East Lancashire Hospitals NHS Trust

Royal Blackburn Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

East Lancashire Hospitals NHS Trust serves a population of 521,000. The trust has two acute sites: Royal Blackburn Hospital and Burnley General Hospital as well as three community sites. There is noticeable deprivation in both Blackburn with Darwen and Burnley. Alcohol-related diseases and adult smoking are among the most prominent health concerns in both areas. 44% of the population belongs to non-white ethnic minorities and life expectancy is 10 years lower for men and 7 years lower for women in the least deprived areas of both boroughs.

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

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

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

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

- The trust had a clear vision, objectives, values, operating principles and improvement priorities. These had been arrived at using a bottom up process and all staff we spoke with were engaged in the strategic direction of the Trust, its vision, demonstrated the values and were dedicated to achieving the best care for patients.
- The hospital services were supported by strong governance processes' including well managed risk registers feeding in to the Board, ensuring a robust overview of the risks within the hospital. There was ongoing work to enhance the Board Assurance Framework and risk management in the Trust. Staff demonstrated their involvement in the solutions to the risks identified which had developed staff ownership of risk and solution and was enhancing achievement.
- A 'Harm free care' strategy, introduced 12 months ago had improved the way they dealt with and learnt from incidents. The strategy included actions such as completing rapid reviews of serious incidents, referral to a panel for discussion and sharing outcomes in senior meetings. We saw evidence of learning and change to practice from incidents and how this learning was shared across the service and trust wide.
- Mortality rates had improved and the latest Trust SHMI value as reported by the HSCIC had remained within expected levels at 1.08, for the third quarter in a row as published in July 2015. The latest published HSMR values (May 2015 report) were within expected levels. The indicative HSMR monthly rebased figure (Dr Foster intelligence) for the most recent 12 month period available (June 2014 – May 2015) was also within expected levels at 101.78.

Summary of findings

- Over the past 12 months the Emergency Department/Urgent Care Centre's had introduced a number of quality innovations that have improved patient experience, patient care, patient safety and patient outcomes. Some of the initiatives that had been introduced included the introduction of a Mental Health Triage Tool and Observation Policy; Rapid Assessment review; Introduction of a Sepsis Nurse Lead; Creation of a Dementia friendly environment and review and development of the Paediatric Emergency Department.
- Following the results of an audit in 2014, improvements were required to improve the care of patients with sepsis. Following the improvements the ED was now the second best provider regionally for the treatment of neutropenic sepsis, with 80% of patients receiving antibiotics within the hour.
- The hospital had consistently achieved better than the England average in respect of the 18 weeks target from referral to treatment between April 2014 and March 2015. Surgical procedures were sometimes cancelled at short notice but systems were in place to ensure patients were rescheduled within 28 days of the cancellation.
- Nurse staffing in ED, medical and surgical departments had improved since the last inspection. Although there was a reliance on agency staff; nurses had been recruited but they were not yet in post.
- The trust employed an Intensive Home Care Team who provided support to the ED and facilitated early discharges of patients from hospital. Established links with local GPs who provided medical support if required were available. Figures for September 2015 showed that out of 86 patients assessed, 69 were discharged into the community.
- Cleanliness and hygiene throughout the trust was of a high standard.
- There was now a full bereavement service available at the hospital which was well received by users although it was noted not to be as well utilised by the ethnic minority groups. Work was underway with the local religious leaders to review this.
- Staff were caring, kind and respectful to patients and involved them in their own care. Improvements had been made in the monitoring of patients to identify if their condition was deteriorating which included revised systems for obtaining prompt medical assistance.
- Staff were proud of the work they did; they worked well together and supported each other when the services were under pressure. The trust ranked in the top 100 places to work in the NHS in an external health journal. Staff and patients told us they felt well engaged with and their views were valued.
- Staff explained that the last few years had been difficult but the stability of the current oard and executive team contributed greatly to the culture of continuous improvement.
- Leadership across the departments was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

However,

- Temporary staff reported a lack of access to electronic patient records when required and the maintenance of the confidentiality of records particularly in communal areas required improvement.
- The risks associated with the use of a separate prescribing document for medicines delivered via a pump were raised with the trust at the time of the inspection. They took immediate action to address our concerns.
- Some improvements were required with regard to the management of records and medicines in the medical wards.
- The A&E department continued to find the 4 hour wait target challenging. Between July 2014 and August 2015 an average of 89% of patients were admitted transferred or discharged within four hours. Over the winter months last year there were 1644 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.

Summary of findings

- There was no designated area for patients not requiring an overnight stay, but who needed to undergo a period of observation or await test results. These areas can 'contribute to patient safety, are highly efficient in terms of providing short term and ambulatory care, reduce admissions, and have been shown to improve crowding. Currently, staff admitted these patients to the Acute Medical Unit (AMU) which the trust had very recently doubled in number of beds from 40 to 80 to improve flow out of the ED. Two weeks prior to this inspection some medical wards had also moved to another area with the expansion of the acute medical unit. It was too early following this move to see any of the expected improvements.
- The audit of assessment of mental health patients in the ED (2014/15) showed that there remained room for improvement particularly in the assessment and recording of a patient's mental state which was only assessed and recorded in 30% of cases. The ED worked closely with a neighbouring trust in providing care for patients with mental health needs which was provided in a timely way 24 hours a day, seven days a week when required.
- Medical staff recruitment in some areas remained a challenge; the ED department relied on locum staff to fill gaps, actions were being taken to develop doctors internally to reduce the need to recruit from outside the trust. There was currently one vacancy for an EOL consultant. The consultants should have provided six sessions in the hospital to support EOL patients but provided just less than five sessions per week.
- There was no paediatric consultant assigned to work in the paediatric area of the ED but consultants could be sourced from the main ED or the children's ward. There was however a dedicated doctor in the paediatric area. Doctors could also be brought from the UCC or the main ED areas if required. The Royal College of Paediatrics and Child Health (2008) recommend that a paediatric consultant should be based in the ED.
- The results from data collected as part of national audits into the outcomes for patients with some clinical conditions showed the hospital was performing worse than the National average. Work was ongoing to improve these outcomes however this was not completed at the time of the inspection.
- The training and development of staff was below the trust's target for nurses within the medical services.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

- Ensure safe and accurate medicines administration and documentation particularly in terms of the recording of controlled drugs which patients have brought into the acute medical unit and oxygen prescribing and documentation on the medicine prescription and administration record.
- Ensure the safe access and use of electronic patient records in terms of all staff having access when required and maintaining the confidentiality of records particularly in communal areas.

In addition the trust should:

In Medicine;

- Consider how medicine storage fridge temperatures could be accurately recorded and action taken where they are not within the correct range.
- Improve staff uptake on the medical wards of mandatory training.
- Consider improving staff awareness of their role should a major incident occur.
- Improve the services for patients who had suffered a stroke including the input from speech and language specialists.

Summary of findings

- Nursing staff on the medical wards should be up to date with an appraisal of their performance.

In End of Life;

- Work with commissioners to provide a seven day service.
- Consider re-audits of DNACPR records to ensure that all records are correctly completed and all discussions with patients and families are documented.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	At the last inspection in July 2014, we rated the service as requires improvement. At this inspection in October 2015 we found improvements had been made in four of the five domains. However, meeting the A&E waiting times remained a challenge. Over the winter months last year there were 1644 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England. The department maintained a culture of reporting, investigating, and sharing learning to promote improvement. The environment was visibly clean and tidy and audit results for cleaning and decontamination of equipment supported this. Medicines were handled in accordance with legislation and guidelines. Patients were assessed for and offered pain relief when required. Records were complete and legible. The department had processes in place to safeguard children but up take of training to help staff safeguard vulnerable adults was lower than the trusts target. Staffing had improved for nurse vacancies since the last inspection however the department relied on locum staff to fill gaps in medical vacancies. Staff felt supported and appraisal systems were in place. Nurses were trained to become 'champions' in specific areas such as dementia, sepsis and safeguarding. Staff were caring and compassionate and patients told us they were treated with dignity and respect and were provided with excellent care. There was a culture of being open, sharing learning and seeking feedback to promote improvement. The number of patients waiting between four and 12 hours for a decision to admit was similar to the England average between April 2014 and April 2015 and the department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment. Access and flow through the department had been an ongoing focus for the department. Improvements had

Summary of findings

been made since the last inspection by introducing a rapid assessment and treatment model in the Emergency Department. Assessments were generally completed within 15 minutes.
An escalation process was in place which helped staff manage the department when it became overcrowded.
There was evidence of adherence to national guidance to provide evidence-based care and treatment.
Risks, incidents, complaints and performance were reviewed through monthly clinical governance meetings. A risk register was in place which covered relevant topics such as the risk of not reaching national targets.

