they had

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adequate support from medical staff throughout the week and out of hours. The sister on Ward 23 informed us they had also recently employed two clinical fellows to increase the availability of medical support available.

- No issues were highlighted regarding lack of availability of services out of hours. Nursing and allied health staff confirmed that they were largely covering seven-day service requirements among them by increasing extended hours and working overtime. However, there were concerns that this was not a sustainable approach.

Are medical care services caring?

Good



Burnley General Hospital had received a rating of 4 out of 5 stars on the NHS Choices website. The majority of patients and relatives we spoke with during our visits to the wards told us they were happy with the way staff had cared for them. Patients and relatives we spoke with during our visits to the wards also told us they felt fully involved in decisions about their care and that options had been clearly explained to them.

We observed staff treating patients in a kind and respectful manner and staff were responsive to patients' needs.

Compassionate care

- The NHS Friends and Family Test results show that the trust performed above the England average for all four months reported (October 2013 – January 2014). Response rates for the trust were also well above England average for the same four-month period. However, response rates across the medical division varied, with some wards consistently achieving expected response rates, while others under-achieved. We discussed this with ward managers who had identified where improvements were needed and they had raised with staff during the weekly 'share to care' meetings.
- Analysis of data from the CQC's Adult Inpatient Survey 2012 shows that the trust was performing 'about the same as other trusts' for all 10 areas of questioning.
- The wards/departments also collected patient experience questionnaires on a monthly basis, asking

patients about a number of areas of their patient experience. In January 2014, the medicine division for the whole of the trust received an overall score of 92% for patient experience.

- Burnley General Hospital has 159 'reviews' on the NHS Choices website. Overall the hospital received a rating of 4 out of 5 stars. Ten of these reviews were received between February 2014 and March 2014. Of these 10 reviews, there were eight positive comments, four of which were rated five stars. Comments include: "caring staff", "relaxed environment", "clean environment", "helpful staff", "knowledgeable and efficient staff".
- The majority of patients and relatives we spoke with during our visits to the wards told us they were happy with the way staff had cared for them. People praised staff for their patient and caring approach, despite being busy. People who attended the listening events also told us they were generally happy with the care they had received at Burnley General Hospital.
- We observed staff treating patients in a kind and respectful manner and staff were responsive to patients' needs.

Patient understanding and involvement

- Some of the people who attended the listening events told us they did not always feel that staff had involved them in decisions about their care. However, the majority of patients and relatives we spoke with during our visits to the wards told us they did feel fully involved in decisions about their care and that options had been clearly explained to them.
- Throughout the hospital there were a range of patient information leaflets on the various services available to them, such as advice on help to choose a care home. Leaflets about how to provide feedback, make comments and raise concerns were also readily available.

Emotional support

- The trust had access to a chaplaincy service. Christian and Muslim chaplains were available and we were told that representatives of other faiths could be called in if requested.

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Are medical care services responsive?

Good



During our inspection we found examples of how the hospital provided a responsive service to meet people's needs. For example, the trust had set up a virtual ward in the community. The aim of the ward was to support patients in the community to manage their ongoing chronic conditions and avoid hospital admission. Also Ward 28 (planned admissions) provided a flexible booking system to meet people's needs and Radiology had increased working hours to provide CT and MRI scanning services at the weekends.

There were clear discharge arrangements in place across all the wards we visited. On Ward 23 we were impressed by the integrated working with community services and general practice. On the Rakehead Rehabilitation Centre the discharge planning process was initiated on admission with full multidisciplinary input.

Service planning and delivery to meet the needs of local people

- The trust had set up a virtual ward. The aim of the ward was to support patients in the community to manage their ongoing chronic conditions and avoid hospital admission. The trust reported that a local outcome analysis had demonstrated that, for the three months following admission to the virtual ward, there were significantly fewer patient admissions to the hospital than in the three months prior to admission to the virtual ward. We were told that this service had been suspended due to concerns around staff levels and skills mix. Following recruitment and staff training, the ward was due to open again at the time of our inspection.
- Ward 28 provided a planned admissions service from Monday to Friday, mainly day case patients with some overnight cases. The service was mainly for patients requiring blood transfusions and chronic disease management. There was a flexible booking system to meet individual needs. A patient told us the staff were always accommodating in their approach when trying to schedule appointments. For example, they worked around patients going on holiday to ensure they still received the care they required.

- Podiatry services told us that there had been an increased demand for community diabetic foot ulcer services and that current staffing levels could not support the demand. This meant that lower risk patients were not being seen as regularly and so prevention work was not taking place. This issue had been added to the divisional risk register and was discussed at the divisional management and governance meeting in February 2014. The department were reviewing the service and skills mix required at the time of our inspection.

Access and flow

- Patients accessing Wards 16 and 23 were planned admissions. These wards had been developed by the trust as 'step down' wards for intermediate care for patients transferred from Royal Blackburn Hospital.
- In general staff reported these wards worked well. However, on Ward 23 it had been noted by staff that the dependency of patients had been increasing. Ward meeting minutes highlighted that there had been some issues around patients being transferred late at night.
- The trust had undertaken a review of discharge processes and there had been some improvements. However, Royal Blackburn Hospital still experienced issues with bed management and patient flow which, on occasion, had led to inappropriate transfers to the medical wards at Burnley General Hospital.
- It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. The trust had 81.7% bed occupancy between October 2013 and December 2013. Prior to this the trust's occupancy levels had been higher than the national average and the 85% threshold and had spiked between January and March 2013 at 91.2%. The bed occupancy level for the general and acute divisions at Burnley General Hospital between April 2013 and March 2014 was 80%.
- Radiology had increased working hours to provide CT and MRI scanning services at the weekends.
- The CQC Intelligent Monitoring report did not identify any risks around referral to treatment times and diagnostics waiting.
- The CQC Intelligent Monitoring report rated all cancers and found no evidence of risk in the following: 62-day

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wait for first treatment from NHS cancer screening referral; 62-day wait for first treatment from urgent GP referral; and 31-day wait from diagnosis (January to March 2013).

Meeting people's individual needs

- Wards had access to a range of specialist link nurses to meet the complex needs of some patients.
- We were told that some patient information leaflets could be provided in other languages and formats. However, we noted that few were available and staff awareness of the services and information available was limited.
- A translation telephone service was also available but we found that relatives were often relied on to provide translation for patients.
- Staff told us that patients with learning disabilities would often arrive with a care 'passport' which provided information about the individual's needs. In the absence of this document, staff said they spoke to relatives and carers to find out about the person's needs, routines, likes and dislikes.
- Wards also had access to a learning disabilities link nurse for advice and support where required.
- The trust was in the process of implementing the Butterfly Scheme (this scheme allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs).
- Clinical nurse specialists and link nurses were available to provide advice and support in specific areas such as stoma care, falls and diabetes management. An alcohol liaison nurse was also available.
- A mental health liaison team was based on site at Royal Blackburn Hospital (provided by Lancashire Care NHS Foundation Trust).
- Wards had an identified dementia champion to advise on and promote awareness of the needs of people with dementia.

Discharge planning

- There were clear discharge arrangements in place across all the wards we visited. On Ward 23 we were impressed by the integrated working with community services and general practice. On the Rakehead Rehabilitation Centre the discharge planning process was initiated on admission with full multidisciplinary input.

- We noted that, while clear verbal handovers were given to patients being discharged into care homes, these were not always supported with the same level of documentation. Community occupational therapists told us it would help to improve the discharge process if all information given to care homes was clearly documented.
- Despite good links with community services, staff reported there were delays in discharge for patients with acquired brain injury and complex needs at the rehabilitation centre. This was due to a lack of suitable facilities being available in the community. An example was given of a 12-month delay in discharge due to there being no safe and suitable available service in the community for one patient.

Learning from complaints and concerns

- The Keogh Mortality Review July 2013 highlighted that the trust's complaints process was poor and lacked a compassionate approach.
- The trust policy had been amended to reflect the need to offer meetings for all persons making a complaint, unless there were specific reasons why a meeting could not be offered. Staff told us that this was happening in practice. This was an improvement since the Keogh Mortality Review.
- We were told that any learning from complaints was communicated via the 'share to care' meetings and ward meetings, though no specific examples were provided.
- According to the trust's quarterly complaints and PALS report (November 2013 – February 2014) while the trust kept complainants updated as to any possible delays, improvements were still needed to ensure investigations were completed in a timely manner.
- This was corroborated by the minutes for the divisional management and quality board (medical division) meeting in February 2014 which highlighted that, while there had been considerable work to improve a backlog in complaints, there was still an issue around meeting the 25-day response time. The minutes also showed that efforts were being made to improve patient engagement and address concerns before they reached complaint stage.

Are medical care services well-led?

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Good



The trust had recently combined its medicine and community divisions to form an integrated care group, the head of which was a GP. The aim was to improve the links between acute care and community care. Staff told us that there had been significant improvements in the culture of the trust within the last 12 months. Staff reported a more open and honest culture where they felt supported to raise concerns and report incidents.

Some staff told us that Burnley General Hospital still felt “separate” from Royal Blackburn Hospital but that this was improving. Initiatives such as monthly team briefs enabled senior members of staff and the executive and non-executive board to better understand the challenges faced by staff and were received positively by staff.

Innovation was encouraged from all staff members across all disciplines and we found examples of how this had led to improvement in practice and working environment.

Ward managers were able to clearly identify the main risks on their wards. However, the use of risk registers throughout the division was inconsistent.

Vision and strategy for this service

- All the staff we spoke with were clear on the trust's vision for the service.
- Staff told us the main aims of the service were to provide safe, effective, personal care and to ensure that the right care is given to the right patient at the right time and by the right staff. Staff at all levels felt there was a genuine commitment to improvement. However, there was some anxiety expressed about the longevity of these changes given that the chief executive, along with several other members of the board, were interim.
- The trust had recently combined its medicine and community divisions to form an integrated care group, the head of which was a GP. The aim was to improve the links between acute care and community care. We spoke with the head of the integrated care group and the chief of medicine who told us there had been a real change in the leadership culture towards openness and honesty. Staff we spoke with confirmed this, reporting a more open and honest culture where they felt supported to raise concerns and report incidents.

Governance, risk management and quality measurement

- All the ward managers we spoke with were able to clearly identify the main risks on their wards. However, the use of risk registers throughout the division was inconsistent. The ward managers on some wards seem to be using the risk register well to identify and monitor risks within the service. However, on other wards, while the ward manager could clearly explain what the main risks on the ward were, the risk register did not always reflect this. For example, on one ward the ward manager explained that one of the main risks was around delays in treatment and that they had developed a protocol to address this, which was going through governance for approval. However, this risk did not appear on the risk register for that ward.
- There were structured monthly governance meetings held by each directorate within the division (e.g. older people, gastroenterology) to discuss and review areas such as incidents, complaints, staffing, training compliance and implementation of ongoing action plans (such as the alcohol-related liver disease action plan). These meetings then fed in to a monthly divisional management and quality board that had oversight of all ongoing issues and projects across the whole of the medicine division such as mortality, complaints, implementation of care pathways, policy development, infection control and the divisional risk register. Minutes from these meetings show generally good attendance with representatives from each division, including the divisional directors, clinical directors, matrons, the divisional governance lead, complaints manager and human resources. Any learning or outcomes from these meetings was cascaded down through ward managers to staff via the weekly ‘share to care’ meetings and ward meetings.

Leadership of service

- Staff reported that there was visibility of the trust's board throughout the service.
- Initiatives such as monthly team briefs enabled senior members of staff and the executive and non-executive board to better understand the challenges faced by staff and were received positively by staff.

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- Some staff told us that Burnley General Hospital still felt “separate” from Royal Blackburn Hospital but that this was improving. Ward managers told us that the chief executive and the chief nurse had visited the wards to see how they worked and what issues they had.

Culture within the service

- In the NHS Staff Survey 2013 the trust's performance was rated as better than expected or tending towards better than expected for 16 of the 28 key findings. Areas where staff felt the trust was performing well included: lack of pressure felt by staff; staff appraisals; low proportion of staff experiencing violence from patients or their friends and families; staff motivation and job satisfaction.
- In the NHS Staff Survey 2013 the trust's performance was rated as worse than expected or tending towards worse than expected for seven of the 28 key findings. Areas where staff felt the trust needed to improve included: training; staff experiencing discrimination; proportion of staff witnessing potentially harmful errors; and number of ‘near misses’. The trust's performance for “Staff recommendation of the trust as a place to work or receive treatment” was tending towards worse than expected.
- We asked staff about the findings highlighted by the survey. They told us that, in the past six to 12 months, they had seen a real change in the culture of the management team. Staff reported a more open and honest culture where they felt supported to raise concerns and report incidents. All staff we spoke with, either individually or as part of focus groups, told us they were proud to work for the trust. The majority of staff told us that they would now recommend the trust as a place to work, even though they stated that 12 months ago they wouldn't have.
- The trust's sickness absence rates by staff group were all below their respective England averages, except for the nursing staff group which was slightly above the England average. Sickness rates for all of the wards we visited were above trust average, though it was not clear from the information provided how this was distributed across qualified and healthcare assistant staff.
- In general terms, the trust had undertaken a recruitment drive to improve staffing levels and so reduce strain on staff. The trust also had a ‘Fast Physio’ service which aimed to support workers with occupational health

issues. Since establishing the service there had been a 5% reduction in musculoskeletal injuries. However, it was not clear what action was being taken specifically to address the issue of staff sickness.

- Staff at all levels told us that the changes to the hospital management team had had a positive impact on their ability to deliver good standards of patient care.

Public and staff engagement

- The ‘Tell Ellie’ (East Lancashire listens, involves, engages) campaign was launched in January 2014 following public feedback requesting that the trust goes out to meet the community rather than expecting the public to attend meetings arranged by the trust. As a result, Tell Ellie roadshows were held in town centres across East Lancashire. The trust also developed a dedicated telephone line and email address, feedback leaflets and a Facebook and Twitter page. The trust reported that over 300 people attended the roadshows.
- ‘Tell us what you think’ leaflets were available throughout the hospital. Some wards displayed ‘You said, we did’ feedback on boards to demonstrate how they had acted on people's comments. However, this was not an approach used consistently throughout the division.
- The minutes for the divisional management and quality board (medical division) meeting in February 2014 state that there was ongoing focus on engaging and supporting new starters in the trust, as it had been highlighted that a large number of new starters leave the organisation within their first year of employment. Suggested actions included sending out a communication update to all staff and the board agreed that senior management visibility was crucial to staff engagement.
- In April 2014 the trust ran a staff engagement campaign called “The Big Conversation” which enabled staff to meet and discuss the improvements they felt were needed to provide safe, personal, effective care. Some of the staff we spoke with told us they had been involved in these events and felt they were useful

Innovation, improvement and sustainability







- The trust had a library and knowledge services that were available for all trust staff. The head librarian had set up a portal for all staff members (also accessible from home) to access around 20,000 journals with

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secure online access through OpenAthens as well as the ability to carry out research. The head librarian confirmed that library staff would also source journals as required.

- There was a research project underway on the Rakehead Rehabilitation Centre to try and understand why the unit had a consistent history of no pressure ulcer development. It was felt this was largely due to the unit's multidisciplinary team work approach to pressure ulcer prevention. The aim was to share learning and replicate practice across the trust.
- Allied health professionals told us staff were encouraged and supported to be innovative. An example of this was the 'Fast Physio' service which aimed to support workers with occupational health issues. Since establishing the service there had been a 5% reduction in musculoskeletal injuries and the service was in the process of developing a new pathway for staff suffering from stress or anxiety. We were told there had been a 50% uptake of the service and, as a result, the trust was recruiting additional staff to support it.

Surgery

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

Information about the service

Burnley General Hospital provided a range of surgical services, including general surgery, urology, ophthalmology, orthopaedics, gynaecology and breast surgery. There were 14 theatres, including day surgery (elective) and emergency surgery theatres.

We inspected the elective orthopaedic ward, the gynaecology and breast ward and the ophthalmology day case ward as well as the pre-operative assessment unit, day surgery theatres and general theatres. We spoke with six patients, observed care and treatment and looked at medical records. We also spoke with a range of staff at different grades, including nurses, doctors, consultants, pharmacists, physiotherapists, ward managers, matrons and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences. We also reviewed performance information about the trust.

Summary of findings

Safety in surgery services required improvement. Theatre staff did not complete the documentation for the theatre equipment lists. Instruments should be checked and accounted for before and after each procedure to ensure they are not missing or left inside a patient.

Patient safety was monitored and incidents were investigated to assist learning and to improve care. Medicines and records were appropriately stored. The majority of staff received mandatory training, including safeguarding training. There was a sufficient number of staff with the right skills mix in place. The environment facilitated safe care, following infection control procedures.

Procedures and treatments within surgical services followed national clinical guidelines. Staff used care pathways effectively. Pain relief was well-managed and the nutritional need of patients were accounted for. The trust took part in national and local clinical audits. Staff were competent to carry out their roles and worked well within multidisciplinary teams.

Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional. Results from the NHS Friends and Family Test were above the England average, which meant a high number of patients would recommend this hospital to their loved ones.

Surgery

Procedures were in place to gain informed consent and involve patients at every stage. We saw evidence of multi-faith services available with timings for specific prayers and services.

Due to the lack of segregation, patients' privacy and dignity were not always afforded, as male and female patients, often wearing theatre gowns, were waiting together in the theatre reception area.

There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. Bed occupancy was below the England national average. Support was available for patients with dementia and learning disabilities. A translation telephone service was available for patients who did not speak English as their first language, and translators could be requested.

Trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. Risks were documented, reviewed and discussed. Leaders were visible and the departments were well-led locally. The teams were motivated and we observed an open and honest culture.

Are surgery services safe?

Requires improvement



Safety in surgery services required improvement. Theatre staff did not complete the documentation for the theatre equipment lists. Instruments should be checked and accounted for before and after each procedure to ensure they are not missing or left inside a patient.

Patient safety was monitored and incidents were investigated to assist learning and to improve care. Medicines and records were appropriately stored. The majority of staff received mandatory training including safeguarding training. There was a sufficient number of staff with the right skills mix in place. The environment facilitated safe care and infection control procedures were followed.

Incidents

- No Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers were reported at Burnley General Hospital between December 2012 and January 2014.
- The number of serious incident reports was in line with expectations for the size of the trust.
- Staff were actively encouraged to report incidents and understood how to report incidents if they encountered practice that could harm patients or staff.
- Incidents of concern were reported by staff on the electronic incident reporting system.
- Staff described recent incidents and clearly outlined what action had been taken. Any incidents relating to nursing care were reviewed by the ward manager and the matron for each area and medical incidents were reviewed by consultants or clinical directors.
- The ward manager for Ward 15 told us that two falls-related incidents were analysed on a monthly basis and reviewed and learning was then shared with the ward staff.
- We saw that all members of the multidisciplinary team were involved in a recent root cause analysis investigation and action plans had been developed and implemented to prevent reoccurrence.

