East Lancashire Hospitals NHS Trust

Royal Blackburn Hospital

Quality Report

Royal Blackburn Hospital
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Date of inspection visit: 30 April, 2 & 6 May 2014
Date of publication: 09/07/2014

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
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	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

Royal Blackburn Hospital is one of seven hospitals and care centres that form East Lancashire Hospitals NHS Trust. It is an acute hospital, which provides accident and emergency (A&E) medical care, surgical care, critical care, children young people's services, end of life care and outpatients. Maternity services were provided at the Blackburn Birth Centre and Burnley General 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, and 1, 2 and 6 May 2014.

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

Our key findings were as follows:

- Staff were caring, compassionate and respectful.
- 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.
- Mattresses were not consistently being cleaned and checked properly, resulting in some being contaminated.
- The trust had undertaken much work to improve its mortality rate – currently slightly above the expected range.
- A significant amount of work had been done to improve response times, although these had improved, they were not consistently being met.
- Some patients who required mental health assessment or admission to a specialist service waited too long in the A&E department which was not resourced to meet their needs.
- There were not enough appropriately qualified staff to care for children 24 hours a day, seven days a week in A&E.
- Patients' experience of A&E was mixed: while we observed staff to be caring and compassionate, we also received negative feedback prior to and after our inspection visit. In addition, the results from the NHS Friends and Family Test suggested there was still room for improvement.
- Record-keeping in relation to medicines in A&E was not satisfactory.
- Patient flow within the hospital had improved. However, there were still instances where patients were inappropriately admitted to wards directly from A&E without full assessment. Patients with chest pains were admitted inappropriately to the ambulatory care unit and patients were not consistently being admitted to the stroke unit with four hours.
- Ward C5 had been specifically designed to meet the needs of patients with dementia and we heard positive feedback regarding this.
- Staffing levels had improved over the last 12 months. However, there remained vacancies for qualified staff, both medical and nursing.
- 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.
- 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.
- The use of risk registers was improving, however, there was inconsistency in how often these were reviewed, and not all risks were contained within them.
- Care for children and young people was safe, effective, caring, responsive and well-led.

Summary of findings

- Patients received safe and effective 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 practice was not embedded.
- 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, often resulting in a long walk to the appropriate clinic.
- Many processes throughout the hospital had not been in place for long, so had not yet been embedded, or had yet to be audited to demonstrate sustained improvement.
- 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 areas of outstanding practice including:

- The vast majority of staff spoke of the improvement they experienced culture in the organisation. They spoke very highly of the executive team who were visible and approachable to staff. They felt proud to work in the hospital and would now recommend it as a place to work.

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

Importantly, the hospital must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled and experienced staff employed in A&E at all times to care for very unwell children.
- Review the facilities and resources in its A&E and Urgent Care Centres for accommodating and supporting people who are experiencing a mental health crisis. This must include working more effectively with the mental health liaison team and crisis team to reduce delays for patients who require assessment and/or admission to a mental health bed.
- 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 the instruments are checked and accounted for before and after each procedure and that there is documentary evidence to support this.
- Ensure that there is an appropriately resourced bereavement service available.
- Take action to ensure that all mattresses are fit for use.
- Take action to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time.
- Take action to ensure that patients are not inappropriately admitted to wards directly from A&E without a full assessment, that patients with chest pain are not admitted inappropriately to the ambulatory care unit and that patients are consistently admitted to the stroke unit within four hours.
- Continue to use risk registers to improve reducing inconsistencies in how often risks are reviewed, and ensure that all risks are included.
- Ensure there are appropriate checks in place to provide assurance that medicines are administered safely by appropriately skilled clinicians, and recorded correctly.
- Ensure patients are not inappropriately moved to discharge wards, step down units or discharged before they are medically fit.
- Ensure that patients have appropriate access to translation services.

Summary of findings

Action the hospital SHOULD take to improve

The hospital should:

- Improve take-up of mandatory training in the A&E department and in particular, ensure that all staff receive formal training so that they understand their responsibilities in respect of the Mental Capacity Act 2005.
- Consider the appropriateness of the out-of-hours cover for end of life care.
- Finalise the strategy for end of life care and embed into practice.
- Consider auditing the care of people at the end of life.
- Consider reviewing the car parking arrangements and provide information to patients regarding this.
- Review the effectiveness of the actions taken to reduce delays in ambulance handover times.
- Review support for people with dementia or other forms of cognitive impairment attending the A&E department.
- Review the privacy and dignity of people discussing personal matters at the A&E reception.

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?
Accident and emergency	Requires improvement 	Patient safety was a high priority and risks to patients were identified and managed. There were mostly good outcomes for patients. However, we had concerns that there were not enough appropriately qualified staff to care for children. Although we observed staff to be compassionate and caring, and patients we spoke with during our visits were positive in their feedback about staff, we also received some negative feedback about staff attitude prior to and following our visit. The results of the NHS Friends and Family Test suggested that there was still room for improvement. Patients with mental health needs were waiting too long in A&E for assessment and did not receive the skilled care and attention they needed. The trust had done a significant amount of work to tackle the capacity and patient flow challenges which had affected their performance. Performance was improving and staff were engaged, enthusiastic and proud of the improvements they had achieved. However, many of the changes had been recently implemented and required time to fully embed to demonstrate that the new ways of working would be sustained.
Medical care	Requires improvement 	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 they were encouraged to raise concerns and report incidents and there was an open and honest leadership culture. Care was provided in a caring and respectful way within clean and well-maintained wards. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working. The trust had undertaken a recruitment drive for nursing and medical staff. However, there were still vacancies across the division in the majority of wards. There was an ongoing shortage of medical staff which meant that gaps in rotas were being covered by locum/agency staff.

Summary of findings

The trust had taken steps to address concerns identified within the medicine division and across the hospital. However, many of the processes had not been in place for long and so had not had chance to embed fully into the culture of the service. Escalation processes had been reviewed to cope with busy times such as winter pressure periods, but we found there were still issues with bed management and patient flow within the hospital. Throughout the hospital we found staff who were involved in local projects to develop and improve patient care. We found that, while significant improvements had been made in the early assessment of patients, the discharge planning processes were fragmented and lacked patient focus. Senior staff spoke with enthusiasm about a number of planned projects and ideas to address this. However, these had not yet progressed further than the ideas or planning stage.
Although it was improving the overall mortality rate is above the expected level.

Surgery **Requires improvement**

Safety in surgery services required improvement. There had been a Never Event in January 2014; we noted a number of mattresses that were contaminated; documentation was not always well managed, with some patient records in poor state of repair, (this meant some records may be misplaced or lost); theatre staff did not complete the documentation of the theatre equipment lists; and we witnessed an incident of poor medicines management.
Care was effective. Procedures and treatments within surgical services followed national clinical guidelines. Staff used care pathways effectively Patients spoke positively about their care and treatment at the hospital and staff were caring, compassionate and professional.
Due to the lack of segregation, patients' privacy and dignity were not always afforded, as male and female patients and children in the theatre reception area were all waiting together, in theatre gowns.
Trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. The teams were motivated and we observed an

Summary of findings

		open and honest culture. There were discrepancies as to how the local risk registers at ward level were being reviewed and not all risks were noted on the risk registers.
Critical care	Good	The critical care services provided safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. The staffing levels and skills mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were completed appropriately. The critical care services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. Patients received care and treatment by multidisciplinary staff who worked well as a team. The critical care services performed in line with similar sized hospitals and performed within the national average for most safety and performance measures. Patients or their representatives spoke positively about their care and treatment. Staff kept patients or their relatives involved in their care. There was no trust-wide bereavement or counselling lead in place to support patients, relatives or staff. However, the trust was in the process of addressing this. There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There was effective teamwork and clearly visible leadership within the critical care services. Staff were highly motivated and positive about their work. Innovation and improvement was encouraged
Services for children and young people	Good	Children and young people received safe and effective care from appropriately trained and competent staff. A programme of training was in place which staff confirmed prepared them for their roles and responsibilities. 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

Summary of findings

satisfied with the care and treatment delivered to their children and told us they felt included and involved. Some parents did state they had only received sufficient information when they had questioned the medical staff.
The environment was clean, bright and airy with sufficient equipment required to deliver the necessary treatments. Toys were available throughout the ward and the children's observation and assessment unit (COAU).
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 that managers were approachable and provided support when required.
Services for children and young people were caring. Patients and their families or carers were treated with dignity and respect. Surveys took place to gather feedback from patients and their families/ carers. Interpreter services were available, although we found these had not been used for one person who spoke very limited English.
The service for children and young people was well-led. Risks were managed at a local and trust level. Staff were confident in the leadership of the children's services at Royal Blackburn Hospital.

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

Summary of findings

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.

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 patients. There was a clear process for reporting and investigating incidents. Themes and trends were identiifed 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 incovenience this caused them. Staff were auditing this and 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.
Patients told us they found car parking at the hospital 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.
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

Royal Blackburn Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; Outpatients

Contents

Detailed findings

Background to Royal Blackburn Hospital

Royal Blackburn 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 of 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.

Royal Blackburn Hospital has 693 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 there were 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 after which it was put under special measures.

The Royal Blackburn Hospital provides services to the people in the local authority areas of Blackburn and Darwen which is a unitary authority in Lancashire in the heart of North West England. The 2010 Indices of Deprivation showed that Blackburn with Darwen was the 17th most deprived local authority (out of 326). Between 2007 and 2010 the deprivation score increased meaning that the level of deprivation worsened. Census data shows that Blackburn with Darwen has an increasing population and a higher than England average proportion of Black, Asian and minority ethnic residents. Life expectancy was 3.1 years lower for men and 4.5 years lower for women in the most deprived areas than in the least-deprived areas of Blackburn with Darwen.

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 Royal Blackburn Hospital:

- Accident and Emergency
- Medical Care (including older people's care)
- Surgery
- Critical care
- 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 we held and asked other organisations to share what they knew about the hospital. These included the two local clinical commissioning groups and 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, when people shared their views and experiences of 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 the 1 and 2 May 2014 and an unannounced inspection between 4pm and 11pm on 6 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 Royal Blackburn Hospital

The Royal Blackburn Hospital provides a full range of hospital services to adults and children. This includes emergency care, general and specialist medical and surgical services, maternity services along with a full range of diagnostic – e.g. magnetic resonance imaging (MRI), computerised tomography (CT) scanning and support services.

Royal Blackburn Hospital is a 693 bedded hospital which specialises in planned (elective) care. Overall the trust, East Lancashire Hospitals NHS Trust, has 7223 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 Blackburn with Darwen being around 147,400.

In 2012/2013 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 2007/8 to 2012/13. In 2012/13 this surplus was about £4.7 million. A surplus is predicted for 2013/14 and the trust has delivered cost improvement savings of £16.2milion.

Between October and December 2013 bed occupancy for the trust was 81.7%. This is below the England average (85.9%) and above the level, 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 figure does not show that it was significantly higher at Royal Blackburn Hospital and lower at Burnley General Hospital reflecting that the Royal Blackburn Hospital provides both emergency and 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. Six of these have been at Royal Blackburn Hospital. In July 2010 an inspection was undertaken in response concerns the outcomes of respecting and involving people who use services, the care and welfare of people who use services, safeguarding people who use services from abuse and staffing minor concerns were found in all these areas. In

Detailed findings

April 2011 a themed inspection was undertaken specifically looking dignity and nutrition the outcomes inspected were met, although there were some areas for improvement identified. Routine inspections took place in November 2012 and May 2013 when all the outcomes inspected were judged to be met.

A further inspection was undertaken in November 2013 in response to concerns that had arisen. At this inspection one outcome was found to be met relating supporting workers, safeguarding people who use services from abuse was not met and a compliance action was issued. The outcomes of care and welfare of people using the service and monitoring of the quality of the service provision were not met and enforcement action was taken in the form of issuing warning notices. A follow up inspection found that the outcome for care and welfare of people using the service had been met. The outcome relating to monitoring of the quality of the service provision was reviewed as part of this inspection."

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	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 Accident and emergency and Outpatients.

Accident and emergency

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

Information about the service

The Accident and Emergency (A&E) department was open 24 hours a day, seven days a week, providing emergency care and treatment to people across East Lancashire. The department treated people with serious and life threatening emergencies. There was an Urgent Care Centre (UCC) which provided treatment for illnesses or injuries which were not life threatening, but still needed prompt treatment, such as minor head injuries or suspected broken bones.

The A&E department was one of the busiest in the country in terms of ambulance attendances. About 100,000 patients attended the department each year, of which some 20,000 were children.

There were 19 bays in the A&E department, eight bays in the resuscitation area (one designated for children). There were seven bays in the UCC. There was a paediatric area, comprising three bays and two consulting rooms, as well as a dedicated waiting area. This operated from 10am to 10pm, seven days a week. Outside of these times, children were cared for in the main department.

There was a medical assessment unit (MAU) where patients could be referred by the A&E department or their GP for assessment. This may include diagnostics, such as blood tests and x-rays. The MAU had 42 beds, provided in both single rooms and in four-bed bays. This was a busy unit with between 70 and 90 admissions per day. Patients usually stayed less than 12 hours on the unit before discharge home or transfer for continued care and treatment on the relevant specialty ward. Around 35% of MAU patients were discharged home. The average length of stay on this ward was 10 hours. Patients who had suffered a stroke were admitted directly to the acute stroke unit from the A&E department.

Patients who required diagnosis, observation, treatment and rehabilitation but were not expected to need an overnight stay attended the ambulatory care unit (ACU). This was new facility opened in January 2014. The ACU was open Monday to Friday as a day care facility and patients could be referred by their GP or other healthcare professional, by A&E, UCC or MAU. The unit accepted patients who were mobile and who did not have an early warning score of more than three. There was exclusion criteria, including no patients under 16 years and no patients with mental health issues. Patients could be discharged home from the unit and booked an appointment to return for further assessment.

We visited over two week days during the day and returned unannounced the following week at night. We talked with 21 patients, and three relatives. We also spoke with staff, including nurses, doctors, consultants, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at 12 care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Prior to our inspection, we reviewed performance information about the trust and information provided by the trust.

Accident and emergency

Summary of findings

Patient safety was a high priority and risks to patients were identified and managed. There were mostly good outcomes for patients. However, we had concerns that there were not enough appropriately qualified staff to care for children.

Although we observed staff to be compassionate and caring, and patients we spoke with during our visits were positive in their feedback about staff, we also received some negative feedback about staff attitude prior to and following our visit. The results of the NHS Friends and Family Test suggested that there was still room for improvement. Patients with mental health needs were waiting too long in A&E for assessment and did not receive the skilled care and attention that they needed.

The trust had done a significant amount of work to tackle the capacity and patient flow challenges which had affected their performance. Performance was improving and staff were engaged, enthusiastic and proud of the improvements they had achieved. However, many of the changes had been recently implemented and needed time to fully embed and demonstrate that the new ways of working would be sustained.

Are accident and emergency services safe?

Requires improvement

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

The department's risk register highlighted staffing levels and patient flow/capacity as the major risks faced by the A&E department. Significant work had been undertaken over the last 12 months to increase capacity and improve efficiency to respond to these risks. Staffing levels, skills mix and staff utilisation had been reviewed and re-aligned, although these improvements currently relied on significant use of temporary nursing and medical staff, pending agreement to recruit more permanent staff. There were insufficient nurses with specialist training in caring for children to ensure that there was always a staff member with appropriate skills to provide safe care.

Record-keeping in relation to medicines was not satisfactory.

Incidents

- The number of serious incidents reported in A&E/UCC trust-wide was in line with expected for the size of the trust.
- Between December 2012 and January 2014, the trust reported four serious untoward incidents and 12 incidents were reported via the national reporting and learning system (NRLS). 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) a number of recent serious incidents had occurred. All of these incidents had been investigated, findings discussed at governance meetings and discussed at 'share to care' meetings.
- Seven child deaths had occurred during the month of April 2014. Due to this unexpected spike, a report had been received by the Trust Board following initial investigations. It was concluded in all cases that the deaths were unavoidable.

Accident and emergency

- The most recent serious incident requiring investigation led to a full root cause analysis and an action plan was in place to ensure that remedial steps were taken to reduce the likelihood of a similar event occurring in the future.
- The clinical director from A&E was the department's patient safety lead and investigated all cardiac arrests and all deaths which were reviewed and presented at monthly governance meetings, with appropriate feedback to clinicians involved. They also participated in secondary mortality reviews
- Most of the staff we spoke to stated that they were encouraged to report incidents and received direct feedback. However, a doctor in the ambulatory care unit told us they had not reported their concerns about the inappropriate attendance of a seriously unwell patient to the department because they believed that this would not be taken seriously or result in any changed practice.
- Feedback was provided to staff at daily 'huddle' meetings (a time when staff of all grades came together for a briefing), weekly 'share to care' meetings and monthly formal governance meetings. Staff were able to describe recent incidents and clearly outline what action had been taken to reduce the risk of a similar incident occurring.

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 were regularly discussed at 'share to care' and governance meetings.

Cleanliness, infection control and hygiene

- During our visit we found the departments were clean and tidy. However, a recent patient-led assessment of the care environment (known as PLACE) audit found seven soiled curtains, blood on a corridor floor and "issues with equipment".
- Hand-washing facilities were readily available and we saw staff regularly wash their hands and use hand gel between seeing patients. However, it was noted in the clinical governance minutes in March 2014 that hand hygiene standards had deteriorated slightly and some further spot checks in the department were planned.
- 'Bare below the elbow' policies were adhered to and staff wore suitable protective clothing, such as aprons and gloves when necessary.
- There were dedicated infection control nurses in the department who acted as a source of information and advice. They carried out regular hand-washing audits and observations of practice.
- There was a staff member on each shift who was designated the decontamination lead and another staff member had lead responsibility for overseeing the environment.