Medical care (including older people's care)

Good

At the last inspection areas were identified for improvement. At this inspection a number of initiatives had improved patient care, staff involvement and the openness of the culture within the hospital. The mortality rates had improved and were now within expected limits.
Two weeks prior to this inspection some wards had moved to another area with the expansion of the acute medical unit. Despite this, ward areas were clean, tidy and well organised. It was too early following this move to see any of the expected improvements. Staff were involved in learning from incidents, complaints and results of audits. There were good infection control measures and patients commented favourably on the cleanliness of the wards. Staff were caring, kind and respectful to patients and involved them in their own care. Improvements had been made in the monitoring of patients to identify if their condition was deteriorating which included revised systems for obtaining prompt medical assistance.
Some improvements were required with regard to the management of records and medicines. There was a shortage of nursing staff and a reliance on agency staff although nurses had been recruited they were not yet in post. The results from data collected as part of national audits into the outcomes for patients with some clinical conditions showed the hospital was performing worse than the National average. Work was ongoing to improve these outcomes however this was not completed at the time of the inspection. The training and development of staff was below the trust's target for nurses within the medical services.

Summary of findings

Surgery

Good 

We rated the surgical services to be good although there were some areas of outstanding practice.
Since our last inspection the trust had made significant improvements, particularly focusing on strengthening their governance structures. Robust governance structures had been implemented, risk registers were fully completed and all staff were familiar with the risks for their areas. Regular governance meetings took place where lessons learned from complaints and incidents were discussed. Leaders were very visible to staff.
We saw evidence that incidents were being reported and staff were aware of the incident reporting system and how to use it. We saw evidence of learning and changes to practice from incidents and how this learning was shared across the service and trust wide.
Cleanliness and hygiene was of a high standard. Staff followed good practice guidance in relation to the control and prevention of infection.
Patients cared for in the surgical division were receiving care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were being completed and subsequent action plans implemented.
The trust participated in national audits including the hip fracture, bowel and lung cancer audits, which showed that overall the trust was achieving better than the National average.
At our last inspection we found that there was a lack of segregation in the theatre waiting area and subsequently patient's privacy and dignity were not always considered as male and female patients, wearing theatre gowns waited together. To address this, the trust has developed separate male and waiting areas.
The trust had consistently achieved better than the England average in respect of the 18 weeks target from referral to treatment between April 2014 and March 2015. Surgical procedures were sometimes cancelled at short notice but systems were in place to ensure patients were rescheduled within 28 days of the cancellation.
Leadership across the surgical division was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.
Staff were proud of the work they did; they worked well together and supported each other when the service

Summary of findings

was under pressure from increased demand. The trust ranked in the top 100 places to work in the NHS in an external health journal. Staff and patients told us they felt well engaged with and their views were valued.
We saw several examples of innovation across the surgical division, including robotic surgery, theatre open days to break down barriers between community and operating theatres and the use of social media.

End of life care

Good

The end of life care service was rated good overall.
The clinical leadership in the specialist palliative care team was effective. There was a strategy and a vision for the end of life service and effective reporting mechanisms to the trust board. All directorates were engaged in the delivery of good quality end of life care.
Staff were enthusiastic and caring and enjoyed working for the trust. They said that the last few years had been difficult but the stability of the current board and executive team contributed greatly to the culture of continuous improvement.
Systems were in place to keep people safe and incidents were reported by staff through effective systems.
Lessons were learnt and improvements were made. An integrated care plan had been launched which was comprehensive and staff had been trained to use it. The plan identified priorities for patients in the last few days and hours of their lives. Patients and their relatives were involved in the planning of their care.
The service had a well-developed education programme for medical staff, nurses and unqualified staff in EOL care. Staff in the specialist palliative care team and on the wards were committed to providing good compassionate care for patients and their relatives.
There were good audit systems in place and the outcomes of these were used to improve the service.
The bereavement service showed care and compassion to those attending the bereavement centre. There were bereavement champions who worked in a range of departments and across directorates to deliver good care after death for patients and their relatives. The chaplaincy was part of the holistic care of the patient and family at the end of life, giving spiritual and religious support to people of all faiths.
Mortuary staff and porters were compassionate and respectful with patients following death and with relatives who were using their services.

Summary of findings

However, consultant cover for out of hours and seven day working was not always available. The specialist palliative care telephone advice line for out of hours was answered by a nurse and referred to a doctor if necessary. This doctor was not always a consultant in palliative medicine and could be a GP. This did not fully meet the National Institute for Health and Care excellence (NICE) quality standards for end of life care.

Royal Blackburn Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; End of life care.

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Royal Blackburn Hospital	12
Our inspection team	12
How we carried out this inspection	13
Facts and data about Royal Blackburn Hospital	13
Our ratings for this hospital	13
Findings by main service	15
Action we have told the provider to take	78

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. 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. We inspected this trust as part of our comprehensive inspection programme in April 2014 following which they exited special measures.

The trust is not a foundation trust. 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. 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 is 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 a follow up inspection to assess if the trust had continued to improve since our last inspection.

Our inspection team

Our inspection team was led by:

Lorraine Bolam, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Director of Nursing, Clinical Services and MD of Community Health Services; Governance and quality lead; Accident and Emergency Nurse; Staff Nurse; MacMillan Nurse, Renal Histopathologist; Manager of health visitor / District Nurses in the community; Consultant Vascular Surgeon; Consultant Nurse Palliative Care.

Detailed findings

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG) and the local Healthwatch.

The inspection team inspected the following four core services at Royal Blackburn Hospital:

- Accident and Emergency
- Medical Care (including older people's care)
- Surgery
- End of life care

We carried out an announced inspection visit of the hospital on 19, 20 and 21 October 2015. We held focus groups with a range of staff in the hospital, including lead managers for each service area we inspected; consultants, other medical staff and all levels of nurses. We also spoke with members of the executive team.

Facts and data about Royal Blackburn Hospital

Royal Blackburn Hospital and Burnley General Hospital are the two main sites for East Lancashire NHS Trust. The trust had no Never Events and 101 Serious Incidents reported between May 14 and April 15. They also had a higher rate of incident reporting than the England average based on May 14 – April 15 data.

Between January and October 2015, the ED and UCC saw 88,860 patients. The emergency department (ED) at Royal Blackburn Hospital saw 36,693 of these patients with the remainder seen in the urgent care centre (UCC) at Burnley General Hospital. Of these 35,164 patients were brought in by emergency ambulance and 18,723 of patients who attended were children.

Hospital episode statistics data (HES) for 2014 showed that 44,231 patients were admitted for surgery at the trust. The data showed that, at Royal Blackburn Hospital, 35% of patients had day case procedures, 17% had elective surgery and 48% were emergency surgical patients.

There were 1862 deaths across the trust in 2014. The Specialist Palliative Care Team (SPCT) received 80-90 referrals a month. About 15% of these were non–cancer referrals.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided at the Royal Blackburn Hospital by the emergency department (ED) and urgent care centre (UCC), which are run as one unit under the trust's integrated care group division.

The service operates 24 hours a day, seven days a week. Between January and October 2015, the ED and UCC saw 88,860 patients. 36,693 of these patients were seen in the ED with the remainder seen in the UCC. 35,164 patients were brought in by emergency ambulance and 18,723 of patients who attended were children.

The emergency department provides care for trauma patients, however, the most severely injured patients will be taken by ambulance or helicopter to the nearest trauma centre at Royal Preston Hospital, if their condition allows them to travel. If not, they will be stabilised at the Royal Blackburn Hospital and then treated or transferred in line with their needs. The department has a helipad.

Patients receive care in four main areas: 'paediatrics' 'urgent care', 'majors' and resuscitation bays.

The paediatrics area had one triage cubicle and three treatment cubicles where children up to the age of 16 years could be assessed and cared for.

Patients with minor illnesses or injuries are assessed in one of two rapid assessment rooms and treated in the 'minors' or 'urgent care centre' (UCC) area.

In the UCC there are six cubicles with six more planned for the future. There are two waiting areas for these patients, one of which is separated for children.

The 'majors' area has 15 bays to care for patients with more serious illness or injury. The resuscitation area has eight bays, one of which is designed for children. There is a designated entrance for patients brought in by ambulance. Ambulatory patients are directed to book in at the main UCC reception.