Surgery

Safety thermometer

- Safety Thermometer information was clearly displayed at the entrance to each ward area. This included information about all new harms, falls with harm, new venous thromboembolisms (VTEs or blood clots), catheter use with urinary tract infections and new pressure ulcers.
- The trust was performing within expectations for these measures.
- Risk assessments for the above were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- The ward areas and theatres we observed were clean, well-maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as:
 - hand-washing facilities and hand gel available throughout the ward area
 - staff following hand hygiene and 'bare below the elbow' guidance
 - staff wearing personal protective equipment, such as gloves and aprons, while delivering care
 - suitable arrangements for the handling, storage and disposal of clinical waste, including sharps
 - cleaning schedules in place and displayed throughout the ward areas
 - clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
 - Data showed that no healthcare associated infections for MRSA or C. difficile had been attributed to surgical wards between April 2013 and January 2014. MRSA and C.difficile rates for the trust were within expected limits.
- All patients admitted to the surgical services underwent MRSA screening.

Environment and equipment

- The environment on the surgical wards and within the theatre areas was safe and well-maintained.
- Compliance with same-sex accommodation guidelines was ensured in all the areas we inspected. Cubicles were all designated for single accommodation with privacy curtains.
- We observed curtains being drawn around each bed prior to the delivery of care and during private discussions with patients about their care.

- There were ample supplies of suitable equipment which was well-maintained, clean and safely stored in both the theatres and ward areas.
- Emergency equipment, such as the defibrillator, was regularly checked and ready for use.
- Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- There was an equipment replacement schedule in place and equipment such as ventilators and monitoring equipment were scheduled for upgrade over the next two years.

Medicines

- Medicines, including controlled drugs, were safely and securely stored in the areas we inspected. The administration of controlled drugs was appropriate and the stock tallied up with the logs we looked at.
- Wastage of controlled drugs was recorded in the theatres and all entries in the theatre and ward areas were signed by two staff to ensure traceability.
- Fridge temperature monitoring records showed medicines were stored at the correct temperatures.

Records

- Patient records were kept securely in trolleys and nursing documentation was kept at the end of patient beds.
- We looked at four patient records. We were able to follow and track patient care and treatment easily as the records we reviewed were well kept, up to date, and accurately completed. Observations were well recorded; the timing of such was dependent on the acuity of the patient.
- Staff could easily locate and obtain any additional notes we required when conducting our patient record review.
- Formal handover sheets were completed, and stored in patient records, to ensure consistent information sharing took place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain consent appropriately and correctly. They were skilled in explaining the benefits, side effects and complications of proposed treatments and procedures to patients.
- Staff had received training in seeking consent from patients and were comfortable and competent in doing so.

Surgery

- We observed positive interactions between staff, patients and /or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.
- Patients and their families were involved in, and were central to, decision making about their care and support.
- We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately and we saw that the Act's associated deprivation of liberty safeguarding was applied.

Safeguarding

- All staff received mandatory training in consent and safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- Staff understood these requirements and knew about the safeguarding link nurses and the safeguarding lead for the division.

Mandatory training

- Staff reported they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety.
- As of March 2014, 78% of permanent staff in the surgical and anaesthetics services division had completed all of their mandatory training modules. Although this was low, all non-compliant staff had been identified and lists sent to their line management for action.
- The board report for March 2014 stated an increase in the uptake of mandatory training, especially around safeguarding training, which had improved from 69% to 75%.
- Although mechanisms were in place for staff to receive clinical supervision, there were inconsistencies in practice. Some staff had not received any clinical supervision and others expressed concern in regards to the lack of structure of the supervision they had received.

Management of deteriorating patients

- The surgical wards used a recognised early warning tool to alert staff to a patient whose condition was

deteriorating. There were clear directions for escalation printed on the reverse of the observation charts and the staff we spoke to were aware of the appropriate actions to take if patients deteriorated acutely.

- We looked at completed charts and saw that staff had escalated cases correctly, and repeat observations were taken within the necessary timeframes.
- Theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The trust had carried out an audit to monitor adherence to the existing WHO checklist policy from January 2014 to March 2014 which highlighted areas of non-compliance. As a result, there was an action plan in place to address these areas.
- We noted that theatre staff did not complete the documentation for the theatre equipment lists at the beginning or end of day of the operations observed. Instruments should be checked and accounted for before and after each procedure to ensure they are not missing or left inside a patient.

Nursing staffing

- Nursing staff handovers occurred twice a day and included discussions around patient needs and any staffing or capacity issues.
- Observations, discussions and information on the wards showed there were a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Information on staffing levels, including actual vs establishment, was clearly displayed near the entrance to the ward areas. This was updated daily and at the start of every shift.
- The ward staff told us they did not use agency or locum staff. Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team working overtime.

Medical staffing

- The junior doctor rota had several vacancies at senior house officer level which meant that the current doctors were covering additional shifts.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that senior support was readily available if they needed support or advice.

Surgery

- Surgical consultants from all specialities were on call for a 24-hour period, during which they were free from other clinical duties.
- Theatre staff worked across both the Burnley and Blackburn sites which meant there were consistent processes and practice.

Major incident awareness and training

- There was a documented major incident plan which listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident.
- Staff were aware of the plans and described the action they would take appropriately.

Are surgery services effective?

Good



Procedures and treatments within surgical services followed national clinical guidelines. Staff used care pathways effectively. Pain relief was well-managed and the nutritional needs of patients were accounted for. The trust took part in national and local clinical audits. Staff were competent to carry out their roles and worked well within multidisciplinary teams.

Evidence-based care and treatment

- Policies and procedures were based around professional guidelines from bodies such as NICE and the Royal College of Surgeons.
- Staff provided care in line with NICE clinical guideline 50 (recognition of and response to acute illness in adults in hospital) as well as the critical illness rehabilitation (CG83) guidance.
- The enhanced recovery programme was utilised within the surgical speciality. The programme focused on improving post-operative recovery process through nutrition, physical rehabilitation and patient education.
- Audits were carried out in line with guidance from professional bodies. The trust participated in all of the clinical audits for which it was eligible in the 2012/13 period.

- Findings from clinical audits were reviewed at the monthly departmental meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the trust.
- The trust's performance for one of the five National Bowel Cancer Audit indicators was found to be better than expected. The trust's performance for the other four indicators was found to be within expectations.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- Patient records showed that patients who required pain relief were treated in a way that met their needs and reduced discomfort.
- The patients we spoke with noted that pain relief was readily accessible when required.
- The dedicated pain relief team regularly reviewed their pain as part of intentional rounding (also known as comfort rounds or round-the-clock care).

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- Where patients had a poor nutritional intake, they were risk-assessed and fluid and nutrition charts were put in place to ensure they received adequate food and drink. Where necessary, a dietician assessment was performed.
- We spoke with three patients who were able to eat and drink normally. They told us they were given a choice of food and drink.
- We saw one occasion where a patient had arrived for a procedure in theatres just before 7:30am and, as per instructions, had not eaten anything for the previous 6 hours. Unfortunately the patient's surgery was delayed until 4pm; however, they were not given any food or fluid, which meant they were unnecessarily fasting for a prolonged period.

Patient outcomes

- There was participation in national audits such as the National Bowel Cancer Audit, hip surgery audit and performance and action plans were reviewed at monthly divisional clinical governance meetings.

Surgery

- The National Bowel Cancer Audit 2013 showed that the trust was performing better than the national average for case ascertainment (99% compared with national average of 95%), for the number of patients that had a computerised tomography (CT) scan (87% compared with national average of 83%) and 90% of cases reported to the audit were discussed at multidisciplinary team meetings. The national level was 97%.
- The National Bowel Cancer Audit 2013 highlighted that trust performance was below the national average for the level of data completeness. There were 105 cases having major surgery. For these cases, the level of data completeness was 61% compared to national average of 71%. The audit also highlighted that 92% of patients were seen by a clinical nurse specialist, compared to the national rate of 82%.
- The National Hip Fracture Database report 2013 showed that hospital performance was comparable with the England average for all the data sets.
- Information on patient-reported outcome measures was gathered from patients who had had groin hernia surgery, vascular vein surgery, or a hip or knee replacement. No risks were identified in relation to outcomes for these groups.
- The national early warning score (a system used to standardise the assessment of acute illness severity) audits were carried out in line with the Royal College of Physicians' guidelines. Results from October 2013 to March 2014 showed a high rate of compliance.

Competent staff

- Newly appointed staff underwent an induction process that lasted up to six weeks, during which time they were supernumerary and their competency was assessed prior to working unsupervised.
- Trust data showed 80% of staff within the surgical division had completed their annual appraisals. Staff we spoke with reported they had received an appraisal within the last year.
- Nursing and medical staff spoke positively about learning and development opportunities and told us they were supported by their line management.
- Theatre nurses who assisted in anaesthesia had undergone a three-month, in-house training course with an internal competency assessment.

Multidisciplinary working

- We saw staff from all disciplines working well in the areas we inspected.
- We saw evidence of effective communication between the teams within the surgical specialties such as minutes of meetings, patient handover notes and also notes in the patient records.
- Trainee doctors, nurses, physiotherapists and pharmacists we spoke with told us they were well supported. Allied health professionals worked well with ward-based staff to support patients' recovery and timely, safe discharge following surgery.
- Multidisciplinary team meetings were well-established to support the planning and delivery of patient-centred care. The daily meetings, involving the nursing staff, therapists, medical staff as well as social workers and safeguarding leads, took place where required, ensured the patients' needs were fully explored and, where necessary, actions put into place to ensure their needs were met.

Seven-day services

- Staff rotas showed that nursing staff levels were maintained in the ward areas at the same levels on weekends and weekdays.
- Medical cover was provided to patients in the surgical wards by the on-call staff from the gynaecology ward and at weekends and out of hours by a GP specialist trainee.
- Out-of-hours, microbiology, physiotherapy and pharmacy support was provided through telephone advice and on-call staff.

Are surgery services caring?

Good



Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional. Results from the NHS Friends and Family Test were above the England average, which meant a high number of patients would recommend this hospital to their loved ones. Procedures were in place to gain informed consent and involved the patients at every stage. We saw evidence of multi-faith services available with timings for specific prayers and services.

Surgery

Due to the lack of segregation, patients' privacy and dignity were not always afforded as male and female patients, often wearing theatre gowns, waited together in the theatre reception area.

Compassionate care

- The majority of patients and relatives we spoke with were positive about the care and treatment they received.
- Patients told us "all the staff are brilliant" and a patient on the gynaecology and breast surgery ward told us "I have been treated very well and staff have gone beyond what was expected, I couldn't have asked for more".
- The NHS Friends and Family Test was conducted between October 2013 and January 2014. The trust scored above the England average with October 2013 producing the highest score of the period, indicating that most respondents would recommend the hospital's wards to friends and family. The response rates were significantly higher than the England average indicating the scores were more likely to be representative of the opinions of the patients receiving care at the trust.
- Patients told us that staff closed the curtains when they were providing care to maintain their privacy and dignity and we observed this in the ward areas. However, patients in the theatre reception area, who were ready for procedures, were all waiting together in theatre gowns. We noted male and female patients as well as children were all waiting together. Due to the lack of segregation, patients' privacy and dignity were not always afforded.

Patient understanding and involvement

- Upon admission, patients were allocated a named nurse, to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.
- Patients and their families were involved in, and were central to, decision making about their care and support. They had been given the opportunity to speak with the consultant looking after them.
- We found that relatives and/or the patient's representatives were also consulted in discussions about the discharge planning process.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried. We observed one patient having an eye operation where the same nurse held their hand all the way through.
- A noticeboard outlined the various multi-faith services available with timings for specific prayers and services. Patients also had access to one-to-one support from the chaplaincy service.
- Patients could be transferred to side rooms to provide privacy and to respect their dignity.
- There was no trust-wide bereavement or counselling lead in place to support patients, relatives or staff. The trust was in the process of appointing a bereavement lead that could provide additional support and advice for staff.

Are surgery services responsive?

Good



There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. Bed occupancy was below the England national average. Support was available for patients with dementia and learning disabilities. A translation telephone service was available for patients where English was not their first language, and translators could be requested.

Service planning and delivery to meet the needs of local people

- Low bed occupancy meant elective procedures could be planned in advance without the risk of disruption.

Access and flow

- The department had sufficient capacity to manage patient flow in a safe and responsive manner. Systems and processes to identify and plan for any potential staffing and bed capacity issues were applied so that patients received care and treatment without undue delays.
- It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care

Surgery

provided to patients and the orderly running of the hospital. Bed occupancy at Burnley General Hospital was 80% between April 2013 and March 2014 within the division which was below the average for England.

- We noted that the theatres at Burnley General Hospital were not used to their full capacity and there were a number of empty lists every week.
- Trust data for April 2013 to January 2014 showed the aggregate position against all 18-week referral to treatment standards was maintained. At treatment function level, four specialties underachieved against the 90% admitted standard in January 2014. These were general surgery, trauma and orthopaedics, ophthalmology and maxillofacial surgery. Actions were in place to reduce the backlog.
- Department of Health data showed that the number of last-minute elective operations cancelled for non-clinical reasons was better than expected at 102. The number of patients not treated within 28 days of last-minute elective cancellation was zero from October to December 2013, which was better than expected versus the England average of 92 for the same period.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. There were dementia and learning disability champions and link nurses on all the wards who were responsible for ensuring staff were appropriately aware of the schemes in place.
- We saw link nurses who were specially trained in dealing with patients with learning difficulties. The nursing staff told us they would ask for a 'Passport to health', a document that captures the patient's care needs.
- A Butterfly Scheme for patients with dementia was in place within the ward areas. The scheme gave staff information about the patient's likes, dislikes and choices and helped staff manage the care of patients with dementia in a sensitive and person-centered way.
- A translation telephone service was available for patients where English was not their first language.
- All staff told us they wouldn't use any relatives or family members to assist patients with consenting procedures during treatment and in theatres. Translators would be requested when required.

- Although there were multiple information leaflets available, there were not many available for the main languages spoken in the community. Considering the diverse population signage we saw in the ward areas was only in English.

Discharge planning

- Discharge and transfer of patients was well-managed with effective systems to ensure that discharge arrangements met the needs of patients. For example, a specific patient discharge list was completed, which included details such as a drugs chart, mental capacity assessment and infections data, and appended to the final page of the nursing assessment document.
- Patient discharges were discussed at the multidisciplinary team meetings and all the staff worked towards the provisional agreed discharge date.

Learning from complaints and concerns

- Ward and theatre areas had information displayed for patients and their representatives on how to raise complaints. This included information around the Patient Advice and Liaison Service (PALS) service. Staff were aware of the policy and processes for receiving and handling complaints.
- The surgical and anaesthetics services division had received 66 complaints for the 13-week period ending 27 April 2014, of which 40 were still in progress at the time of our inspection. Complaints were discussed locally in the ward at the 'share to care' meetings and at divisional and board level.
- We looked at three complaints that had also been raised on the online incident recording system and found staff had followed the correct process and timescales.

Are surgery services well-led?

Good



Trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. Risks were documented, reviewed and discussed. Leaders were visible and the departments were well-led locally. The teams were motivated and we observed an open and honest culture.

Surgery

Vision and strategy for this service

- The trust vision, to be widely recognised for providing safe, personal and effective care, was visible throughout the areas we inspected. It was printed on staff identification badges and on promotional material.
- The trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved.
- The trust's core objectives were focused on patient safety, clinical effectiveness and patient-centred care.
- Staff underwent a corporate induction that included the trust's core values and objectives and were able to repeat the vision and felt involved in the decision-making process.

Governance, risk management and quality measurement

- Performance and quality data at ward level showed that information relating to patient safety, risks and concerns was accurately documented, reviewed and updated at least monthly.
- Senior staff we spoke to were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators such as the nursing key performance indicators.
- Clinical governance systems were in place that allowed risks to be escalated to divisional and Trust Board level through a range of committees and steering groups. Performance was monitored from 'board to ward' and risks were managed. There were routine staff meetings to discuss local performance risks and staff issues. Staff had confidence in their managers to escalate and manage issues of concern.
- We saw risks were rated from low to high, with the lower risks being managed at ward level. Any medium risks were added onto the divisional risk register and all the higher risks were escalated on to the main trust risk register. The local risk register was only reviewed every six months.
- Quarterly governance meeting minutes showed all staff in the directorate were encouraged to attend including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.

Leadership of service

- There were clearly defined and visible leadership roles within the surgical division. The division of surgery and anaesthesia was divided into clinical units based on specific surgical specialties. Each of the surgical specialities had a clinical lead and a divisional lead.
- The departments were well-led locally by the senior staff on the wards and by the matrons. The teams were motivated and worked well together with good communication between all grades of staff.
- Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive or inappropriate in supporting the effective running of the service.

Culture within the service

- Staff were positive and proud of the work they did and felt their efforts were acknowledged by their managers. They reported an open culture and felt managers listened and reacted to their needs.
- Staff told us they were encouraged to report any issues in relation to patient care or any adverse incidents that occurred.
- We observed that staff from all specialities worked well together and had mutual respect for each other's specialities.
- The overall ethos in the surgical division was that patient safety came first, with patient experience being seen as a priority and everyone's responsibility.

Public and staff engagement

- Hospital areas such as corridors, ward areas and reception areas had information on how the public could provide positive and negative feedback. The trust's website also contained a number of feedback mechanisms to allow the public to engage with them.
- A quarterly East Lancashire Hospitals NHS Trust newsletter was produced and included feedback from the public.
- Staff received communications in a variety of ways, for example, newsletters, emails and briefing documents. We saw evidence of this. Staff told us they were made aware when new policies were issued and felt included in the organisation's vision.
- In a local staff survey, within surgery, 84% of staff said they would recommend the department as a place to work and 88% said if a friend or relative needed treatment they would be happy with the standard of care provided by department.

Surgery

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines.
- The flow and pathway through the breast surgery and gynaecology ward was innovative and well-thought-out. The early pregnancy unit, ultrasound scanning suite and gynaecology theatres were all in close proximity and built for purpose with staff having input into the planning of the building. This created an outstanding setting to facilitate a responsive service for both outpatients visiting the early pregnancy unit and inpatients staying on the ward. For example, patients were actively encouraged to attend the assessment area if they experienced any post-operative complications so they could be seen by a gynaecologist quickly rather than having to attend A&E.
- Staff told us they had provided input into the original plans in 2007 before the new parts of the hospital were built.
- Women who attended the department for treatments, including for breast cancer, received appropriate and timely scans and diagnosis within the outpatient area situated within the ward.
- The consultant orthopaedic surgeon told us they had adapted to meet local changing needs, such as increased population, by having theatre lists seven days a week for emergency trauma in the morning and performing elective surgery in the afternoon.
- The clinical director for general surgery told us they were trying to be more consultant-led in the division by reviewing patients twice daily.
- There were action plans in place to address key risks to the services, such as winter capacity pressures, equipment upgrades and ensuring sufficient staffing for seven-day services.

Maternity and family planning

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

Information about the service

A full range of maternity services is provided at the Lancashire Women and Newborn Centre at Burnley General Hospital which include: midwifery-led birth centre; antenatal, postnatal and transitional care; birth suite; antenatal clinic; day assessment unit (Monday – Friday 9am–5pm); integrated midwifery; and ultrasound department.