Environment and equipment

- The A&E and UCC departments were well laid out and, most of the time, were large enough to accommodate the number of patients attending the unit. There had been recent upgrades to the unit which included the creation of a dedicated ambulance entrance. This ensured patients had direct access to assessment rooms and improved their privacy and dignity as they we not visible from the main waiting area. The resuscitation area had been upgraded and was spacious, light and appropriately equipped. A doctor told us that the layout of this section enabled staff to monitor patients safely. A new paediatrics area had also been provided and this was appropriately decorated and furnished.
- The x-ray department was situated next door to the unit and was easily accessible.
- There was a secure room used for monitoring patients with mental health problems who had been assessed as being at risk of harming themselves or others. This room was visible from the nurses' station and had windows so that the patient could be observed. However, the room was cold, stark, had bad acoustics and was poorly furnished, with only two wooden benches which were fixed to the wall. Staff told us that this room was used on a daily basis and patients could be confined in this space for up to 12 hours. Nursing, medical and mental health liaison staff we spoke with all acknowledged that this room was not fit for purpose.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment in all areas. The shift coordinator was responsible for ensuring that the department remained fully equipped and stocked.

There were checklists in use for daily checks of resuscitation trolleys and bays, the Resuscitaire® and fridge temperatures, and these confirmed that equipment and stock was fit for purpose.

- The trust had done extensive work to investigate the reasons for its poor performance against the four-hour waiting target and the issue of patient flow which impacted on this. The trust had been supported by the emergency care intensive support team. Factors which had contributed to poor performance included bed capacity within the hospital and the wider health community, staffing levels and utilisation and delayed first assessment. A project board had been established to tackle these issues and to monitor and report weekly on the delivery of an action plan entitled 'right care, right time, every time'. Reports included an analysis of the source of patient attendance and their destination, i.e. admission, transfer or discharge, analysis of attendances by time of day, day of week and the reasons for delays.
- Staffing levels, skills mix and appropriate staff utilisation had been reviewed and some further staff had been employed. A bid for further staff was currently under consideration, although in anticipation temporary staff were being employed to ensure increased staffing levels were maintained. Recruitment was ongoing.
- A rapid assessment protocol had recently been developed to ensure that diagnosis and treatment was initiated promptly. There were early indications that this was effective. A&E and ambulance staff told us that patient flow had improved, although this had not yet been formally audited.
- The target to achieve ambulance handover within 15 minutes continued to be a challenge, with the hospital reporting in February 2014 measure of 83.3% against a threshold of 95%. It was noted that this was higher than the figure reported by the ambulance trust. An ambulance liaison officer had been employed (by the ambulance trust) to work across Lancashire to work with the trust to reduce delays.

Medicines

- Medicines were stored correctly in locked cupboards or fridges where necessary. Fridge temperatures were correct. During our announced inspection, we did a spot check of controlled drugs and the stock balance was correct. However, on the day of our unannounced inspection, we found incomplete records in the administration of a controlled drug. The controlled drugs register had not been checked by departmental or pharmacy staff since March 2014 and there were at least six occasions between 1 and 6 May 2014 when the clinician administering the medicine had not signed the record. We also found 16 occasions in the same timeframe where the amount of medicine given and the amount wasted were not recorded. This meant we could not be assured that medicines were given safely by appropriately trained clinicians.

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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our visit we saw patients consented to treatment appropriately and correctly. Most interventions in the department 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, that they may speak with relatives, carers or the patient's GP. However, they demonstrated little or no knowledge of the requirements of the Mental Capacity Act 2005. Three nurses told us they had received no formal education in this area. There was therefore a risk that practice may be inconsistent. The trust told us that training on the Act was available, although this was not mandatory for all staff. 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 department used a child risk assessment tool to identify any concerns regarding child welfare. At a previous inspection we found this was not consistently

completed. The department had been auditing this on a weekly basis and performance was reported at the directorate governance meeting in March 2014 to be between 90% and 100% across all A&E/UCC departments. We looked at a sample of 20 records and the checklist had been consistently completed.

- 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.
- There was a safeguarding lead and a safeguarding resource folder in the department.

Mandatory training

- The trust's report on mandatory training compliance as at February 2014 shows that 63% of A&E and UCC staff were up to date with mandatory training. This posed the risk of inconsistent practice.

Management of deteriorating patients

Nursing staffing

Medical staffing

- The trust had a policy entitled 'the deteriorating patient and recognition of the sick patient' to ensure care was proving promptly and appropriately.
- The department 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 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 be taken 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. We were told that this was regularly audited, although we did not see evidence of this.
- Nursing numbers and skills mix had recently been assessed in the A&E department using a recognised staffing tool. This process had shown that more nursing staff were required and the department was staffing up to this level using temporary bank and agency staff. The nurse staff to patient ratio had been increased from one nurse to seven patients to one nurse to five patients. Most temporary staff were employed regularly so that they were familiar with the department. Staff told us that temporary staff received appropriate induction training, which included completion of an induction booklet.
- There were three paediatric-trained nurses employed in the department and two dual-trained (adults and paediatrics) nurses. Two of the three paediatric nurses were newly qualified band 5 nurses. The matron acknowledged that the current skills mix and staffing levels were not appropriate, telling us, "We know we need more". It had been agreed that a further two trainee advanced practitioners would be employed and recruitment was underway.
- Between 10am and 10pm there were two nurses on duty. One worked a long (12-hour) shift, the other worked a twilight shift so that there were two on duty at peak times. At night children were cared for in by adult trained nurses. This meant that the department did not always have an appropriately trained nurse to care for children. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Setting (2012) identifies that there should be always be registered children's nurses in emergency departments or trusts should be working towards this and staff should, as a minimum, be trained in paediatric life support.
- The trust's resuscitation policy (May 2013) stipulated that all band 6, 7 and 8 nurses should be trained in at least paediatric intermediate life support (PILS). All clinical staff involved with direct paediatric care should be trained in paediatric basic life support. We were provided with a training summary report which showed that the department had not complied with this standard. Training figures were unclear and could not be verified in discussion with the matron. The matron told us that they had looked at the forthcoming month's nurse duty rota and were confident that there would be sufficient nurses on duty with appropriate resuscitation training 99% of the time. We were concerned, however, about the lack of reliable training data and a clear training plan. We could not be assured of the department's ability to consistently achieve and maintain the required standard.
- We noted that a staff member had raised concerns about staffing levels in the paediatric section at a recent governance meeting. It had been recorded that their concerns would be looked into.

- In the MAU there was a nurse to patient ratio of 1:6. The matron told us that because there were 18 single rooms, it was sometimes difficult to ensure patients were observed with the current staffing levels. This was not included in the department's risk register, although it was recorded that there was difficulty hearing nurse call bells.

Major incident awareness and training

Ambulatory care

- There were consultants on the A&E 'shop floor' from 8am to 11.30pm, providing on-call cover overnight. Overnight there was always a middle grade doctor (ST4 and above) on duty. There was no consultant cover in the UCC after 5pm.
- A lead consultant was designated on each shift and took responsibility for 'managing the shop floor'. This included monitoring staffing levels, patient flow, and providing supervision and support to more junior doctors.
- The medical division's and the trust's risk register recorded "Low medical staffing levels adversely affecting performance and patient care" as a major risk. There were several medical staff vacancies at middle grade and the clinical director accepted that the department used "too many locums".
- Junior doctors told us there were adequate numbers of junior doctors on the unit, both in and out of hours. They told us that consultants were contactable by phone out of hours if they .needed any support.
- There was a full patient handover at the beginning and end of every nursing shift and all commenced with a 'safety huddle'. Staffing for the shift was discussed as well as any high-risk patients or potential issues.
- We were told that medical handover occurred twice a day and was led by the consultant on the shop floor.
- Staff in the A&E department were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT).
- There were suitable security arrangements in the department. Security staff were employed within the hospital 24 hours a day, seven days a week and could be called on to support A&E staff. Staff told us they were responsive and visible.
- The ambulatory care unit (ACU) was opened in January 2014 as part of the trust's strategy to reduce inappropriate A&E attendances and hospital admissions and thus improve patient flow. Patients could be referred by their GP or transferred by the A&E department for assessment, diagnosis and treatment. There were specific criteria with regard to the type of patients that could attend ambulatory care but primarily the department existed to provide care for patients who were mobile and stable and not expected to require hospital admission.
- A doctor in ACU told us they had concerns about patients being inappropriately transferred to the unit. They provided an example of a patient who attended A&E with chest pain and who was subsequently transferred to the ACU, despite an instruction from the A&E consultant to admit to MAU. The patient was later transferred to the cardiac care unit and the outcome was good. However, the doctor was concerned that the decision to admit to ACU was target-driven, rather than based on clinical risk and decision making.
- We spoke with staff about the appropriateness of transferring patients with chest pain. They were quite clear that there were appropriate criteria to ensure that only stable patients would be referred. There was a protocol which staff used to assess whether a patient was appropriate.
- We looked at a register of attendances for a period of four days prior to our visit. There were nine patients admitted to wards via A&E and ACU during that time, of which five presented with chest pain. We were unable to make a judgement that these were inappropriate. However, we requested information from the trust to demonstrate that they were auditing the application and appropriateness of the admission protocol in accordance with their standing operating policy 2014.

Accident and emergency

Are accident and emergency 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

Pain relief

- The A&E department 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. In February 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 NICE and other guidelines were adhered to. Examples of local audits included the management of cardiac arrest, management of acute upper gastrointestinal bleeding, use of tetanus prophylaxis and smoking cessation (all NICE). All of these audits resulted in staff education and changes in practice to improve patient care.
- There was a range of clinical pathways based on national guidance for the treatment of certain conditions such as stroke, pneumonia, and fractured neck of femur and the department audited compliance with these pathways. At the acute directorate governance meeting in February 2014 it was reported that 56% of patients had arrived on the stroke unit within four hours. It was reported that patients with pneumonia were failing to get antibiotics within six hours. An audit of the treatment of fractured neck of femur had shown that only 36 out of 56 patients had the relevant care bundle in their notes. The aim was to transfer patients to a specialty ward within four hours. The current performance was 4.7 hours.

Nutrition and hydration

- All patients we spoke with, except one, reported that they had been offered appropriate pain relief and this had been administered promptly. Patients' records also confirmed this.
- The department had participated in two national College of Emergency Medicine audits, pain relief in children (2011/12) and renal colic (2012/13) which assessed the expedience of pain relief. Both audits showed room for improvement. Actions had been taken in response to these audits including further training, the introduction of patient group directives and the introduction of rapid assessment.

Patient outcomes

- A new system of offering drinks to patients waiting within the UCC and A&E every two hours had recently been introduced. There was a designated staff member on each shift to oversee this.
- While not all patients we spoke to had been offered a drink, we saw evidence that refreshments were offered during the course of our visit. One person we spoke with told us that staff had offered her daughter a sandwich and drink when she was admitted to the department late at night. She commented that this was a great improvement on previous visits to the department.

Competent staff

- The department 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 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 the department regularly re-audited to monitor improvements.

- Readmittance rates to A&E within seven days were above the 5% target set by the Department of Health. (January 20 April 2014)

Multidisciplinary working

Seven-day services

- Staff told us that they had attended training on key parts of their job role and had mandatory training. Mentorship and appraisals were in place but required further development for some groups of staff, such as support workers. Medical staff we spoke to confirmed that they had undergone appraisal and accessed training relevant to their learning needs.
- There was input from a range of specialists. Staff told us they were 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. In the event that they did not respond within this timescale, patients would be transferred directly to the relevant department for assessment.
- Physiotherapists were based in the UCC department seven days a week and provided first-line treatment to appropriate patients, which meant that treatment could be initiated more promptly. They were also providing open access clinics for soft tissue injuries and could refer patients to the fracture clinic. Such developments were designed to improve the patient experience and patient flow through the department.
- During the winter months, an occupational therapy team had supported the department, however, this had now ceased.
- A named paediatric doctor based themselves in the department when there were more than five child patients in the department at any one time.
- A clinical nurse specialist in oncology was supporting staff by educating them about neutropenic sepsis. This had been an area where the department had not been meeting clinical standards.
- 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 department 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. 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 many staff, we were concerned that the department was not giving this matter the necessary attention.
- Patient experience was supported through a partnership with Age UK who provided a 'safely home' transport service to patients from East Lancashire. This service provided transport and basic home care support to patients aged over 60. A rapid assessment service operated out of core hours. This service provided immediate occupational and physiotherapy support to patients and accessed additional support for patients to help avoid admission to hospital.
- There was evidence of good partnership working with the local ambulance service. Historically there had been

problems with delays in ambulance crews being able to hand over patients to A&E staff. Staff reported that this was now much improved. There were two ambulance liaison officers who worked in the trust's A&E and UCCs. Regular meetings took place with the matron to ensure that the two services worked cooperatively to ensure delays were kept to minimum.

- A further example of effective partnership working was the introduction of a police liaison service, supported by key partners such as the clinical commissioning group. Nursing and police staff we spoke with reported early positive findings from the pilot, including de-escalation of incidents, prevention of absconding patients and family liaison in relation to the sudden death of a patient.
- - There were at least two consultants present in the A&E department from 1pm to 9pm at the weekend.
  - The x-ray department was open 24 hours a day, seven days a week. There was limited access to specialist investigations such as MRI and CT scans and to a radiologist to interpret scans. An on-call radiologist was available. A local agreement existed whereby senior A&E staff were able to interpret certain scans out of hours so that treatment/admission was not delayed.
  - Physiotherapists were employed in the department seven days a week.
  - Pharmacy services were not available seven days a week but a pharmacist was available on call out of hours. During working hours, patients attending A&E or UCC who required medication were directed to the hospital pharmacy. In some cases, medicines were collected for them. The departments held a stock of frequently used medicines such as antibiotics, pregnancy tests and painkillers which staff could access out of hours. Stock levels were appropriate and were regularly checked to ensure the supply was adequate for peak times such as weekends and public holidays.

Are accident and emergency services caring?

Requires improvement

Evidence captured prior to and following our inspection and from speaking to patients during our inspection, provided a mixed picture and did not provide us with sufficient assurance that the A&E department at Royal Blackburn Hospital was consistently providing a caring service. The department had worked hard to increase the friend and family test response rate (which was now above the national response rate) however, the resultant scores were significantly below the national average. While we witnessed many positive interactions and received positive feedback from patients during our visit, feedback from other sources was not universally positive.

Compassionate care

- The A&E department participated in the NHS Friends and Family Test. It was reported in February 2014 that the response rate and the score for the test "both remain low at 6% and 45 compared to the latest England average of 17.4% and 57 in January 2014." Following the introduction of a text messaging system in March the response rate improved (11.5%), although the score worsened (17).
- A recent PLACE audit reported positively with regard to staff attitude and a bright, clean and welcoming environment.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Comments were mostly very positive and included: "The service is outstanding" and "I felt reassured that I was in safe hands." The only negative comment we received related to delayed pain relief. We received four negative comments from patients who contacted us prior to or following our inspection. These related to staff attitude (medical staff) and waiting times.

Accident and emergency

- There was no provision for patients to provide personal information to receptionists privately. A receptionist told us that if a patient did not want to discuss their problem they would simply record it as 'personal'.

Patient understanding and involvement

Emotional support

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- On the A&E Department there was a relatives' room where distressed relatives could sit in a private space. Investigation reports following deaths in the department showed that relatives had been offered appropriate support.

Are accident and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

The department had done a significant amount of work to improve response times and patient experience by working proactively with partners to tackle the obstacles which affected patient flow. Response times were improving although were not consistently met. Some of the initiatives such as the introduction of rapid assessment and the re-alignment of staff were still new and the full benefits of these changes were still to be realised.

There was limited evidence that the complex needs of vulnerable groups were always met. In particular, patients who required a mental health assessment waited too long in the A&E department and were not adequately supported by suitably trained or skilled staff.

Service planning and delivery to meet the needs of local people

Access and flow

- The department 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 were taking place so that capacity was constantly monitored.

Meeting people's individual needs

- The trust scored within expectations in relation to the questions about waiting times in the NHS A&E survey.
- The trust had been struggling to meet the national standard which required that 95% of patients waited less than four hours to be admitted, transferred or discharged. The end of year position as at 31 March 2014 was below the target, although performance was improving. While the target was not consistently met, the trust had met the target for three out of four weeks in April 2014. Trust-wide performance at the end of the week of our visit exceeded the target at 98.4%.
- The target to admit patients to the acute stroke unit within four hours (an element of the advanced quality stroke indicator) was not being met. Analysis showed that most of the breaches occurred due to the late transfer of patients from the A&E department to the acute stroke unit. Work was ongoing to "pull patients through the system" and involved a nurse seconded from the A&E department to support the stroke pathway.
- Patients attending A&E or 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 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 site. There was regular dialogue with the trust which provided this service and we were told by the mental health liaison team manager that staffing of this service was under review and that there were plans to increase staff numbers from June 2014 and this would enable them to base a practitioner in the department overnight.

- The trust was proactively working with its commissioners and local GPs to introduce admission avoidance measures. For example, they had developed an ambulatory care pathway. An ACU was opened in January 2014 with clear access criteria designed to reduce attendances at A&E and hospital admissions, thus improving patient flow.
- The hospital 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 hospital, and other agencies working together.

Learning from complaints and concerns

- We saw little evidence of support available for patients with dementia or other forms of cognitive impairment. There was no specific training for nursing staff in these areas but they told us there were sources of support available within the hospital.
- There was little support for people with mental health needs. A mental health liaison service was available but a small team covered the whole hospital, as well as serving Burnley General Hospital and did not have the capacity to provide anything more that telephone advice and to undertake mental health assessments. Patients awaiting assessment or awaiting a mental health admission were often left for a long period without adequate support. They were monitored by nursing, support and security staff for their own safety but the department 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.
- The A&E department 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. In February 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.
- There was a range of patient information in the form of leaflets and posters. Information was available in different languages and formats.
- We noticed that there was no information given to patients when they arrived at the UCC with regard to current waiting times. A receptionist told us that signs would be displayed when the department was busy and long delays were anticipated.
- A staff member had produced a patient leaflet, which was currently in draft. The leaflet, entitled 'Your journey through the Emergency Department' aimed to explain in simple language how the department worked and what people could expect when they attended.
- 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 throughout the departments we visited. 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 'staff huddles', 'share to care' meetings and governance meetings.