The department has access to an ambulatory care unit (ACU) and an acute medical unit (AMU) where some patients are referred following initial assessment and treatment in the ED. Patients are referred to the ACU or AMU by certain hospital units, GPs or other designated healthcare professionals. In the ACU, patients not requiring admission can be assessed, diagnosed and treated. In the AMU patients are initially assessed and diagnosed whilst admitted, usually for 2-3 days until, following medical review; they are discharged or sent to a medical ward to continue treatment.

During the inspection we spoke with 24 patients and 23 staff from different disciplines including doctors, nurses, matrons, cleaners and allied health professionals. We reviewed 12 patient records and observed daily activity and practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Urgent and emergency services

Summary of findings

At the last inspection in July 2014, we rated the service as requires improvement. Improvements were required in areas such as the environment; staffing levels; the recording of controlled drug stocks, the views of those using services, the care of patients with mental health needs and capacity and flow.

At this inspection in October 2015 we found improvements had been made in four of the five domains. However, meeting the A&E waiting times remained a challenge. In July 2015 88% of patients were admitted transferred or discharged within four hours and in August 2015 the figure was 89% and over the winter months last year there were 1644 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.

The department maintained a culture of reporting, investigating, and sharing learning to promote improvement. The environment was visibly clean and tidy and audit results for cleaning and decontamination of equipment supported this. Medicines were handled in accordance with legislation and guidelines. Patients were assessed for pain and offered pain relief when required. Records were complete, legible and contained the necessary information. The department had processes in place to safeguard children but up take of training to help staff safeguard vulnerable adults was lower than the trusts target.

Staffing had improved for nurse vacancies since the last inspection however the department relied on locum staff to fill gaps in medical vacancies. Staff felt supported and appraisal systems were in place. 92% of staff (excluding those on maternity leave or long term sickness absence) had received their annual appraisal. Training was managed by Practice Educators in the department, including core mandatory training and additional training including chemical decontamination and advanced life support. Nurses were trained to become 'champions' in specific areas such as dementia, sepsis and safeguarding.

Staff were caring and compassionate and patients told us they were treated with dignity and respect and were provided with excellent care. There was a culture of being open, sharing learning and seeking feedback to promote improvement.

The number of patients waiting between four and 12 hours for a decision to admit was similar to the England average between April 2014 and April 2015 and the department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.

Access and flow through the department had been an ongoing focus for the department. Improvements had been made since the last inspection by introducing a rapid assessment and treatment model in the Emergency Department. Assessments were generally completed within 15 minutes.

An escalation process was in place which helped staff manage the department when it became overcrowded. There was evidence of adherence to national guidance to provide evidence-based care and treatment.

Risks, incidents, complaints and performance were reviewed through monthly clinical governance meetings. A risk register was in place which covered relevant topics such as the risk of not reaching national targets.

Urgent and emergency services

Are urgent and emergency services safe?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of protecting people from abuse and avoidable harm.

There was a culture of reporting, learning and making changes following incidents. The areas and equipment we inspected were visibly clean and tidy. Hand hygiene practice was adopted by staff. Medicines, including controlled drugs were stored safely and records of usage were in line with legal requirements. Patient records were completed appropriately.

Numbers of staff up to date with mandatory training met the trust's target of 85%. Systems were in place to safeguard patients from abuse. Staff accessed the trust safeguarding team during office hours and a duty team outside of these hours. Although most staff were up to date with training to protect children from abuse, only half were up to date with training to protect vulnerable adults.

There were plans in place and staff were trained to deal with major and chemical (HAZMAT) incidents.

Staff used tools to manage risk when assessing and monitoring patients and a rapid assessment model was used to improve patient experience by maintaining access and flow through the department.

The trust had worked to accurately calculate the right number of staff required to care for patients but core staffing numbers did not always meet demand. However, regular locum doctors and bank or agency nursing staff were sourced when there were shortfalls.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Staff reported incidents using an electronic system which provided email notifications to confirm receipt and outcome of investigations. They showed us how they would report incidents such as when the department reached capacity.
- Incidents were shared at senior level and disseminated to staff in daily, weekly or monthly meetings depending upon the issues identified.
- A 'Harm free care' strategy, introduced 12 months ago had improved the way the emergency department dealt with and learnt from incidents. The strategy included actions such as completing rapid reviews of serious incidents, referral to a panel for discussion and sharing outcomes in senior nurse meetings.
- Three serious incidents occurred between August 2014 and August 2015. We saw that investigations using root cause analysis took place following incidents and actions were implemented as a result.
- Staff adhered to Duty of Candour legislation. This is a legal duty to inform and apologise to patients if there have been mistakes in care in certain defined circumstances. A system was in place to ensure patients were informed when something went wrong. Senior staff acknowledged formal education was still required for some staff however; staff were open in their approach to patients when errors were made and provided us with examples.
- Mortality and morbidity was discussed at monthly governance meetings where lessons for learning were identified.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy with hand sanitizers available around the department. Reminders to use alcohol hand gel were displayed and we saw staff follow hand hygiene guidance when moving around the department.
- Results from the CQC patient survey 2014, showed the department scored nine out of ten for patients reporting cleanliness. 11 patients told us that the department appeared clean and tidy which supported our finding that staff practice was consistently in line with infection prevention and control practice.
- We observed staff washing hands before and after treatment and using gloves and hand gel when required in line with good practice guidance.
- Hand hygiene and commode cleanliness audits were completed monthly. The ED score for hand hygiene audits was 67% in April 2015. However scores were 100% for May, June and July 2015. The scores for

commode cleanliness ranged between 94% and 100% between April and July 2015. The ED was also audited for decontamination of equipment and scored 100% between April and July 2015.

Environment and equipment

- Patients taken to the emergency department by ambulance entered through a separate entrance for majors (for more serious cases) from other patients turning up for ambulatory care or minors (for minor injuries or illnesses) treatment. All entrances were adequately signposted.
- There was a secure entrance which led to the paediatric assessment area. Here there were toys, children's television and a baby change area.
- There was a room in the department designed for mental health patients to remain safe. The room had windows which allowed monitoring to take place, fixed furniture and no ligature points. In addition there were two exits to maintain the safety of staff.
- Equipment was stored in an organised way in a clean room and was within its expiry dates.
- The dirty utility room where commodes were cleaned and stored was clean and tidy. Equipment was labelled to indicate when it had last been cleaned.
- Resuscitation equipment was visibly clean and within expiry date. Records showed it was regularly checked. Some equipment which should be sealed to keep it sterile was found to be open.
- Patients had access to call bells to support them in the event of them needing to summon staff quickly.
- Triage and assessment rooms were well equipped with chairs and a trolley dependant on the patient's mobility. Panic buttons were accessible to keep staff safe.

Medicines

- We checked the medicines and controlled drugs in the emergency department and found the stock balances were correct and within expiry date. However, the controlled drugs record book was disorganised and difficult to follow which could pose a risk of misunderstanding its contents. Whilst records should be completed daily we found that checks were not recorded on seven dates in August and seven further dates in September 2015.
- We observed staff checking and administering medicines from storage used the correct procedure. This included two staff checking and completing an entry in the drugs book.
- Records showed that fridges used to store medication requiring storage at low temperature were kept within the required range.

Records

- Patient records were in paper format and stored securely behind the reception desk in a closed office.
- We reviewed 12 patient records (six children's records) which were clearly completed. Clinical observations were appropriately recorded, and included information relating to allergies and pain. We saw evidence of appropriate referral to a health visitor, and use of the National Poisons Information Service where appropriate. We saw evidence that risk assessments were completed for adults and children who were admitted to the emergency department after their initial assessment.
- Staff used a range of extra cards and proformas to ensure relevant information was sourced from patients or relatives. These included information about social and family history, allergies, and clinical observations. A separate proforma for patients who presented with chest pain was used. In addition a nursing assessment form was completed which prompted staff to review safeguarding issues, pain, risk assessments, and whether refreshments had been offered.

Safeguarding

- The trust had a safeguarding team who worked Monday to Friday 9am and 5pm. An emergency duty team was accessible to staff outside of these hours. A safeguarding nurse worked within the paediatric ED team to ensure links between these teams.
- The paediatric team had links with social services, for referring concerns or seeking advice. Staff we spoke with knew how to identify suspected abuse and confirmed they were familiar with the referral process to social services if they had concerns that an adult or child was at risk of abuse.
- Using the department's child risk assessment tool also helped staff identify safeguarding issues.
- Trust figures showed that in October 2015, 78% of nursing and healthcare assistant staff and 68% of

medical staff in the ED were up to date with safeguarding training. Senior staff told us that the figure could be broken down into both child and adult safeguarding training. Whilst we could not corroborate this, staff said that approximately 95% of staff were up to date with child safeguarding training, but only 50% were up to date with vulnerable adult training. Senior staff were aware of the need to improve this following a period of focus on training in other areas such as trauma life support.