Between October 2012 and November 2013 there were 7,587 deliveries across the whole of the service which included births at the Lancashire Women and Newborn Centre, at the Blackburn Birth Centre, Rossendale Birth Centre, a two-bed standalone birth centre in Rossendale, and home births.

The birth suite comprised 20 delivery rooms, which included two rooms equipped with birthing pools, a bereavement suite and two operating theatres which are adjacent to a further three theatres used for gynaecological surgery. There was also a further room with two beds used as a close observation unit.

The day assessment unit was incorporated within the antenatal clinic and comprised three rooms. Triage occurred adjacent to the antenatal ward in a large facility with four side rooms and two four-bed bays.

There were 16 antenatal beds for women admitted during their pregnancy, and a total of 38 postnatal beds, of which 12 were used for the provision of transitional care. Due to the layout of the postnatal ward, it was staffed as three separate areas or zones (A, B, and C). Each had its own facilities though shared resuscitation equipment.

The birth centre, a midwife-led unit, had seven delivery rooms, of which three included birthing pools and accounted for around 1,000 births per year. This area was staffed by fully integrated midwives who provide care both in the community as well as the birth centre and the two-bed birth centre at Rossendale where some 100-120 births take place each year. Multi-professional antenatal clinics were held at the Lancashire Women and Newborn Centre, and at the Royal Blackburn Hospital. The antenatal clinic was now the only maternity service provided on the site of the Royal Blackburn Hospital.

Maternity and family planning

Summary of findings

The maternity and family planning services were found to be safe, and effective with caring staff. The service was responsive to the needs of the local population, providing a mix of standalone birth centres, an alongside birth centre (both of which are midwife-led) and obstetric-led birthing options for women. The service was also found to be well-led. There were established governance processes in place. Staff received feedback from incidents and there was evidence of learning as a result.

Are maternity and family planning services safe?

Good



Maternity and family planning services were safe. Staff had received training in obstetric emergencies and there was a good understanding of risk management and evidence of learning from incidents.

There were five birth pools used for labour and delivery. There was no appropriate equipment available to allow for the safe evacuation in the event of a sudden maternal collapse in the pool. While there were other staff easily accessible to call for assistance, this did pose a risk to women and midwives should inappropriate equipment be used.

Midwives reported their staffing levels to be satisfactory. Midwifery sickness rates were low. There was dedicated obstetric and anaesthetic cover on the birth suite at all times.

Incidents

- Incidents were reported on the trust electronic incident reporting system, and a 'trigger list' was used to ensure staff were aware of the type of incidents to report. There had been no recent Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) reported, though staff were able to describe learning from a recent serious incident that had occurred. Following this incident, changes in practice were implemented. Staff we spoke with knew about these changes and we saw evidence of them put in place.
- Incident reports were received for review by senior midwives and also the risk management midwife who ensured investigations occurred as necessary.
- Trends were monitored and actions taken as a result. For example, when reviewing incident reports, we identified a number of babies born below the expected birth weight. This had been identified as an in area to be addressed. As a result, cases were reviewed and staff reminded to use the correct chart for plotting size during scans. In addition, senior staff were in discussion with radiology staff regarding the option for increased scanning.

Maternity and family planning

- Incidents were investigated and feedback given to the staff. Incidents were also discussed at the 'share to care' meetings held weekly, formed part of the 'message of the week' and also reported in the monthly newsletter, Safe Hands, produced by the risk midwife.
- Incidents were also reviewed at the risk management group and reported to the family care division quality and safety board.
- All staff we spoke to stated that they were encouraged to report incidents and were aware of the process to do so.
- There was a good culture of incident reporting among staff. There were maternity-specific 'trigger lists' detailing the type of clinical incidents to report (for example, massive obstetric haemorrhage, and third-degree tears) evident in wards and departments. Staff were knowledgeable about how to report incidents and what they would report. The quality and safety board received a quarterly governance report that showed trends in incidents as well as locations where incidents occurred. We reviewed these papers and saw they made reference to targeting areas that were felt to be under reporting.

Cleanliness, infection control and hygiene

- The trust's infection rates for *Clostridium difficile* (C. difficile) and MRSA were within an acceptable range, taking into account the trust's size and the national level of infections.
- The trust had a 'bare below the elbows' policy for anyone working in clinical area. We saw staff observed this policy at all times.
- Personal protective equipment, such as gloves and aprons were readily available for the use of staff throughout the clinical areas and we saw these in use throughout our inspection.
- Antibacterial hand rub was prominent at entrances. We saw staff wash their hands and apply hand gel appropriately.
- The unit was clean and bright, and there were no odours.
- Infection control audits were undertaken monthly and results were posted on the wall for staff and patients to see. These covered hand washing, the cleanliness of shower stools, bed pans and the knowledge of staff of the high-impact interventions (an evidence-based approach that relate to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately). The seven high-impact

interventions come from the Saving Lives programme (Department of Health, 2006) which was introduced to support healthcare providers in reducing healthcare-associated infections. Results showed 100% compliance over the three months preceding our inspection.

- On the birth centre and the birth suite, we observed bedside checklists in use to demonstrate a room had been cleaned following use. These were left on the bed until the room was reused, at which point they were filed in the next women's notes on admission.
- Areas and equipment were clean. We saw evidence that equipment had been cleaned and marked with stickers to indicate when it had been cleaned and who had undertaken the task.

Environment and equipment

- Entry to all wards and both the birth centre and the birth suite was secure. Entry was gained via a locked door, controlled by a buzzer, with CCTV observation.
- The general environment was bright and spacious. Delivery rooms were bright and welcoming, and each had an en suite shower room. Of the 20 delivery rooms on the birth suite, two contained pools. Within the birth centre, an alongside midwifery-led unit, of the seven delivery rooms, three contained birthing pools.
- The birth suite has a bereavement suite, known as the serenity rooms, which provide a bedroom, bathroom and kitchenette/lounge area for the use of women and their families.
- There were sufficient cardiotocography (CTG) machines to undertake recordings of the foetal heart in labour, and telemetry was in use.
- Equipment was appropriately checked and cleaned regularly. We saw emergency resuscitation trolleys had been checked thoroughly daily and records were maintained to demonstrate this. There was adequate equipment on the wards to ensure safe care (specifically CTG and resuscitation equipment)
- Resuscitaires® were present on the birth suite, the birth centre and also on the postnatal ward. We saw evidence that resuscitation equipment was checked, though this was not always undertaken daily.
- There were two dedicated obstetric theatres. These were housed adjacent to the birth suite and within a suite of five theatres, meaning additional capacity could be accessed if required.

Maternity and family planning

- There was a two-bed unit on the birth suite for the close observation of women who needed a greater degree of care, known as the close observation unit (COU). These could be women who, for example, had suffered a major post-partum haemorrhage or who had significantly raised blood pressure. During the Keogh Mortality Review in 2013, the use of this area had raised some concerns. We spoke to staff in-depth about how this area was managed. Staff were allocated to work in the area, ensuring a midwife presence on each shift. Midwives who worked in the unit had received additional in-house training which had been provided in conjunction with intensive care staff to ensure personnel had the necessary skills to care for women in that area. Women who were cared for in the COU in general had catheters in place, ensuring a close monitoring of their fluid balance. When catheters were removed, should the woman not be ready for care to be stepped down, she would be moved to a delivery room which had en suite facilities. Management of the COU was overseen by a lead obstetrician and a lead obstetric anaesthetist. Women in receipt of care in the COU were under the care of both consultants. Where ventilatory support or dialysis was required, transfer to the intensive care unit at the Royal Blackburn Hospital occurred. We saw the COU was well stocked with equipment such as pumps for the controlled delivery of medicines and fluids.
- The trust had an electronic database of all equipment, which provided information about the date of purchase, cost, servicing, maintenance and where in the hospital the equipment was located. Each piece of equipment was given an asset number when it was purchased to cross-reference information about it. Staff told us the electronics biomedical engineering department was responsive to requests for assistance with faulty equipment and were prompt when machinery was due for servicing. We reviewed the maintenance stickers on a wide variety of equipment such as pumps, and monitors. All had stickers to indicate when they had last been checked. All had been checked within the last year.
- General maintenance of the birth centre, the birth suite and the antenatal clinic was undertaken by the trust maintenance department. The antenatal and postnatal wards were housed within 'phase 5', a private finance initiative build. As a result, maintenance was undertaken through a private company. Staff said that both the in-house and the private company were

responsive to their needs, and repairs occurred quickly, though if environmental changes were required within 'phase 5' there could be some delay. For example, a 'welcome desk' had recently been installed within the entrance to the postnatal ward following feedback from patients and relatives. Staff we spoke with said this had taken some time to have agreed and built.

- No emergency evacuation equipment existed in the rooms with birthing pools. When asked how evacuation would be conducted should a woman collapse in the pool, staff told us they would use rolled-up towels under the woman's arms and had practised with this within training scenarios. The recommended number of staff for lifting during an emergency evacuation is four. Within the birth suite and the birth centre, additional staff could be summoned quickly from other areas if required.

Medicines

- Medicines were stored in locked cupboards within a locked room.
- Medicines which required storage at a low temperature were stored within a specific medicines fridge. We saw evidence that temperatures were checked and recorded regularly and were within acceptable limits.
- Gas and air for pain relief was piped into delivery rooms.
- Stronger analgesia was available for women in labour and was subject to a two-person check prior to administration.

Records

- Women were given hand-held records at booking by the midwife. These were added to following each episode of care, whether with a doctor or midwife. Medical records were obtained to allow staff to cross-reference the woman's history and reviewed the detail of previous deliveries.
- Records were kept behind the midwives desk, though were not securely locked.
- Following delivery, postnatal records were written and carried by the woman on discharge, when there care was continued by the community midwives.
- We reviewed four sets of records which were clear and easy to follow. The name of the person documenting and their role was clear to see. Where plans had been made for care of women in COU, these were clear and detailed. Risk assessments were in place for issues such

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as urinary catheters, venous thromboembolisms (VTEs or blood clots) and pressure damage. These clearly showed the increased risks and actions needed to address them.

- Audits of record-keeping form part of each midwife's annual supervisory review.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent was obtained appropriately and correctly. At the time of the inspection, there were no women who did not have capacity to consent to their procedure.

Safeguarding

- Staff worked in conjunction with the East Lancashire Women's team who provided care and support to women with complex social needs, including teenage mothers. Staff were aware of their responsibilities with regards to safeguarding and had undergone training at the appropriate level.

Mandatory training

- Compliance with mandatory training was good. Staff said access was good and midwives received the trust's mandatory training as well as obstetric emergency skills training, neonatal and adult resuscitation.
- Midwives who were newly qualified undertook a period of preceptorship training, which lasted a total of two years. During that time they rotated through all areas of the East Lancashire Maternity service, which included the alongside and standalone birth centres. This ensured they were equipped with both the skills and confidence to provide an integrated maternity service.
- East Lancashire Maternity service employed an experienced midwife whose role was to work alongside preceptorship midwives providing direct support, guidance and supervision when necessary. Junior and senior midwives spoke of the benefit of this role.

Management of deteriorating patients

- All staff attended obstetric emergency skills training.
- Emergency resuscitation equipment was available for both mothers and babies and was regularly checked.
- The unit used the modified emergency obstetric warning scoring system. Instructions for completion were placed around the unit, on noticeboards and in staff changing areas. Staff we spoke with were aware of

the appropriate action to be taken if patients scored higher than expected. Use of the warning system is audited monthly and reported through the COU multidisciplinary meeting.

- We looked at completed charts and saw that staff had escalated cases correctly, and repeat observations were taken within the necessary timeframes.
- Staff undertook checks on the birth suite, ensuring that cardiotocograph readings were reviewed hourly by a 'fresh pair of eyes', usually the birth suite coordinator, who was supernumerary.
- Staff used the 'Situation, Background, Assessment, Response' (SBAR) communication tool when handing over or discussing concerns. This was recorded on a template and filed in the records.
- On the birth suite, there was a midwife who had undergone additional training allocated to COU for each shift.
- Use of the COU is subject to audit. Cases are reviewed and discussed at monthly multidisciplinary meetings
- In 2014 to date there have been two transfers of acutely ill women to the Royal Blackburn Hospital. Both cases were reviewed and deemed timely and appropriate.
- There is a policy for the de-escalation of care needs for women in COU. This states they should not have their level of care stepped down at night. Audit showed 100% compliance with this.
- We saw there had been good planning in preparation for a difficult caesarean section, where a major obstetric haemorrhage had been anticipated and had occurred. Staff described having two consultant obstetricians in theatre as well as consultant urologists. Close liaison had occurred with the blood bank locally as well as regionally to ensure adequate supplies of blood and blood products. Staff also received a debrief following the event and a further debrief was planned to include additional theatre support staff who had not been present at the initial debrief.

Midwifery staffing

- Sickness rates were 2.3%, well below the national average for midwives (4.3%).
- At the entrance to each ward, a large display board detailed the expected number of staff on duty and the actual number on duty. Staff we spoke with told us there had been a positive increase in staffing numbers over the last few months.

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- Staff reported that one-to-one care for women in labour was always provided. As the service was fully integrated, community midwives were familiar with working in the birth centre.
- Overall as a service, midwife-to-birth ratio was reported on the service dashboard as 1:30 which was outside the national guidance (Safer Childbirth October 2007) which was a minimum ratio of 1:28.
- All midwives must have access to a supervisor of midwives at all times, (NMC 2004 Midwives rules and standards - Rule 12). The ratio of supervisor of midwives to midwives was 1:18. This is higher than the recommended ratio of 1:15, though the head of midwifery told us there were five midwives in training to become supervisors and five places had been secured on the course for 2015. Supervisors of midwives are required to carry out annual reviews with all midwives. All midwives we spoke with had received a supervisory review and were aware of how to contact a supervisor if required. There was information on supervision of midwives on noticeboards. The local supervising authority had undertaken the annual audit into the standards of supervision and midwifery practice in October 2013 and the unit had been commended on the support they provided to student midwives.

Medical staffing

- Anaesthetic cover was present on the birth suite seven days a week, 24 hours a day. In January 2013 this was audited and showed 100% compliance. Monday – Friday 8am – 6pm, a second anaesthetist (consultant grade) has responsibility solely for the birth suite. Out of hours, there was a resident second on call (staff grade) and the consultant anaesthetist was on call for emergencies from home. An additional anaesthetist was rostered to cover elective caesarean sections (three per day, Monday to Friday).
- There were 82.5 hours of consultant cover in the delivery suite each week. There was always a consultant obstetrician on call. In addition, there was a gynaecologist on call 24 hours a day, seven days a week who was generally an obstetrician. Staff we spoke with said they found this of benefit as they could easily access a second opinion or emergency support if required, for example, in the event of a massive obstetric haemorrhage. Consultants were described as responsive and willing to attend out of hours. We

reviewed the notes of a woman who had experienced a very large post-partum haemorrhage. This occurred during the night. We saw that the time from being called to arrival by the consultant was only 18 minutes.

- The General Medical Council National Training Scheme Survey 2013 showed trainee experiences to be similar to expected.
- In line with the national picture, there was some difficulty in recruiting middle grade obstetric staff. As a result, gaps in the medical staffing rota were filled with locum staff, who were given an induction before commencing clinical practice.
- We spoke with a locum obstetric registrar who described the support from senior medical staff as good, and staffing levels to be good.

Major incident awareness and training

- Midwives and medical staff undertook training in obstetric and neonatal emergencies training at least annually.
- All midwifery staff we spoke with were aware how to contact a supervisor of midwives at all times. The birth suite staff room and the wards had noticeboards indicating who the supervisors of midwives were, who was on call and how to contact them.

Are maternity and family planning services effective?

Good



The maternity and family planning services were effective. Staff followed nationally recognised policies and procedures. Outcomes were monitored and there was good multidisciplinary working.

Evidence-based care and treatment

- Policies and procedures for the wider trust were available on the intranet and in use in the centre. These had been developed in line with both NICE and the Royal College of Obstetricians and Gynaecologists' guidelines.
- Records were audited as part of the supervisor of midwives audit of record-keeping. These demonstrated good documentary practices.

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- Monthly hand hygiene audits and infection control audits were undertaken. The results of these were on boards at the entrance to wards and departments and showed 100% compliance.
- The service had an audit midwife in post who developed a programme of audit across the year, undertaken by midwives and obstetricians. These audits were presented and actions monitored at a monthly audit meeting. This meeting reported into the family care directorate quality and safety board.
- The caesarean section rate was reported on the service dashboard as being 25.3% and had shown as a red flag against the local stretch target, for eight out of the last 11 months. We spoke to staff about this figure and were told of initiatives planned to reduce the rate, including multidisciplinary team training sessions for staff on normal birth. This was being led by an obstetric consultant and involved midwives from the midwife-led birth centres.
- There was an antenatal screening coordinator in post. Compliance with screening was monitored and reported into the quality assurance program for Lancashire each quarter. Following our inspection, a request was made for this information, however, this was not received.
- To address the number of stillbirths, the trust has implemented the growth assessment protocol, devised and implemented nationally by the perinatal institute as a tool to reduce the number of stillbirths previously described as unexplained. Stillbirths are reported as clinical incidents and cases are reviewed. The number of stillbirths was monitored and reported on the performance dashboard to the quality and safety board. Onward escalation occurred to the Trust Board level following recent changes to the trust level governance structure and committees. The Keogh report had identified that increased instances had not been escalated to the Trust Board. The performance dashboard was colour coded red/amber/green. By reporting this into the trust quality and safety board it was clear to see when peaks had occurred.

Pain relief

- Women were encouraged to remain mobile in labour. Walls were painted with positive slogans such as 'sit, walk, stand, squat, get active – give birth!' Pools were available in three delivery rooms on the birth centre and two rooms on the birth suite, to provide pain relief.

- There was anaesthetic cover for 24 hours per day, seven days per week, providing women with the option of an epidural if they chose.
- Staff told us they had been part of a hypnobirthing trial; however, we saw no evidence of alternative therapies available to women in labour.

Nutrition and hydration

- Where women required strict fluid management, we saw fluid balance charts maintained and input and output recorded.
- Women were encouraged to breastfeed and the unit had achieved UNICEF accreditation as a baby-friendly unit. Breastfeeding initiation rates were reported as 71% and was slowly increasing. The national rate was 81%.

Patient outcomes

- The maternity service had a quality dashboard which was reviewed monthly at the quality and safety meeting. This used a red/amber/green flagging system to highlight areas of concern. This was provided to us prior to the inspection.
- The number of women suffering a third or fourth degree tear of the perineum during assisted delivery had increased sharply over the first three months of 2014, rising from 3.00% in December 2013 to a high of 15.6% in February 2014. These were reported as clinical incidents, and were currently being reviewed within the birth suite forum, to attempt to identify why this had occurred.
- The dashboard reported a high incidence of low forceps and a low incidence of ventouse (assisted forceps or vacuum) deliveries. When questioned why, senior obstetric staff told us this was also being reviewed as they believed it to have been a coding error.
- The home birth rate was below 2%. Staff told us they felt this was because women often chose the option of delivery at one of three midwife-led units if they were deemed low risk.
- The number of women booked before 12 weeks and six days gestation ranged from 86.7 to 90.85%; however, there was no record on the performance dashboard for the three months immediately preceding the inspection.