- The matron in the MAU told us that they had received numerous complaints about meals being served cold. In response to this the ward had reorganised the staff working patterns so that more staff were on duty at mealtimes and could serve meals more promptly when they arrived on the ward.
- The matron in A&E/UCC reported that they were emailing patients who had posted negative feedback on the NHS choices website, inviting them to discuss their concerns.
- The department used the NHS Friends and Family Test to measure patient feedback. The department had received a poor response rate and had recently introduced a system where patients were sent a text message following their attendance. A staff member was designated on each shift to oversee this. This had significantly improved the level of response which was reported to have increased incrementally from 6.1% in February to 11.5% in March and 20% in April 2014. However the responses had become less positive.
- It was noted in the minutes of the directorate governance meeting held in March 2014 that there had been a recent increase in complaints about staff attitude/ behaviour practice. It was agreed that a departmental code and a list of standards were to be produced and discussed with staff at 'share to care' meetings.
- There was a secure room used for monitoring patients with mental health problems who had been assessed as being at risk of harming themselves or others. This room was visible from the nurses' station and had windows so that the patient could be observed. However, the room was cold, stark, had bad acoustics and was poorly furnished, with only two wooden benches which were fixed to the wall. Staff told us that this room was used on a daily basis and patients could be confined in this space for up to 12 hours. Nursing, medical and mental health liaison staff we spoke with all acknowledged that this room was not fit for purpose.

Are accident and emergency services well-led?

Requires improvement

The department had experienced significant change over the last 12 months with changes in management, clinical leadership, working practices and physical upgrades to the department. 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 over 20 staff, from a range of clinical and non-clinical backgrounds. Staff were engaged and motivated. They all spoke positively about the changes in the department 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, many of the changes had been recently implemented and required time to fully embed and to demonstrate that the new ways of working would be sustained.

Vision and strategy for this service

Governance, risk management and quality measurement

- The trust's vision was visible throughout the departments. 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 department did well and where it could improve. Their views mirrored those of the management team.

Accident and emergency

Leadership of service

- 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 directorate maintained a risk register which fed into the divisional and ultimately the trust-wide risk register. This was regularly reviewed at governance meetings.

Culture within the service

- The department was managed by a triumvirate, including a clinical lead (A&E consultant) matron and a directorate manager. The matron and directorate manager were new in post. 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 department. The team worked cohesively and cooperatively and were respected by staff.

Public and staff engagement

- Staff within all the departments we visited spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- All but one staff member 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. Many staff commented on the positive impact the newly appointed matron had had on the department and staff morale.
- Staff were enthusiastic and engaged. They told us they enjoyed working in the department and that this had a positive impact on patient care.
- Staff felt supported professionally, with opportunities for learning and peer support.
- Staff felt supported psychologically and emotionally. Regular debriefs took place with all staff disciplines following serious incidents or events. Staff said this had a positive effect on their wellbeing.

Innovation, improvement and sustainability

- Staff were well-informed, engaged and involved.
- There was information displayed within all of the departments we visited to inform patients how the departments were performing. This included results of the NHS Friends and Family Test, waiting times and results of the PLACE audit.
- Innovation was encouraged from all staff members and they felt empowered to find solutions to problems and to continually improve practice. Many staff were involved in quality improvement projects and were able to give examples of practice that had changed as a result. A trainee advance nurse practitioner had undertaken an audit of the management of paediatric patients with asthma and then worked with others to develop a guideline and management plan for the treatment of children with moderate or severe asthma. Training had taken place and a patient group directive was introduced so that nursing staff can initiate treatment immediately following triage.

Medical care (including older people's care)

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

Information about the service

Royal Blackburn Hospital provides a range of general and specialist medical services to people across East Lancashire, 24 hours a day, seven days a week. The medicine division provides services in cardiology, gastroenterology, respiratory, diabetes and rheumatology, older people's medicine and general medicine, along with a range of community-based services for chronic disease management. The medicine division at Royal Blackburn Hospital has 423 beds in total.

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.

There was a medical assessment unit (MAU) where patients could be referred by the A&E department or their GP for assessment. This may include diagnostics, such as blood tests and x-rays. The MAU had 42 beds, provided in both single rooms and in four-bed bays. This was a busy unit with between 70 and 90 admissions per day. Patients usually stayed less than 12 hours on the unit before discharge home or transfer for continued care and treatment on the relevant specialty ward. Around 35% of MAU patients were discharged home. The average length of stay on this ward was 10 hours.

During our inspection we visited wards B2 (acute stroke unit), B4 and C5 (older people), B18 (cardiology), CCU (coronary care unit), C2 (medical), C4 (fast flow), C3 and C11 (gastroenterology), D1 (medical step down) and D3 (diabetes).

We visited the wards over two working days during the day and returned to wards C4 and C11 as part of an unannounced visit at night the following week. We spoke with 22 patients and five 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 at all levels, including nurses, matrons, allied health professionals, consultants, junior doctors, sisters 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.

Medical care (including older people's care)

Summary of findings

Staff told us they were encouraged to raise concerns and report incidents and there was an open and honest leadership culture. Care was provided in a caring and respectful way within clean and well-maintained wards. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working. The trust had undertaken a recruitment drive for nursing and medical staff. However, there were still vacancies across the division in the majority of wards. There was an ongoing shortage of medical staff which meant that gaps in rotas were being covered by locum/ agency staff.

The trust had taken steps to address concerns identified within the medicine division and across the hospital. However, many of the processes had not been in place for long and so had not had chance to embed fully into the culture of the service. Escalation processes had been reviewed to cope with busy times, such as winter pressure periods, but we found there were still issues with bed management and patient flow within the hospital.

Throughout the hospital we found staff who were involved in local projects to develop and improve patient care. We found that, while significant improvements had been made in the early assessment of patients, the discharge planning processes were fragmented and lacked patient focus. Senior staff spoke with enthusiasm about a number of planned projects and ideas to address this. However, these had not yet progressed further than the ideas or planning stage.

Although it was improving the overall mortality rate is above the expected level.

Are medical care services safe?

Requires improvement

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.

The trust had undertaken a recruitment drive for nursing and medical staff. However, there were still vacancies across the division in the majority of wards. There was an ongoing shortage of medical staff which meant that gaps in rotas were being covered by locum/agency staff. The trust had taken action to address escalation processes and had a dedicated ward for winter pressures. However, we found that patients were, on occasion, being inappropriately admitted to discharge wards directly from the emergency department without proper clinical assessment.

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 is 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, the trust submitted seven patient safety alerts which were classified as 'deaths'; medical specialities accounted for three notifications.
- Strategic Executive Information System (STEIS) data between December 2012 and January 2014 showed pressure ulcers, grade 3 and 4 accounted for the highest number of incidents in this timeframe, with a combined total of 40%. These incidents primarily occurred at the Royal Blackburn Hospital. We found that all grade 3 and 4 pressure ulcer incidents in the medicine division were

investigated. In some instances, investigations found there were issues with how ulcers were classified and graded. The trust told us this was under review at the time of our inspection.

- Incidents were recorded 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, allied health professional staff and healthcare assistants were 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, in particular medical 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' meetings, and weekly ward meetings, demonstrated that learning from incidents and any identified themes were reported back to staff. For example, on Ward C3, a serious incident investigation following a grade 4 pressure ulcer led to increased staff awareness of the importance of completing dietary assessment charts and repositioning charts properly. The tissue viability nurse also provided pressure area care training to new staff.
- All serious incidents were fully investigated. We reviewed the investigation report following a patient death and found the investigation had been undertaken by the trust's safeguarding lead and action plans were in put in place to reduce the risk of a repeat event. Actions included the development of a risk assessment template to identify patients at risk of depression and other mental health issues, and a task group had been set up to develop links with the mental health liaison team.
- 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. Incidents were also discussed during the divisional governance meetings to identify any issues and actions required across specific medical divisions (e.g. older people, gastroenterology).
- Mortality rates and outliers were discussed during divisional governance meetings and as part of monthly patient safety lead meetings. Learning and actions from these meetings was cascaded via multidisciplinary ward meetings and 'share to care' meetings.
- A suicide had recently occurred on the MAU. This incident had been subject to a root cause analysis and an action plan was in place to prevent occurrences in the future.

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. We looked at results for the trust.

- 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 worse than 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 better than 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 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 states 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

will 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.
- The bed management team told us that four beds in the urology assessment area had been used to accommodate patients who met specific admission criteria. Likewise, we were told that patients would only be admitted from the emergency department to Ward C2 if a full medical assessment was in place. We found that this was not always occurring in practice. There had been at least two instances in the 16 weeks prior to our inspection when ill and deteriorating patients had been admitted to Ward C2 directly from A&E without a full medical assessment.

Cleanliness, infection control and hygiene

- The trust's infection rates for C. difficile and MRSA lie within a statistically acceptable range, taking into account the trust's size and the national level of infections.
- 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.
- It was noted that some of the side rooms, most notably on Ward C3, did not have en suite facilities. Where this was the case, it had been identified as a risk and, where possible, one of the main bathrooms had been restricted for the use of isolated patients only. On Ward C3 this had been highlighted on the ward's risk register and was being reviewed every three months. We were told that there were plans to relocate the ward but there was no specified timeframe for this.
- Hand hygiene and commode audits were undertaken every month. No significant issues had been identified with infection control and cleanliness standards as a result of these audits on the wards we visited.
- An annual Patient-led assessment of the care environment (known as PLACE) assessment took place in April 2013. The assessment found the Royal Blackburn Hospital 95.77% compliant for cleanliness.
- The majority of patients told us they were happy with the levels of cleanliness on their ward. Patients commented that that they saw cleaners on the ward throughout the day and that they appeared to be "doing a good job".

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. Maintenance request logs showed portable appliance testing was carried out routinely by the hospital.
- Resuscitation equipment was available on each ward and records showed equipment was checked daily.
- Where identified as required, pressure-relieving mattresses were used in the prevention and management of pressure ulcers. Additional low-rise beds had also recently been purchased by the trust to assist in the prevention and management of falls.

Bed management

- During our inspection we found there were ongoing issues surrounding bed management. As a result, there were instances where patients were being inappropriately admitted to Ward C2 (discharge ward) directly from the A&E department. The admission criterion for C2 was for patients who were medically fit

but could not be discharged immediately. The unit was therefore nurse-led and did not have a dedicated consultant/junior doctor. Doctors reported that people were being sent from A&E without a full medical assessment. When we visited the ward, one patient was deteriorating and required consultant review and another deteriorating patient who was being reviewed by a junior doctor. This impacted on the safety of patient care in terms of sufficient staffing, medicines management and suitable environment.

- During our previous inspection we had identified concerns regarding the escalation processes in place within the trust. Following this, all escalation processes were reviewed. Ward D1 was established as a winter pressures ward and Ward C4 was established as a fast-flow ward for patients that need to be admitted but a bed on the relevant ward is not available. However, as previously stated, there had been incidents where patients had been inappropriately referred to Ward C2 directly from A&E. Junior doctors also raised this as a concern during their focus group.

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.
- As Ward C2 was a nurse-led ward, staff reported it had been difficult to get junior doctors to come to the ward to review or prescribe medication. This was corroborated by pharmacy staff who told us it was difficult to get take-home medication prescriptions filled in for patients on this ward.

Records

- All notes on the medical wards were in paper format. Generally, we found notes to be well-maintained. However, there were inconsistencies in the completion of fluid intake charts and dietary assessment charts on some wards. We discussed this with the ward manager on one of the wards and were told that completion of fluid balance charts had been an ongoing issue and had been discussed during ward meetings.
- Risk assessments for VTEs, falls, pressure ulcers and malnutrition were completed on admission and were updated throughout a patient's stay.
- 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.
- Additional modules were available as part of the safeguarding training, however, staff awareness that this training was available appeared 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 division 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 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 was 81%. However, this figure did not include bank (overtime), 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 the Royal Blackburn 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.
- All newly qualified nursing staff were given a full preceptorship training period. However, concerns were identified that the presence of newly qualified staff, while good for the long-term, did put additional pressure on more experienced staff who were also acting as preceptors.
- 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.
- The majority of medical wards, however, still had qualified staff vacancies (medical and nursing), with the percentage of vacancies ranging from 2% up to 17% (and in one instance 26%) per ward.
- In the NHS Staff Survey 2013, the trust performed in the top 20% for staff working extra hours meaning that staff were working extra hours.
- Minutes from the trust integrated performance report, April 2014 highlight that the trust continued to experience high levels of bank and agency spend with 23% of spend on middle grade doctors and a further 25% of spend on qualified bank and agency nurses.
- Where possible, attempts were made to use the same bank staff who were familiar with the wards. In the event of a new member of bank or agency staff being used, an induction checklist was completed to orientate them to the ward.
- Overall, the nursing staff we spoke with reported an improvement in staffing levels in the last 12 months. In the MAU there was a nurse to patient ratio of 1:6. The matron told us that because there were 18 single rooms, it was sometimes difficult to ensure patients were observed with the current staffing levels. This was not included in the department's risk register, although it was recorded that there was difficulty hearing nurse call bells.

Medical staffing

- 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. The trust had employed eight additional clinical fellows to try and support junior doctors in covering rotas but remaining gaps in the rotas were being covered with locums.
- Out-of-hours cover was provided by medical staff. Junior doctors reported that excessive on-call commitments were having an impact on their ability to gain ward-based experience. However, they also told us this was being reviewed. These issues were included on the divisional risk register and were discussed at monthly divisional management and governance meetings.
- Junior doctors told us that ward handovers were consultant-led and that this approach worked very well. No concerns were reported regarding weekend handovers.
- A clinical response team was introduced six months ago to pick up routine tasks such as intravenous cannulation. This was in response to feedback and has had a positive impact by reducing delays to patient care.

Medical care (including older people's care)

Major incident awareness and training

- Major incidents and business continuity plans, including winter pressure arrangements, were discussed during divisional management board meetings.

Are medical care services effective?

Requires improvement

Care was provided in line with national best practice guidelines and the trust had participated in a range of clinical audits. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Some improvements had been made to discharge processes and readmission rates. However, we found there had still been incidents where patients had been inappropriately escalated to discharge wards and step down units (for intermediate care) or had been discharged before they were medically fit. In terms of patient outcomes, trust performance varied. The trust had triggered two mortality outliers in 2013 for alcohol-related liver disease and acute renal failure. Action plans were in place to address the identified areas for improvement. The trust had also identified that it was failing to meet its target for the proportion of patients directly admitted to a stroke unit within four hours of presenting at A&E.

Evidence-based care and treatment

- Best practice guidelines were utilised throughout the medicine division to standardise care. For example, NICE guidelines and Advancing Quality standards were used in the management of myocardial ischaemia and stroke.
- Policies and protocols referenced research and best practice guidance. Care pathways had been introduced to standardise care and improve compliance with best practice guidelines and quality standards.
- The cardiology service provided a coronary interventional service including more than 650 percutaneous coronary interventions (or coronary angioplasties), around 1,800 angiograms and more than 100 other interventional procedures. The service has hosted two national meetings for coronary angioplasties attended by cardiologists from across the UK to discuss relevant issues and develop links nationally between centres.
- The trust had participated in all of the clinical audits for which it was eligible in the 2012/13 period.
- According to the trust's clinical audit annual report, in 2012, the medicine division completed 80 out of a possible 140 projects with a further 43 classed as ongoing.
- From the report it is not possible to see how many of the 80 completed related to national guidance. 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 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 is not clear whether this occurred, what action was taken at ward level or how this was followed up.
- Mortality rates and outliers were discussed during divisional governance meetings and as part of monthly patient safety lead meetings. Learning and actions from these meetings was cascaded via multidisciplinary ward meetings and 'share to care' meetings.

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.
- Patients' pain relief was reviewed and modified to meet their changing needs. For example, a patient who had changed from solid to liquid nutrition had their pain relief medication changed from tablets to liquids also.

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.
- Dieticians' assessments were completed where required and clear care plans were in place for staff to follow as a result. However, it was not clear whether these

instructions were always followed. We found gaps in completion of dietary assessment charts and fluid balance charts. These records were not completed to a consistent standard across all wards.

- Halal and vegetarian menu options were available for patients who followed these diets. However, we noted that the halal options available were limited and patients we spoke with confirmed this.
- Snack menus were also 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 needed to be improved. Patients told us the food was bland and often arrived cold.
- Feedback from NHS Family and Friends Test results for the gastroenterology wards and Ward D1 in November, December and February 2014 all highlight food as being 'below expectations'. The NHS Friends and Family Test summaries produced by the trust state: "Feedback regarding food passed to catering manager for information and actions." However, it is not clear what actions have been taken as result.
- 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. On Ward B4 in particular, mealtimes appeared to be well-organised with all staff involved to ensure patients received the support they required.

Patient outcomes

- In July 2013 we received a mortality outlier alert for alcohol-related liver disease from Dr Foster Intelligence (a provider of healthcare information). A review was undertaken by the trust which identified several areas for improvement, including completion of fluid balance charts, completion of a diagnostic ascetic tap within 24 hours of admission, blood cultures to be routinely performed in all identified patients, dietetic assessments to be completed within 48 hours. An action plan was submitted by the trust and this was being implemented at the time of our inspection.
- In September 2013 we received a mortality outlier alert for acute and unspecified renal failure from Dr Foster. The trust told us they had undertaken a review and found improvements were required in several areas, including better identification of patients with acquired kidney injury, better awareness of care bundle approach for the condition and improved documentation within case notes. An action plan was submitted by the trust and this was being implemented at the time of our inspection.
- A review of the Sentinel Stroke National Audit Programme report for July to September 2013 showed that Royal Blackburn Hospital had achieved an overall score of E – the lowest possible score from A to E). Of the participating teams across the country, 43% also achieved an E score and 42% achieved a D score. This meant that the Royal Blackburn Hospital was not performing significantly worse than other hospitals across the country.
- The trust had identified that it was failing to meet its target for the proportion of patients directly admitted to a stroke unit within four hours of identification. As a result, a stroke care pathway had been developed and a stroke action plan had been implemented. Outcomes were reviewed at divisional governance meetings. However, this remained an ongoing challenge for the trust.
- The hospital's performance was found to be within expectations for three of the five Myocardial Ischaemia National Audit Project (MINAP) indicators. There was no data for the remaining two indicators.
- The trust's performance was rated as 'within expectations' for all but one of the 19 indicators in the Royal College of Physicians' Audit of Falls and Bone Health in Older People.
- The Keogh Mortality Review, July 2013 noted a relatively short length of stay for patients (which is positive) but also high levels of readmission for some specialties and a high incidence of patients readmitted for the same condition. According to the trust's Readmissions Update report March 2014, the trust had a readmissions action plan which identified actions taken in an attempt to reduce readmissions, including the development of the virtual ward in the East Lancashire area, ambulatory care service and increased partnership working with the clinical commissioning group, social services and Lancashire Care NHS Foundation Trust.