Mandatory training

- Practice educators and an assistant business manager worked with staff to ensure training was up to date and maintained staff training status by way of an electronic matrix.
- Mandatory training covered a range of topics including fire safety, risk management, dementia care, infection prevention and control, incident reporting, early warning score systems, cardio-pulmonary resuscitation and equality and diversity training. Training was repeated three yearly or annually dependent upon the topic. Staff training was a combination of on line work and the use of DVD's.
- Senior staff told us that approximately 95% of ED staff were up to date with mandatory training and trust figures supported this (94.5% excluding those on maternity leave or long term sickness). This met the trust target of 85%.
- Mandatory training was discussed on a weekly basis at 'share to care' meetings attended by a range of staff including doctors, nurses, housekeepers and clinical development staff.
- Staff completed training in addition to mandatory training, 91% of staff had completed suicide and self-harm awareness training and 90% of nursing staff were up to date with enhanced training to manage trauma patients. 86% of nurses had completed intermediate life support (more advanced than basic life support) and 73% of nurses had completed paediatric intermediate life support.
- Figures provided for advanced paediatric life support training showed that in July 71% of staff had completed the training. Senior staff told us that the department was on target to ensure that 100% of eligible staff would complete this training by December 2015.
- Practice educators were looking to source staff to undertake specialist training to provide staff with skills to train their colleagues and to identify staff to become departmental leads for particular topics.

Assessing and responding to patient risk

- The ED staff followed clear processes by using tools to triage and assess patients. These included the Manchester Triage System (MTS) and an Early Warning Score (EWS) system.
- The MTS tool aims to reduce risk through triage, ensuring patients are seen in order of clinical priority and not in order of attendance. We saw evidence of MTS being used to triage patients.
- The EWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. A EWS score was required as part of the patient's initial assessment. We looked at completed charts and saw patients were escalated appropriately.
- The ED used a rapid assessment and treatment model to ensure patients were assessed and treatment commenced as soon as possible. The College of Emergency Medicine states that 'a rapid assessment should be made to identify or rule out life threatening conditions and ensure patient safety' (triage position statement April 2011).
- In July 2015 the median wait time for initial assessment of patients arriving by ambulance was 6 minutes with the longest wait 22 minutes. In August 2015 the median wait time was 5 minutes with the longest wait 23 minutes. The department of health target for initial assessment is within 15 minutes.
- Staff used risk assessment tools when assessing children and patients with mental health care needs.
- For patients deemed to present a risk to themselves or others, the ED had a procedure in place to deploy security staff with restraint and mental healthcare training to assist as necessary. Patients were cared for in cubicles which were visible to the nurses station and had appropriate fixtures and fittings to minimise the risk of harm for patients whilst in the department.
- The department worked closely with specialist mental health teams, who deployed staff to provide one to one care for patients if required.

Urgent and emergency services

Nursing staffing

- The ED assigned different grades of nursing staff who were assigned in an organised way to different areas of the ED.
- The department used a recognised workforce planning tool recommended by the Royal College of Nursing as well as the 'Baseline Emergency Staffing Tool (BEST) to ensure staffing levels were adequate in the ED. The most recent workforce planning review had been done within the last 6 months.
- Based on this, senior nursing staff confirmed the department was staffed to establishment and there were no nurse vacancies.
- However, in September 2015 the trust commissioned a review of the ED by the Emergency Care Intensive Support Team (ECIST). ECIST provide support for NHS organisations by reviewing services and recommending steps to improve them. The review recommended that nurse staffing levels be reviewed. This was because if one area of the ED reached full capacity staff had to be pulled from other areas which meant staffing levels were reduced until they returned. At the time of our inspection it was not possible to determine what action would be taken as a result of the recommendation.
- In the meantime agency staff provided cover if necessary. They were provided with an induction to ensure they were able to work safely within the department. An agency nurse confirmed this.
- Sickness absence rates were 4.5% which was above the trust threshold of 3.75%. However it was in line with the national average for NHS staff sickness. Actions were in place to try to reduce sickness levels.
- Handovers between shifts were completed in resuscitation, majors and UCC areas. We observed the handover process for night staff commencing duty. Here, staff gave appropriate details regarding each patient including possible diagnosis and treatment.

Medical staffing

- The department employed 5.5 whole time equivalent consultants but the establishment was for 11 consultants. The short fall was filled by regular long term locum staff. The department was aware that other local hospitals having trauma centre status made it difficult to recruit. This issue was on the departmental risk register with actions being taken to develop junior doctors internally to reduce the need to recruit from outside the trust.
- There was a full establishment of junior doctors in the ED.
- Medical staff rotated between Blackburn and Burnley hospital sites and also rotated across different disciplines such as acute medicine and intensive care.
- Consultant cover was available between 8am and 11.30pm each weekday and from 08.30 until 11.30pm at weekends. Outside of these times consultants were available on an on call basis.
- A senior consultant told us that whilst more middle grade doctors would be beneficial for weekend cover, current levels were appropriate and allowed cover 24 hours a day seven days a week.
- A dedicated doctor worked in the paediatric area of the ED. Doctors could also be brought from the UCC or the main ED areas if required. There was no paediatric consultant assigned to work in the paediatric area but consultants could be sourced from the main ED or the children's ward. The Royal College of Paediatrics and Child Health (2008) recommend that a paediatric consultant should be based in the ED.
- Junior doctors told us that they found the rotas very restrictive due to the fact that these were planned prior to the start of an ED placement. They described difficulties obtaining leave and this impacted on their work-life balance.
- Succession planning had been done in relation to consultants. Two consultants were due to retire in 2016 and a further retirement was expected in 2019. To limit the impact of this the department placed an emphasis on ensuring that middle grade staff would be in a position to fill these posts when they arose. For example, training was done on rotation to develop experience.

Major incident awareness and training

- The trust had an up to date policy and plan for use during major incidents. The documents contained instructions for staff to follow should an incident be declared.
- Staff in the department knew where to find plans and action cards for use should an incident occur.

Urgent and emergency services

- Practice educators were responsible for ensuring staff remained up to date with training for chemical decontamination and major incidents. Staff were trained in decontamination and 50% of staff were trained for higher level decontamination.
- The ED kept an organised stock of decontamination and major incident equipment which was recertified annually.
- Documentation relating to major or chemical incidents was up to date except for the decontamination policy which expired in 2013. The practice educator told us this was currently being updated. Other documentation readily available to staff included laminated action cards, information cards, flow charts for decontamination and a list of contacts within the trust.
- The ED staff had recently completed refresher training by way of a simulation exercise, jointly run with Burnley General Hospital.
- Multi-disciplinary critical incident debriefs were held following large scale incidents and debriefs were also held following smaller scale incidents, staff confirmed these were usually held within days of an incident.
- Staff in the ED were trained to manage patients who may present with Ebola or Middle East Respiratory Syndrome (MERS). Ebola and MERS are serious viruses originating in other countries. Reception staff were trained to identify possible cases of these viruses and knew the action to take to protect people who may be present in the ED at the same time as the patient.
- There were two designated isolation rooms to care for patients as required.
- Posters were displayed in the department to prompt people to inform staff if they had recently travelled to countries where Ebola was prevalent.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Summary

At the time of the last inspection there was not enough evidence to provide rating for effectiveness in emergency and urgent care services. Following this inspection we have rated the service as good for the provision of effective services.

There were a range of pathways and care bundles written in line with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments. There was evidence of multidisciplinary working.

The department had achieved mixed outcomes in the College of Emergency Medicine (CEM) audits on severe sepsis and septic shock and assessing patients with mental health problems. Action plans were in place to address the areas for improvement and staff told us improvements were evident in the delivery of antibiotics for patients with neutropenic sepsis.

Appropriate pain relief was offered to patients and pain scores were routinely recorded.

Staff felt supported by their managers and there were appraisal systems in place. Across the trust over 90% of medical staff received their appraisal between April 2014 and April 2015. Senior staff told us that ED nursing staff were up to date with annual appraisals. However, we were unable to find supporting evidence for this because records provided by the trust were inconclusive. Staff understood the requirements of the Mental Capacity Act 2005.

Evidence-based care and treatment

- Staff followed guidelines issued by NICE and from these had in place a range of local guidelines and care bundles. These were included in on line handbooks covering adult and paediatric care. The adult handbook listed care bundles detailing care for alcohol liver disease, pneumonia, sepsis, acute kidney injury, and chronic obstructive pulmonary disease. Separate

guidance was available for paediatric care and included information about caring for critically ill children and specific conditions such as croup, fever and bronchitis. Calculations relevant to basic and advanced paediatric life support were also included as well as how to manage pain in children which included paediatric drug dosage calculations for analgesia.