Competent staff

- Preceptorship midwives were rotated through all areas during their two-year preceptorship period to ensure they were fully competent midwives with the skills and confidence to work in all areas of the service.

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- Some staff were described as being core staff, meaning they remained working in one area. Other staff rotated throughout all areas. The birth centre staff worked as a fully integrated service, meaning they worked within the community and birth centre, providing the full range of midwifery care. As such, this ensured they maintained skills in all areas. When there was a home birth or a woman requested delivery at the Rossendale Birth Centre, their care was provided by the community midwives. Preceptorship midwives were rotated through all areas during their two-year preceptorship period to ensure they were fully competent midwives with the skills and competence to work in a standalone midwife-led unit and to undertake home births. During personal development reviews, midwives could also request to work in other areas of the service to refresh skills.
- Every midwife had a named supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (Rule 8, NMC 2012). They are someone midwives go to for advice, guidance and support, and they monitor care by meeting with each midwife annually, (Rule 9, NMC 2012) auditing the midwives' record-keeping and investigating any reports of problems/concerns in practice. All midwives we spoke with had received an annual supervisory review.
- Personal development reviews had not always been conducted annually, though most staff we spoke with reported having had a review within the last year. Compliance within the antenatal clinic was only 50%, and on the postnatal ward, ranged from 52.31% to 75.41% across the three months immediately preceding the inspection.

Multidisciplinary working

- Communication between obstetric, anaesthetic, neonatal and midwifery staff was described as good. Multidisciplinary meetings were held for areas such as the birth suite and COU.
- Joint perinatal mortality and morbidity meetings were held which reported into the family care group quality and safety board.
- A multidisciplinary approach was used to develop new guidelines.

- The antenatal screening coordinator met regularly with the laboratory staff to discuss any incidents or issues that had arisen.

Seven-day services

- Access to theatres was available at all times. Out-of-hours consultant cover was provided by on-call consultants.
- Routine pharmacy services were not available on Sundays.

Are maternity and family planning services caring?

Good



The service provided was caring. Staff provided compassionate care and emotional support to women and their partners.

Compassionate care

- The CQC Maternity Service Survey 2013 received responses from 140 women who were asked about their care at the hospital. This was a response rate of 12.1%. From the responses seen, the trust compared about the same as other trusts for all aspects of maternity care, including antenatal, during labour and birth and in the first few weeks after birth.
- The maternity section of the NHS Friends and Family Test was being carried out. Uptake was low and alternative methods of collecting the data were being considered, such as text messaging. From the results that were available, this showed 98.4% of respondents were likely to recommend the service to friends and family.
- The maternity service undertook monthly patient experience surveys, with results being reported into the quality and safety board. These looked at dignity, information giving, involvement and quality. Overall scores for quarter two were positive being reported as 94%.
- Throughout our inspection we witnessed women and their partners being treated with compassion, dignity and respect. We saw that call bells were in the main, answered promptly.
- We looked at patient records and found they were completed sensitively and detailed discussions that had been had with women and their partners.

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- Partners were encouraged to visit and visiting times were waived for mothers in labour. Overnight facilities were available in the serenity suite for partners in the event of a stillbirth or neonatal death. Plans were being made to provide additional facilities by converting another delivery room.
- The birth suite undertook terminations of pregnancy for foetal abnormalities from 16 weeks gestation. In conjunction with 'The Friends of Serenity', a support group of parents, memory boxes were given to each set of parents undergoing the loss of a baby on the birth suite.
- Midwives and medical staff spoke of good team work, support and of enjoying coming to work.

Patient understanding and involvement

- Women were involved in their choice of birth at booking and throughout the antenatal period.
- The Friends of Serenity group were working with the trust to look at the design and planning of the additional bereavement facilities planned for the birth suite.
- Women carried their own records throughout their pregnancy and postnatal period of care. These contained information as well as contact points and were used by all staff to document care.

Emotional support

- Staff were described as "supportive" at all times.
- Despite acknowledging the need for a second bereavement facility on the birth suite, the trust did not employ a bereavement specialist.
- Chaplaincy care was available. Support for other faiths was arranged as required.

Are maternity and family planning services responsive?

Good



The services provided were responsive to the needs of the local people, however, there was little support for women and partners who did not speak English as their first language. There were systems in place to ensure learning from complaints and concerns.

Service planning and delivery to meet the needs of local people

- Women could elect for delivery at home, at the birth centre in Rossendale and Blackburn or at the main hospital. If women were deemed low risk, they could choose to have midwife-led care. In the case of a higher risk, obstetric-led care was provided at the Lancashire Women and Newborn centre.
- Satellite antenatal clinics were held daily at the Royal Blackburn Hospital and weekly at Rossendale Birth Centre. This allowed women to access antenatal care in a location convenient to them.
- The satellite antenatal clinic at the Royal Blackburn Hospital was seen during the inspection. The waiting room was very small and lacked capacity for all the women attending. As a result, additional seating had been placed in the corridor. The clinic was some way from the main entrance and coffee shops. There did not appear to be facilities for women to get cold drinks during their wait.
- Anaesthetic clinics were held as were weekly multidisciplinary team diabetic and medical clinics. Due to a high incidence of consanguinity (being related through blood, usually as a result of marriage between first cousins), a genetic counselling clinic was held monthly allowing early referral and prenatal screening.
- Glucose screening clinics were held to screen women identified as high risk, for evidence of diabetes in pregnancy.
- There was no female genital mutilation care pathway, though the head of midwifery reported some staff as being trained to deal with the issue. It was also included within safeguarding training which was undertaken by all staff.

Meeting people's individual needs

- Information was available regarding the trust on their website that could be translated into other languages for people whose first language was not English.
- The trust employed three bilingual support workers who worked primarily within the community but also within antenatal clinic.
- A telephone translation service was available to all staff. Some staff we spoke with said they had not used this service as they had found it difficult with clinical

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information. Other staff had not witnessed it used, instead they had seen other staff and relatives used to interpret. Staff told us they found this less than ideal at times.

- Some leaflets were available to print off in other languages, for example, antenatal screening literature, however, we saw very little evidence of signage or information in a language other than English.
- Women with complex social needs were cared for by the East Lancashire Women's team. The service employed a drug and alcohol midwife, a diabetes specialist midwife and infant feeding specialists. The trust did not employ a HIV specialist midwife but reported close working relationships with genitourinary specialist staff.
- The trust did not employ a bereavement specialist midwife. And, while the need for a second bereavement facility on the birth suite was acknowledged, the trust had no plans for this.

Learning from complaints and concerns

- Complaints and concerns were reported to the head of midwifery and were included on the performance dashboard for monitoring at the quality and safety board. Where complaints were received, staff offered to meet with the complainant, and any meeting was followed up with the outcome in writing. Learning from complaints was shared with staff through the 'share to care' meetings.

Are maternity and family planning services well-led?

Good



The maternity and family planning services were well-led. Staff felt managers were visible and approachable. Staff were aware of the wider organisational vision and all reported a positive feel as a result of the changes at board level.

Vision and strategy for this service

- The trust vision for providing safe, personal and effective care was visible on badges, posters and at the bottom of letters and minutes. Staff we spoke with were aware of it. Staff reported having the same vision for the maternity service, and there was a board detailing the values and vision on the wall leading into the birth suite.

Governance, risk management and quality measurement

- Wards and departments held risk registers which were reviewed annually. Staff were not sure how these risks were monitored or where. However, from the papers seen it was clearly an agenda item at the quality and safety board.
- The service had a well-defined governance structure. Meetings existed which oversaw activity, performance, quality, safety, audit and risk. These all fed into the family care division quality and safety board. From here, issues were escalated to the trust quality and safety board.
- We saw evidence that trends had been identified through incident reporting and these had triggered actions to address. For example, as a result of an increased number of post-partum haemorrhages, the policy for managing them had been reviewed. We saw evidence that this had been communicated to staff through minutes on noticeboards and in 'share to care' meetings.
- The service employed an audit midwife, a risk management midwife and a lead for NHS litigation standards. All three shared and office and reported close working relationships.
- Performance and outcome data was reported and monitored via the service performance dashboard.
- The delivery suite had a governance board where access minutes and information on various actions as a result of incidents, for example, actions to reduce the risk of retained swabs.

Leadership of service

- Staff described the senior management team as "visible" and "supportive". They knew who led the service and felt that leaders promoted the service well within the trust.
- Matrons were seen in clinical areas and had a good awareness of activity within the centre during the inspection.
- Ward and department area managers all had a good understanding of the activity and performance within their areas. Staff were clear who their manager was.
- Staff described a positive change in culture within the wider trust following changes at board level after the Keogh Mortality Review. Staff told us they believed the trust was a better place to work and were positive about

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the future, though some expressed concerns that the interim senior management would not remain long enough and the positive changes would not be sustained.

Culture within the service

- Staff were aware of the whistleblowing policy and were encouraged to raise any concerns they may have. The trust had a 'speak out safely' campaign which detailed how to access the whistleblowing policy on various notice boards in staff areas.
- Staff spoke of an open, supportive and friendly culture.
- Staff spoke passionately about the service, and it was clear from all we spoke with that they enjoyed working at the trust. This included locum staff and students.

Public and staff engagement







- The trust held public listening events, launched in January 2014 named 'Tell Ellie' (East Lancashire listens, involves, engages). Public meetings had been held in areas across East Lancashire and a website was available for people to share their views with the trust.

- The maternity service had a dedicated website and Facebook page. We saw this was used by women for answers to general enquiries such as times of parent education sessions.

Innovation, improvement and sustainability

- East Lancashire Hospitals NHS Trust's maternity services were awarded the Royal College of Midwives' Mothercare Maternity Service of the Year Award (along with Downpatrick Community Maternity Services, Northern Ireland and NHS Forth Valley, Scotland). They received the award for improving normal birth rates, reducing Caesarean section rates and increasing birth choice for women.
- The day after the inspection, staff from the centre were presenting their model of integrated midwifery at a conference led by the patient experience network in partnership with NHS England in order to share their positive practice.

Services for children and young people

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

Information about the service

Burnley General Hospital is part of the East Lancashire Hospitals NHS Trust and provides paediatric services which include:

- Children's minor illness unit (CMIU)
- Children's urgent care centre
- Day care unit Ward 27
- Level 3 neonatal intensive care unit (NICU)

The CMIU provided short stay care for up to seven children within individual cubicles. Referrals were accepted from GPs, health visitors and the Urgent Care Centre (UCC) and children were observed and investigations were undertaken with the aim to discharge them home, thus avoiding a hospital admission. Children were also able to attend the unit for some nursing procedures, such as wound dressings, or support with medication. The unit was open for referrals from 10am to 6pm Monday to Friday, with telephone advice available until 8pm. At the weekends and on bank holidays, the opening hours were from 12 noon to 6pm.

The children's urgent care centre was located within the main UCC at Burnley General Hospital, with two rooms dedicated to the care of children. The centre provided treatment for injuries which required urgent attention but were not life threatening. For example, minor head injuries and suspected broken bones or sprains. The unit was staffed by doctors and emergency nurse practitioners who examined the children and either treated the ailment or referred the patient to appropriate specialists or x-ray.

The children's day surgery unit (Ward 27) provided care to children who required a minor operation and would usually be discharged home the same day. Children who were booked to attend the ward for their operation also came into the ward for a pre-operative assessment prior to the planned date of surgery. Children and young people also attended the unit to have a variety of medical investigations carried out.

The NICU provided facilities to care for up to 34 babies, including six intensive care cots and eight high-dependency cots. Two isolation cots were available when required to meet the needs of individual babies. The unit was designated as a level 3 neonatal unit and was part of the Lancashire and South Cumbria transport and retrieval service. This service provided a dedicated transport service for babies who required transportation between neonatal units. The neonatal unit also had the facility to support parents on site prior to their babies discharge. This was achieved by enabling parents to stay in rooms to care for their baby with support, if needed, from the neonatal staff team. Accommodation for parents who do not live locally could be provided on the hospital site.

During our inspection of Burnley General Hospital's services for children and young people, we spoke with 15 parents/carers, two children and 22 members of staff. The staff included medical, nursing, management and ancillary staff.

We visited NICU, CMIU, Ward 27 and the UCC where we spoke with people, observed care and reviewed records and documentation.

Services for children and young people

Summary of findings

Children, young people and neonates received safe and effective care from appropriately trained and competent staff. We saw that staff treated patients with dignity and respect, showing compassion and empathy to them and their families/carers.

Staff were positive about working in the family care division of the trust and told us they felt supported and valued in their roles. Parents and carers were satisfied with the care and treatment delivered to their children and told us they felt included and involved.

The environment was clean, bright and airy, with sufficient equipment to deliver the necessary treatments. Toys were available in waiting and treatment areas. However, on the NICU, there were no facilities for parents/carers to have a hot drink or sit on the ward away from the cot side. There was a refurbished waiting area outside of the unit which provided seating, toys and a cold water fountain.

The care and treatment provided to children and young people was based on national guidelines and directives. Policies and procedures were reviewed regularly and updated as necessary. The care and treatment was audited to monitor the quality and effectiveness and, as a result, action had been taken to improve the service.

Staff were provided with regular and appropriate training and an annual performance development review. There was no process for staff to receive formal supervision throughout the year but, during our discussions with staff, we were told the managers were approachable and provided support when required.

Services for children and young people were caring. Patients and their families/carers were treated with dignity and respect. Surveys took place to gather feedback from patients and their families/carers. Interpreter services were available when required.

Are services for children and young people safe?

Good



The children and young people's services provided at Burnley General were found to be safe. Incidents were reported in line with trust policy and staff were confident action would be taken to address issues. Medications were stored, administered and recorded safely to protect the children and young people. Staff used recognised early warning systems for neonates and paediatrics, designed for early identification of the deteriorating patient.

The environment was clean, tidy, bright and child-friendly. Infection control was promoted by the provision of plentiful hand-washing facilities, antibacterial gel and personal protective equipment for staff. For example, we saw staff consistently use disposable gloves and aprons. Security for patients and staff was good with locked doors to units and wards.

Incidents

- There had been no recent Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) reported within the directorate.
- Staff reported incidents through the hospitals electronic reporting system when concerns or serious incidents had been observed. The directorate investigated such incidents and action was taken as a result of these investigations. For example, two incidents had been reported regarding the skin integrity of babies on the NICU. Following the investigation, necessary changes had been communicated to staff and we saw these in practice during our inspection.
- The directorate held meetings known as 'share to care'. These meetings took place each month and were attended by all grades of staff throughout the directorate. Staff we spoke with were able to inform us that reported incidents were discussed at these meetings along with the learning which had resulted from the investigations. The content and outcomes from the meetings were recorded in minutes that were held on each ward or unit.

Services for children and young people

- Staff said they were encouraged to report incidents through the electronic reporting system and were confident they would be able to do so, would be listened to and feedback given to them on any action taken.
- A mortality review took place each month during the child health quality and safety board. Minutes from previous meetings showed a mortality and morbidity review took place and identified any areas where care or treatment could have been improved, with action to take in future. For example, one review showed the necessity of good communication with parents and the importance of clear end of life plans for children with life-limiting conditions.

Safety thermometer

- We saw reference was made, in the children's units and NICU, to the trust's Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections). However, it was acknowledged that this was not fully appropriate for use with children and neonates and some adaptation had been made.
- An audit had taken place of the Safety Thermometer in the children's and family directorates and had been report on at the January meeting of the child health quality and safety board. This had shown one young person had not been appropriately assessed on admission. We were told additional guidance had been provided to staff in response to reduce the risk of this reoccurring.
- The dashboard information provided prior to the inspection informed us there was no evidence of risk relating to paediatric and congenital disorders and perinatal mortality.

Cleanliness, infection control and hygiene

- The trust's infection rates for *Clostridium difficile* (C. difficile) and MRSA were within an acceptable range, taking into account the trust's size and the national level of infections.
- The trust had a 'bare below the elbows' policy for anyone working in clinical area. We saw staff observed this policy at all times. Staff told us they would be confident to challenge anyone not complying with the policy.

- Personal protective equipment, such as gloves and aprons, were readily available for the use of staff throughout the clinical areas and we saw these in use throughout our inspection.
- Hand-washing facilities and antibacterial gel was available in all areas and staff were observed to use these correctly prior to, and after each contact with patients. Visitors to the wards were also required to use the hand gel on arrival.
- The ward areas were clean, bright, free from odours, tidy and clear of clutter.
- Domestic staff were in evidence during the inspection and told us there was a clear organisational structure in place and written cleaning schedules to work with.
- Audits were completed to monitor compliance with infection control procedures and the outcomes, which were all good, were displayed on noticeboards in the relevant areas.
- Equipment was cleaned after it had been used and a label attached to show the date and name of cleaner. The NICU had a large store of equipment which had been cleaned prior to storage, as evidenced by the attached labels.

Environment and equipment

- The areas where children were cared for were light, spacious, child-friendly and appropriately decorated.
- Entry to the day care unit and the NICU was secured with locked doors. Visitors to these areas were required to press a buzzer and verbally request access.
- The trust had an electronic database of all equipment, which provided information about the date of purchase, cost, servicing, maintenance and where in the hospital the equipment was located. Each piece of equipment was given an asset number when it was purchased to cross-reference information about it. Staff told us the electronics biomedical engineering department was responsive to requests for assistance with faulty equipment and were prompt when machinery was due for servicing.
- Contracts were in place for the servicing and manufacturers' maintenance of some medical equipment, for example, neonatal incubators. Each piece of equipment was labelled with the date it was last serviced and when it was next due.
- Breastfeeding mothers were provided with privacy to express their milk in a separate room with comfortable chairs. A milk kitchen provided safe storage for the

Services for children and young people

expressed milk within a fridge and/or freezer and the temperature was checked each day. Sterilising equipment was in place for feeding bottles with a separate sterilising container for each baby. The solution was changed on a regular basis and the date and time recorded at each change.

- Resuscitation equipment on the NICU was readily available and checked regularly. There was a resuscitation trolley in the CMIU with a log to record daily checks in place. However, this had not been completed for the four days prior to our inspection, which meant it was not clear that all equipment would be available if required in an emergency.
- We observed in the children's urgent care unit, one cubicle was not ready for use, as the oxygen supply did not have any tubing in place. This meant access to oxygen would have been delayed if required in an emergency, which may have placed a patient at risk.