Medical care (including older people's care)

Competent staff

- The General Medical Council National Training Scheme 2013 Survey results showed that the trust's performance was found to be worse than expected in general medicine in clinical supervision, adequate experience and feedback.
- According to the trust's 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; and 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 May 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. However, allied health professionals told us they were understaffed, particularly when trying to provide seven-day services. Specific examples were given by staff on Ward B2 (acute stroke), in the pharmacy and radiology.
- Allied health professionals at Burnley General Hospital told us there was good communication and cross-site working between Burnley General and Royal Blackburn hospitals.
- The trust had recently combined its medicine and community divisions to form an integrated care group. The aim was to improve the links between acute care and community care. However, this had been a relatively new change at the time of our inspection and the head of integrated care told us that the discharge and transfer of care process still required improvement.
- A mental health liaison team was based at Royal Blackburn Hospital but was provided by Lancashire Care NHS Foundation Trust. The links and working relationships with this team varied across the wards. For example, Ward C3 told us they had a good relationship with the team and would contact them for advice regarding any vulnerable patients. However, Ward C4 reported that they had very limited links with the team, while Ward C11 told us that the team would only attend to see a patient if they were medically fit or ready for discharge. This meant it was difficult for staff to access advice regarding the best way to support patients with mental health issues when they were medically unwell.

Seven-day services

- Seven-day consultant cover was provided. All patients were seen on a daily basis during the week. At weekends any new patients, deteriorating patients or patients ready for discharge had a review.
- Junior doctors reported that excessive on-call commitments were having an impact on their ability to gain ward-based experience. However, they also told us this was being reviewed.
- Junior doctors told us that ward handovers were consultant-led and that this approach worked very well. No concerns were reported regarding weekend handovers.
- Allied health professionals confirmed they were providing a seven-day service, though as previously identified, due to staffing levels, they told us they were feeling the strain of this.
- No issues were highlighted regarding a lack of availability of services out of hours. Nursing, medical and allied health staff all confirmed that they were largely covering seven-day service requirements among themselves and were trying to avoid use of bank or agency staff. However, there were concerns that this was not a sustainable approach.

Are medical care services caring?

Good

The NHS Friends and Family Test results for the trust were above the England average (October 2013 – January 2014). However, we noted that response rates for some of the medical wards could be improved. In January 2014 the medicine division scored 92% for overall patient experience according to the trust's patient experience survey.

During our visit we observed staff treating patients in a kind and sensitive manner. This was corroborated by the

majority of patients we spoke with when we visited the wards. People told us they were happy with the level of care they had received and that staff had treated them with dignity and respect.

Compassionate care

- Inpatient NHS Friends and Family Test results show that the trust performed above the England average for all four months reported (October 2013 – January 2014). However, out of the 38 inpatient wards 15 scored below the trust average of 74. Response rates for the trust were also well above England average for the same four-month period. However, four of the medical wards had some of the lowest response rates, all well below the trust average.
- 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 trust performed 'better than other trusts' nationally for five of the 69 questions asked in the 2012/13 Cancer Patient experience Survey. Associated with this, they have also performed 'worse than other trusts' for 15 of the other questions asked in the survey.
- 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 received an overall score of 92% for patient experience which is good.
- People who attended the listening events told us they were not always treated with compassion, dignity and respect. They also told us that they were spoken to in a condescending manner by medical and nursing staff. Examples were given where people raised concerns about their or their relative's care but were dismissed or made to feel like they were "making a fuss" by nursing and medical staff. We had also received complaints from patients and relatives prior to our inspection regarding the level of care provided at the hospital.
- However, 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. Likewise, we spoke to a further nine patients during our unannounced out-of-hours inspection and all patients reported that they were happy with the level of care they had received.
- We observed staff treating patients in a kind and sensitive manner. Staff were responsive to patients' needs and we witnessed episodes of kindness from motivated staff, most notably on wards C3, C5 and B4.

Patient understanding and involvement

- People who attended the listening events told us they did not always feel that staff listened to them and 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 had regular meetings with a consultant and their treatment 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 and contact details for the community alcohol services in Blackburn with Darwen and East Lancashire. Leaflets about how to provide feedback, make comments and raise concerns were also readily available.
- On admission, patients were given a discharge planning booklet which contained information about the discharge process, predicted date of discharge and ward manager contact details.

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.
- 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 (provided by Lancashire Care NHS Foundation Trust). The links and working relationships with this team varied across the wards.

Are medical care services responsive?

Good

During our inspection we found examples of how the trust had been responsive to the needs of people who used the service. For example, the trust had created a dementia-friendly environment on Ward C5. The ward had been designed specifically to meet the needs of patients

with dementia. Escalation processes had been reviewed to cope with busy times such as winter pressure periods. In addition, wards 16 and 23 at Burnley General Hospital had been developed as 'step down' wards for intermediate care for patients transferred from Royal Blackburn Hospital.

However, there were still issues with bed management within the hospital. We found instances where patients had been inappropriately admitted to wards directly from A&E without full assessment. Junior doctors raised concerns that there was sometimes pressure to move patients from the medical assessment unit directly out on to wards before they felt it appropriate. We found that, while significant improvements had been made in the early assessment of patients, the discharge planning processes were fragmented and lacked patient focus. Senior staff spoke with enthusiasm about a number of planned projects and ideas to address this. However, these had not yet progressed further than the ideas or planning stage.

Service planning and delivery to meet the needs of local people

- A dementia screening pathway was in use throughout the hospital. We found that patients aged over 75 years were screened using the pathway for both planned and unplanned admissions. The trust was in the process of implementing the Butterfly Scheme (The Butterfly 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).
- Following a successful bid from the King's Fund, the trust created a dementia-friendly environment on Ward C5. The ward has been designed specifically to meet the needs of patients with dementia. The aim is that learning from this ward will be shared with other wards throughout the trust. In addition, all wards have an identified dementia champion to advise on and promote awareness of the needs of people with dementia.
- Ward C4 was participating in the Age UK "safely here, safely home" project. This initiative highlights the importance of planning for a safe discharge from the point of admission. As part of the initiative, pharmacists attended ward rounds to make recommendations on alternative medications or changes to the preparation they are given in.
- During 2013 the inpatient finished consultant episodes (where the patient has completed a period of care under a consultant and is either transferred to another consultant or discharged) for cardiology was nearly two times the national average. For interventional cardiologists, the number was nearly three times the national average. Overall, we were impressed by the comprehensive seven-days-a-week, consultant-led cardiology service provided at Royal Blackburn Hospital and found it was supported by highly motivated and dedicated staff.
- We found the trust had undertaken a review of discharge processes and there had been some improvements. For example, the discharge process was now a multi-professional decision. Ward C2 was established as a discharge ward for patients who were medically fit but could not be discharged immediately. In addition, Wards 16 and 23 at Burnley General Hospital had been developed as 'step down' wards for intermediate care for patients transferred from Royal Blackburn Hospital. As a result, readmission rates were reducing. However, reports from the incident management system from October 2013 to April 2014 showed that there had still been incidents where patients had been inappropriately transferred to wards before they were medically fit.

Access and flow

- 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 between April 2013 and March 2014 was, on average, 91%.
- Junior doctors raised concerns that there was sometimes pressure to move patients from the medical assessment unit directly out onto wards before they felt it appropriate. They told us this had happened recently with pressure coming from the emergency department and bed management team.
- Minutes from the gastroenterology governance meeting January 2014 highlighted that alcohol-related liver disease outliers were not being allocated to a gastroenterology ward by the bed management team, even when a consultant had requested this. Bed

management staff would allocate the bed to a patient that was on their list or who needed moving. It was then left for the wards to 'swap' patients. There appeared to be no system in place at that time for consultants' instructions to be followed by bed management.

- Pharmacy support and how it was provided was under review at the time of our inspection. Some wards had been involved with a pilot whereby they had a designated pharmacist. The pilot had shown positive results in ensuring people had access to their medicines in a timely manner and the aim was to roll this approach out across the division.
- 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 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.
- On Ward D3, patients had access to a dedicated translation service via the bedside television. We were told a translation telephone service was also available but that, due to difficulties in the practicalities of its use, often relatives were relied on to provide translation for 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 varied from ward to ward.
- 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. Relatives we spoke with confirmed that staff had taken the time to speak with them but that this information was not always passed over to other wards when the person was transferred, meaning that they had to keep repeating the same information over and over.
- We saw that call bells were answered promptly on MAU. Patients' comments included: "I have been well looked after. The nurses have been wonderful and the doctor has clearly explained everything."

Discharge planning

- The trust had undertaken a review of discharge processes and there had been some improvements. For example, the discharge process was now a multi-professional decision. Ward C2 was established as a discharge ward for patients who were medically fit but could not be discharged immediately. In addition, wards B16 and B23 at Burnley General Hospital had been developed as 'step down' wards for patients transferred from Royal Blackburn Hospital. As a result readmission rates were going down. However, incident reports from October 2013 to April 2014 show there had still been incidents where patients had been inappropriately transferred to wards before they were medically fit.
- The bed management meeting was attended by relevant staff such as the clinical director for integrated care, bed managers and matrons. Operational plans to manage capacity over a forthcoming bank holiday weekend were in place. At the meeting, staff demonstrated high levels of commitment to ensure agreed plans were acted on and action taken.
- We interviewed the divisional general manager for integrated care and medicine and the discharge facilitator team leader. We noted that, while significant improvements had been made in the early assessment of patients, the discharge planning processes were fragmented and lacked patient focus. Senior staff spoke with enthusiasm about a number of planned projects and ideas to address this. However, these had not yet progressed further than the ideas or planning stage.

Learning from complaints and concerns

- The Keogh Mortality Review July 2013 highlighted that the trust's complaints process was poor and lacking a compassionate approach.
- The trust policy had been amended to reflect the requirement to offer meetings for all persons making a complaint unless there are specific exceptions as to why a meeting cannot be offered. Staff told us that this was happening in practice.
- Any learning from complaints was cascaded via the 'share to care' meetings and ward meetings, though no specific examples were provided.

Medical care (including older people's care)

- 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 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 show that efforts were being made to improve patient engagement and address concerns before they reached complaint stage.

Are medical care services well-led?

Requires improvement

Staff told us that there had been significant improvements in the culture of the trust in the last 12 months. Staff reported a more open and honest culture where they felt supported to raise concerns and report incidents. The trust's performance in the NHS Staff Survey 2013 for "Staff recommendation of the trust as a place to work or receive treatment" tended towards worse than expected. However, all the staff we spoke with during our inspection told us they were proud to work for the trust and would now recommend the trust as a place to work.

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. There also appeared to be inconsistent approaches as to how often risk registers were reviewed.

While the trust could demonstrate they had taken steps to address areas of concern throughout the service, many processes we observed had not been in place for long and so had not had time to embed within the culture of the service. There was some anxiety expressed by staff about the longevity of these changes, given that the chief executive, along with several other members of the board, were interim. We found that, while senior managers were able to describe the ideas they had for improving services, the implementation and management of these ideas in practice was disjointed and lacked operational planning and oversight. There was little evidence of follow-through and implementation.

Vision and strategy for this service

- The Trust Quality Account identified three key priorities for 2013/14:
- **Safe care:** reduce further their hospital standardised mortality ratios; increase the number of patients who are harm-free; reduce readmissions.
- **Effective care:** increase the number of patients achieving NICE quality standards; improve performance in national clinical audits; improve compliance with care bundles.
- **Personalised care:** improve on the national and local patient experience survey question responses; maintain dignity through implementing approach to eliminating mixed-sex accommodation. Specifically in relation to medicine, the trust planned to introduce and embed a care bundle approach for conditions with a high risk of mortality, such as pneumonia, acute kidney injury, alcoholic liver disease and stroke. The trust also aimed to improve the quality of care for patients suffering from acute myocardial infarction, heart failure, pneumonia, stroke and hip and knee replacements via participation in the Advancing Quality standards, and to improve the package of care provided to dementia patients.
- 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 and 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, and all clinical directors were being supported to attend leadership development programmes.

Medical care (including older people's care)

Governance, risk management and quality measurement

- 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 HR. 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.
- The head of the integrated care group and the chief of medicine told us they attended 'share to care' meetings to review complaints, incidents and mortality cases. This also then fed back into the divisional management governance meetings, along with weekly meetings with the chief executive and medical director.
- 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. There also appeared to be an inconsistent approach as to how often risk registers were reviewed; some ward managers clearly explained how often individual risks were reviewed while others were more vague and told us they would be reviewed every 12 months (or more often if required).

Leadership of service

- Staff reported that there was clear visibility of the trust's board throughout the service.
- Initiatives such as 'The perfect week' and 'Back to floor Friday', where senior members of staff and the executive and non-executive board visited wards to better understand the challenges faced by staff, were welcomed and received positively by staff.
- Staff within the medicine division knew who the chief of medicine was and described him as approachable and genuinely committed to making improvements. The head of integrated care was less-well-known, though given this was a new position, this was not surprising.
- We were told that there was greater visibility and access to senior management teams. In particular, staff spoke highly of the chief nurse.
- All clinical directors were being supported to attend leadership development programmes.

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 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 that 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. There were six wards in the medicine division at Royal Blackburn Hospital that were experiencing sickness levels higher than the trust average. 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 and that previous poor practices such as medical escalation and 'surge' had ceased.

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.
- There was a new patient and carer involvement focus group being developed to advise about the hospital environment, specifically on the newly refurbished Ward C5. The people invited were carers and service users with dementia among other multidisciplines who were dementia champions within the trust.
- We found there was greater visibility of the matrons and deputy chief nurse at ward level. Staff told us they regularly attended ward rounds to understand the challenges faced by staff in delivering the service.
- The minutes for the divisional management and quality board (medical division) meeting 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. Suggest 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

- We were told that two wards that had been opened as part of the 'winter pressures' plan were due to close shortly. There appeared to be a lack of clarity around when this change would happen and any short-, medium- or long-term impact this may have on patients' experience or flow.
- The hospital has a discharge facilitation team, however, it was unclear what impact this team had on improving the patient experience or facilitating/coordinating complex discharges. Key performance indicators were lacking to enable success of this teams work to be monitored.
- Overall we found that, while senior managers were able to describe the ideas they had for improving discharge facilitation services, the implementation and management of these ideas in practice was disjointed and lacked operational planning and oversight. There was little evidence of follow-through and implementation.
- Throughout the hospital we found staff who were involved in local projects to develop and improve patient care. Examples of this were on Ward D3 (Diabetes) where the junior sister was developing a tool to assess feet with regard to preventing diabetic foot ulcers. The aim was that the assessment will follow the patient to provide a full assessment history of feet. On Ward C3 (gastroenterology) one of the band 5 nurses, as part of their degree, was developing a deprivation of liberty safeguards and safeguarding folder which would contain example forms and would act as an educational resource pack for staff. The aim was that, once completed, this would be taken to the sisters' meeting for roll-out across all wards.

Medical care (including older people's care)

- 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 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.

Surgery

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

Information about the service

The Royal Blackburn Hospital provided a range of surgical services, including general surgery, urology, trauma and orthopaedics, head and neck, ear, nose and throat (ENT) as well as having a surgical triage unit. There were 11 theatres, including day surgery (elective) and emergency surgery theatres.

As part of the inspection, we inspected the surgical triage unit, orthopaedic wards (Wards B22 and B24), the elective general surgery ward (Ward C14), the emergency general surgery and vascular ward (Ward C18), urology and general surgery fast flow (C22) as well as the urology assessment unit.

We spoke with 10 patients, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades, including allied healthcare professionals, nurses, doctors, consultants, 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, and we reviewed performance information about the trust.

Summary of findings

Safety in surgery services required improvement. There had been a Never Event (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) in January 2014; we noted a number of mattresses that were contaminated; documentation was not always well-managed, with some patient records in poor state of repair (this meant some records may be misplaced or lost); theatre staff did not complete theatre equipment lists; and we witnessed an incident of poor medicines management.

Care was effective. 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.

Patients spoke positively about their care and treatment at the hospital and 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 others. 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 and children, often wearing theatre gowns, were waiting together in the theatre reception area.

Trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. The teams were motivated and we observed an open and honest culture. There were discrepancies as to how the local risk registers at ward level were being reviewed and not all risks were noted on the risk registers.

Are surgery services safe?

Requires improvement

Safety in surgery services required improvement. A Never Event occurred in January 2014 which could have been avoided. Documentation was not always well-managed, with some patient records in poor state of repair. This meant some records may be misplaced or lost. Theatre staff did not complete 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 and there should be documented evidence of this process. Audits of the World Health Organization (WHO) surgical safety checklists were undertaken, which showed good compliance. However, these audits simply checked the paper documentation rather than the correct use of the checklist.

The environment facilitated safe care however with infection control procedures were not consistently being followed, we noted a number of mattresses that were contaminated.

Patient safety was monitored and incidents were investigated to assist learning and to improve care.

We noted that one anaesthetist had three sets of different drugs ready at the start of the day for three separate procedures due to be conducted in the afternoon. This was not good practice, for example, if the theatre list changed, they could be mixed up.

Incidents

- The trust reported no Never Events between December 2012 and December 2013; however, one occurred in the theatre at Royal Blackburn Hospital in January 2014 which was categorised as "Retained foreign object post-procedure".
- We found the main reasons for this Never Event were lack of teamwork and not following procedure. The trust was still investigating this at the time of our inspection.
- The number of serious incidents reported was in line with the expected number for the size of the trust.
- National Reporting Learning System (NRLS) data showed that there were a total of 40 incidents in the surgical services with eight patient safety alerts being

classified as "severe" and one which resulted in a death between March 2013 and February 2014. The majority of these incidents occurred at the Royal Blackburn Hospital site.