- There were pathways, protocols and care bundles in place to support staff providing care. Junior doctors described an incident whereby the 'massive haemorrhage' pathway was successfully activated for a patient who made a good recovery.
- Standard Operating Procedures such as procedures for particular staff to come and care for patients with mental health needs were in place.
- Local audits were undertaken on a monthly basis. These included use of the child risk assessment tool, the modified early warning score (MEWS) system and the aseptic non touch technique.
- Audit results for use of the MEWS system between April and August 2015 showed that scores were completed in a minimum of 86% of records except for July 2015 where 78% of records had completed MEWS for every set of clinical observations taken.
- We observed the care of a patient suffering with sepsis where the diagnosis was made quickly and fully explained to the patient. A thorough assessment by a doctor was done within 30 minutes and treatment commenced within 45 minutes. This treatment was in line with NHS England guidance which recommends that swift diagnosis and treatment are critical to survival from sepsis and as such should occur within one hour.
- Staff in the department took the lead in various areas. There were leads or 'champions' in dementia, safeguarding and sepsis care.

Pain relief

- A screening process was in place to identify any patients requiring pain relief. Pain was assessed using a pain score method between zero and ten and patients were asked about their pain when being assessed.
- Pain scores were recorded in patient records and we observed patients being asked about pain.
- In the CQC A&E patient survey 2014 the ED scored eight out of ten for patients feeling staff did everything they could to help control pain.

Nutrition and hydration

- Volunteers worked within the ED to provide hot drinks to patients and those with them.
- However we asked 11 patients if they were offered anything to eat or drink and nine of them reported that they had not.
- A vending machine was available to patients, relatives and other visitors.

Patient outcomes

- The Department of Health target for less than 5% of patients to re-attend within 7 days was not met in July or August 2015. The rates were 6% for both of these months.
- The trust employed an Intensive Home Care Team who provided support to the ED and facilitated early discharges of patients from hospital. A tiered care at home service, following assessment was provided before stepping down care to providing self-care education. Established links with local GPs who provided medical support if required were available. Figures for September 2015 showed that out of 86 patients assessed, 69 were discharged into the community.
- Outcomes for patients relating to specific diagnoses were discussed on a weekly basis in 'share to care' meetings. These meetings; chaired by the matron covered issues relating to the care of patients with for example, sepsis or a fractured neck of femur. We observed one of these meetings and saw the matron explain updates to care pathways as well as how well staff were using these. Areas for improvement were identified such as completing documentation were covered.
- The trust participated in national audit programmes by the College of Emergency Medicine (CEM) and action plans were generated to improve performance as a result of these. We reviewed the latest audit and action plans. The audit of assessment of mental health patients in the ED (2014/15) showed that against a target of 100%, risk assessments were completed and recorded in only 76% of patient records. Previous mental health history was recorded in only 84% of patient records and an examination of a patient's mental state was only assessed and recorded in 30% of cases. Although the trust had this recorded this, the only action they had recorded was to present the national data when available. This was scheduled on the action plan for November 2015.

- The audit to review the assessment and care of older people (2014/15) found that early warning scores were recorded in 37% of patients and cognitive assessments were not done for any patients in the sample. The trust concluded that data relating to early warning scores may not be reliable and that a further internal audit was required. Further action to review records internally was therefore planned as well as plans to review what cognitive tools could be best adopted in the ED. Findings were due to be presented in November 2015.
- The trust told us that following the results of an audit in 2014, improvements were required to improve the care of patients with sepsis. Following this senior staff told us that the ED was performing very well in treating neutropenic sepsis, with 80% of patients receiving antibiotics within the hour. This was corroborated in the minutes of meetings held in the ED in October 2015.
- The department continued working to improve sepsis care for patients and encouraged staff to maintain record keeping standards and communicate with colleagues, including attending ambulance staff.

Competent staff

- Specific competency assessments were in place for staff working in triage and resuscitation areas. The assessments covered a range of duties relating to the use of equipment, clinical assessments and knowledge of pathways and documentation.
- There was a management and leadership programme in place for senior staff as well as masterclasses about leadership in clinical areas. The leadership programme was a yearlong course using workshops, group support and reflection and coaching to teach staff.
- Information that supported staff with competency was available. The ED had a website where learning could take place. It included information about care bundles, the handbook, the triage system used, meetings, and 'newsflashes', which were key pieces of information for staff.
- The junior doctors we spoke with told us they felt well supported by the consultants, they received medical supervision, regular teaching sessions and they were able to discuss any issues or concerns as required.
- In addition to other traditional training styles, ED staff were trained through simulation. In June 2015 staff undertook a simulation day based on decontamination. A 'trauma simulation day' was scheduled for November 2015.
- Staffs competencies were assessed for approximately 12 months prior to triaging any patients. Once staff were competent enough to progress to triaging patients, they underwent a period of supervision before being confirmed competent.
- Staff took part in annual appraisals which were completed by senior staff. The trust told us that over 90% pof medical staff across the trust had received an annual appraisal within the last 12 months. Records of completed and outstanding appraisals for nursing staff were inconclusive. Out of 116 staff, only three showed the latest appraisal date, two of which showed that they had not received an appraisal within the previous 12 months.

Multidisciplinary working

- We saw evidence that multidisciplinary working took place both internally and externally to support the planning and delivery of patient-centred care.
- Blackburn ED and Burnley UCC staff worked in partnership to ensure patients received care at the correct location. Patients requiring emergency care were transferred from Burnley UCC to Blackburn ED. The local Ambulance Service NHS Trust provided the resource for transfers but staff were managed by the trust. Between July and October 2015 the ambulance transferred between 2 and 11 patients daily.
- The ED had links with the local ambulance service who would assist with ambulance admissions, attend bed management meetings to assist managing patient flow into the department
- The Intensive Home Care Team worked with a range of disciplines to provide care for patients being discharged from hospital. These included; physiotherapists and occupational therapists, dieticians, podiatrists and social services.
- A representative from Age UK worked in the ED to provide help for patients as required.
- The ED matron conducted weekly meetings called 'share to care' which included a range of staff including housekeepers, nurses, doctors and practice educators. Attendance was recorded.
- Physiotherapists assisted in the ED by completing mobility assessments following limb injuries Monday to Friday between 8am and 6pm.
- Details of nurses specialising in areas such as alcohol misuse were displayed for staff with contact details.

Urgent and emergency services

- GP's worked within the UCC providing support for patients with minor injuries. They were available between 2pm and 11pm on weekdays and from 11am to 11pm on weekends and bank holidays.
- The ED worked closely with a neighbouring trust in providing care for patients with mental health needs. Should patients require admission to hospital under the Mental Health Act 1983, this was done by the neighbouring trust that provided a response 24 hours a day, seven days a week when required.
- Relations with other agencies including local NHS trusts and commissioning bodies were reportedly good. In addition senior staff attended resilience group meetings which involved social services and the ambulance service.
- The ED was part of the North West Children's Major Trauma Network. The North West Children's Major Trauma Network (NWChMTN) is a network which provides a service for children who have experienced a major trauma.

Seven-day services

- The ED was open 24 hours a day, seven days a week.
- The paediatric department was open from 10am until 2am Monday to Friday. However, this was due to increase to 7 days per week from November 2015. In December 2015 hours were expected to increase from 7.15am until 2am each day.
- GP's worked within the UCC seeing patients suitable for GP care, following initial triage. GP's were available between 2pm and 11pm Monday to Friday and from 11am to 11pm on weekends and bank holidays.

Access to information

- Staff were able to access the information required to care for patients. This included diagnostic reports, frameworks and care bundles. The bundles provided information about a range of clinical presentations including alcohol liver disease, pneumonia, sepsis, acute kidney injury, fever in children and chronic obstructive pulmonary disease.
- The results from diagnostic tests for example, Computed Tomography (CT Scans) a method of examining body organs using x-rays and a computer to construct a series of cross-sectional images to form 2D and 3D imaging were usually provided within the hour. If an urgent request was made staff said they could be received within half an hour. However during very busy periods it could take up to one and half hours for CT scan results to be received. This could lead to patients being in the department longer than necessary.
- Junior doctors told us there were frameworks to support them in caring for patients suffering with common problems such as difficulty breathing or chest pain.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a training package in place to educate staff about the Mental Capacity Act annually, and a policy to support staff seeking consent to examine or treat patients.
- We saw evidence of consent in some patient records and patients told us staff had asked their permission prior to undertaking examinations.
- Records showed that out of 116 staff, 94 had completed mental health act training within the last six months.