Medicines

- Medicines were stored securely and appropriately in locked cupboards in rooms which had a key pad entry. Additional medication cupboards were located within the bays on the NICU, and the keys were held by the senior nurse working in the bay. Medication which required cool storage was securely stored in fridges specifically for medicines. The temperature was checked daily and previous records showed this had been within acceptable limits.
- Hospital pharmacists supported staff on the day assessment unit and NICU regarding the medication prescribed and administered for babies and children.
- The pharmacist visited each baby on the NICU daily and reviewed their medication records. The pharmacist explained to us that they checked the medications prescribed against the babies gestation and weight to ensure safe prescribing had taken place. This provided an extra safety check for each baby. Any observed errors were discussed immediately with the medical team and an incident report completed.
- A previous serious medication incident had led to a revised protocol regarding the prescribing, checking and administration of a certain medication. We saw evidence which showed staff followed the revised protocol.
- An audit had been completed in March 2014 of medication incidents in 2013 within the family care division. We were told and data showed 63 medication

incidents had been reported through the electronic system. However, these had not all resulted in errors being made or harm coming to the child or baby. For example, some incidents were related to delays in obtaining medication from pharmacy or for patients to take home. Following the audit, a full report had been produced which showed how practice had been reviewed and changes made to reduce the risk of further incidents.

- Detailed information had been developed by the pharmacist, based on the British National Formulary for Children and the Neonatal Formulary, and was available in all bays on the neonatal unit regarding prescribed medications. This provided staff with information on the medication, normal dosage, routes of administration and additional comments. This formulary had been reviewed and updated within the last year. We saw one update had been handwritten on the formulary, signed and dated. This had been put in place to support staff when administering medication and reduce the risk to patients from incorrect medication administration.

Records

- We reviewed the medical and nursing records for three babies on the NICU at the time of our inspection and found their records were detailed and contained up-to-date information. Risks were identified with information on how to reduce the risk. At the start of each shift, the nurse caring for the neonate recorded information on the checking of the equipment. Records showed discharge planning took place and the involvement of the parents/carers in this planning was documented. The nursing staff clearly recorded at each shift who had responsibility for the neonate and from what time. Information was included on the nursing and medical care provided to the neonate – for example, if they were being breastfed and details on the administration of medications.
- When not in use, medical records were stored securely in lockable trolleys near the nurses' stations. Nursing records on the neonatal unit were located next to each cot.
- Records in the CMIU were completed by the nursing and medical staff while in the unit. If the child or young person was transferred to another department in the trust for further treatment and care, these notes were sent with them

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Consent

- Staff we spoke with were knowledgeable about gaining the consent of parents and, in the case of older children, the child themselves.
- The trust had implemented a policy and procedure to provide guidance to staff regarding the Mental Capacity Act 2005 and deprivation of liberty safeguards. This policy referred to gaining consent from children and their parents. Staff we spoke with were aware of where policies and procedures were located and how to access them.
- Records showed consent was sought prior to the delivery of care and/or treatment.
- Parents we spoke with confirmed they felt involved and informed about their child's care and treatment. Parents on the NICU informed us the medical staff had given them information about the preferred and initial plan of treatment and also about any further treatment that may have been necessary for their baby.
- We spoke with a patient on CMIU who told us they had been provided with information regarding their treatment and what would happen next. They felt they had received a positive experience.

Safeguarding

- The hospital had a dedicated safeguarding team who provided support to staff and investigated any reported potential safeguarding incidents.
- Staff we spoke with were aware of how to raise safeguarding concerns. They told us the safeguarding team were responsive and provided prompt assistance following a safeguarding incident being reported to them.
- A child health quality and safety board met each month and reviewed reported incidents to ensure appropriate action had been taken.
- Safeguarding issues were discussed at a local level at the 'share to care' meetings and the action taken and outcomes discussed. We were told this was to ensure appropriate action had been taken and, if necessary, improve practice to promote the safety of children and young people.
- Safeguarding training at an appropriate level was provided to all staff, with updates provided at the mandatory annual training day. We found from evidence produced by the trust that the mandatory

safeguarding training had been attended by 82% of the staff. The children's safeguarding training had received positive feedback from an external assessment commissioned by the trust.

Mandatory training

- Training was provided for all grades of staff. Mandatory training took place annually and records were maintained electronically to evidence which staff had attended.
- The trust had developed a policy which identified who was responsible for ensuring training took place.
- Staff on the NICU attended a mandatory neonatal training day each year which we were told included the use of equipment. Information was displayed to inform staff of the next planned annual update.
- One experienced member of staff told us the training was not as thorough as it used to be and for new staff there was a gap in some areas, for example, regarding the use of equipment within NICU. We were told the department used to conduct training internally, in addition to the annual mandatory training, led by medical and/or nursing staff, however, this had ceased. Manufacturers provided training to staff, when supplying new equipment. Staff told us they found this beneficial and would be helpful to be repeated more regularly for the benefit of new staff and as an update for the existing staff team.

Management of deteriorating patients

- We saw evidence of paediatric early warning scoring systems and neonatal early warning scoring systems which alerted staff to any deterioration in the child or babies' health. From the nursing and medical records it was clear that appropriate action had been taken to summons appropriate medical assistance when necessary.
- Staff we spoke with were clear of the escalation process to follow when a patient's health deteriorated and written information was available which clearly identified the parameters for reporting.
- The NICU had experienced a period over a weekend in December 2013 when the unit was full due to a number of very unwell newborns. As a result, additional staff had been brought in to work at short notice to ensure the safety and wellbeing of the babies. This showed the trust responded to identified risks.
- The medical records of neonates who were discharged from the NICU were scanned and available

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electronically. This ensured that, should they become unwell and required further care and treatment from other departments within the trust, their records were easily accessible to ensure full information was available.

Nursing staffing

- The trust used recognised guidelines from the Royal College of Nursing and Keith Hurst (the Telford method) to determine staffing levels. The neonatal unit followed guidelines produced by the British Association of Perinatal Medicine to determine the staffing levels in the unit. A specific acuity tool for paediatrics was not used.
- The nursing staff on the neonatal unit had a handover at each shift change. We did not attend one of these handovers but staff told us they consisted of a verbal handover both in the office and at the bedside. Staff in the CMIU and the UCC passed on verbal information at the change of their shifts regarding any child in the department.
- Staff on the neonatal unit told us the staffing levels had been low in the past but were able to provide examples of how this had improved greatly by a recruitment drive, making a difference to the care delivered to patients and their families.
- We heard that agency staff were not regularly used and this was supported by the duty rotas. The hospital had a number of bank (overtime) staff who could be called upon to cover shifts but staff said the teams were flexible and often covered shifts at short notice, for example, in the case of sickness.
- New staff were provided with a full induction period to the neonatal unit and were provided with a named mentor to help them become competent within their new role. We were able to speak to a newly appointed registered nurse who made positive comments about their experience of starting work on the unit.
- The neonatal unit and day surgery unit (Ward 27) displayed boards which showed the agreed numbers of staff for each shift, together with the actual numbers of staff. We found the neonatal unit was staffed accordingly, while Ward 27 had been reduced by one member of staff on the day of our inspection visit. The nurse in charge stated the shift had been manageable and safe as not all of the beds had been filled.
- Analysis by the trust of incidents reports showed there was a reduction in the number of incidents reported by staff regarding staffing levels. Additional actions had

been taken by the board in response to high incident reports around staffing. For example, a new system of contacting staff by text to seek cover for gaps in the duty rota, reviews of sickness and a stress risk questionnaire sent to staff.

Medical staffing

- The medical staff had a handover at the start of each shift and during the day. We attended one handover and found detailed information was shared between the medical staff to enable them to treat and care for patients consistently.
- There was paediatric consultant cover in the hospital seven days a week. Junior medical staff told us they were encouraged and felt able to phone senior medical staff, including the consultants at any time they required advice or guidance. Out-of-hours consultant cover was available with an on-call rota in place and available to the medical teams, both within the neonatal and paediatric departments.
- Paediatric anaesthetist cover was arranged by the theatre department and appropriate cover was in place to ensure that planned and emergency surgical procedures were supported by appropriately skilled and trained anaesthetists.
- During the opening hours of CMIU, we were told a paediatric-trained anaesthetist and nurse were on duty to provide appropriate care and treatment when necessary.
- There was a locum doctor working within the NICU medical team to cover a period of maternity leave. We were told it was difficult to recruit middle grade doctors nationally but at the current time the trust had a full complement of medical staff.

Major incident awareness and training

- An escalation procedure was in place which had been reviewed in March 2014. There were clear actions to be taken regarding obtaining additional staff in the case of a major incident or when the hospital had reached capacity.
- The trust were part of Lancashire and South Cumbria neonatal transport and retrieval team. This provided a dedicated neonatal transport system for all babies who needed to be transferred to another area or back to East Lancashire. This was managed by a nurse who was

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based on the NICU. This service assisted with the management of the available cots to ensure appropriate care and treatment was provided to babies who required high-dependency or intensive care.

Are services for children and young people effective?

Good



Services for children and young people were effective. The care and treatment provided was based on national guidelines and directives. Policies and procedures were reviewed regularly and updated as necessary.

Audits took place within the trust to monitor the care and treatment delivered to children and young people and actions were identified to improve practice. Performance development reviews were undertaken for staff on an annual basis but there was no system of formal supervision throughout the year.

Evidence-based care and treatment

- The children and families directorate which included the NICU, CMIU, Ward 27 and children's urgent care centre, used a combination of guidelines and directives from the Royal College of Paediatrics and Child Health, and NICE to base their treatment and care on.
- The child health quality and safety board, which met monthly, reviewed any updated guidelines from NICE and amended the trust's information for staff accordingly.
- The trust had recently developed and implemented new diabetes best practice guidelines which were in accordance with national guidelines. Staff were aware of these new guidelines.
- The policy and procedure relating to the cooling of babies had been updated and was next due for review in 2015.
- The use of inhaled nitric oxide on the NICU for babies with difficulty maintaining adequate oxygen levels was detailed in a policy and procedure which reflected national guidelines.
- Audits had taken place to ensure the paediatric department were complying with practice guidelines. We saw an anaesthetic audit had been completed for

pain control as the department was considering changing the analgesia regime. This showed the trust considered the effectiveness of current practices prior to changing protocols.

Pain relief

- The children and young people's services within the trust used a pain scale system to determine the level of pain and discomfort experienced by patients.
- Medication records we reviewed showed clear prescribing for pain relief and the time, route and dose of the medication administered.
- We spoke to a young person in the CMIU who said they had received pain relief following their assessment and there had been no delay in the administration of this.
- Prior to injections, blood tests or intravenous cannulation, the medical and nursing staff applied a local anaesthetic cream to minimise pain and discomfort. Play specialists were employed by the trust and worked with the medical and nursing staff to distract children and young people during procedures such as blood tests.

Nutrition and hydration

- Children and young people on Ward 27 were provided with a light snack following their operation. We spoke with one child and their parents and saw they had been provided with toast, water and squash once they were suitably recovered from the operation.
- The CMIU provided sandwiches and snacks to children during their time on the unit. One young person we spoke with told us they had been provided with sandwiches and a drink which they said were "very good".
- Food and fluid charts were maintained when required. We saw fluid charts in NICU identified the type and amount of intravenous fluids administered as well as the amount, frequency and route (for example orally or nasal gastric tube) of milk that had been taken.
- To support the baby-friendly initiative, consideration had been given to breastfeeding mothers who were staying with their baby and a menu with a choice of meals had been made available. However, NICU did not have the facilities available for parents to make a hot drink while on the unit.

Patient outcomes

- The trust monitored the paediatric readmission rates over the past and had produced a readmissions

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trajectory and key actions to reduce this by 4%. The child health quality and safety board had reviewed the numbers of paediatric readmissions at their January 2014 meeting and key points of the data were discussed.

- Audits regarding infection control, including hand-washing and aseptic non-touch technique (used to reduce hospital acquired infections) were conducted and found that staff complied with appropriate procedures. The outcomes of these audits were discussed at the child health quality and safety board to ensure any learning was cascaded through the family and children's care division.
- The use of ketamine sedation (often used as an anaesthetic in paediatrics) had been reviewed and an updated policy and procedure had been developed. We were shown the updated policy which was available to staff on the intranet. We were told this had been produced following a review of local and national guidelines.

Competent staff

- The trust had an annual performance development review which staff told us had replaced the annual appraisal. Staff said that, during their review, they had the opportunity to discuss their progress with their line manager, along with any difficulties and training requirements they had.
- Performance development review records were available locally and were held securely by line managers.
- We spoke to senior staff who were involved in conducting annual reviews for staff members and were told they had not been provided with any training on how to conduct an effective review session.
- No other form of formal supervision took place in the clinical areas, although staff were clear that they were able to approach the wards' senior staff, managers and matron for advice and support whenever they needed it.
- Staff said senior staff worked with them, providing care and treatment to patients which gave the opportunity for discussions and feedback about their clinical skills.
- Bereavement training had been accessed by individual staff members through Alder Hay Children's NHS Foundation Trust in Liverpool. This was a one day training course which provided staff with guidance on how to support bereaved parents. Three staff members we spoke with had attended this training course and

found it beneficial to improve their practice and knowledge. The training was not mandatory and it was not clear from records how many staff had attended this course.

- The pharmacy department were involved in training ward doctors who were new in post about prescribing for children, babies and neonates. A similar programme of training for nursing staff was in the process of being rolled out.
- Medical staff told us they were supported to increase their clinical knowledge and skills by their seniors. We observed consultants including junior medical staff in discussions on the ward round and at handover to increase their knowledge.

Multidisciplinary working

- Pharmacists provided support to paediatric staff. We met with the pharmacist on the NICU and found they visited daily to provide guidance and advice on any medication issues. Staff were positive in their comments regarding the support they received from the pharmacy.
- Regular ophthalmology assessments were undertaken on the NICU for retinopathy of prematurity screening. Clinics were held once a week in the NICU for these assessments and a nurse lead was in post.
- Play specialists, who were hospital registered, assisted staff on all units and wards where children were cared for or treated. The register for hospital play specialists is managed by the Hospital Play Staff Education Trust (HPSET) and play specialists who successfully complete the appropriate training are eligible for registration. The nursing staff were complimentary about the benefits of this service to the children they cared for. Children we spoke with who had received care from this service said, "they are really nice" and "we had fun".
- The trust provided support to children with mental health issues through their East Lancashire Child and Adolescent Services (ECLAS). While there were no inpatient beds for children with mental health issues in Burnley hospital, the ECLAS team provided support to children staff alerted them to. Staff were positive about the response they received from ELCAS when a referral had been made.
- Children and young people who were seen at the hospital could be referred to a paediatric diabetes team. This team also had a dedicated ELCAS practitioner for support when required.

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- Support was also provided to children, young people and their families and carers through the paediatric liaison and youth offending mental health team.
- We saw in the CMIU and UCC that procedures were in place for transferring children and young people who required further treatment and/or admission to hospital. The staff had clear procedures to follow when requesting ambulance transfer. These included the expected response time from the ambulance service according to the condition of the patient. We observed the transfer arrangements for one young person from the CMIU to the Royal Blackburn Hospital children's ward. Staff had assessed that the child was well enough to be transported by their parents. Staff at CMIU and Blackburn's children's ward communicated well to ensure the transfer experienced by the young person was seamless and anxiety free.

Seven-day services

- Consultants were on duty during each day and evening. The duty rotas demonstrated the on-call consultant cover overnight.
- Senior nurse/matron cover was available 24 hours a day and staff were aware of the process to follow to summons assistance when needed.
- After 6pm Monday to Friday and 12pm on Saturdays and all day Sundays, the CMIU was closed for referrals. Children and young people were required to access the main UCC or Royal Blackburn Hospital during those times. We were told this was not always convenient for people who did not have their own transport due to limited public services from Burnley to Blackburn.

Are services for children and young people caring?

Good



Services for children and young people were caring. Patients and their families/carers were treated with dignity and respect. Surveys took place to gather feedback from patients and their families/carers.

Communication and information sharing was perceived as good by children, young people and families we spoke with. Written and verbal information was provided.

Staff provided bereavement support to families/carers but there was no dedicated bereavement support team in place at the time of our inspection, although we were told this was in the process of being developed.

Compassionate care

- During our inspection we observed children, young people and their families and carers were treated with respect and dignity. We saw that when staff provided care and treatment to people, this was carried out in a manner which demonstrated consideration had been given to privacy and dignity. Curtains were pulled closed and doors of cubicles and side rooms closed.
- Staff showed empathy and understanding to those they cared for. We saw staff communicated well with children and their carers. We had received concerns prior to the inspection regarding some NICU staff being abrupt at times, but saw no evidence of this during our inspection. All of the 15 families/carers we spoke with during the inspection made positive comments about the compassion and dedication shown by the staff.
- A patient experience survey took place each month in the NICU. The results we were shown evidenced a high level of satisfaction.
- Results from the PLACE audit from 2013 had been published. This gathered people's views of the food, cleanliness, facilities and their privacy dignity and wellbeing. Burnley Hospital scored 77.4% for food and 92.8% for cleanliness. We were told the children and family services had been included in this assessment.
- Parents were able to visit at any time and spend as long as they wished with their child. We were told by two parents they had been informed they could call at any time of the day or night if they had any concerns or wished to know how their child was. The visiting arrangements on the NICU were being reviewed at the time of our inspection. The matron informed us the current system was for only parents and siblings to visit their baby on the unit. We heard this was to be changed so that members of the extended family could visit. During our inspection we saw one baby was being visited by their mother, father, sibling and grandmother. The family told us they were pleased to be able to visit together.
- Comments made to Ward 27 and the NICU by families and friends were displayed on noticeboards and provided information on action taken in response by the trust. For example, the NICU had improved the family

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waiting and visiting area that was situated outside of the unit. We also saw information on Ward 27 which showed that, in response to feedback, the parents' room had been refurbished and one parent could now collect their child from the theatre recovery department.

- Parents were able to purchase tea and coffee on Ward 27 and make their own drinks in the visitors' kitchen and rest room, which was located off the ward. It was the policy of the ward to not have hot drinks in the vicinity of the children to reduce the risk of burns and scalds. The parents we spoke with had not had a drink during their five-hour stay on the ward as they were unsure of the procedure to follow.
- Parents and carers who were staying in the hospital had access to the hospital's cafes and restaurants during their opening times. Parents and carers on Ward 27 had access to a kitchen and sitting area outside of the ward. This was stark and unwelcoming in appearance. There was nowhere for parents in the NICU to make a hot drink or to be able to sit and rest, away from the cot side. A waiting area had been developed outside of the unit, with a play area and water fountain. We were told by staff that there was a room that parents/carers could use on the ward. However, this room was signed as a 'discussion room' and, during our inspection, we saw medical and nursing staff used it on frequent occasions for discussions with parents and carers about their babies. Therefore, it was not available for use as a general rest area.

Patient understanding and involvement

- The neonatal unit provided a noticeboard for parents and carers with details about support groups and how to access further information. Written information on caring for premature babies was provided to new parents.
- Parents we spoke with were positive in their comments about the communication and provision of information from the medical and nursing staff.
- We observed parents in the NICU who were providing care to their babies. Staff were close at hand to support when necessary and we saw they were attentive but discreet in offering assistance.
- We observed that a young person and their parent on the CMIU were provided with full information about the

planned pathway of care and the requirement for them to be transferred to another hospital. Full opportunity and encouragement was provided to them for asking any questions or obtaining further clinical information.

- Information on how to access support with domestic violence was displayed discreetly within the children's urgent care centre.