- Staff told us that East Lancashire Hospitals NHS Trust had signed up to the 'Speak out safely' campaign spearheaded by the Nursing Times to help bring about an NHS that is open and transparent, actively encouraging staff to raise the alarm and protecting them when they do so.
- We reviewed a number of incidents from the electronic reporting system at the trust and found one where a patient was seen by a foundation year doctor who had failed to recognise some major symptoms. The consultant had not reviewed this patient who had since passed away. The trust was still investigating this at the time of inspection.
- The trust's performance for one of the five National Bowel Cancer Audit Project indicators was found to be better than expected. The trust's performance for the other four indicators was found to be within expectations.

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 expected 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.
- We looked at four trolley mattresses in the surgical triage unit. Two of the four were stained on the outside and three were stained on the inside of the cover when we unzipped them, and one was very heavily stained with blood. On the ward areas, across the surgical specialty, we looked at over 15 mattresses and found staining on either the covers or the inside foam on nine of these. These mattresses could pose a potential infection risk
- Ward staff tried to replace the dirty mattresses and informed us they had contacted the estates department during the inspection.
- Ward managers in all the areas told us that all staff should unzip the mattresses to ensure they were clean. The nursing and domestic staff we spoke with told us they did not always unzip the mattresses regularly to check if they were clean.
- Ward areas had cleanliness checklists which were completed when the beds became free. These included a section to verify the staff member had unzipped the mattress and whether it was clean or not. We noted two of the dirty mattresses had actually been checked on the days of our inspection.
- Data showed that healthcare associated infections for MRSA and Clostridium difficile (C.difficile) rates for the trust were within expected limits.
- All patients admitted to the surgical services underwent MRSA screening. We saw evidence of MRSA swabs being taken and recorded in patient notes.

Environment and equipment

- The environment on the surgical wards and within the theatre areas was mostly 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 in regards to 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.
- In the theatres we noted that any wastage of controlled drugs was recorded and all entries in the theatre and ward areas were signed by two staff to ensure traceability.
- Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- We noted the anaesthetist had three sets of different drugs ready at the start of the day for three separate procedures due to be conducted in the afternoon. This was not good practice, for example, if the theatre list changed, they could be mixed up.

Records

- Patient records were kept securely in trolleys and nursing documentation was kept at the end of patient beds.
- We looked at five patient records. We were able to follow and track patient care and treatment easily. Observations were well recorded; the timing of such was dependent on the acuity of the patient. However, we saw documentation falling out of several sets of paper notes which meant they could be misplaced.
- The "SOS" handover file in the surgical trauma unit was not always fully completed and had variation between the staff completing it which meant that information could be misinterpreted.
- We saw do not attempt cardio-pulmonary resuscitation (**DNA CPR**) records in patient files with discussions around the decision being documented. Evidence was included where discussions involved family members.

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.
- 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 its associated deprivation of liberty safeguarding was applied.

Safeguarding

- 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. However, we noted these were not always fully completed. For example, on one occasion the 'sign out' check was missed.
- 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.
- Theatre staff did not complete the documentation for the equipment lists at the beginning or end of any of the operations observed. Senior staff explained they expected this to be completed but, on questioning, staff acknowledged that they never did this.
- WHO checklists were completed however the "sign out" process was not embedded. The list was completed but the actual practice of all staff stopping and participating was lacking.
- While there were audit of the WHO checklists, which showed good compliance, these audits were of the paper documentation rather than the actual practice associated with this.

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 tried not to 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.
- One patient expressed concerns relating to the care provided by agency staff, they felt they were not as competent as the permanent staff.

Medical staffing

- We saw daily ward reviews led by registrars. We spoke with some foundation year doctors who confirmed they were involved in daily patient reviews and went on ward rounds with the registrar. This meant that a consistent approach to care was provided.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.
- Surgical consultants from all specialities were on call for a 24-hour period, during which they were free from other clinical duties.
- Medical staff we spoke with told us the nursing staff were very experienced and there was ample doctor presence. The surgical triage unit had junior doctors to see and treat patients as soon as they arrived to enable a quick turnaround and to ensure best use of facilities.
- Staffing within the theatres met The Association for Perioperative Practice (AfPP) standards.

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 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.

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 making sure that patients are fully aware of the expectations to aid their own recovery process.
- 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.

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 and relatives we spoke with did not highlight any concerns relating to prolonged waiting to receive pain relief.
- There was a dedicated pain relief team in place. One patient said, “They are able to adequately assess pain relief and the doctors have explained what’s going on.”

Nutrition and hydration

- Tools such as the malnutrition universal screening were used in patient records to identify any nutritional requirements and risks. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- We spoke with a number of patients who told us they were given a choice of food and drink. One patient told us, “I’m a coeliac and the hospital has provided me with gluten-free bread and biscuits.”
- Another patient told us his halal dietary requirements had been met and the food was “fantastic”.

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.
- 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.
- Mortality reviews were carried out and each incident was reviewed and investigated. The trust had an avoidable mortality reduction action plan with clinical care bundles in place and was working towards reducing mortality rates. Patient mortality and progress against action plans were reviewed on a monthly basis.
- 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 for patients undergoing major surgery 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.

- 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.
- We saw a clear induction pack for locum surgical staff in the ward areas.
- 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 and some had attended an external course at university.

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 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.
- A number of care pathways were in use, such as for fractured neck of femur, which required input from all specialities.

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 surgical out of hours service.
- Out-of-hours, microbiology, physiotherapy and pharmacy support was provided by both 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.

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, "The care has been good and the staff have been really good," and a patient on the urology unit told us, "I have been treated very well and the care has been good throughout my stay."
- 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.

Surgery

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 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. 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 were clear about 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.
- 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. We saw the chaplain walking around the wards speaking with patients.
- Patients could be transferred to side rooms to provide privacy and to respect their dignity.
- Patients told us staff closed the curtains when they were providing care to maintain their privacy and dignity and we observed this in the ward areas.
- 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 above the England national average which meant the quality of care provided to patients and the orderly running of the hospital could be affected. 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

- Patients could be admitted for surgical treatments through accident and emergency, GP referrals or transfers from other hospitals.
- There was a responsive coordination of the trauma services by the trauma coordinator who arranged beds, investigations, outpatient appointments, scans and theatres for patients as well as managing the surgical outliers. This ensured the service could better manage patients at busy times.
- The surgical triage unit had a "hot clinic" where patients were referred to from a number of routes, including their GPs, the emergency department, the Urgent Care Centre (UCC) and specialist nurses. They ran clinics such as ENT and made decisions whether the patient should be put on a trolley and admitted or if they could be seen in the day units. This enabled them to relieve the patient flow.
- Electronic bed management systems were in place in each ward area which enabled staff to keep an eye on the movement and flow of patients. We saw this was effective and enabled ward staff to respond to patients needs when they arrived on the ward – for example, the system noted if patients had an infection so a single room could be allocated.
- There was a range of patient information in the form of leaflets and posters. Information was available in different languages and formats.

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 provided to patients and the orderly running of the hospital. Bed occupancy at Royal Blackburn Hospital was 91% between April 2013 and March 2014 within the division.
- Trust data for April 2013 until January 2014, showed the aggregate position against all 18-week referral to

treatment standards was sustained. 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.
- Bed management meetings were held three times daily where concerns were highlighted and addressed.

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 large, diverse population of the area, signage we saw in the ward areas was only in English.

Discharge planning

- The 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, which included details such as a drugs chart, mental capacity assessment and infections data was 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.
- We noted some delays in discharging patients such as due to the delayed availability of medication.

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. Complaints were discussed locally in the ward at the 'share to care' meetings and at divisional and Board level.
- One matron told us she tried not to attend the 'share to care' meetings regularly so she could remain impartial in dealing with any issues and to empower the ward staff to make the meetings ward ked.
- 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?

Requires improvement

Trust vision, values and objectives had been cascaded across the surgical departments and staff had a clear understanding of what these involved. The teams were motivated and we observed an open and honest culture. There were discrepancies as to how the local risk registers at ward level were being reviewed and not all risks were noted on the risk registers.

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

- Senior staff were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators such as the nursing key performance indicators.
- Risks were rated from low to high with the lower risks being managed at ward level. Any medium risks were added on to the divisional risk register and all the higher risks being escalated onto the main trust risk register.
- There were discrepancies as to how the local risk registers at ward level were being reviewed. Some were reviewed on a six-monthly basis while some areas were reviewed annually. Theatre-based staff we spoke with told us their risks were reviewed once yearly and those deemed low "would be boxed off" locally. This meant that risks may not be captured sufficiently and the rating could change if not reviewed more frequently.
- Not all the risks were noted on the risk register, such as the fact that, in the urology ward, there were beds used for escalation purposes during busy times.
- 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 also 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.
- A matron told us coaching was mandatory for band 7 and over nurses and divisional leadership had improved recently, especially with the "Back to floor Friday" every month where executive staff carried out roles such as nursing and domestic duties to get a feel for the environment.
- Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive of, or inappropriate to 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. They recognised that the culture was improving.
- 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.
- A matron told us staff were encouraged to work across both main sites if possible and this had increased working relationships.

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.

Surgery

- 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.
- East Lancashire Hospitals NHS Trust had launched its 'staff thank you and recognition' (STAR) awards and was asking the public to get involved and nominate their 'unsung hero'. The theatre areas had devised their own award with certificates and prizes to acknowledge the hard work staff in the surgical division did.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines.
- 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.

Critical care

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

Information about the service

The critical care services were based at Royal Blackburn Hospital. The critical care unit had 24 inpatient beds, including 14 single rooms and six bay beds. Combined intensive care and high dependency care was provided within the unit. There was also a post-operative care unit that had an additional four beds. The critical care services provided care and treatment to adult patients with a range of serious, life-threatening illnesses located in Blackburn, Burnley and the surrounding areas.

As part of the inspection, we visited the critical care services and spoke with five patients and the relatives of another five patients. We observed care and treatment and looked at patient records. We also spoke with a range of staff at different grades, including nurses, doctors, consultants, support staff, allied health professionals and the senior management team. 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.

Summary of findings

The critical care services provided safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. The staffing levels and skills mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were completed appropriately.

The critical care services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. Patients received care and treatment by multidisciplinary staff who worked well as a team. The critical care services performed in line with similar sized hospitals and performed within the national average for most safety and performance measures.

Patients or their representatives spoke positively about their care and treatment. Staff kept patients or their relatives involved in their care. There was no trust-wide bereavement or counselling lead in place to support patients, relatives or staff. However, the trust was in the process of addressing this.

There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Critical care

There was effective teamwork and clearly visible leadership within the critical care services. Staff were highly motivated and positive about their work. Innovation and improvement were encouraged.

Are critical care services safe?

Good

The critical care services provided safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises.

The staffing levels and skills mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were completed appropriately.

Incidents

- There were 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) in the critical care services.
- National Reporting Learning System (NRLS) data showed that there were no patient safety alerts that were classified as "severe" and no patient deaths recorded in the critical care services between March 2013 and February 2014.
- The staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Complaints and allegations of abuse were managed through separate reporting systems.
- The staff we spoke with told us they were encouraged to report incidents and received direct feedback from the matron.
- Themes from incidents were discussed at a weekly multidisciplinary meeting and staff were able to give us examples of where practice had changed as a result of incident reporting. For example, there had been an improvement in the number medication errors within the critical care services.
- Patient mortality and morbidity was reviewed at the weekly multidisciplinary meeting. This information fed in to a monthly trust-wide mortality review steering group meeting, which was chaired by the medical director and attended by the clinical director for critical care services.

Critical care

Safety Thermometer

- NHS Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, catheter and urinary infections) information showed that the critical care service was performing within the expected range for falls with harm, new venous thromboembolisms (VTEs or blood clots), catheter use with central line infections and new pressure ulcers.
- Information relating to the NHS Safety Thermometer was not visibly displayed within the critical care services.

Cleanliness, infection control and hygiene

- Information supplied by the trust showed there were no cases of Clostridium difficile (C.difficile) infections between April 2013 and March 2014 across the critical care services.
- There was one case of MRSA reported in October 2013. We looked at the investigation report for this incident and saw that there was clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- All patients admitted to the critical care services underwent MRSA screening procedures so that any at-risk patients could be identified and treated promptly.
- Intensive Care National Audit & Research Centre (ICNARC) data from 2012 also demonstrated that unit-acquired MRSA rates were within statistically acceptable expectations.
- Overall, infection rates were within an acceptable range for the size of the trust.
- The staff we observed demonstrated adherence and good awareness of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- There was a sufficient number of hand-wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.

Environment and equipment

- The critical care services and equipment we inspected were clean, safe and well-maintained.
- The staff we spoke with told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- 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.
- Intubation equipment (for placement of tube in patient's airways) was shared with the adjacent theatre's department.
- Bronchoscopes (used for viewing a patient's airways) were located in the endoscopy unit. Staff told us they could acquire these promptly if needed.
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored.
- Staff also carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We saw that medicines that required storage at temperatures below 8ºC were appropriately stored in a medicine fridge. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.

Records

- We looked at the records for three patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for VTEs, pressure care or nutrition and these were completed correctly.
- Standardised nursing documentation was kept at the end of the patient's bed. Observations were well-recorded; the timing of such was dependent on the acuity of the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in obtaining patients' consent. The staff we spoke with were able to describe how consent was sought verbally and in writing.

Critical care

- Staff understood the legal requirements of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
- Where patients lacked the capacity to make their own decisions, staff told us they made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the trust's "vulnerable adults" policy.

Safeguarding

- NRLS data showed that one incident of abuse had been reported in relation to the critical care services between March 2013 and February 2014.
- We saw that the safeguarding incident had been reviewed by the matron for critical care services and was also reviewed at the trust-wide quarterly safeguarding board meeting.
- The matron for critical care services told us safeguarding incidents were shared with staff to aid learning and improvement.
- The staff we spoke were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was displayed in the staff room.
- Safeguarding incidents were reviewed by the matron for critical care services and also reviewed at trust-wide safeguarding board meetings on a quarterly basis.

Mandatory training

- Data supplied by the trust showed that 78% of staff in the critical care services had completed mandatory training between March 2013 and February 2014. However, this was below the trust target of 95% compliance.

Management of deteriorating patients

- Ward staff across the trust used early warning scores and notified the critical care outreach team where patients were identified as at risk.
- Critical care staff carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.

Nursing staffing

- Nursing staff handovers occurred twice a day and included discussions around patient needs and any staffing or capacity issues.
- The critical care services had 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.
- All level 3 patients (those with complex needs including respiratory support) were nursed one-to-one, and all level 2 patients (those who have less urgent needs) receive care on a one nurse to two patients ratio.
- Information on staffing levels, including actual vs establishment, was clearly displayed near the entrance to the unit and this was updated daily.
- The matron for critical care services 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 this meant that there was a consistent workforce.

Medical staffing

- There were two critical care consultants and four doctors (middle grade) based in the critical care unit during the day.
- During the night, medical cover was provided by two doctors based in the unit and an on-call critical care consultant. On weekends, there was one consultant and two doctors providing medical cover.
- The consultant to patient ratio did not exceed 1:14.
- Medical staff handovers occurred twice a day and included discussions around individual patient needs.
- The clinical director told us they did not use agency or locum medical staff and cover was arranged from the existing team.

Major incident awareness and training

- There was a documented major incident plan within the critical care services and this 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.

Are critical care services effective?

Good

The critical care services provided effective care and treatment that followed national clinical guidelines and

Critical care

staff used care pathways effectively. The services participated in national and local clinical audits. Patients received care and treatment by multidisciplinary staff who worked well as a team.

The critical care services performed in line with similar sized hospitals and within the national average for most safety and performance measures.

Evidence-based care and treatment

- The critical care services carried out routine clinical audits to review compliance against internal standards as well as national guidelines such as NICE and other professional guidelines.
- At the monthly departmental meetings, findings from clinical audits were reviewed 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.
- Nursing and medical staff were involved in a number of national and trust-led audits including ventilator-associated pneumonia (VAP) reduction audits and high-impact intervention audits (audits of evidence-based, clinical procedures or care processes that can reduce the risk of infection).
- Trust data showed that there had been an overall decrease in VAP rates between April 2012 and November 2013.
- Since November 2013, the critical care services carried out surveillance for ventilator-associated pneumonia events based on guidelines from the Centers for Disease Control and Prevention, based in the United States. The trust was one of the early adopters of these guidelines.
- Trust data showed that between April 2012 and March 2014, there had been only one central line infection reported during December 2012. This demonstrated that staff practice was effective in minimising central venous catheter infections.

Pain relief

- The patient records we looked at showed that patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.
- The patients and relatives we spoke with did not highlight any concerns relating to prolonged waiting to receive pain relief.

Nutrition and hydration

- The patient records we looked at included an assessment of patients' nutritional requirements.
- Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff to ensure patient safety.
- 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.

Patient outcomes

- ICNARC data showed that trust performance was within acceptable levels for hospital mortality, out-of-hours discharges, non-clinical transfers out, and unplanned readmissions within 48 hours.
- The majority of patients and relatives we spoke with were positive about the care and treatment they received.

Competent staff

- Trust data showed the majority of staff in the critical care services had completed their annual appraisals.
- The critical care services had two practice educators that oversaw training processes and carried out staff competency assessments.
- The nursing and medical staff we spoke with spoke positively about learning and development opportunities and told us they were supported well by their line management.
- The matron for critical care services told us about 70% of staff had completed the post-registration award in critical care nursing and that this was above national guidance of a minimum level of 50%.
- Newly appointed staff underwent an induction process that lasted up to six weeks supernumerary and their competency was assessed prior to working unsupervised.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services. Routine handovers and team meetings took place to discuss patient care.
- There was a daily ward round which had input from nursing, microbiology, pharmacy and physiotherapy.