Are urgent and emergency services caring?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of being caring.

The ED provided a caring and compassionate service to patients and their loved ones. We observed staff treating patients with dignity and respect and patients told us this was the case.

Patients felt involved in their own care and staff spent time explaining treatment options to explain what treatment they required and why. Patients and relatives felt supported and spoke positively about the staff and the treatment they had received.

Compassionate care

- The Friends and Family Test asks a standard question: "How likely are you to recommend our ward to friends and family ". Since March 2014 the percentage of patients who would recommend the service to friends and family rose. In July 2014 the figure was 70%, rising to 81% in February 2015.

Urgent and emergency services

- Patients told us they were treated with dignity and respect and that staff explained actions during eye examinations, asking permission before undertaking eye examinations. This reduced the potential for patients to feel intimidated.
- Nine patients told us that curtains were pulled around their cubicle to maintain their dignity. Two patients told us the curtains were left open but they were happy with this.
- We observed a patient who had passed away being treated with dignity as an area of the ED was cordoned off during transportation to a place of rest.
- Patients reported that staff introduced themselves and were friendly and polite.
- We observed three patients during initial assessment and saw staff treat them with compassion, dignity and respect.

Understanding and involvement of patients and those close to them

- In the 2014 CQC patient survey the trust scored seven out of ten for people feeling they were as involved as they wanted to be in decisions about their care in the ED.
- Ten patients told us that staff appeared knowledgeable and explained what treatment they required and why. One patient felt that staff did not explain themselves or appear to listen.
- We observed three patients undergoing initial assessment and observed staff introduce themselves to patients. They explained what would happen next and when the patient could expect to be seen by a doctor.
- We saw staff talking to relatives and building a rapport with them by explaining the care and treatment being given to loved ones. Relatives told us they were very satisfied with the care received.

Emotional support

- There were a range of lead nurses to ensure patients with dementia and safeguarding needs were properly supported whilst visiting the department.
- In the 2014 CQC patient survey the trust scored 6 out of ten for people feeling reassured by staff when feeling distressed in the ED.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Summary

This inspection has resulted in no change of the rating of requires improvement in terms of being responsive.

Treatment was usually provided in a timely way however the trust struggled to maintain targets for the percentage of patients being discharged, admitted or transferred within four hours of arrival in the ED. Between July 2014 and August 2015 an average of 89% of patients were admitted transferred or discharged within four hours.

The number of patients waiting between four and 12 hours for a decision to admit was similar to the England average between April 2014 and April 2015 except for a peak in August 2014.

Between November 2014 and March 2015 there were 2134 occasions when ambulance handovers took longer than 30 minutes. This placed the trust in the highest quarter for ambulance handover delays in England.

The department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment. There were a number of actions to try to limit this, such as the rapid assessment and treatment model, liaison with the local ambulance service to provide assistance and regular hospital bed management meetings. Patients were able to see how long they could expect to spend in the department on screens in the waiting area.

Children were catered for in a designated area seven day a week between 10am and 2am. Translation was available for patients whose first language was not English. Sign language was also available. Patients living with dementia were catered for with dementia friendly rooms and staff trained as 'dementia champions'. Staff were 'champions' for dementia and safeguarding which enabled them to offer support to these patients in particular.

We saw evidence that learning took place from complaints and this was shared with staff at regular meetings.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people.
- Children up to the age of 16 years were seen in the paediatric area of the ED. The environment was more appropriate for children than in the main ED with murals on the walls and toys to play with. This part of the ED was open between 10am and 2am Monday to Friday with plans to increase the hours to weekends in December 2015. Outside of these hours children were seen in the main ED. There were no separate areas for young people.
- Play specialists were employed to assist children visiting the ED
- The main reception area was glass fronted which enabled the staff to observe patients in the waiting area.
- A review of the department by a local Healthwatch team in July 2015 highlighted that waiting times were not routinely displayed. Following this ED staff took action and at the time of our inspection average waiting time, number of patients in the department and expected length of stay in the department were all displayed on screen for the ED. In addition this information displayed wait times for attendance at the UCC at Burnley General Hospital and the minor injury unit in Accrington.
- Information leaflets for patients about health and injury problems such as knee injury, head injury, shoulder impingement, and chest injury were given to patients prior to discharge. These were written in English but details were provided in Urdu and Polish, should leaflets be required in these languages.
- Staff said they had used the translation service that was available via a telephone service called 'language line' which helped them communicate with patients. The hospital switchboard also kept details of staff who spoke different languages to assist if required.
- Staff demonstrated an understanding of the need to recognise the cultural, social and religious needs of individual patients. One staff member spoke a range of Asian languages. This was useful given that 44% of the local population were from a non-white ethnic minority background.
- Two patients reported that car parking was difficult.

Meeting people's individual needs

- Areas of the ED were accessible for those using wheelchairs. These areas included the toilets, and spacious rooms which could facilitate hoists if necessary.
- Staff were familiar with 'health passports' a document that captures patient care needs, particularly if patients are not able to verbalise their needs.
- The ED had areas designed to meet the needs of patients living with dementia. This included a triage room which had coloured walls and images of the sky showing on ceiling tiles to enhance perception. Two dementia 'champions' were employed who had specialist knowledge of dementia and could assist colleagues if required.
- Staff used the 'butterfly scheme' to identify patients with dementia or patients with memory problems.
- Staff had access to sign language translation via an assigned staff member.
- Dogs assisting people with sight problems were allowed in the department.
- Children and adolescents requiring mental health services (CAMHS) were provided for in the paediatric area. Clinical staff told us that CAMHS were usually provided for children and young people on the following working day after admission to the ED.
- Staff explained that children with learning disabilities or complex needs often had direct access to the children's ward and therefore did not present very often in the ED. However, on occasions when these children did arrive in the ED staff could liaise with the paediatric team so they could usually transfer them quickly to a ward where staff were aware of their medical history.
- The trust had a shared protocol with the local mental health NHS trust in order to provide care for patients requiring a mental health assessment. The protocol focused on the benefits of shared working for patients which included ensuring they were seen and assessed in a timely manner. It also covered training requirements and flow charts.
- Mental Health patients were able to wait for care or treatment in a designated room. Staff used signage to identity when there was an adult with mental health requirements in the ED. The signage helped staff to identify and raise their awareness that someone with mental health needs was present.
- There were a range of lead nurses to ensure patients with dementia and safeguarding needs were properly supported whilst visiting the department.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients

within four hours of arrival. The last inspection highlighted that the trust was struggling to meet this target and this remained the case. Between July 2014 and August 2015 an average of 89% of patients were admitted transferred or discharged within four hours.

- The number of patients waiting between four and 12 hours for a decision to admit was similar to the England average between April 2014 and April 2015 except for a peak in August 2014.
- Between November 2014 and March 2015 there were 2134 occasions when ambulance handovers took longer than 30 minutes. The department met the Department of Health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.
- The department predicted how many patients would attend the ED based on activity the previous week. A table was used to present the minimum, average and maximum numbers expected.
- The rapid assessment and treatment (RAT) model to triage patients arriving in the ED assisted with flow by ensuring actions to care or treat the patient commenced as soon as possible. The RAT team consisted of a senior nurse, a consultant as and when required, and two less senior staff. However, the review completed by the Emergency Care Intensive Support Team (ECIST) recommended that the trust formalise the availability of the consultant (or a doctor) rather than providing this as and when required. The Royal College of Physicians states that early senior review in EDs could improve diagnosis, patient outcome and relieve pressure within an ED which would support the ECIST recommendation.
- Bed meetings were held every three hours and we observed one of these taking place. Information was provided about ED attendances. Staff from other areas of the hospital discussed bed availability and patients awaiting assessment or discharge. Patients awaiting a bed were prioritised by early warning score. The meeting was chaired by the deputy director of operations.
- The department employed advanced nurse practitioners and emergency nurse practitioners to provide assessment and care for patients. This increased the skill mix of staff.
- Clinical staff knew how many patients they could accommodate in the department. Given that there were beds available for 23 patients; we were told that 25 patients in the department caused pressure and that if this rose to 35 the department was considered to be under extreme pressure.
- Staff were able to tell us what they did when the department came close to reaching capacity. Actions included escalation to bed management, identifying patients suitable for discharge and organising transport for patients to go home.
- The trust funded one ambulance used to transfer or discharge patients.
- Clinical staff working within the paediatric area of the ED told us that links had been improved with the main ED through team building and improving systems over the last year.
- To improve flow through the department, some patients could be referred to an observation area. These patients included those awaiting social assessment or physiotherapy, those requiring analgesia or those with certain head injuries.
- A screen was visible to all staff detailing capacity within the department. This included the number of patients within the ED, how many were awaiting triage review by a doctor or admission; how many bed requests had been made and how many arrivals had occurred within the last hour.
- There was no assigned area solely for ED patients who needed to undergo a period of observation or await test results (often called a clinical decision unit). The Emergency Care Intensive Support Team (ECIST) recommended that this be considered given that these areas 'contribute to patient safety, are highly efficient in terms of providing short term and ambulatory care, reduce admissions, and have been shown to improve crowding'. In the meantime, staff could refer patients to the Ambulatory Care Unit (ACU)or Acute Medical Unit (AMU). The ACU accommodated patients not requiring admission but for short term clinical supervision. Referrals were accepted from within the hospital or via a GP or other designated healthcare professional. The AMU accommodated patients requiring admission for a short period of time (2-3 days). Two weeks before our inspection the trust doubled the number of beds in the AMU from 40 to 82 which consisted of 62 acute medical beds and 20 fast flow. Following the planned reconfiguration, 6 bed were decommissioned.
- The ED had an escalation policy which used triggers such as numbers of patients in the waiting area to