Emotional support

- A community neonatal team staff offered support to parents whose babies had been discharged home and also to those parents who had returned home following a bereavement.
- The trust had a paediatric oncology shared care unit in operation which improved the care and treatment provided to children and young people who would otherwise have had to travel to Manchester for their care.
- The trust provided support to staff through a telephone counselling service if this was required and staff told us they were aware of how to access this service. We spoke with two members of staff who had worked in the NICU for a number of years. They told us they had not used this service and peer support was always available from within their staffing team.

Are services for children and young people responsive?

Good



Services for children and young people were responsive. The trust had procedures in place to ensure the flow of patients through the service so that children and young people received appropriate treatment and care in a timely way.

The service was designed to meet the needs of all children, including those with additional needs. Interpretation services were available when required.

Service planning and delivery to meet the needs of local people

- The trust had implemented an escalation policy and procedure to ensure that at busy times of admission the service provided was safe. This included the process to

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ensure sufficient staff were on duty. We were given an example of when this had been put into practice in NICU when seven neonates required care and treatment in a short period of time.

Access and flow

- The NICU nursing and medical staff maintained close communication with the midwifery and obstetric department which provided early information regarding babies who potentially required care and treatment in the unit.
- The CMIU received referrals from GP surgeries, the UCC at the hospital, midwives, health visitors and nurse practitioners. On admission to the unit, observations, examinations and tests were carried out and a plan of care and treatment put into place.
- Arrangements were in place, and implemented, when children and young people seen in the CMIU or UCC required admission to the children's ward at the Royal Blackburn Hospital.
- Ward 27 had protocols in place for children who had initially been treated as day care patients but who were not well enough to return home and required overnight care at Blackburn Hospital.
- A telephone advice service was available through the CMIU for GPs who had seen children and young people in their surgeries. Records held by the trust showed this had reduced the number of patients referred to the hospital.
- The trust had commissioned a review of the readmissions of children within 30 days of discharge. The review took place in December 2013. This showed a number of children were readmitted and discharged through the CMIU as they did not require an overnight stay.
- Discharge letters were produced by the nursing and medical staff when transferring the care of children and young people to other departments or professionals – for example, to the children's ward at the Royal Blackburn Hospital, GPs or other hospital trusts. The discharge letters were stored electronically and a paper copy sent with the patient. The letter contained information on the reason for admission, investigations undertaken and any results and treatment.

Meeting people's individual needs

- Information was available about the trust on their website that could be translated into other languages for people whose first language was not English.

- Noticeboards at the entrance to each department welcomed people in a variety of languages.
- Staff were clear on the processes to access interpretation services. Face-to-face interpretation services were available by prior booking and a translation telephone service was available over the 24-hour period.
- Staff demonstrated an awareness of cultural issues. For example, staff were aware of the need to offer clinic appointments at a time which did not conflict with people's prayer times.
- Staff sought the advice and support from specialist departments and clinical nurse leads for children with complex medical conditions or additional needs such as learning disabilities. This support could be accessed through employees of the trust and, in some cases, from other NHS trusts.
- The CMIU provided care to children and young people in separate cubicles. Ward 27 was split into bays with two cubicles. Staff told us the children were allocated beds according to age rather than gender but that, for reasons of privacy and dignity, teenagers were separated according to their gender when possible. This did not correlate with guidance from the Department of Health in that young people often find comfort from being with others of the same age and should be given the choice.
- The Rainbow Centre provided a neurodevelopment service to children and young people and was located at Burnley General Hospital. This service supported children and young people with additional needs such as autism, attention deficit and hyperactivity disorders, dyspraxia and behavioural problems.
- At the time of our inspection, there was no bereavement support team in operation. We were told that this was in the process of being set up. A room was available for recently bereaved parents to spend time with their baby. This provided the facilities for them to be able to stay overnight and receive support from the midwifery or neonatal teams.
- A café and restaurant were located in the hospital where parents/carers were able to purchase food for themselves.
- We found discharge planning commenced soon after admission on the neonatal unit and this included considering the medication and support parents would

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need with administering this on discharge. The hospital pharmacy and community neonatal teams liaised at times when there was an issue for parents regarding obtaining medication from their GP.

Learning from complaints and concerns

- The trust had a policy and procedure to deal with complaints. Initially parents and carers were encouraged to raise any complaint with the senior nurse on duty. A log was made of all complaints and these were reported to the matron. The matron was aware of complaints in the children and young people's directorate and the action that had been taken in response. This information was disseminated to staff at the 'share to care' meetings.
- Information was displayed throughout the children's units on how to make a formal complaint. The information directed people to PALS. PALS data showed complaints for paediatrics had increased in 2013/14.

Are services for children and young people well-led?

Good



The children's and young people's service was well-led. Staff were positive about the leadership and management structure of the family care directorate at the hospital. The culture was open and staff felt able to discuss any concerns or raise incidents and were confident they would be listened to.

A system of risk management was in place, with appropriate action taken to reduce identified risks.

Vision and strategy for this service

- The trust vision "to be widely recognised for providing safe, personal and effective care" was visible in areas of the hospital.
- The paediatric division promoted the six 'Cs'. This related to providing care, communication, compassion, competence, commitment and courage. Posters were displayed throughout the wards and departments. We spoke with student nurses, healthcare assistants and trained staff, who were all aware of this initiative.

Governance, risk management and quality measurement

- The paediatric units and the NICU at Burnley General Hospital maintained a local risk register, which detailed actions to reduce future risk and was reviewed regularly. The matron told us this linked into the trust's risk register which was accessible electronically. We were also told the trust board had discussed the local risk registers and reviewed each risk and associated actions.
- Risk management meetings took place in the NICU and we were provided with minutes from previous meetings. We saw that incidents reported through the trust's electronic system were discussed at the risk management meetings and actions logged.
- Reported incidents were subject to auditing and a trend analysis completed by the trust. We saw that, for the last trend analysis, which included incidents up to September 2013, there were no paediatric serious incidents reported and the family care division scored 100% on harm-free care on the Safety Thermometer.
- At Burnley Hospital, risk registers were monitored at a local and trust level. Staff were able to discuss with us the risks identified within their clinical areas and also the action that was being taken to address these.
- A child health quality and safety board met once a month with staff attending from both Burnley General Hospital and the Royal Blackburn's children's units. Minutes from these meetings were circulated and actions arising from the meeting were allocated to individuals to take responsibility for ensuring they were addressed. The actions were followed up at subsequent meetings to ensure a satisfactory conclusion had been reached.
- At the last inspection there were shortfalls in the operation of the governance systems in NICU and a compliance action was made. From the findings detailed above we judged these actions to have been implemented and the relevant standard now met.

Leadership of service

- Staff on the neonatal intensive care unit told us there had been regular changes in the management of the unit and trust. However, they were positive in their comments regarding the current management structure and one person told us "we have been shouting for a long time but now feel listened to".
- Nursing staff in all areas had an identified matron who visited the ward and units regularly. All of the staff we

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spoke with made positive comments about the support they received from their matron including “approachable”, “helpful” and “professional and supportive”.

- The NICU, CMIU and the UCC had ward managers located on them. Ward 27 shared the ward manager from the CMIU and received support from the matron.

Culture within the service

- Staff we spoke with all said they would be able to raise concerns, would feel listened to and were confident action would be taken. We were told the senior staff were approachable and responsive.
- New matrons had been recently appointed in some areas of the family care directorate. Staff were very positive about the support they received from the matrons and all said they were able to speak to them at any time or call for advice or support.
- Staff were aware of the whistleblowing procedures and how to report concerns through the electronic reporting system or in person.
- Staff spoke positively about working at the hospital and the teams they worked within. There was obvious respect between the medical, nursing and support staff.
- We were told many times how teams in different areas worked well together and about the support received. For example, we heard compliments about the efficiency with which the children’s wards at the Royal Blackburn Hospital responded when a bed was requested for a child who had attended Burnley General Hospital.





Public and staff engagement

- Patients, families and carers were provided with opportunities to complete questionnaires regarding their views of the service provided. The actions taken in response were available on the wards.
- The outcomes of the 2013 NHS Staff Survey were made available for the inspection. The survey had been organised into key areas and in most the trust received positive responses. We were told the areas where improvements were required were being addressed. Staff we spoke with were positive about the changes within the trust and the areas they worked in.

Innovation, improvement and sustainability

- We were provided with evidence which demonstrated the trust had increased services to provide a higher standard of care to children and young people. For example, the advanced paediatric team had increased in number so that it could be provided over five days a week.
- A training event had taken place for GPs on key aspects of paediatric emergency care to increase communication and consistency in the clinical approach. This had been widely attended and we were informed further events were to take place in 2014.
- Links had been made with University of Central Lancashire in Preston and a band 6 nurse from the paediatric department had been invited to be part of the teaching programme on the cadet nursing scheme.
- The baby-friendly initiative was in progress within the NICU, with the aim of promoting breastfeeding.
- We talked with management staff throughout the paediatric directorate and found they were all, without exception, enthusiastic and positive about their roles within the trust.

End of life care

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

Information about the service

End of life/palliative care services were provided throughout the trust. There were no dedicated wards for the provision of end of life care at Burnley General Hospital. Patient care was delivered by generalist staff on the medical wards in the hospital. They were supported by a hospital consultant-led specialist palliative care team. This team coordinated and planned care for patients at end of life on the wards and was available Monday to Friday 9am to 5pm, excluding bank holidays. Out-of-hours support was provided via a telephone hotline to the local hospice.

We visited two wards where end of life care was provided. We also visited the spiritual centre, the hospital mortuary and the chapel of rest.

During this inspection we spoke with three patients on the wards. We spoke with a range of staff including domestic, healthcare assistants, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We also spoke with members of the hospital specialist palliative care team, including the clinical lead for palliative care, the end of life care coordinator and nurses. We met with Macmillan nurses who provided a support service for staff, patients and their relatives at the hospital.

We observed care and treatment and we looked at care records. We looked at appropriate policies and procedures as part of our inspection of this service.

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

The end of life team team worked closely with primary and secondary healthcare professionals to adopt nationally recognised best practice tools: Gold Standard Framework, Preferred Priorities for Care and good practice guidance to replace the Liverpool Care Pathway for end of life care.

End of life care

Summary of findings

Care for patients at the end of life was supported by a consultant-led specialist palliative care team. Staff followed end of life care pathways that were in line with national guidelines and used those pathways effectively. Staff were clearly motivated and committed to meeting patients' different needs at the end of life and they were involved in developing their own systems and projects to help achieve this.

Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents. The palliative care team staff were clear about their roles and benefitted from good leadership. We observed that care was given by supportive and compassionate staff.

Relatives of patients who received end of life care spoke positively about the care and treatment patients received and they told us patients and their relatives were treated with dignity and that their privacy was respected. The relatives of patients, and nurses and doctors spoke positively about the service provided from the specialist team.

However, we found that shortfalls in the hospital bereavement service impacted on the quality of service they provided to grieving relatives. The strategy for end of life had been revised and was in draft format, therefore this was not yet embedded in the care provided.

Are end of life care services safe?

Good



End of life care was safe and met the needs of patients. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were safe and well cared for on the ward we visited.

There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

The end of life care teams monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, Never Events (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers), complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers.

Incidents

- There had been no recent Never Events in the specialist palliative care service between December 2012 and January 2014.
- Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, Never Events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers.
- The National Reporting and Learning System (NRLS) data did not have a specific end of life category for reporting patient safety incidents. We saw evidence of incident reports and learning from these were displayed on the wards. Staff told us any themes from incidents were discussed at ward meetings, and staff were able to give us examples of where practice had changed as a

End of life care

result of incident reporting. One staff member told us about when a patient had fallen and how this had made them review and look at the risks for patients and how they further monitor them.

- Nursing and medical staff told us they were encouraged to report incidents and they were fully aware of the process to follow where necessary. The consultant told us they also acted as a named investigator and meetings were held to discuss any risks and actions required.
- We spoke with staff who confirmed they attended weekly multidisciplinary ward meetings to review issues relating to care. A review of minutes from this meeting showed that incidents were discussed.

Safety thermometer

- We looked at up-to-date information about the wards' NHS Safety Thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections). It showed that the trust was well below the England average in relation to these for the entire year for all patients. There was not a Safety Thermometer directly related to end of life care.

Cleanliness, infection control and hygiene

- Ward areas were generally clean, domestic staff undertook audits of the environment to ensure continued cleanliness.
- During our inspection we observed staff adhering to infection control guidance including; 'bare below the elbow' guidance, washing their hands, wearing gloves and aprons as necessary and using hand gel as necessary.
- Burnley General Hospital mortuary provides additional storage for Royal Blackburn if needed and has postmortem facilities. There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection. We looked at the report dated November 2013 carried out by the Human Tissue Authority (the specific regulators to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased) which showed Burnley General Hospital had met all required standards. are

Environment and equipment

- Ward 16 was clean and free of clutter. Staff told us the wards had sufficient moving and handling equipment to enable patients to be safely cared for.
- Equipment was maintained and checked to ensure it continued to be safe to use.
- Access to syringe drivers for people needing continuous pain relief was available. Patients could be discharged with appropriate equipment for controlling their pain.
- There were systems in place for checks to be carried out in relation to the use of syringe drivers. These included checking the needle site, battery and volume of infusion remaining in the syringe.

Medicines

- We saw that anticipatory end of life care medication had been appropriately prescribed. We spoke with junior doctors about prescribing medications to relieve symptoms for patients who were dying; they told us they found the advice from the Macmillan nurses useful.
- We looked at the medication administration record charts for a number of patients on wards we visited and saw appropriate medication was prescribed. Medical staff told us they were provided with advice and support on this from the trust's specialist palliative care team.
- New syringe pumps had recently been introduced to deliver sub-cutaneous medication. Staff told us they had received a full day's training on the use of these.
- Staff confirmed the syringe drivers were accessible if an end of life patient was being discharged home rapidly in to the community and required this as part of their treatment package.
- Two of the specialist palliative care team nurses were nurse prescribers and another nurse had completed the course.

Records

- We looked at two patients' records on the wards we visited; we saw the care and treatment was recorded by the specialist staff, nursing care and medical records. We saw completed risk assessments, for example, for venous thromboembolism to minimise the risks of patients developing blood clots, and also for falls, nutrition and pressure relief.
- The end of life coordinator told us about the new documentation that was planned across the trust to be implemented in April 2014. This meant that staff were able to deliver care in accordance with patient's individual preferences and wishes.

End of life care

- The trust had not yet carried out an audit of DNA CPR forms. One of the specialist palliative care team nurses told us that auditing of these forms was planned for a future date.
- We saw that records were stored securely to ensure they could not be accessed by people who did not have the authority.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence of best interest meetings when discussions about DNA CPR and end of life care took place. These included recorded discussions of conversations with people's families or the involvement of independent mental capacity advocates.
- Patients who did not have capacity to consent to end of life care were treated appropriately.
- One staff member showed us their 'mental capacity tool kit'. They told us they felt increasingly confident around mental capacity assessments and deprivation of liberty safeguards. They had recently attended 'best interest' meetings for people who had been assessed as not having capacity to make decisions for themselves.
- Staff told us they received training in the Mental Capacity Act 2005 during induction and they were aware of action they needed to take. One staff member told us, "We have recently had training on safeguarding; this is now being cascaded to other staff at the same time as mental capacity training".

Safeguarding

- There were adult safeguarding policies and procedures in place supported by mandatory staff training. Staff we spoke with were aware of how to raise and escalate concerns in relation to abuse or neglect for both vulnerable adults, and children.
- Staff we spoke with confirmed they had attended ongoing mandatory training, including safeguarding.

Mandatory training

- All staff employed by the trust completed a core mandatory training programme.
- Training uptake was reported and monitored. We reviewed the record of staff uptake of training which confirmed that staff received regular mandatory training and staff we spoke with confirmed this.
- The specialist palliative care team were monitoring the uptake of the training programme for palliative and end of life care training. The trust were part of the

Commissioning for Quality and Innovation (CQUIN) framework for 2013/14 to secure improvements in quality of services and better outcomes for patients. Specific training included an introduction to the palliative care/end of life, communication skills, symptom management and end of life care and discharge. This training was not seen as mandatory training by the trust but the CQUIN would ensure a percentage of staff would attend the training programme in end of life care.

- The specialist palliative care team were promoting the development of end of life care champions through ward-based link nurses for palliative care. We spoke with a healthcare assistant who spoke favourably about their role in promoting end of life care. They told us they found the training valuable and they felt communication with patients, relatives and staff had improved on their ward as a result. They went on to say, "I have seen patients become less agitated when they have been put on the amber care package, it makes doctors and nurses really look at what that individual needs".

Management of deteriorating patients

- Staff on the wards confirmed that the national early warning score was used throughout the trust to alert medical and nursing staff to changes in patients' health, so appropriate and timely action could be taken. This monitoring would be stopped, as appropriate, when a patient moved towards their end of life.
- Specialist support was available from the specialist palliative care team when required and out-of-hours specialist advice could be sought from the medical/nursing staff at the hospice.

Nursing staffing

- Patients with end of life needs were nursed on the general wards in the hospital; therefore the nursing care was reliant on the staffing arrangements on the individual wards.
- Patients spoke positively about the staffing levels on the wards we visited as part of this inspection. A staff member told us, "The staffing here is very good, I may need to do a one-to-one on a patient so I think today they have got me as extra".

End of life care

- On the wards we visited we observed there were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were safe and well cared for.
- The specialist palliative care/end of life team consisted of both a hospital and community based team of clinical nurse specialists. There were three Macmillan clinical nurse specialists in the hospital-based team who supported the ward staff. We were told a business case had been proposed for three more nurses to double the hospital establishment and support more fully end of life care across the trust.

Medical staffing

- For patients with end of life needs, medical cover was provided on the general wards in the hospital. There were four consultants in palliative medicine; two based in hospice and community locations, and two mainly hospital based. During the inspection were found that two of these staff were on long-term leave. One consultant told us the trust had made attempts to recruit to one of these posts and this had been unsuccessful.
- The specialist palliative care team was available 9am to 5pm Monday to Friday, excluding bank holidays.
- Out of those hours, consultant support was provided via a telephone hotline to the local hospice.

Are end of life care services effective?

Good



People's care and treatment achieved good outcomes, promoted a good quality of life and was evidence-based.

During our inspection we tracked three cases – patients the specialist palliative care staff had identified were in receipt of end of life care. In addition, we spoke with patients on the ward areas. Patients and their relatives spoke positively about the way they were being supported by all staff to meet their care needs.

Staff on the wards were aware of the approach the trust was using for patients receiving end of life care. All staff we spoke with were aware of how to contact the specialist palliative care team. We saw that end of life champions had

been appointed on the ward areas. These staff were the appointed lead in the clinical areas to share any new information re end of life care with ward staff and to attend meetings where any updates were provided.