Critical care

- Patients underwent an assessment of their rehabilitation needs and the subsequent plan for their rehabilitation needs was clearly documented in patient records.
- An antibiotic pharmacist was based on the unit. There was also a dedicated team of physiotherapists as well as occupational therapy support.
- The critical care services were supported by a dietician during weekdays.
- The staff we spoke with told us it was sometimes difficult to get access to a speech and language therapist. However, the trust was in the process of recruiting three additional speech and language therapists to provide additional support for staff across the trust.
- Because critical care services were not provided at Burnley General Hospital, patients requiring critical care were transferred to the critical care services at Royal Blackburn Hospital. Ambulance staff were aware that all emergency patients were to be taken to Royal Blackburn.
- The critical care outreach team was highly regarded by staff within the critical care services and across the trust. The outreach team was a well-led, high-performing team who also carried out additional activities such as staff training.
- Data supplied by the trust showed that about 90% of urgent referrals to assessment by the critical care outreach team were seen within one hour.

Seven-day services

- Staff rotas showed that weekend nursing staff levels were maintained at the same levels as during the week.
- During the night, medical cover was provided by two doctors based in the unit and an on-call critical care consultant.
- On weekends, there was one consultant and two doctors providing medical cover.
- The clinical director for critical care services told us they planned to recruit two additional consultants over the next year to increase the weekend cover to two consultants.
- At the weekends, microbiology, physiotherapy and pharmacy support was provided by telephone.

Are critical care services caring?

Good

Patients or their representatives spoke positively about their care and treatment. Staff kept patients or their relatives involved in their care. Further improvements could be made to the level of emotional and bereavement support provided for patients and their relatives.

Compassionate care

- The staff we spoke with were passionate about the care they offered to patients.
- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- Patients and relatives we spoke with said they thought staff were kind and caring and gave us positive feedback about the ways staff showed them respect and ensured that their dignity was maintained.
- Patients and relatives we spoke with in the critical care unit gave a mixed response about staff attitude. They told us some staff were very friendly and helpful while others were quite passive and "did their job and went".
- When possible patients were nursed in side rooms in order to segregate male and female patients.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality.

Patient understanding and involvement

- Upon admission to the critical care services, patients were allocated a named nurse, to ensure continuity of care.
- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible, the views and preferences of patients were taken into account.
- The patients we spoke with told us they were seen daily by a consultant or doctor and the medical staff had clearly explained their care and treatment to them.
- When necessary, relatives could arrange face-to-face meetings with a consultant, and all relatives we spoke with stated that they had been kept fully updated and had had opportunities to have all their questions answered.

Critical care

Emotional support

- There were defined visiting hours for relatives. However, relatives could arrange to visit patients at any time during the day. Relatives were also encouraged to phone staff if they wanted updated information about a patient's care.
- The critical care services were able to provide overnight accommodation for relatives of patients.
- Staff told us they could seek advice and support from the trust's palliative care team if a patient required end of life care. We were not able to verify this as staff told us there were no patients receiving treatment on an end of life (palliative) care pathway within the critical care services during our inspection.
- Staff provided relatives of patients with bereavement leaflets that provided information. The majority of patients and relatives we spoke with told us they were satisfied with the communication and level of support they received.
- However, the relatives of two patients spoke negatively about the lack of information and emotional support they received from staff.
- There was no trust-wide bereavement or counselling lead in place to support patients, relatives or staff. The matron for critical care services acknowledged that further improvements were needed in this area to ensure staff as well as patients and relatives were fully supported.
- The trust was in the process of appointing a bereavement lead that could provide additional support and advice for staff.

Are critical care services responsive?

Good

There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The critical care services had allocated 14 intensive care beds and six high dependency care beds. There were also four post-operative care beds. These allocations could be changed depending on patient needs because the service operated as a combined unit.
- We found there was sufficient staffing and equipment available within the unit to meet patient needs.
- The matron for critical care services highlighted that bed capacity increased during the winter and some elective surgery procedures were cancelled to reduce pressure on the critical care services.
- The trust provided critical care services for adults only. If a child was admitted to the service, they would be assessed and then transferred to neighbouring hospitals for treatment.
- The critical care services had identified young adults within the community who had previously received paediatric critical support. There were arrangements in place to provide specialist support for these patients in their home and to allow direct admission to the critical care services if needed.

Access and flow

- Staff carried out daily meetings with the bed management team to ensure patient flow was maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Bed occupancy was managed effectively within the critical care services. The Department of Health data between October 2013 and December 2013, showed that 67.9% of critical care beds were occupied compared to the England average of 81.4%.

- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the critical care services.
- Trust data between April 2013 and March 2014 showed that:
  - Around 96% of patients were admitted within four hours of referral.
  - 6.2% of patients were discharged out of hours, which was within the trust target of less than 10%.
  - 24 elective surgery procedures were cancelled due to a lack of clinical care beds. This included 10 cancellations during December 2013 and five during January 2014.

Critical care

- ICNARC data showed there was a low rate of transfer out for non-clinical reasons in comparison to other trusts.

Meeting people's individual needs

- The critical care services were provided by specialist trained staff.
- Information leaflets about the services were available in the relatives' waiting areas. We did not see written information readily available in different languages or other formats, such as braille. However, staff told us this could be provided on request.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia care. Where a patient was identified with dementia or learning disabilities, staff could contact a trust-wide specialist for advice and support.
- Staff involved carers and family in the patient's care and specific care plans were put into place. The critical care services also provided accommodation for carers to ensure patients with complex needs received the appropriate level of care.
- The outreach team followed up all patients who had been discharged from the critical care services for up to 36 hours.

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care services and included contact details for the Patient Advice and Liaison Service (PALS). The patients and relatives we spoke with were aware of how to raise complaints.
- Complaints were recorded on a centralised trust-wide system. There was a centralised team that managed formal complaints. The trust target was to respond to formal complaints within 25 days.
- The matron for critical care services told us they aimed to respond to requests from the complaints team within 10 days. The matron was responsible for analysing complaints data to look for trends.
- Complaints data for critical care services showed that there had been 13 complaints raised during 2013, and four formal complaints raised during 2014 at the time of our inspection.
- We looked at records and saw that complaints were investigated and requests from the complaints team were dealt with in a prompt manner.
- Complaints were discussed during monthly team meetings to raise staff awareness and aid future learning.

Are critical care services well-led?

Good

There was effective teamwork and clearly visible leadership within the critical care services. Staff were highly motivated and positive about their work. Innovation and improvement was encouraged.

Vision and strategy for this service

- The trust had a clear vision and strategy with clear aims and objectives.
- The trust vision relating providing "safe, personal and effective" care was displayed across the areas we inspected.
- The trust quality strategy 2014–2019 incorporated this vision and included specific performance targets relating to patient safety and personal and effective care. However, the quality strategy had only been approved by the Trust Board during April 2014 so it was too early to assess performance against it.
- The vision, values and objectives had been cascaded across the critical care services and staff had a clear understanding of what these involved.

Governance, risk management and quality measurement

- There was a clinical governance system in place that allowed risks to be reviewed and escalated to divisional and trust board level through various committees and steering groups.
- During the inspection, we looked at the departmental and divisional risk registers and saw that key risks had been identified and assessed.
- The frequency of review of specific risks on the risk registers varied from monthly to annually depending on the level of risk. There were action plans in place to address the identified risks.
- There were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place within the critical care services to monitor performance against objectives.

Critical care

Leadership of service

- The critical care services were incorporated into the division of surgery and anaesthetics. There were clearly defined and visible leadership roles within the critical care services.
- The service was consultant-led and medical staff were overseen by the clinical director.
- The ward staff were managed by supernumerary clinical coordinators, who reported to the matron for critical care services.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were highly motivated and positive about their work.
- Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- The matron for critical care services told us nursing staff turnover over the past 12 months was about 10%, whereas this had previously been about 5%. The matron told us a number of experienced staff had progressed to other posts within the trust or externally.
- The nursing staff we spoke with told us this had affected morale within the unit but they still felt proud to work at the trust.

Public and staff engagement

- There was positive communication and team work between medical and nursing staff. We saw that staff were involved in discussions about patient safety in the critical care services
- Staff survey data for the critical care services was not available but the trust's overall performance was rated as better than expected or tending towards better than expected for 16 of the 28 key findings in the NHS Staff Survey 2013.
- Trust data showed that overall staff sickness levels within critical care services between April 2013 and January 2014 were 4.72%. We saw that staff sickness levels were reviewed and staffing levels were maintained through the use of bank (overtime) staff to ensure patient safety was not compromised.
- The majority of patients and relatives we spoke with were complimentary towards the staff and had received good care.
- The critical care services did not participate in the NHS Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment.
- Staff sought feedback from patients and their relatives by asking them to complete patient experience questionnaires. Trust data showed that, between January 2013 and April 2014, 157 questionnaires had been submitted and the overall satisfaction score was 98.36%.
- A review of the data from the CQC's Adult Inpatient Survey 2013 showed that the trust performed within expectations in comparison to other trusts for all 10 sections.

Innovation, improvement and sustainability

- There was positive culture that encouraged research and development activities within the critical care services.
- A consultant in the critical care services was the trust research and development lead. The research lead was also part of the Greater Manchester Clinical Research Network and collaborative work took place with other trusts.
- There were a number of research projects that were either taking place or about to start in the near future, including research studies relating to ventilation, analgesia and the use of medication to manage septic shock.
- The critical care services also carried out collaborative work with the Lancashire and South Cumbria Critical Care Network. There were two quality improvement leads who carried out quality audits and shared this information with the care network.
- The matron and the clinical director for critical care services were confident about the ability of the service to meet patients' needs in the future. They told us financial position, facilities and staffing was sufficient to ensure a sustained service.
- There were action plans in place to address key risks to the critical care services, such as winter capacity pressures, equipment upgrades (e.g. new ventilation equipment) and ensuring sufficient staffing for seven-day services.

Services for children and young people

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

Information about the service

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

- Children's ward
- Children's observation and assessment unit (COAU)

The children's ward has 51 beds which provide care and treatment for babies, children and young people aged from a few days old up to the age of 16. Children with additional needs can be cared for on the ward after the age of 16. Children receive care from a team of paediatricians. For some patients, responsibility for care and treatment is shared with other medical and surgical directorates which includes general surgery, ears nose and throat specialists, orthopaedics and maxillofacial surgery. Children and young people with mental health issues receive support on the ward and following discharge, if necessary, from the trust's specialist child and adolescent psychiatry team at the East Lancashire Child and Adolescent Service (ELCAS). The trust has a play team consisting of registered hospital play specialists, play leaders and nursery nurses. An education service is provided which enables school-age children to attend lessons while on the ward during term times. The school teacher works on the ward three days a week and liaises with the children's schools, during the children's admission and following discharge, to ensure their education is continued.

The COAU provides a 24-hour service to children from birth to 16years-old who have been referred by the emergency department, Urgent Care Centre (UCC), their GPs, midwives, health visitors or social services. The COAU assesses the child's condition, makes observations, conducts tests, provides a second opinion and either discharges or refers the child on for further treatment. For example, for admission to the children's ward. The COAU has 10 beds/ cot spaces and three cubicles. There were two assessment rooms, a small waiting room and two small play areas.

During our inspection of the hospital's services for children and young people, we visited the children's ward and the COAU and spoke with 17 parents/carers, 10 children/young people and 16 members of staff. The staff included medical, nursing, management and ancillary staff. We also observed aspects of the care provided to children and young people and reviewed records and documentation.

Services for children and young people

Summary of findings

Children and young people received safe and effective care from appropriately trained and competent staff. A programme of training was in place which staff confirmed prepared them for their roles and responsibilities.

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. Some parents did state they had only received sufficient information when they had questioned the medical staff.

The environment was clean, bright and airy with sufficient equipment required to deliver the necessary treatments. Toys were available throughout the ward and COAU.

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, although we found these had not been used for one person who spoke very limited English.

The service for children and young people was well-led. Risks were managed at a local and trust level. Staff were confident in the leadership of the children's services at Royal Blackburn Hospital.

Are services for children and young people safe?

Good

The children and young people's services provided by East Lancashire NHS Trust were found to be safe. Incidents were reported by staff and appropriate action taken by the trust. The investigation and learning from incidents was cascaded to staff to reduce the risk of recurrence.

Medical and staffing levels met the assessed care and treatment needs of children and young people and systems were in place for additional staff to be on duty when required.

The standard of cleanliness and control of infection within the children's ward and COAU was monitored and staff complied with the hospital's policies and procedures promoting the control of infection.

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 hospital's electronic reporting system. When concerns or serious incidents had been observed, we saw that action was taken within the directorate to investigate. For example, following a reported incident regarding enteral feeding (a nutritionally complete liquid which is delivered directly into the stomach), information-sharing during referrals to other professionals and additional training had been put into place for staff.
- The directorate held meetings known as 'share to care'. These meetings took place each week and were attended by all grades of staff throughout the directorate. Staff we spoke with were knowledgeable about these meetings and were positive about the opportunity they provided for dissemination of information. We saw minutes from the meetings which showed incidents had been discussed and the investigations and actions discussed.
- 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. We spoke with a student nurse who had recently started a placement on the ward. They told us that, on the first day on the ward, part of their induction was regarding the importance of completing incident forms when necessary.

Safety Thermometer

- We saw that reference was made in the family care directorate 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). It was acknowledged that this was not fully appropriate for use with children and some adaptation had been made. Information regarding the Safety Thermometer was displayed on the wall in the ward managers office of the children's ward. This showed children were provided with harm-free care and that there had not been any reported falls, catheter related urinary tract infections or pressure damage on the ward.
- There had been a Safety Thermometer audit in the children's and family directorates, reported during 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 that additional guidance had been provided to staff in response to reduce the risk of this reoccurring.
- The dashboard information provided to our team 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 trusts size and the national level of infections.
- The trust had a 'bare below the elbows' policy for anyone working in clinical areas. We saw all grades of staff observed this policy at all times. Staff told us they would be confident to challenge anyone not complying with the policy. We observed this during our inspection.
- Personal protective equipment, such as gloves and aprons, were readily available for staff to use throughout the clinical areas and we saw these in use throughout our inspection.
- Hand-washing facilities and antibacterial gel were available in all areas and staff were observed to use these correctly prior to, and after contact with patients. Visitors to the wards were also required to use the hand gel on arrival. We observed one member of staff advising visitors to the ward of its location and use.
- The ward areas were clean, bright, tidy and free from odours. We saw equipment in the corridors of the children's ward, although this did not impair access to the walkway. Staff told us this occurred due to limited space for storage on the ward.
- 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. The domestic staff member we spoke with had a clear understanding of their role in the cleaning of bed spaces and cubicles when they became empty. The trust had a process for identifying the level of risk when beds became empty. There was an 'isolation team' who deep-cleaned cubicles which had been used to care for someone with an infection. Staff were positive in their comments about this team and how they responded promptly.
- 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 the cleaner. Toys were plentiful throughout the ward, and the play team was responsible for cleaning them weekly or more frequently if required.

Environment and equipment

- The areas where children were cared for were light, spacious, child-friendly and appropriately decorated.
- Entry to the ward and CAOU was secured with locked doors. Visitors to these areas were required to press a buzzer and verbally request access. The ward had CCTV cameras installed which enabled staff to view who was at the door from the nurses' stations on each unit. We saw that staff checked who the visitors were, and who they were visiting, prior to opening the door for them.
- 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.

- Resuscitation equipment was available in the high dependency unit on the ward and in COAU. We saw a log which showed this equipment was checked daily to ensure it would be ready to use in an emergency.

Medicines

- Medicines were stored securely and appropriately within locked cupboards in rooms which had a key pad entry. Medication which required cool storage was securely stored in fridges specifically for medicines, the temperature of which was checked daily. Previous records showed the temperatures were within acceptable limits.
- Hospital pharmacists supported staff on the ward and COAU. The pharmacy technician visited the ward and COAU once a week to check stored medication and restock as necessary. A stock list was held which was amended to reflect current prescribing trends to ensure adequate supplies of appropriate medication were held in the clinical areas. No record was kept of medication returned to pharmacy, either by the ward or pharmacy staff, for example, once it was out of date. This meant there was not a full audit trail of medication that had left the ward and where it had gone.
- An audit had been completed in March 2014 of medication incidents in 2013 which had occurred within the family care division across all sites. We were told, and data showed, that 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 delays in obtaining medication from pharmacy or a delay in obtaining medication 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. As this had been newly implemented, there had not been any completed audits of any issues identified and actions taken.
- The pharmacy department and ward staff referenced a medicine Safety Thermometer which identified general issues and alerted staff to issues regarding high-risks drugs. For example, insulin and medication for the treatment of epilepsy. This meant staff were provided with up-to-date information regarding the medication that was used and stored on the ward.

Records

- We reviewed the medical and nursing records for eight children and young people on the children's ward. On arrival to the ward or CAOU, an assessment document was used to record the nurse observations, paediatric early warning scoring system records and the medical assessment.
- Records in the COAU 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.
- When not in use, medical records were stored securely in closed, lockable trolleys near the nurses' stations. However, during our inspection, we saw that the trolleys were not locked.
- Each child or young person had care plans in their nursing notes. These outlined the action staff needed to take to ensure their care needs were met. A number of the care plans we saw were generic, had not been individualised, and therefore did not reflect the individual care needs of the child or young person. For example, care plans relating to play and distraction did not inform of the preferred toys or activities of the child or young person or if they had a favourite toy or object of comfort.
- Risk assessments were in place for individual children and young people. For example, to identify those at risk of pressure damage while on the ward and to highlight the risk from venous thromboembolism (VTE or blood clots). Written instructions detailed any action required to reduce this risk.

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 its associated 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.

- The records we reviewed showed consent was sought prior to the delivery of care and treatment.
- We observed that staff informed children and young people of anything they were going to do and explanations were given and consent obtained prior to continuing treatment. For example, when removing a cannula or adjusting a monitoring lead.
- Parents we spoke with confirmed they felt involved and informed about their child's care and treatment.
- We spoke with a patient on the children's ward who told us they had been provided with information about their treatment and what would happen next. They had also been referred to the ELCAS team who they also made positive comments about.