initiate actions. Senior ED staff were in the process of improving the escalation plan which would use a traffic light system to rank the level at which the trust was operating in terms of bed capacity.
- We asked 11 patients how long they had been waiting. All of them waited less than 2 hours. One patient told us the waiting time had improved and was better than it used to be.

Learning from complaints and concerns

- Staff were knowledgeable about how to advise patients and relatives about the complaints process.
- Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. Where possible complaints were dealt with at the time they occurred. Within the last 8 months the trust had introduced a scheme whereby senior staff were bleeped to attend to people wishing to make a complaint. This enabled them to deal with the matter at the time if possible.
- Complaints and compliments were shared in weekly 'share to care' meetings. The meetings were attended by a range of staff, ensuring awareness of developing trends.
- Out of nine patients, seven were able to tell us how they would make a complaint if necessary.
- The department welcomed patients back to tell their stories about the care they had received. Senior staff met these patients, took action and shared information with staff to ensure learning took place.

Are urgent and emergency services well-led?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of leadership.

Staff were clear about the organisation's vision and values. Monthly governance meetings were held and attended by staff including clinical directors, consultants, doctors, and matrons. Minutes were available for all staff. Items covered a range of issues such as updates, complaints and training information. Weekly meetings were held in the ED for all staff. There was a clear structure in place for managing investigations under the 'harm free care' strategy. Quality was measured with monthly audits. Risk to staff was managed, for example by the use of security guards and panic buttons.

Leaders were approachable, staff felt supported and part of an open culture. Public and staff engagement took place to drive a better service and improve wellbeing. For example, patient experience information was gained through forums, questionnaires and meetings with patients. Staff were encouraged to feedback to senior management based on teaching and rota development. Newsletters were published for staff and the Chief Executive communicated with staff to thank them for hard work.

Vision and strategy for this service

- We saw the trust's vision and values were visible in the areas we visited.
- Junior doctors told us senior managers regularly approached them for their views on how to improve services and that action was taken to do this when appropriate.
- Staff were positive about the changes that had occurred since the last inspection. They were positive about the inspection and engaged in the trust wide approach to improvement.

Governance, risk management and quality measurement

- Monthly governance meetings were held by the department. We reviewed the minutes for June 2015 which covered elements such as trauma, audit and medicine updates as well as incidents, complaints and training. Staff were invited to attend or accessed minutes and relevant action plans on line.
- Weekly 'share to care' meetings were held by the ED Matron. A range of topics were discussed including incidents, risks, complaints, clinical pathways and outstanding issues. In the meeting we observed infection control, the administration of medicines and information relating to equipment was discussed. Minutes of these meetings were also available on line.
- The trust's 'Harm free care' strategy had been implemented 12 months ago. This gave a structured approach to handling serious incidents such as completing rapid reviews, referral to a panel, notifying governance and sharing learning.

- Other risk management initiatives included the introduction of 'Safer Thursdays' and monthly safety audits.
- Security guards were employed 24 hours a day 7 days a week. These staff were trained in physical and clinical restraint and patrolled the ED, with the aim of providing a safe, secure environment for patients and staff. The staff told us that incidents requiring the intervention of security guards were recorded.

Leadership of service

- Key leaders in service were a matron, a clinical director (ED consultant) and a business manager. These leaders worked within the Integrated Care Division which was led by the divisional director (a consultant), an deputy chief nurse and a deputy director of operations.
- Staff felt that line managers and senior management were approachable, listened and took action when required.
- Junior doctors told us that trust leaders regularly approached them to seek their ideas for improving services. For example, they had input in reviewing rotas for future cohorts. They also felt heard by leaders. For example, following confusion about who to request via the bleep system managers responded within hours, providing an explanation.

Culture within the service

- Staff felt supported in their roles.
- Junior doctors reported a culture whereby feedback drove the improvement of services and feedback was a compulsory part of learning sessions for this reason.
- Junior doctors described 'a culture of engagement' between managers and staff. They told us they were welcomed and were generally given ownership in solving problems. Although junior doctors reported to us they were happy at work, they found that inflexible rotas and pre-allocated leave caused an imbalance between work and home life. Despite raising this, they felt this issue was repeatedly ignored by the trust.
- Staff explained they felt able to raise concerns which would be taken seriously. For example, one nurse had cited a lack of support for new starters which led to the development of a preceptorship programme which was in use.
- Junior doctors described feeling that following a period of low morale staff had worked together to improve services.

Public engagement

- The trust business plan 2015/2016 highlighted key areas for engaging with the public. These included conducting focus groups, working with Healthwatch and encouraging patients, family and friends to complete questionnaires about their experience of the service.

Staff engagement

- Staff had the opportunity to discuss concerns or queries in daily meetings.
- Junior doctors told us that the trust was keen on sourcing feedback and this was compulsory following learning sessions.
- Staff spoke highly of the chief executive and told us they were visible and communicated with staff via a blog. Staff received thanks from the chief executive for work which was undertaken.
- Other initiatives such as junior doctor forums and trainee pizza nights also helped engage with staff.
- A newsletter was published for staff which included updates on work and upcoming awards nominations.

Innovation, improvement and sustainability

- The ED was one of the busiest departments in terms of the number of ambulance arrivals in the country. Figures showed it received 30% more ambulances than the next busiest trust in the local area. In July 2015 the department was receiving requests from other EDs to come and see how the department coped with the level of ambulance arrivals.

Medical care (including older people's care)

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

Information about the service

We visited Royal Blackburn Hospital as part of our announced inspection on 19 and 20 October 2015. The medical care services at the hospital provided care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology.

During the inspection we visited AMU (a) and AMU (b) (acute medical units); wards B2 (stroke ward); B4 (medicine for older people); B18 (Cardiology); C1 (general medicine); C2 (Gastroenterology); C4 (Gastroenterology); C5 (Medicine for older people); C8 (respiratory); C11 (Medicine for older people); D1(Endocrine); D3 (Endocrine); the Coronary care , ambulatory care and the endoscopy units.

We reviewed the environment and staffing levels and looked at 24 care records and 10 prescription charts. We spoke with two family members, 13 patients and 43 staff of different grades, including nurses, doctors, ward managers, matrons, domestic assistants, a ward clerk, agency nurses, safeguarding team members and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

At the last inspection areas were identified for improvement and an action plan was developed to address these. At this inspection a number of initiatives had improved patient care, staff involvement and the openness of the culture within the hospital. The mortality rates had improved and were now within expected limits.

Two weeks prior to this inspection some wards had moved to another area with the expansion of the acute medical unit. Despite this, ward areas were clean, tidy and well organised. It was too early following this move to see any of the expected improvements. Staff were involved in learning from incidents, complaints and results of audits. There were good infection control measures and patients commented favourably on the cleanliness of the wards. Staff were caring, kind and respectful to patients and involved them in their own care. Improvements had been made in the monitoring of patients to identify if their condition was deteriorating which included revised systems for obtaining prompt medical assistance.

Some improvements were required with regard to the management of records and medicines. There was a shortage of nursing staff and a reliance on agency staff although nurses had been recruited they were not yet in post. The results from data collected as part of national audits into the outcomes for patients with some clinical conditions showed the hospital was performing worse than the National average. Work was ongoing to

Medical care (including older people's care)

improve these outcomes however this was not completed at the time of the inspection. The training and development of staff was below the trust's target for nurses within the medical services.

Are medical care services safe?