Evidence-based care and treatment

- The clinical nurse specialists for palliative care team told us care was based on NICE Quality Standard QS13 and the Gold Standards Framework. This quality standard defines clinical best practice within end of life care for adults.
- The trust was currently updating its policy for care of the dying and was developing further guidance and care plans in line with the strategic clinical network. We looked at the local policy on 'care of the dying patient', good practice guidance which outlined the principles of care for any dying patient. This was in response to the national independent review of the Liverpool Care Pathway until guiding principles and proposed outcomes will be published by NHS England.
- The specialist palliative care team had acted on the Department of Health's National End of Life Care Strategy recommendations. They had introduced the 'amber care bundle' – an alert system to identify patients who were not responding to current treatment. The care bundle encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.
- The amber care project included ward-based training for staff (including advanced care planning, rapid discharge, care of the dying patient, communication and coordination of care). The lead nurse told us that a programme to follow up on the training was already provided on wards to ensure patients were being identified appropriately for the amber care bundle. One ward sister told us, "The amber care bundle has been a very positive experience. It has enabled clear discussion with patients and their families around prognosis. It has made shared decision making better and has raised the staffs' awareness of the deterioration of patients".
- At the time of this inspection, the clinical nurse specialist who was leading the end of life project told us that six wards were currently using the amber care bundle, and there were plans to roll this out to additional wards over the coming weeks.
- Policies and procedure were accessible for staff on the intranet and staff were aware of how to access these.

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- The palliative care service held a GP learning event in March 2014 which included workshops on 'Care of the dying patient' and the use of end of life care pathways.

Pain relief

- Patients we spoke with told us they were given pain relief when they required it. Anticipatory prescribing took place to ensure pain relief was administered to patients in a timely manner.
- Medical and nursing staff could contact the specialist palliative care team for advice about appropriate pain relief if required.
- The specialist palliative care team did not undertake local audits to assess the effectiveness of treating pain and pain management.

Nutrition and hydration

- The ward staff supported patients to eat and drink normally for as long as possible. We saw patients had access to drinks and patients who were able to tell us said the food was good.
- We saw that fluid and nutrition was accurately recorded when it needed to be. The ward areas maintained fluid balance charts, and these were accurately totalled. This meant this information could be used to influence clinical decisions as necessary.
- We observed that all patients had access to drinks which were within their reach on the wards we visited.
- We saw that patients were screened using the malnutrition universal screening tool to identify those who were nutritionally at risk. Staff we spoke with were aware of these patients.

Patient outcomes

- All the staff we spoke with were highly motivated and committed to meeting patients preferences about where they ended their life.
- The trust had contributed to the National Care of the Dying Audit but national results were not available at the time of our inspection.
- There was some evidence of local audit activity. One local audit showed that 81% of referrals were received by the team on the first day of diagnosis. This showed that patients who were referred for palliative/end of life advice were seen in a timely way.

Competent staff

- All new staff were provided with an induction programme where they undertook mandatory training. Two recently recruited members of staff told us they had

received a trust-level and local induction at ward level when they joined the hospital. Junior doctors and consultants we spoke with confirmed they had received some end of life care training.

- There was an education and training programme in place. Link nurses and end of life champions were appointed to promote end of life care.
- Staff told us that they received annual appraisals and that they had regular supervisions within their ward areas.
- All of the staff told us they knew they could get support from the palliative care team when they needed advice.
- The end of life care coordinator and the palliative care consultant told us that training was ongoing and there were plans to continue this throughout 2014.
- We were told that 219 staff, including nurses and healthcare assistants, had completed transforming end of life care training across Blackburn and Burnley Hospitals, along with 116 people who did not work directly in the clinical areas. It was not clear if there was a target number of staff to receive this training.

Multidisciplinary working

- The multidisciplinary team worked well together to coordinate and plan the care for patients at the end of life. The service included spiritual support from the chaplaincy team. In addition there was a daily multidisciplinary team meeting on all the medical wards to discuss and manage patient risks and concerns. Patients at the end of life were included in this discussion so all disciplines could contribute to effective and consistent care for patients at the end of life.
- One consultant told us they felt the input from the physiotherapist and occupational therapist and social worker as necessary was invaluable to the team. They said, "We are still improving discharge arrangements, however, we have been told that length of stay has reduced by half".
- The palliative care consultant told us that they worked alongside district nursing and hospice staff to ensure rapid discharge and that people's preferred place of death was achieved as far as reasonably possible.
- The specialist palliative care/end of life team were working with commissioners to develop a locality wide electronic palliative care coordination system. This would be a shared register of patients in the last year of life which would adequately record the rationale behind decisions made by and on behalf of patients.

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Seven-day services

- The palliative care team were available 9am to 5pm Monday to Friday, excluding bank holidays.
- Out of those hours, support was provided via a 24-hour telephone hotline to the local hospice providing nurse and medical advice.
- The palliative care consultant told us the national standards for a seven-day service was a priority for the team and they were looking to extend the availability of the service. A business plan had been proposed for an additional nurse.

Are end of life care services caring?

Good



Evidence gathered prior to our inspection, and from speaking with patients, relatives and carers during our inspection, provided us with assurance that the staff at Burnley General Hospital were providing a caring service. We observed caring interactions from staff and feedback from individual patients and relatives. Two patients spoke positively about the care provided by staff. Comments included: “The staff are very good here”; “They are kind and helpful”.

Information on ‘do not attempt resuscitation’ was discussed with patients or their relative/carer.

Compassionate care

- Patients were treated with dignity, respect and compassion from the ward to the mortuary. We saw evidence of a number of thank you cards on the wards.
- Staff told us they generally had enough time to spend with patients and their relatives when they were delivering end of life care. They told us how important it was for relatives and their families at this difficult time.
- There was a relatives’ room or office on most wards where sensitive conversations could be conducted. We saw staff using this facility to speak with patients’ relatives during this inspection.
- Normal visiting times were waived for relatives of patients who were at the end of their life. Relatives we spoke with confirmed this. The trust had one relative’s room but staff told us relatives choosing to stay would generally stay in the side room with their relative.

- Staff we spoke with demonstrated commitment and compassion to providing good end of life care and the importance of dignity after a patient had died.
- The NHS Friends and Family Test results for 2012 showed the trust to be performing above the England average for the inpatient test, but these did not specifically relate to people receiving end of life care.
- We visited the mortuary and the staff we spoke with showed how they continued to treat patients with dignity and respect after their death.
- In the mortuary there was a viewing room where relatives were able to spend time with their deceased relative.
- The chaplaincy staff demonstrated a caring and compassionate approach towards patients, relatives and staff.
- The patients who had been referred to the Macmillan nurse specialists were too unwell to speak with us during these ward visits so we could not determine their satisfaction with the care offered. .
- There was limited patient feedback regarding the hospital specialist care team. One of the Macmillan nurses told us that the team made 10 phone calls per month to gather the views of relatives but we did not see the results of these calls.

Patient understanding and involvement

- We heard from patients and relatives how staff did work to establish a good rapport with patients and their relatives/close friends.
- We observed doctors and nurses speaking with patients about their care and checking they understood what they had been told.
- We saw that, where patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.

Emotional support

- The specialist palliative care team, the chaplaincy and nurses provided emotional support to patients and relatives. Patients and relatives told us staff were supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance. On one ward we saw where a patient’s condition had deteriorated, medical and nursing staff communicated with and offered support to the person’s family. We saw that privacy and dignity were

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maintained. We revisited this patient on the ward the following day and the patient's notes confirmed the Macmillan nurse had provided additional support to the patient's relatives that evening.

- Chaplaincy staff were visible within the hospital and staff within the ward areas told us they could access religious representations from all denominations. Staff told us that, on some of the wards, the demand for rooms could mean that patients at the end of their life may not have access to a side room.
- The mortuary manager told us that they had close links with representatives from the local mosque who would provide them with any updates required to ensure they were fully aware of any new religious requirements within the Muslim community as necessary.

Are end of life care services responsive?

Requires Improvement



The palliative care multidisciplinary team worked across the hospital and in community settings. This showed their close working relationships, good communication and how staff could respond to patients' changing needs. Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were working hard to ensure patients receiving end of life care had a positive experience.

Patients had emotional support from the specialist palliative care team and chaplaincy, however, there was a lack of bereavement services across all areas of the trust. The trust had acknowledged this and was in the process of addressing it.

Service planning and delivery to meet the needs of local people

- A survey by the specialist palliative care team was carried out in April 2012 to survey patient experience. Since then the team administrator had undertaken a monthly telephone survey of both community and hospital patients. The palliative care consultant recognised the need for more systematic audits, as current surveys were not extensive enough to ensure that services provided a patient experience to meet the needs of the local population.

- The trust had a relationship with the local hospice to ensure medical and nursing support was available 24 hours a day.
- The palliative care team had links with primary care services. The end of life coordinator worked with GPs and information was shared with community nurses.
- The palliative care team had provided training for end of life champions to cascade their knowledge within the ward areas where patients and their families who require end of life care were supported.
- Patients referred to the specialist palliative care team were seen promptly according to patient need. The team's quarterly audit consistently demonstrated 100% compliance with response to referral times (within 48 hours of referral).
- Across the trust, there was a focus on ensuring care was carried out in the patient's preferred place. The specialist palliative care team supported patient preferences to ensure a rapid discharge home, where possible, for patients who identified a wish to be cared for in their own home. This ensured that patients had choice at the end of their lives.

Access and flow

- Patients were mostly seen within 24 hours of referral. The palliative care nurse told us that sometimes, if they were unable to make their assessment on the day they received the referral, they would contact the ward manager to check if the patient's condition had changed since the referral was received and urgent advice was needed. This was regularly audited.
- The specialist palliative care team were looking to expand to better support staff and patients in A&E and across the trust.
- We saw that multidisciplinary team board rounds were undertaken on each of the ward areas on a daily basis where plans for discharge were discussed.
- Rapid response for discharge to preferred place of care was coordinated by the end of life team. Staff told us there was a multidisciplinary approach to discharge planning which involved the hospital and the community staff to facilitate a rapid but safe discharge for patients. We looked at the rapid discharge pathway policy which guided staff on this approach.

End of life care

- The team aimed to achieve 100% of patients dying in their preferred location. Currently they were achieving 81%. The palliative care consultant explained that sometimes patients were too ill to be transferred to the community for their end of life care.

Meeting people's individual needs

- Spiritual and religious care was provided to dying patients and their families by chaplains, who provided spiritual, religious, and pastoral care to patients, their relatives and the trust staff. There were Christian chaplains for a range of denominations and Muslim chaplains. A nurse told us, "We take patients to the prayer room or chapel as necessary; it's important to look after their religious needs".
- A patient's relative at the listening event told us they felt they did not receive any counselling or support. We were told by senior staff the provision of a bereavement counselling service and the need for a bereavement coordinator had been recognised by the trust as a service to be developed
- Multi-faith chaplaincy was available 24 hours a day, seven days a week. Arrangements had been made with the mortuary and local coroners to ensure that, where necessary for religious reasons, bodies could be released promptly.
- During this inspection we did not see any patients who did not speak English in receipt of end of life care. We saw information leaflets in different languages in the mortuary and on the wards, and staff told us that translation services were available within the hospital.
- Facilities for relatives include arrangements for a bed to be set up in the side rooms if they wanted to stay with their relatives at the end of life.
- The trust had a rapid response service for discharge to a preferred place of care. However, recent data about preferred place of death was not available. Staff told us how a patient had not been able to leave the hospital due to deterioration in their condition. They told us, "I feel we gave them the best care possible and that is of the utmost importance to me for themselves and their relatives".
- The specialist palliative care nurses did not express any concerns about the end of life care about patients on the wards. They told us that, at times, they felt the

referrals from ward staff were not always timely enough. This meant that patients could be at risk of not receiving advice and treatment in a timely way to manage their symptoms from the specialist staff.

- There was support available for people with dementia. The senior nurse told us there were plans to re-launch the 'This is me' booklet – person-centred information for people with dementia who are receiving professional care to ensure staff know their individual needs. We were told there was not currently a dementia nurse specialist in post. This means patients with a dementia-type illness may be at risk of not receiving the specialist support they needed. We observed staff talking to patients with dementia in an appropriate way. One healthcare assistant told us, "I like this ward as I feel I have the time to spend with patients and give them the best. I have eight patients to look after today, which gives me enough time to be able to take my time". The wards used the Butterfly Scheme which helps staff to identify and work with patients with a diagnosis of dementia.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint, they would speak with the shift coordinator. If they were not able to deal with their concern satisfactorily, they would be directed to PALS. If they still had concerns, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the trust.
- Staff told us that they would be consulted if a complaint specific to end of life care had been raised as they would be asked to contribute towards this. A hospital matron advised us that they now took a lead role to investigate and provide a written report on complaints. They felt this was a positive step forward to ensure a detailed, accurate response was provided.
- The palliative care team engaged with bereaved relatives by telephoning a number of them within 12 weeks of the death of their family member. The team used the feedback to consistently improve their service.
- The current record-keeping system had no systematic way to identify if a complaint or incident was linked to end of life. The chief nurse was looking at ways to make this possible.

End of life care

Are end of life care services well-led?

Requires Improvement



There was a draft trust strategy for adult palliative and end of life care. However, hospital staff we spoke with were not aware of its contents or how it had an impact on patient care. We received generally positive comments from staff regarding positive changes in culture within the trust. There was good local leadership and an enthusiasm within the service. Staff worked well as a team and were supportive towards each other. Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients. End of life care was not monitored across the hospital in ward areas to ensure standards were being met.

Vision and strategy for this service

- In line with national guidance, the trust had phased out the Liverpool Care Pathway for end of life care. The trust had launched the 'Care of the dying patient' good practice guidance, in the interim until new guidance is published by NHS England.
- We saw a draft copy of the trust's vision for end of life care and priorities for 2014/15. The trust has identified its priorities in the strategy, including: establishing an end of life register; reducing inequalities and ensuring equitable access; coordinated care at end of life; raising the profile of end of life care; and more staff education and training. Staff told us they believed improvements would occur when the end of life service was expanded in the trust.
- We met with the end of life care coordinator who told us that patients should expect to receive a good end of life care experience which offered them choice. The team were working towards shifting the terminology and attitudes of staff.
- The vision for end of life care was visible within the ward areas. The end of life champions were enthusiastic about their role and how they were going to put their learning into practice. One healthcare assistant who was passionate about improving care and support for people at the end of their life told us, "I think people are getting better at seeing where people need the support and then the right decisions can be made".

Governance, risk management and quality measurement

- We saw that performance quality dashboards were on display in the ward areas we visited. This is important so that staff can see what standard the trust is aiming for.
- Complaints, incidents, audits and quality improvement projects were discussed at directorate level, ward level and in departmental meetings. We saw evidence of learning from these. There were plans to link incidents and complaints and to identify any themes in end of life care where improvements were needed.
- Senior staff clearly discussed areas they had identified as a risk within their directorate and department, and were able to tell us about the actions they were planning to minimise these risks.
- We were told the end of life strategy and operational group had met twice. This had yet to include teams looking after children. The strategy for end of life care was not yet embedded into practice or audited against.
- A review of the last six months of board papers there was no evidence of end of life discussion.

Leadership of service

- The trust had a new leadership structure; they had recently appointed the chief nurse as the executive lead as well as a non-executive lead for end of life care.
- It was evident the team responsible for end of life care were passionate about ensuring patients and their families received a good end of life care experience. Team members told us, "The team was small for the size of the trust" and they would like to see "new appointments in bereavement, and to expand the team were necessary for this to progress".
- Ward staff we spoke with knew the Macmillan nurses and who the leads were for end of life care. Staff spoke highly of the end of life education manager who was leading the amber care project and felt she was supportive and visible in the ward areas.
- Staff told us that the new chief nurse was often visible within the trust and was approachable.

Culture within the service

- Staff within the palliative care team spoke positively about the service they provided for patients.
- Staff we spoke with told us how the "culture within the trust was changing for the better". They spoke positively about the service they provided for patients.

End of life care

- Staff reported positive working relationships and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- Staff were positive about the service they provided for patients and expressed they wanted to do their best for patients.

Public and staff engagement






- The trust had been part of the National Care of the Dying Audit but the results were not available at the time of this inspection.
- There was currently a monthly telephone audit of palliative care and staff recognised the need for more systematic audits, including a bereavement survey.

- Staff spoke positively about the recent visibility of the leadership board.

Innovation, improvement and sustainability

- The trust acknowledged they had shortfalls in the provision of a bereavement service. They had a bereavement steering group, whose role was to promote and develop services relating to bereavement care, including staff training and the appointment of a lead person across the trust to develop these services.
- The end of life care team had rolled out the amber care bundle. It is designed to enable treatment to occur alongside palliative care, however, staff recognised that sustaining the training for this was going to be challenging once the project had been rolled out.

Outpatients

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Good	
Overall	Good	

Information about the service

East Lancashire Hospitals NHS Trust offered outpatient services at the following sites within the area:

- Royal Blackburn Hospital
- Burnley General Hospital (main outpatients and phase V)
- Rossendale Primary Care Centre
- Pendle Community Hospital
- Accrington Victoria Hospital

Some specialities were available on all sites, while others were available on specific sites only.

Burnley General Hospital had two general outpatient departments located in different areas of the hospital. They provided outpatient services across a range of medical and surgical services. There were also specialist outpatient clinics for a wide range of conditions. The clinical outpatients directorate management structure and leadership arrangements covered all locations within the trust. This meant some staff worked across more than one location, dependent on their role and the clinical needs of the service.

During our inspection of the Burnley General Hospital site, we visited both the general outpatient departments, maxillofacial, orthotics, and ophthalmic outpatient clinics. We also visited the appointment booking centre. We spoke with 15 patients who were attending the clinics. We spoke with sisters in charge of the departments, three members of nursing staff, three medical consultants, reception and administration staff, and booking centre manager and staff.

Summary of findings

Patients were treated with dignity and respect by caring staff. Patients spoke positively about their care and felt they had been involved in decisions about their care. Staffing numbers and skills mix met the needs of the patients. There was a clear process for reporting and investigating incidents. Themes and trends were identified and action taken to minimise risks. The outpatient departments we visited were clean and well-maintained.

Patients and staff told us that clinics were sometimes cancelled at short notice and we found that clinics frequently ran late. Patients spoke of the anxiety and inconvenience this caused them. Staff were auditing this and were considering ways to address it. Changes to the patients' ambulance transport services had caused confusion for staff, resulting in them not knowing which patients had transport arranged. Patients could wait for long periods for transport if their appointment was late.

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other. Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients.

Outpatients

Are outpatients services safe?

Good



Overall care in the outpatients was safe. There was a clear process of reporting and investigating incidents within outpatients. Themes and trends were identified and action taken to change practice to minimise risks.

The outpatient departments we visited were clean and well-maintained and were safe and fit for purpose. Medicines were stored correctly and patients confirmed their prescribed medication had been explained to them by the staff in the clinic and they had been given the opportunity to ask questions.

There was a clear system in place for managing patients' records and ensuring that medical staff had timely access to patient information and test results.

There were policies and procedures in place in relation to consent and the Mental Capacity Act 2005 and its deprivation of liberty safeguards. Staff were clear on how to obtain informed consent and to assess people's capacity to make decisions for themselves. We saw there were safeguarding policies in place, and clear procedures to follow if staff had concerns. Staff were aware of how to raise and escalate concerns in relation to abuse or neglect for both vulnerable adults, and children.