Safeguarding

- The hospital had a dedicated safeguarding team who provided support to staff and investigated any reported potential safeguarding incidents. Staff were confident of reporting concerns to this team and said they would refer issues they were unsure about for additional support from the team.
- 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. Staff were positive about the way these meetings were conducted and that actions would be identified and followed up.
- Safeguarding training at an appropriate level (level 2 or 3 dependant on their role) was provided to all staff every three years. Updates in the interim period were provided at the annual paediatric study day. We saw 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. The training matrix for the children's ward showed 98% of staff had completed this training. One member of staff was due to attend the three-year mandatory training.
- A quality safety board met monthly and a recent area reviewed by this group was the Disclosure and Barring Service (DBS) checks which staff were required to complete to ensure they were of suitable character to work with children and young people. This check had replaced the Criminal Records Bureau (CRB) check and we were told the trust were in the process of ensuring all staff had a DBS check in place.

Mandatory training

- Training was provided for all grades of staff. Mandatory training took place annually and records were maintained electronically to evidence which training staff had attended. The ward also had a training matrix displayed on the wall of the office to provide a reference for staff and managers.
- The mandatory training included moving and handling, health and safety and safeguarding update.
- At a previous inspection we found shortfalls in staff attendance at safeguarding training for children and issued a compliance action; we now judged this to be satisfactory and the standard met.
- Clinical paediatric staff were also required to attend a paediatric study day and paediatric life support annually. The manager confirmed staff were up to date with their training. The training matrix was not fully updated but we were provided with additional information to show staff had completed their mandatory training as necessary.

Management of deteriorating patients

- We saw evidence that paediatric early warning scoring systems, which alerted staff to any deterioration in the child or young person's health, were in use. From the nursing and medical records it was clear that appropriate action had been taken to summon appropriate medical assistance when necessary. A system was in place to provide a visual alert on the records of a child or young person who had been identified as requiring additional care or treatment.
- Staff were made aware of the procedures to follow when a patient's health deteriorated and required escalating. Written information clearly showed staff the parameters for reporting.

Nursing staffing

- The paediatric directorate used guidelines from the Royal College of Nursing and the Keith Hurst (Telford method) staffing tool to determine appropriate staffing levels. The ward managers told us the bed occupancy

rates were usually above 90% and, when reviewing staffing levels, their professional judgement was also used. There was no acuity tool in use on the children's ward.

- The staffing levels had been raised as a risk and a business case presented to the board for additional staff. As a result, seven members of staff had been provided with temporary contracts last year and had received permanent contracts this year. A further 4.5 full-time equivalent staff posts had been agreed by the board and were due to be recruited and appointed.
- Staff we spoke with said there were enough staff on duty over the 24-hour period to meet the assessed care needs of children and young people. On each shift a band 6 registered nurse was allocated as a coordinator to manage the flow of patients through the ward. We were told that, at times, they would also be responsible for the care of a named group of patients, the pressure of which caused stress. The ward manager and matron told us this was currently under review and it was planned to make the coordinator supernumerary.
- The high dependency unit provided care and treatment to children and young people who had complex needs and required a higher level of staffing. For example, continuous positive airway pressure treatment, which is a treatment that uses mild air pressure to keep their airways open and is used for children and young people who have breathing problems. A flowchart had been developed for the coordinators to follow to ensure an appropriate skills mix and level of staff were on duty at such times.
- The nursing staff on the children's ward had a verbal handover at each shift change. We did not attend one of these handovers but staff told us they consisted of a detailed and informative verbal handover regarding the care, treatment and discharge plans for each child or young person. Staff in the COAU passed on verbal and written information at the change of their shifts regarding any child in the department.
- We were told that agency staff were not used and this was supported by the duty rotas. The ward and COAU had a number of bank (overtime) staff who could be called on to cover shifts but staff said the teams often covered shifts at short notice and were flexible in changing the duty rota, for example, in the case of sickness.
- New staff were provided with a full induction period to the children's ward and were given with a named mentor to help them become competent within their role. Newly qualified nurses were supported as part of a preceptorship training programme with an aim to enhance the competence and confidence of newly registered nurses. Preceptorship nurses were supported by staff on the ward who were provided with training regarding their mentoring role through the university. One member of staff told us that they and two other registered nurses were in the process of completing this training.
- Analysis by the trust of incident 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 we spoke with told us they were supported well and encouraged and felt able to call senior medical staff, including the consultants, at any time they needed advice or guidance. Out-of-hours consultant cover (after 10pm) was available with an on-call rota in place and available to the medical teams, both within the neonatal and paediatric departments.

Major incident awareness and training

- An escalation procedure was in place which identified the action staff would take for obtaining additional staff in the case of a major incident or when the hospital had reached capacity.
- Coordinators, in close liaison with the ward manager and matron, had previously closed beds when children and young people with complex needs had required care in the high dependency beds, and there had been insufficient staffing levels.
- The staff in COAU were able to call on the assistance of other staff within the children's team, for example, from the ward and matron, when the unit was busy.

Services for children and young people

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 children's ward and COAU, used a combination of guidelines and directives from the Royal College of Paediatrics and Child Health, and the National Institute for Health and Care Excellence (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.
- Audits had taken place to ensure the paediatric department were complying with practice guidelines. We saw an anaesthetic audit had been completed in respect of 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 and issue appropriate pain relief.
- Medication records we reviewed showed clear prescribing of pain relief and the time, route and dose of the medication administered. However, two medication records we inspected showed two doses of pain relief had been omitted with no clear reason evidenced.
- We spoke to a young person and their parents on the ward who were concerned that they had requested pain relief three times before it was administered. Other parents we spoke with had no concerns regarding their child's pain control.
- 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 work 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 the ward were able to choose their meals from a menu which had been specifically developed. This was brightly coloured and offered numerous choices for both lunch and the evening meals.
- There were supplies of juice and water throughout the ward for children and young people and their parents.
- We spoke with children, young people and their families and carers regarding the food provided to them and were told the food was "good", "lovely sandwiches" and "I haven't felt hungry since I've been here but there is a good choice of food if I was hungry".
- The COAU had a supply of sandwiches, light snacks and drinks to give children, young people and their parents who were on the unit for a period.
- Food and fluid charts were maintained when required. We saw fluid charts in the neonatal intensive care unit identified the type and amount of intravenous and/or enteral fluids administered as well as the amount, frequency and route of oral fluids which had been taken.
- Consideration had been given to breastfeeding mothers who were staying with their baby and a menu had been made available.

Patient outcomes

- The trust monitored the paediatric readmission rates and had produced a readmissions trajectory with key

actions to reduce this by 4%. The child health quality and safety board had reviewed the number of paediatric readmissions at their January 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. Feedback from the audits was displayed on the ward and COAU and showed a high compliance rate with the trust's policies and procedures.
- 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 and to ensure the sedation use across the trust was consistent.
- An audit had been completed regarding the use of the paediatric early warning system and found that all records had been completed. Any action taken following escalation was documented in 98% of the records reviewed.

Competent staff

- The trust had a system of annual performance development reviews for all staff which we were told had replaced the annual appraisal. Staff told us that, during their review they had the opportunity to discuss their progress, any difficulties and any training requirements with their line manager.
- Performance development review records were available locally and were held securely by line managers.
- 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 that senior staff worked with them on the ward and in COAU, providing care and treatment to patients, which gave the opportunity for discussions and feedback about their clinical skills. There was a programme of staff rotation between the ward and COAU to enable personnel to build their knowledge and competencies. One member of staff we spoke with who had recently moved to COAU as part of this programme was positive about the support and training provided.

Multidisciplinary working

- Pharmacists provided support to paediatric staff. We met with the pharmacist on the ward 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.
- Play specialists assisted staff on all units and wards where children were cared for or treated. The play specialists had all completed the necessary training course to enable them to register with the Hospital Play Staff Education Trust. Though this is not a statutory regulatory body, it monitors and promotes the quality and professional status of the practicing hospital play specialist.
- 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, "I like to go to the play room" and "they brought me some colouring and painting to do as I had to stay in bed."
- The trust provided support to children with mental health issues through ECLAS. Staff were positive about the response they received from ELCAS when a referral had been made. Members of the ELCAS team attended the ward to assess the child or young person and supported them on discharge. A 24-hour telephone advice service was provided by the ELCAS team and, on occasions, they had provided one-to-one support to patients on the ward.
- 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.
- Support was also provided to children, young people and their families and carers through the paediatric liaison and youth offending mental health team.

Seven-day services

- Consultants were on duty during each day and evening. The duty rotas demonstrated the on-call consultant cover overnight.
- The emergency department was located at the Royal Blackburn Hospital and provided care and treatment to children.

Services for children and young people

- Nursing staff told us they had access to senior management staff at all times. The on-call rota was available for inspection and showed cover over the 24-hour period, seven days a week. Staff were aware of the process to follow to summon assistance when needed.
- Pharmacy support was available seven days a week and the weekend opening times had recently been extended by two hours each day.
- X-ray facilities were available in the hospital seven days a week.

Are services for children and young people caring?

Good

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

Communication and information sharing was generally perceived as good by children, young people and families we spoke with. Parents/carers and their children were able to ask medical and nursing staff questions about their care and treatment. 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 generally treated with respect and dignity. There were curtains around each bed and at windows, and cubicles were screened by a door to promote people's privacy and dignity when staff provided care and treatment to people. We observed one episode of care where this had not been respected. However, this was addressed promptly during and following our observation.
- Staff showed empathy and kindness to those they cared for. We observed staff communicated well with children and their families/carers.
- Results from the Patient Led Assessments of the Care Environment (PLACE) audit from 2013 had been published. This gathered people's views of the food, cleanliness, facilities and their privacy, dignity and wellbeing. Results for the Royal Blackburn Hospital were positive. 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.
- Comments made to the ward by families and friends were displayed on noticeboards and provided information on action taken in response by the trust. For example, on the COAU, sandwiches and snacks and been provided for carers and children following feedback obtained from users of the service.
- Parents/carers who stayed overnight with their children were provided with breakfast and a hot drink in the morning.
- A café and restaurant was located in the hospital where parents/carers were able to purchase food. A shop trolley visited the ward each day to enable parents/carer to purchase snacks without leaving the ward.
- A system was in place for parents/carers in financial hardship who were staying on the ward with their child to be provided with a voucher to purchase food in the hospital. However, there did not seem to be a standard system or assessment process for the allocation of these vouchers.
- Parents and carers were able to purchase coffee and tea on the ward and make a hot drink in the parents' room.

Patient understanding and involvement

- Staff had access to written information to provide to parents/carers about their child's medical conditions and how to access support groups.
- Parents we spoke with were generally positive in their comments about the communication and provision of information from the medical and nursing staff.
- Two parents told us the information from medical and nursing staff had only been forthcoming after they had asked questions, and one parent said the information they had been given by different medical staff had been conflicting.
- A National Paediatric Diabetes Audit had been carried out, commissioned by the Healthcare Quality Improvement Partnership. The trust had been part of this and children and their parents/families who used the diabetes services had been asked to give their views.

Services for children and young people

The results showed positive outcomes for the communication and information giving by doctors, diabetes specialist nurse, dietician and psychological service.

Emotional support

- 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.
- 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.

Are services for children and young people responsive?

Good

Services for children and young people were responsive. Procedures were in place and followed which promoted the flow of patients through the service. This benefitted children and young people as appropriate treatment and care was provided in a timely way. Discharge planning was efficient and included parents/carers and professionals who would support the children and young people at home.

The service was designed to meet the needs of all children, including those with additional needs. Interpretation services were available when required, although they had not always been accessed. Care and treatment from specialist services were accessed when necessary. For example, from the diabetes and ELCAS teams.

Service planning and delivery to meet the needs of local people

- The trust had implemented an escalation policy and procedure to ensure that, at times of high admission, the service provided was safe.
- Additional services had been implemented to provide improved care to children and young people such as advanced paediatric nurse practitioners and a paediatric oncology service.
- A new service development was in the planning stages to include a respiratory specialist nurse for the care of children and young people with asthma as part of a multi-agency care team.

Access and flow

- Additional paediatric consultants had been recruited to cover frontline shifts within the COAU to increase the senior medical cover which had previously been provided by middle grade doctors. GPs were able to contact the COAU for advice and to refer children and young people for observation and some treatments as an alternative to hospital admission. This helped the flow of patients and available beds on the children's ward.
- COAU received referrals from GP surgeries, emergency department the Urgent Care Centre (UCC) at Burnley 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/or treatment put into place.
- Children and young people who were seen in the COAU were either discharged home, to the ward or another health provision outside of the trust. Arrangements were in place, and implemented, when children and young people required transport to another health trust. When children were transferred from COAU to the children's ward, located in close proximity, an assessment was made to ensure a safe transfer. Dependent on the outcome of the assessment, the child would be accompanied by either their parent/carer, nurse or doctor.
- 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 the larger group of readmissions (92.5%) were readmitted to the Royal Blackburn Hospital, with 52.5% resulting in parents/carers using their open access service. This provided parents direct access to a paediatric review if they were concerned about their child. Open access was available to children and young people with complex and life-threatening disorders as well as to all patients for up to 48 hours following discharge.
- Discharge letters were produced by the nursing and medical staff when the care of children and young people was transferred to other departments or professionals. for example, to their GP or another

hospital trust. Information included the reason for admission, investigations undertaken and any results and/or treatment. The trust policy was for nursing staff to countersign the discharge letter to confirm that the information had been provided to the child, young person and their parent or carer.

Meeting people's individual needs

- Information about the trust was available on their website and it 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 telephone translation service was available over the 24-hour period. We observed one child and their relative who did not speak English and had a very limited understanding. We asked staff if they had accessed the services of an interpreter for this person and were told they had not. Family members had provided some support with the permission of the parent or child, and we were told "we have managed with nonverbal communication like body language and signs." The staff member commented this had not been an issue as no interventional treatment had been required. However, we noted the child had a cannula inserted. There was no record in the child's care plan documentation regarding the language difficulties. This meant the child and their parent were at risk of not understanding their planned care and treatment or procedures that were to take place.
- Staff sought the advice and support from specialist departments and clinical nurse leads for children with specific medical conditions, for example, diabetes, 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 ward provided care for children and young people in bays and in separate cubicles. The ward was separated into three units (A, B, and C) with units A and B primarily for children and young people with medical care needs and C for surgical care and treatment. Staff told us the children and young people 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. We were told that ultimately the decision was made on available bed space. We also heard that children and young people were sometimes kept apart due to their conditions. This did not correlate with guidance from the Department of Health that young people often find comfort from being with others of the same age and should be given the choice.
- However, one parent compared the service received at Blackburn children's ward as not being as good as at Burnley children's minor illness unit. They told us they had experienced delays in obtaining pain relief for their child and had waited a long time to see the medical team. At the time we were told this, the medical team were conducting a ward round and had not yet reached the child and their parents.
- The children's ward had recently installed a sensory room for the use of children with additional needs which was also used as a distraction and relaxation room during some procedures, such as intravenous cannulation. We were told this room was predominantly used by the play leaders with individual patients, with the support of their parents. However, no training had been provided to staff in the use of the equipment and any advice about why it might not be suitable for children with specific medical conditions.
- The opening hours of the pharmacy department on the Blackburn site had recently been extended at the weekends, and it was now open from 9am until 4pm, whereas previously it had closed at 2pm.
- We found discharge planning included issues with medication and the medicines children would require on discharge home. We were told a request for discharge medication would take about two hours to receive from the pharmacy. However, when possible, the discharge planning ensured sufficient notice was given to the pharmacy to prevent a delay. Out of hours there was a medication cupboard within the CAOU where medications for discharge could be obtained.

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 which 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 the paediatrics service had increased within 2013/14.

Are services for children and young people well-led?

Good

The children and young people's service was well-led. Staff were positive about the leadership and management of paediatric services at the hospital. The culture was open and staff were able to discuss any concerns or raise incidents and stated they 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 a student nurse and a trained nurse, who were both aware of the initiative and where information about it was located.

Governance, risk management and quality measurement

- A risk management group met at the Royal Blackburn Hospital and a representative from the children's ward attended this. Incidents were reported through the trust's electronic system and were discussed at the risk management meetings, with decided actions recorded.
- 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 the Royal Blackburn 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.
- Risk assessments were in place on the children's ward and were reviewed annually. These identified potential risks and provided staff with direction on how to reduce such risks. For example, abduction of a child, ligature points and data protection and confidentiality.
- 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 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.

Leadership of service

- Nursing staff in all areas had an identified matron who visited the ward and units regularly. All of the staff we spoke with made positive comments about the support they received from their matron including "approachable", "regularly on the ward and available by phone"" and "knowledgeable and supportive."
- Staff were positive about their immediate line manager and local leadership within the family care division. However, not all staff were aware of the organisational structure above matron level and did not know who the board members, including the chief nurse, were. We were told by one member of staff "I heard they [chief nurse] did a walk round but I wasn't here and they haven't been back".

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.
- Staffs 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. One person who worked on the children's ward, but was not employed directly by the trust, said they felt valued by all of the team and were included in ward meetings and received information to enable them to provide a good service to the children and young people.

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 ward.
- The outcomes of the NHS Staff Survey 2013 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.
- Information known as 'team brief' was cascaded to all staff through discussion at staff meetings, electronically and printed information. We spoke to different grades of staff who were aware of this information. A domestic worker told us that, when they signed into work, the team brief was often printed and left in the vicinity to ensure staff were aware of any new information.
- Public listening events had been held by the trust. As a result, a new initiative was 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 to allow people to share their views with the trust.

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.
- An additional paediatric respiratory nurse specialist had been appointed and planning was in progress to provide outreach support into the community as part of an integrated multi-agency group for the care of children and young people with asthma.
- 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.
- Care pathways for croup, bronchiolitis, fever and gastroenteritis had recently been developed.
- A paediatric oncology service (level 1) had been established which improved the care and treatment for children and young people who otherwise would have been required to travel out of the area.
- 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 across two sites – Royal Blackburn Hospital and Burnley General Hospital. People with palliative/end of life needs were nursed on the general wards in the hospital. They were supported by a hospital consultant-led specialist palliative care team (SPCT). 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 consultant support was provided via a telephone hotline to the local hospice.

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

During this inspection we spoke with 13 patients and four relatives 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 SPCT including the clinical lead for palliative care, the end of life care coordinator and nurses from the SPCT. 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 work 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 effectively followed end of life care pathways that were in line with national guidelines. 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.

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 system and confirmed that incident reporting was encouraged by managers.
- The National Reporting and Learning System (NRLS) data does 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 where practice had changed as a result of incident reporting.

End of life care

- One staff member told us there had been a prescription error in relation to pain management for a patient. Staff acted immediately to resolve this. The incident was raised at the monthly team meeting and the need to be vigilant was reinforced.
- 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 where incidents were discussed.

Safety Thermometer

- We looked at the information relating to the Safety Thermometer on the wards we visited. This provided up-to-date information about the ward's 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 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, and using hand gel as necessary.
- 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 the Royal Blackburn was found to have met all required standards.

Environment and equipment

- The ward areas were 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

- Anticipatory end of life care medication was appropriately prescribed. We saw where advice was given from the Macmillan nurses to junior doctors in relation to prescribing medications to relieve symptoms for patients who were dying.
- We looked at the medication administration record charts for a number of patients and saw where appropriate end of life medication was prescribed. Medical staff told us they were provided with advice and support from the trust's SPCT.
- New syringe pumps had recently been introduced to deliver subcutaneous medication. Staff told us they had received a full day's training on the use of these. One palliative care nurse told us, "The ward staff need to sometimes think outside of the box. There are frequently issues with the compatibility of drugs, however, these can be sorted quickly, but staff need continued education and support".
- 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 SPCT nurses were nurse prescribers and another nurse had completed the course.

Records

- We looked at five patient's records on 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 (VTE) to minimise the risks of patients developing blood clots, and for falls, nutrition and pressure relief. We saw where one patient had an alert sheet due to a recent fall and where a patient was nursed on a pressure-relieving mattress due to their potential risk of tissue damage.
- We were shown on one ward where the trust was piloting new care plans and risk assessments. Staff told us they felt this pilot was positive and would help improve record-keeping. 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 a patient's individual preferences and wishes.

- We looked at 14 DNA CPR forms on the wards we visited. We saw these were signed appropriately by a senior member of staff. In the main, staff had completed these in line with guidance published by the GMC. Relatives of end of life patients told us that DNA CPR orders had been fully explained to them prior to completion and there was evidence of discussion with the patient's relatives if the patient lacked capacity. However, one person's DNA CPR form stated that discussion with the patient's family will take place, yet the form had been ticked to say the family were aware. It was, therefore, unclear whether the person's family had been involved in the discussion.
- The trust had not yet carried out an audit of DNA CPR forms. One of the SPCT nurses told us that auditing of these forms was planned for a future date.
- In all of the ward areas we saw that records were stored securely to ensure they could not be accessed by people who did not have the authority to access them.
- The trust were involved in a Lancashire-wide system to share relevant oncology information to support information sharing.

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
- Out of 20 assessment records we looked at, 18 showed the patient's mental capacity status had been assessed. Three staff we spoke with confirmed they had recently attended 'best interest' meetings for people who had been assessed as not having capacity to make decisions for themselves.
- A number of staff we spoke with 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 had training on safeguarding at the same time as mental capacity".
- On one ward, staff were able to tell us the arrangements available to support a patient who had a learning disability.

Safeguarding

- There were adult safeguarding 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.
- We saw there were safeguarding policies in place, and clear procedures to follow if staff had concerns.
- We saw safeguarding was included in the ongoing mandatory training programme and staff we spoke with confirmed they had attended.

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 SPCT 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 SPCT were promoting the development of end of life care champions through ward-based link nurses for palliative care. We spoke with a link nurse and a healthcare assistant who spoke favourably about their roles in promoting end of life care. They told us they found the training was valuable and they felt communication with patients, relatives and staff had improved on their wards in relation to end of life care.

Management of deteriorating patients

- Staff on the wards described the national early warning score used throughout the trust which alerted medical and nursing staff to changes in the patient's health so appropriate and timely action could be taken.

End of life care

- Specialist support was available from the SPCT when required and out-of-hours specialist advice could be sought from the medical/nursing staff at the hospice.

Nursing staffing

- Patients with palliative/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. One patient told us, "I am getting brilliant care from the staff here". One relative told us, "The staff are really good, they are really looking after my husband well. There seem to be enough of them as they come in and change him at regular intervals and I feel he has proper care in place. I don't believe he could have better 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 SPCT/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 more fully support end of life care across the trust.

Medical staffing

- For patients with palliative/end of life needs, medical cover was provided on the general wards in the hospital. There are four consultants in palliative medicine: two based in hospice and community locations; and two mainly hospital based. During the inspection we 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 palliative care team were 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 patients the SPCT 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 and how to contact the SPCT. We saw that end of life champions had been appointed as leads in the clinical areas to share any new information about 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 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 'care of the dying patient' policy and was developing further guidance and care plans in line with the strategic clinical network. We looked at the local policy and good practice guidance which outlined the principles of care for any dying patient. This was in response to national recommendations to phase out us of the Liverpool Care Pathway until guiding principles and proposed outcomes are published by NHS England.
- The SPCT had acted on the Department of Health's national End of Life Strategy recommendations. They had introduced the 'amber care bundle' – a simple approach used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It 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 and involved 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 already provided on wards to ensure patients were being identified appropriately for the amber care bundle had commenced. 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 staff's 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. There were plans to roll this out to additional wards over the weeks following our inspection.
- Policies and procedure were accessible for staff on the intranet and staff were aware of how to find these.
- 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 SPCT for advice about appropriate pain relief if required.
- The SPCT 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 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 and national results were not available at the time of our inspection.
- There was some evidence of local audit activity but this was not provided as evidence. 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 attended the trust induction when they joined the hospital and had received a local induction at ward level. 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 or clinical reflection times within their ward areas.
- All of the staff told us they knew they could get support from the SPCT 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. In addition, 116 people who did not work directly in the clinical areas.

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. We joined a multidisciplinary meeting which used video conferencing which demonstrated good communication across the settings, evidence of involving patients and family in decision making around treatment and discussion around patient's preferred place of care. In addition there was a daily

multidisciplinary 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.

- 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. One patient whose relative had terminal cancer told us, "I have received a really clear explanation about my relatives' condition. Communication has been good and care from staff has been brilliant. The preferred place of care was discussed and the decision not to resuscitate was clearly discussed. Although there was a delay in us being told the diagnosis, this issue was resolved in a professional manner".
- The SPCT 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.

Seven-day services

- The SPCT 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 showed us that the staff at Royal Blackburn Hospital were providing a caring service. During the inspection we observed caring interactions and staff treating patients with dignity. However, patients' feedback or their views on their experiences were not regularly collated for the trust to act on. Feedback from individual patients and relatives was positive about caring staff. However, there were some negative comments made from relatives where staff allegedly were reported as being "too busy to listen at times".

Information on do not attempt resuscitation was discussed with patients or their relative or 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. One patient's relative had written, "We want to express our gratitude for the professional and compassionate manner in which you looked after our mother. The staff were empowered to use their professional judgement to make Mum's days as comfortable as possible".
- 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 to have the time for relatives and their families at this difficult time. Staff were observed closing the curtains when a patient required privacy and were heard speaking with them in an understanding way.
- 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 relatives' 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. We saw staff referred to the deceased people by their name at all times.

End of life care

- There were two viewing rooms where relatives were able to spend time with their deceased relative. There was one larger and one smaller room depending on the number of people.
- The chaplaincy staff demonstrated a caring and compassionate approach towards patients, relatives and staff.
- One patient we spoke with said, "They are looking after me quite well. The staff come to my attention quite readily, some days seem busier than others, but I feel well cared for".
- There was limited patient feedback regarding the hospital's SPCT. One of the Macmillan nurses told us that the team made 10 phone calls per month to gather the views of relatives.

Patient understanding and involvement

- We heard from patients and relatives about how staff did work to establish a good rapport with patients and their relatives/close friends. Patients and their relatives were complimentary about the way staff communicated with them and they told us they felt involved in their care. Patients told us, "I see the doctor or the nurse every day. I feel like I know what's happening to me".
- We observed doctors and nurses speaking with patients about their care and checking they understood what they had been told. One patient told us, "I do feel involved in what's happening with me. They have listened and I am going home". This assured us patients were involved in decision making. We were not able to speak with some patients about their involvement in care as they were too unwell. We saw from patients' notes that discussions had taken place with patients and their families about care, treatment, prognosis, discharge and preferred priorities for care.
- 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.
- 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.

Emotional support

- The SPCT, 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, and medical and nursing staff communicated with and offered support to the person's family. We saw that privacy and dignity were 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 representatives from all denominations. Staff told us that, on some of the wards, the high demand for 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.
- Relatives told us that, after a death, they had to collect the death certificate and their relative's belongings from the general office. Sometimes they had to sit and wait on a main corridor rather than having somewhere private to wait. This had an impact on the quality of the service for relatives.

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 SPCT were seen promptly according to their needs. The SPCT were working hard to ensure patients receiving end of life care had a positive experience.

There was a lack of bereavement services across the trust.

Service planning and delivery to meet the needs of local people

- A survey by the SPCT was carried out in April 2012 to survey patient experience. In addition since then, the team administrator had undertaken a monthly telephone survey of both community and hospital

patients. This meant that audits and surveys were not extensive to ensure patient experience met the needs of the local population. The palliative care consultant recognised the need for more systematic audit.
- The trust had a relationship with Pendleside hospice to ensure medical and nursing support was available 24 hours a day.
- The SPCT had provided training for end of life champions who then cascade training within the ward areas where patients and their families who required end of life care were supported.
- Patients referred to the SPCT were seen promptly according to patient need. The SPCT quarterly audit consistently demonstrated 100% compliance with response to referral times (within 48 hours of referral).
- Across the trust, work was focused on ensuring care was carried out in the patient's preferred place. The SPCT 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 patients had choice at the end of their lives.

Access and flow

- We were told patients were generally 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 and seek urgent advice. This was regularly audited.
- The SPCT 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 facilitating a rapid but safe discharge for patients.
- 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 may not have time to be transferred back into 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 also provided pastoral care to patients, their relatives and the trust staff. There was access to chaplains from a number of Christian denominations and Muslim chaplains.
- A 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, where necessary, for religious reasons, bodies could be released promptly.
- We were told by senior staff that 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. A patient's relative at the listening event told us they felt they did not receive any counselling or support. The chair of the bereavement steering group told us that, following raised issues, the A&E department now had a quiet room where people could be spoken with sympathetically.
- 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. Staff told us that translation services were available within the hospital.
- Facilities for relatives included 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.
- The specialist palliative care nurses did not express any concerns about the end of life care for 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 to manage their symptoms from the specialist staff.
- There was support available for people with dementia, particularly on the specialist ward. The senior nurse told us there were plans to re-launch the booklet, 'This is me' which contains person-centred information for people with dementia who are receiving professional care, to ensure staff know their individual needs. We were told

End of life care

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 required.

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 then they would speak with the shift coordinator. If they were not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this 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 SPCT engaged with relatives of recently bereaved by calling a number of relatives within 12 weeks of the death of their relative. They used the feedback to consistently improve their service.
- The current recording system had no systematic way to identify if a complaint or incident was linked to end of life. However, the chief nurse was looking at a system to improve this.

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 about changes in culture in the trust. There was good local leadership and a 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, including: establishing an end of life register; reducing inequalities and ensuring equitable access; coordinated care at end of life; and raising the profile of end of life care and education/training. Staff told us they believed improvements would occur when the end of life /palliative care 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 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 was passionate about improving care and support for people at the end of their life, and 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 so that staff could see standard the trust and was 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 within their own 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 and was a developing strategy for adults. This had yet to include children.
- Audit results were presented at senior meetings however from a review of the last six months of board papers there was no evidence of end of life discussion.

End of life care

Leadership of service

- The trust had a new leadership structure and had recently appointed an executive and 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 the new appointments in bereavement and to expand the team were necessary for this to progress".
- Ward staff we spoke with knew the Macmillan nurses 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 in the SPCT spoke positively about the service they provided for patients.
- Staff told us how the "culture within the trust was changing for the better". They spoke positively about the service they provided for patients.
- 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 more 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 to support teams in identifying and responding to a person's end of life care needs when their recovery is uncertain. It was designed to enable treatment to occur alongside palliative care, however, staff recognised 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.

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

During our inspection to the Royal Blackburn Hospital site, we visited the general outpatients department, paediatric outpatients department, medical records department, and the pharmacy. We spoke with 18 patients who were attending the clinics. We spoke with nursing sisters in charge of the departments, two members of the nursing staff, three medical consultants, reception and administration staff, and medical records department 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 identiifed and action taken to minimise risks. The outpatient departments we visited were clean and well-maintained.

Both 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 incovenience 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 in not knowing which patients had transport arranged. Patients could wait for long periods for transport if their appointment was late.

Patients told us they had difficulty with the car parking arrangements at the hospital. 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.

Outpatients

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.

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. The clinical outpatients department employed a full-time learning disabilities nurse to provide support to patients and staff where required. The paediatric outpatients department also had access to a play leader with skills and techniques in supporting children during treatments or long waiting times.

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.

Outpatients

- 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 Thermometer (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 within their own department, and were able to describe what action they were taking to minimise the risk. By monitoring clinic start and finish times, the Royal Blackburn Hospital had identified that the highest risk was 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 on 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 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.
- The department attained 100% following a 'secret shopper' hand hygiene audit. This report was published in February 2014.
- The paediatric outpatient department had recently been refurbished with new flooring which was easier to clean and reduced infection risk.

Environment and equipment

- The environment in the outpatient areas we visited was safe and fit for purpose.
- The paediatric outpatient department had recently been refurbished with the corridor walls painted in bright colours presenting a cheerful and relaxed atmosphere.
- Equipment was appropriately checked and cleaned regularly.
- There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in outpatients 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.
- Both nursing and medical staff told us it was very rare for them not to have the full set of patient's notes in front of them during an appointment.
- One consultant described how quickly medical records could be obtained, giving a recent example of an urgent appointment.

Outpatients

- 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, Mental Capacity Act 2005 and its associated 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 endorsed 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 have 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.
- 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 constitutes 'safe' nursing staffing levels in outpatient departments.
- Senior nursing staff described how staffing arrangements were planned to meet the requirements of the clinics. The numbers 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 with confirmed there were sufficient numbers of staff 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 and had access to mandatory training, and training specific to their clinical area of interest.

Outpatients

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

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

The service was delivered Monday to Friday. Out-of-hours clinics were 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.
- 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.
- 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 action taken to respond to patients' comments.
- 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 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 would also be discussed during these meetings.
- We reviewed the record of staff uptake of training which confirmed that staff received regular mandatory training.
- We saw staff had access to training specific to their clinical area of interest.
- 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, a recent gastroenterology clinic had been scheduled one evening due to the 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

Outpatients

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. One patient we spoke told us, "I've been treated with respect here. Another patient said, "The staff here have a good attitude."
- 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, and offered food if this was over a meal time, particularly in the diabetic clinic.

Patient understanding and involvement

- We spoke with 18 patients regarding the information they received in relation to their care and treatment.
- Patients we spoke with stated they felt that they had been involved in decisions regarding their care. One patient told us, "I've been taken through my treatment plan. The staff are very helpful".
- Patients 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.
- The paediatric outpatient department also had access to a play leader with skills and techniques in supporting children during treatments or long waiting times.

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.

Outpatients

- 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

- 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 required. This gave patients the autonomy to make their own transport arrangements. However, nursing staff working in the clinics expressed concerns about 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 if their appointment was late.
- There was a sufficient amount of seating for people waiting for their appointments.
- 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 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 60 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 to already full clinic lists at short notice. This was to meet a patient's individual clinical need where it was not appropriate to wait for the next available appointment. This was confirmed by one patient we spoke with who spoke positively about how the clinic had "squeezed me in straight away." This indicated the service was responsive to patients' needs, however, this had a negative impact on the waiting times experienced by other patients.
- Most patients we spoke with at the time of this inspection told us it was unusual to experience long delays in their appointment time. One patient said, I'm usually in fairly quick. Today is unusual. I've waited an hour".

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 were 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 the person still had concerns, they would be advised how to make a formal complaint.

Outpatients

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 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 risks 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 was disseminated to staff through staff meetings and information 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 within 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

- The vast majority of staff spoke of the improvement they experienced in the culture of organisation. They spoke very highly of the executive team who were visible and approachable to staff. They felt proud to work in the hospital and would now recommend it as a place to work.

Areas for improvement

Action the hospital MUST take to improve

The hospital must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled and experienced staff employed in A&E at all times to care for very unwell children.
- Review the facilities and resources in its A&E and Urgent Care Centres for accommodating and supporting people who are experiencing a mental health crisis. This must include working more effectively with the mental health liaison team and crisis team to reduce delays for patients who require assessment and/or admission to a mental health bed.
- 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 the instruments are checked and accounted for before and after each procedure and that there is documentary evidence to support this.
- Ensure that there is an appropriately resourced bereavement service available.
- Take action to ensure that all mattresses are fit for use.
- Take action to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time.
- Take action to ensure that patients are not inappropriately admitted to wards directly from A&E without a full assessment, that patients with chest pain are not admitted inappropriately to the ambulatory care unit and that patients are consistently admitted to the stroke unit within four hours.
- Continue to use risk registers to improve reducing inconsistencies in how often risks are reviewed, and ensure that all risks are included.
- Ensure there are appropriate checks in place to provide assurance that medicines are administered safely by appropriately skilled clinicians, and recorded correctly.
- Ensure patients are not inappropriately moved to discharge wards, step down units or discharged before they are medically fit.
- Ensure that patients have appropriate access to translation services.

Action the hospital SHOULD take to improve

The hospital should:

- Improve take-up of mandatory training in the A&E department and in particular, ensure that all staff receive formal training so that they understand their responsibilities in respect of the Mental Capacity Act 2005.
- Consider the appropriateness of the out-of-hours cover for end of life care.
- Finalise the strategy for end of life care and embed into practice.
- Consider auditing the care of people at the end of life.
- Consider reviewing the car parking arrangements and provide information to patients regarding this.
- Review the effectiveness of the actions taken to reduce delays in ambulance handover times.
- Review support for people with dementia or other forms of cognitive impairment attending the A&E department.
- Review the privacy and dignity of people discussing personal matters at the A&E reception.