Staffing numbers and skills mix met the needs of the service. There was an ongoing programme of mandatory training for staff to ensure they maintained knowledge and skills in carrying out their jobs safely.

Incidents

- We spoke with staff who stated they were encouraged to report incidents and were able to describe the types of incidents they would report.
- Staff were knowledgeable about the incident reporting procedures and confirmed they received an automated acknowledgement that the information had been submitted.
- Reported incidents were investigated by senior managers and themes and trends were discussed at divisional meetings and practice changed as a result.
- The results of learning from these had been disseminated through staff meetings and information displayed on staff noticeboards

Safety thermometer

- Information from the NHS Safety Thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections) showed that the trust was well below the England average for the entire year for all patients. There were no specific details available relating to outpatients.
- Senior staff were able to describe areas they had identified as a risk within the directorate and their own department, and were able to describe what action they were taking to minimise the risk. The highest risk identified at Burnley General Hospital was the relocation of the Urgent Care Centre (UCC) to a new part of the hospital site, and its replacement by a general outpatients department. This had led to incidents where patients with urgent care needs had presented at the outpatients department instead of the new UCC. The trust had taken action to address this. This included: improving the signage for the UCC; providing staff at the main doors to outpatients to redirect patients promptly; the development of a flowchart protocol for outpatient staff to follow in the event of the presentation of a seriously ill patient; and extra training for outpatient staff in dealing with a seriously ill patient.
- By monitoring clinic start and finish times, the department had identified as a risk the lengthy waiting times for patients due to clinics overrunning their allocated time. A more detailed analysis of patients' waiting times had recently been carried out in the department and they were awaiting a report on the audit findings so action could be taken to identify improvements.

Cleanliness, infection control and hygiene

- The outpatient departments we visited were clean and well-maintained.
- We saw that staff observed 'bare below the elbow' guidance and were observed to adhere to the hospital's control and prevention of infection guidance.
- There was an ample supply of alcohol hand-gel dispensers and hand-washing facilities readily available.
- Toilet facilities were clean and soap and hand towel dispensers were adequately stocked.
- The department carried out internal audits and had external audits and checks relating to infection prevention and control. There were no outstanding issues.

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- The department attained 100% following a 'secret shopper' hand-hygiene audit. This report was published in February 2014.

Environment and equipment

- The environment in the outpatient areas we visited was safe and fit for purpose.
- Equipment was appropriately checked and cleaned regularly.
- There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys were centrally located and checked regularly.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked and were within acceptable limits.
- Prescription documentation was stored securely.
- Staff told us medication changes were explained to patients.
- Patients we spoke with confirmed their prescribed medication had been explained to them by the staff in the clinic, and said they had been given the opportunity to ask questions.

Records

- At the listening event prior to the inspection, some people told us they had attended outpatient appointments and their medical records had not been available.
- We discussed this with reception staff and looked at the systems and processes in place for managing patients' records and ensuring that medical staff had timely access to patient information and test results. There was a clear system in place.
- Regular monthly audits were undertaken to monitor availability of records and reported to the Trust Board. The audit demonstrated 98% of records were available for the previous month of outpatient appointments. We saw this result had been consistent over the past 12 months.
- Nursing and medical staff told us it was very rare for them not to have the full set of patients' notes in front of them during an appointment.

- One consultant described how quickly medical records could be obtained, giving a recent example of requesting records for a patient with an urgent appointment for the following day, and the records had been obtained.
- Staff told us some information, such as test results and x-rays, were accessed electronically and computers were available in all clinics.
- Oncology services used a mixture of the hospital medical records, and Lancashire-wide electronic records which held information such as regular height and weight checks, medication records including chemotherapy details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place in relation to consent, the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- Staff we spoke with were able to explain how they obtained consent, including implied consent through discussion and agreement. Consent forms were used to record consent for more complex procedures.
- We saw the trust was registered with EIDO Healthcare website. EIDO Healthcare produced patient information leaflets validated by clinicians, patients, and external organisations such as the Plain English Campaign and Patient Concern. These were designed to support patients in making informed decisions about their care and treatment. Staff told us they used the clinical information leaflets available on this website for patients as required.
- Staff told us the majority of patients attending appointments had the capacity to give consent to examination or treatment. Staff were clear on how to assess patients' capacity to make decisions for themselves. They described how they would involve others to support people who did not have capacity. The department employed a full-time learning disabilities nurse to provide support to patients and staff where required.

Safeguarding

- When we spoke with staff, it was clear that they were aware of how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place, and clear procedures to follow if staff had concerns.

Outpatients

- We saw safeguarding was included in the ongoing mandatory training programme. We saw evidence staff were accessing this training and were up to date.

Mandatory training

- The trust had a core mandatory training programme for staff.
- Training uptake was reported and monitored across the directorate.
- We reviewed the record of staff uptake of mandatory training. This confirmed staff received regular mandatory training.

Nursing staffing

- There were no agreed national guidelines as to what constituted 'safe' nursing staffing levels in outpatient departments.
- Senior nursing staff described how staffing arrangements were planned to meet the requirements of the clinics. The number of nursing staff and skills mix was determined by the nature of the clinic to ensure there were sufficient personnel with the appropriate skills to safely run the clinic.
- Nursing and support staff and consultants we spoke to all confirmed that staffing levels were appropriate to meet the needs of the different clinical outpatient departments.

Medical staffing

- Medical consultants and other specialists arranged outpatient clinics directly with the outpatient department to meet the needs of their speciality.
- Consultants were supported by junior colleagues in some clinics where this was appropriate.

Major incident awareness and training

- There was a clear policy of action to take if the hospital was involved in a major incident.
- There were also business continuity plans in place to ensure the delivery of the service was maintained.
- Senior staff were aware of these policies and procedures.

Are outpatients services effective?

Not sufficient evidence to rate



Care and treatment in the department was provided in accordance with national guidelines. Staff had regular supervision and appraisal meetings with senior staff. Staff attended regular mandatory training, and had access to training specific to their clinical area of interest.

Staff worked well together in a multidisciplinary environment to meet patients' needs. Information relating to patients' health and treatment was obtained from relevant sources prior to clinic appointments. Information was shared with the patient's GP and other relevant agencies after the appointment to ensure seamless care.

Patient outcomes and patient views were taken into account in ensuring the service was effective by means of routine patient satisfaction surveys.

The service was delivered Monday to Friday. Out-of-hours clinics could be arranged to meet service demand.

Evidence-based care and treatment

- Care and treatment in the department was provided in accordance with national guidelines. For example, a commercially produced manual for clinical nursing procedures was used for nursing procedures.
- Policies and standard operating procedures were updated in line with NICE guidance. This work was led by the clinical specialists in the appropriate directorate, and the information cascaded to the outpatients department to implement in their service.

Pain relief

- Patients had access to pain relief as required. This could be prescribed and administered in the department for immediate effect, or could be prescribed for the patient to take home with them.

Patient outcomes

- Outpatient surveys were carried out routinely in all departments and the results displayed on noticeboards in the patient waiting areas. The survey asked patients about being treated with dignity and respect, about being given the correct amount of information, and to rate the care they had received from staff in the outpatient clinic.

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- The monthly survey results were reported for the directorate as a whole, to enable monitoring of trends and issues to be addressed.
- Results of the survey were also displayed on noticeboards with coloured graphs demonstrating patients' responses to the survey for that particular service area and the action taken to respond to patients' comments.
- The national NHS Friends and Family Test is to be rolled out to include outpatient departments from 2015. We were told the department intended to introduce this as soon as possible and had taken steps to obtain the relevant documentation with the intention of local implementation from July 2014.

Competent staff

- Staff had regular supervision and appraisal which included discussions about training requirements and requests.
- Competency issues were also discussed during these meetings.
- The trust reported that 95% of staff working in the speciality of clinical outpatients were compliant with core mandatory training during the period of 1 March 2013 to 28 February 2014.
- We reviewed the electronic record of staff uptake of training for the departments which confirmed staff received regular mandatory training. The record included the date each staff member had last undertaken training in each of the mandatory areas, and indicated when training was next due.
- We saw staff also accessed further training in their area of interest or clinical specialism.
- Staff we spoke with confirmed access to training was good.

Multidisciplinary working

- There was evidence of good multidisciplinary working in outpatients. Doctors, nurses and allied health professionals such as physiotherapists and occupational therapists worked well together.
- Letters were sent by the outpatient department to people's GPs to provide a summary of the consultation and any recommendations for treatment.
- People could request a copy of the GP letter to be sent to them at their home address.

Seven-day services

- Outpatient department clinics ran Monday to Friday with morning and afternoon lists.
- Clinics outside these hours were arranged only in exceptional circumstances as required. For example, in the weeks prior to our inspection, a gastroenterology clinic had been scheduled one evening due to the high number of patients awaiting reviews. This meant patients were seen within acceptable timescales.

Are outpatients services caring?

Good



Patients were treated with dignity and were involved in decisions about their care and treatment.

Compassionate care

- Throughout our inspection we witnessed patients being treated with dignity and respect.
- The environment in the outpatient department allowed for confidential conversations.
- Information leaflets on noticeboards in the waiting rooms indicated patients could choose to be accompanied by a relative or friend during a consultation if they wished.
- There was sufficient nursing staff to ensure patients had a chaperone during appointments which required an intimate examination, or when requested.
- Staff listened to patients and responded positively to questions and requests for information.
- Patients spoke positively about the care provided by staff. Comments included: "The staff are very good"; "The staff are pleasant and helpful"; and "I could not praise the staff more highly".
- Vulnerable patients were managed sensitively and attended to as quickly as possible. For example, staff described how they monitored people who had accessed the department by ambulance to ensure they were ready for their pick-up time. However, staff told us this had become more difficult since the introduction of the booking centre as it was not always clear to staff when patients were reliant on the ambulance service to take them home.
- Nursing staff and one of the clinical consultants told us patients were offered drinks if clinics were running late,

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and offered food if this was over a meal time, particularly in the diabetic clinic. We observed patients being offered drinks as the clinic was running 45 minutes late.

Patient understanding and involvement

- We spoke with 15 patients regarding the information they received in relation to their care and treatment.
- Most of the patients we spoke with stated they felt that they had been involved in decisions regarding their care. One patient told us, "They took me through everything at my last visit and I was given lots of literature." Another patient said, "The doctor took me through my treatment and checked I was happy with it." However, another patient told us they had not had their treatment explained.
- Patients we spoke with were aware of why they were attending the outpatients department.
- Requests for consent to treatment included an explanation of benefits and risks so that patients could make an informed choice about their treatment options.
- Medical and nursing staff described how they provided patients with information and involved them in reaching decisions about any further treatment.
- Nursing staff described and demonstrated the EIDO Healthcare website which they used to provide patients with relevant information leaflets relating to their condition. These were designed to assist patients understanding and involvement in making informed decisions about their care and treatment. Staff told us they used the clinical information leaflets via this website to print off for patients as required.

Emotional support

- Patients and relatives told us they had been supported when they had been told a difficult diagnosis and had been given sufficient psychological support.

Are outpatients services responsive?

Requires improvement



Regular audits of service delivery and patient experience were carried out to ensure the service met the needs of the local population.

The organisation of clinics was not responsive to patients needs. Many clinics frequently over-ran and some patients

told us they had experienced long delays in their appointment time. Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. Nursing staff expressed concerns regarding the changes to patient ambulance transport services. With the new system staff were not aware of which patients had transport arranged and they gave examples of patients waiting for long periods for transport if their appointment was late.

Patients who drove themselves to their appointment told us they found car parking difficult as the demand for spaces was high, and often required a long walk to get to the department. This often made them late for appointments and made them feel anxious.

Service planning and delivery to meet the needs of local people

- Regular audits of service delivery and patient experience were carried out to ensure the service met the needs of the local population.
- The service had identified the high number of people who did not attend appointments had an impact on the service delivery.
- The service had introduced a text message or phone call service to remind patients of their appointments. Staff reported this was having a positive impact on non-attendance.
- Further plans were in place to introduce a system to partially book appointments planned for six months or more. The system would prompt hospital staff to contact patients nearer the time of their appointment to arrange a convenient date, time and location. This was intended to reduce the number of patients who did not attend because they found the appointment time was no longer convenient.

Access and flow

- Patients who drove themselves to their appointment told us they found car parking difficult as the demand for spaces was high, and often required a long walk to get to the department. This often made them late for appointments and made them feel anxious.
- Some patients told us the signposting for departments was not always clear.
- There was a sufficient amount of seating for people waiting for their appointments.

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- The initial appointment letter sent out to patients was clear. It contained information about where the clinic was located in the hospital and contact numbers for cancellation or rearranging appointments.
- The information also included contact details to arrange transport for their appointment if this was needed. However, nursing staff working in the clinics expressed concerns regarding this change. When ambulances were arranged by the hospital, the staff were able to ensure the patient was ready for the arranged pick-up time. With the new system, staff were not aware of which patients had transport arranged and they gave examples of patients waiting for long periods for transport if their appointment was late.
- Patient surveys indicated a high level of satisfaction with the new reminder system and patients during our inspection also gave positive feedback on this.
- Staff we spoke with from the booking centre and outpatient departments informed us that consultants and specialists using the outpatient department to hold their clinics were required to inform both the outpatients department and booking centre of a cancellation of their clinic due to planned leave at least six weeks in advance. They told us this did not always happen and clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled.
- During our inspection we observed some clinics running late by up to 45 minutes. We saw information regarding the waiting times was displayed on whiteboards in the waiting room areas.
- All staff we spoke with confirmed many clinics frequently and consistently over-ran. One explanation given for this was because additional patients were often added to already full clinic lists at short notice. This was to meet patients' individual clinical needs where it was not appropriate to wait for the next available appointment. This indicates the service was responsive to patients' needs, however, this had a negative impact on the waiting times experienced by other patients.
- Some patients told us they had experienced long delays in their appointment time. We spoke with one patient who was very concerned as the clinic was running late and this meant they would be late for another outpatient appointment at clinic elsewhere in the hospital.

Meeting people's individual needs

- The department employed a full-time learning disabilities nurse to provide support to patients and staff where required.
- Paediatric outpatients had access to a play leader to entertain children waiting for long periods, and was skilled in distraction techniques to assist children and their patients through consultations or procedures where required.
- Contact details for interpretation services were available on the trust's intranet. Staff told us interpreters were booked in advance at the same time as the appointment booking was made.
- Clinical information leaflets were available in several languages via the EIDO Healthcare website which staff printed off for patients as required.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Initial complaints would be dealt with by the outpatient senior staff. If they were unable to deal with the person's concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If there were still concerns following this, the person would be advised how to make a formal complaint.

Are outpatients services well-led?

Good



Risk management systems were effective. Complaints, incidents, audits and quality improvement projects were discussed at directorate level, in sisters' meetings, and in departmental meetings. Senior staff were able to describe areas they had identified as risks within the directorate and their own departments, and were able to describe what action they were taking to minimise the risk.

There was good local leadership and a positive culture within the service. Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients.

Vision and strategy for this service

- The trust's quality strategy for 2014/15 set goals to "deliver safe, personal and effective care". This vision

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was visible throughout the outpatient departments as these headings were used consistently on noticeboards to reflect ongoing developments in the departments. Staff we spoke with were aware of these goals.

Governance, risk management and quality measurement

- Complaints, incidents, audits and quality improvement projects were discussed at directorate level, in sisters' meetings, and in departmental meetings.
- Senior staff were able to describe areas they had identified as a risk within the directorate and their own departments, and were able to describe what action they were taking to minimise the risk.
- Information relating to these risks was disseminated to staff through staff meetings and information was placed on staff noticeboards within the departments.
- Patient surveys were undertaken to measure quality and identify areas for improvement.
- Information relating to the outcome of patient satisfaction surveys and action taken was presented on noticeboards in patient waiting areas.

Leadership of service

- There was good local leadership and a positive culture within the service.
- Staff worked well as a team and supported each other.
- Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients.
- Staff at all levels were aware of the challenges within the service, such as the long waiting times and over-running clinics. They demonstrated a commitment to address these challenges and to improve their service.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients.
- All medical, nursing and administrative staff spoke positively about how they saw patient experience and quality of service as a priority and everyone's responsibility.

- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatient departments.

Public and staff engagement

- Patient surveys were carried out routinely in all outpatient departments. Results of the surveys were displayed on noticeboards in the patient waiting areas using coloured graphs to demonstrate patients' responses to the survey for the past month. Some noticeboards also provided details of what action had been taken in response to patients' feedback.
- The national NHS Friends and Family Test is to be rolled out to include outpatients departments from 2015. We were told the department intended to introduce this as soon as possible and had taken steps to obtain the relevant documentation and with the intention of local implementation from July 2014.
- Senior nursing staff described an outpatient partnership group which met quarterly. They told us the group had recently recruited new members, which included a representative from Age UK and patients. The aim was to increase public and patient engagement in service developments.

Innovation, improvement and sustainability

- Outpatient departments had introduced an electronic self-check-in service. This was intended to speed up the booking process for patients and reduce clinic waiting times.
- The appointment booking centre had introduced a text and automated phone reminder service. This was intended to reduce the number of patients who do not attend their appointments. There was also a business case agreed to introduce a partial booking system for appointments planned for six months or more. The system would prompt hospital staff to contact patients nearer the time of their appointment to arrange a convenient date, time and location.

Outstanding practice and areas for improvement

Outstanding practice

- East Lancashire Hospitals NHS Trust's maternity services were awarded the Royal College of Midwives' Mothercare Maternity Service of the Year award for their 'innovative work' in improving normal birth rates, reducing Caesarean section rates and increasing birth choice for women.
- The breast and gynaecology ward was very well designed. The early pregnancy unit, ultrasound scanning suite and gynaecology theatres were all in close proximity and built for purpose with staff having

input into the planning of the building. This created an outstanding setting to facilitate a responsive service for outpatients visiting the early pregnancy unit and inpatients staying on the ward. For example, patients were actively encouraged to attend the assessment area if they experienced any post-operative complications in order for them to be seen by a gynaecologist quickly rather than having to attend A&E.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that there are always sufficient numbers of suitably qualified, skilled and experienced staff employed in the Urgent Care Centre (UCC) at all times to care for very unwell children.
- Work more effectively with the ambulance service to ensure that acutely unwell patients who attend the UCC and who require emergency or urgent transfer to the Royal Blackburn Hospital or other centre receive the appropriate response.
- Ensure that people who attend urgent care with mental health needs receive prompt effective, personalised support from appropriately trained staff to meet their needs.
- Ensure that there is an appropriately resourced bereavement service available.
- Take action to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time.

- Ensure that instruments are checked and accounted for before and after each procedure and that there is documentary evidence to support this.

Action the hospital **SHOULD** take to improve

- Consider the appropriateness of the lack of lifting equipment should a person fall or collapse and be unable to lift themselves.
- Consider improving the management of theatre activity to increase patient flow.
- Work to improve the number of staff in UCC attending mandatory training.
- Review the layout of the theatre reception area to maintain the privacy and dignity of all patients.
- Take action to finalise the strategy for end of life care and ensure this is embedded in practice.
- Assess the frequency of the review of local risk registers.