Requires improvement

Summary

This inspection has resulted in no change of the rating of requires improvement in terms of protecting people from harm.

Medicines were securely stored however not all records for medicine prescribing, administration and storage were accurate or clear. Some aspects of record keeping resulted in a lack of clarity, accessibility and security of information. Not all staff had completed up to date training in the protection of vulnerable adults and there was a lack of clarity regarding the safe use of security guards to provide one to one observation of patients. Staff were not up to date with their mandatory training on most wards. There was a shortage of nursing staff on most of the medical care wards with a high use of bank and agency staff and a high percentage of nursing day shifts remaining unfilled. Plans were in place for the recruitment of new staff. Staff were not aware of their role should a major incident occur.

There were good systems in place and an open culture for staff to report incidents. The outcomes of investigations and learnings were shared and when necessary practices were changed. There were good infection control measures in place and where shortfalls were identified action plans for improvement were present. Some of the wards had moved to another area two weeks prior to the inspection. Despite this they were clean, tidy and well organised. Equipment was checked within expected timescales. Staff were aware of their responsibilities to protect patients in their care and there were systems in place to do this. Systems were present to identify patients whose condition was deteriorating and obtain medical assistance quickly.

Incidents

- From May 2014 to April 2015, 37 serious incidents were reported, the majority being slips, trips and falls. Nine were due to suboptimal care of the deteriorating patient. The introduction of the new acute medical unit meant increased observation of patients should be possible which should reduce this risk.

Medical care (including older people's care)

- At the last inspection 40% of incidents were pressure ulcers grade 3 or 4. At this inspection this had reduced to 7%.
- The largest number of incidents in the medical services occurred in the acute medical unit, urgent care centre and emergency department with the second highest being in older people's care, rehabilitation and stroke care.
- The highest numbers of incidents, at 24% of the total, in the 12 months from July 2014 to August 2015 were due to slips, trips and falls. Measures to reduce these incidents included the use of one to one care for patients identified as at high risk and a falls collaborative which had recently been formed. This group would investigate further measures to reduce falls including the use of technological advances to alert staff to patients at risk.
- Learning from incidents was discussed at the weekly "share to care" meetings which were held on each clinical area and ward. These were multi-disciplinary and described as an open forum with a clear no blame culture where incidents and changes as a result were discussed.
- On some medical wards the root cause analysis of incidents was available for staff to read and discuss as a way of sharing incidents and outcomes.
- Practices were changed as a result of incidents and the impact of these changes was monitored. On one ward with a high number of patient falls the positioning of staff throughout the day had been changed so that increased observation could be maintained. This had reduced the number of falls in a 12 month period from 92 to 20.
- Safety huddles were used to discuss any incidents which may require immediate dissemination of information. One example was when a specific type of glove had not provided the level of protection required and this was immediately shared through the huddle system.
- Junior doctors told us they were actively encouraged to report incidents by the medical director although there were other senior doctors who discouraged this practice due to the record keeping involved. This meant they were not receiving a clear message about incident reporting.
- If an incident was reported as a moderate outcome or above a rapid review took place within 48 hours. Staff who reported the incident were involved in the investigation and feedback was given during team meetings with open discussion encouraged.
- Doctors were aware of the duty of candour regulations and their resulting responsibilities. Examples were given of where this had been adhered to.
- A specific prompt for duty of candour had been introduced as part of the incident reporting. Support was offered by senior managers to those clinical staff who were unfamiliar with the duty of candour regulations.

Safety thermometer

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- The safety thermometer reflected the fall in pressure ulcers and falls.
- There were a low number of catheter urinary tract infections during the period June 2014 to June 2015.
- Information from the safety thermometer such as the number of falls within a month was displayed on the entrance to every ward. Staff told us this information was used to monitor the quality of care given and was the focus for discussions on how improvements could be made.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Patients commented favourably on the cleanliness of the medical wards.
- Between April 2014 and March 2015, there were no cases of MRSA in the medical services however there were five cases of Clostridium Difficile.
- Staff were aware of the infection control precautions to take should this be present.
- Staff on most wards used personal protective equipment appropriately. On one ward we saw staff wearing the same aprons when assisting more than one patient with personal care and carrying used linen through the ward area.

- Infection control audits such as commode cleanliness were completed on each medical ward. The results were reviewed as part of the infection control governance report and an action plan was then agreed if any ward was not meeting the required standard. On one ward the manager had an action plan for commode cleaning due to a score of 94% on the previous audit.
- Hand hygiene audits were completed and the results displayed. In July 2015 only 50% of medical wards were meeting the trust's target. We saw staff members washing their hands between assisting patients and using the hand gel.
- 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 to make staff aware of the additional precautions they must take when entering and leaving. These rooms were also used to protect patients with low immunity.

Environment and equipment

- Two weeks prior to this inspection several of the medical wards had been moved around to accommodate the opening of a new expanded acute medical unit (AMU). This meant for some staff the environment and equipment were not familiar. Despite this the areas were clean, tidy and well organised.
- 18 of the 42 beds on the acute medical unit (A) were single occupancy rooms. This provided accommodation for people admitted with infections or those who required end of life care and were too unwell to move. We were told the lack of single occupancy rooms on the wards meant some of these patients remained on AMU for longer than necessary.
- On one of the wards for the care of older adults the environment had been specially designed to assist with orientation and provide a calming effect. This included the use of various colours on the walls and lighting to enhance a calm mood, murals on the walls and various areas for relaxation.
- Resuscitation equipment had been checked daily with a complete weekly check in line with the trust's policy.
- Equipment such as that used for moving and handling patients had been checked and maintained at the correct intervals and electrical equipment had been checked and labelled.
- Some equipment such as that for a specific type of cardiac monitoring was due for renewal and the current out of date equipment meant some patients waited for more detailed cardiac monitoring. . Staff in the unit had reported this but were unaware of plans for replacement.

Medicines

- Medicines on the wards and departments were stored securely.
- On the acute medical unit there were two books in which the stock and administration of controlled drugs were recorded. One was for medicines brought to the unit by a patient and the other for those provided by the hospital. These records were inaccurate. For example in one book it was recorded a patient had left the hospital and taken their medicines but in the other they remained in stock. This meant the audit trail of controlled medicines brought in by patients was unclear. This was discussed with the person in charge who confirmed that the process would be changed to make it safe and records clear.
- Some records in the controlled drug book had been crossed through making the record unclear. These corrections were not signed or dated therefore it was not possible to clarify why they were present, the person responsible or the resulting actions. This issue was brought to the attention of the person in charge who stated they would investigate the issue and make sure all staff were following the correct procedure.
- On the medication records we saw oxygen had not been prescribed even when a person had this administered. This meant there was no record of the prescription of the oxygen from the relevant authorised prescriber. This was recorded on the medical division risk register.
- Where medicines had been changed on the administration record the changes had not always been signed and dated. This meant there was no record they had been changed by a person authorised to do so or the change was up to date.
- Staff received medicines management training as part of their induction and were asked to read the trust policy on medicine management. The trust informed us that online training was then available for all registered staff, completion of which was required every 2 years. However staff were not aware of the requirement. There was further training or assessment of competency if a

specific staff member's practice indicated this was required. This meant staff could administer medicines without their competence to do so safely being monitored.
- Fridge temperatures were monitored and recorded. However the record stated it should be "below 5" (degrees) and it was recorded as 5 with no clarity as to whether action needed to be taken.
- Up to date policies for the safe management of medicines and relevant guidelines such as the Nursing and Midwifery Council were present on the wards and units.

Records

- Recent changes to nurse record keeping included electronic risk assessments for malnutrition, the use of bed rails, risk of falls and developing a pressure ulcer. In the records we saw these had been completed.
- On some wards staff used the computers to view and complete the risk assessments. On others they printed them and put them in the person's file. The printed versions were faint and it was not clear what the outcome of the risk assessment was.
- Nursing records had been completed including the necessary clinical observations dependent on the patients' condition.
- The health care assistants did not have access to the computerised patient records which meant the paper copies were required for them to deliver the care included in each patient's individual plan.
- Agency qualified nurses did not have a password for access to the computer records. They had used another nurses' password to gain access. This compromised the security of the system; however they could not complete the records of the care they had delivered in any other way.
- On one ward confidential patient information was visible to anyone entering the ward. The computer screen which displayed patient records was located at the entrance to the ward with information displayed whilst the screen was unattended.
- We found one instance where a patient's notes had not moved with the patient when they were accommodated on another ward. This meant the information which staff required about that patient's medical condition and needs was not available to them.

Safeguarding

- Staff were aware of their responsibilities to protect patients in their care. They knew how to report any concerns including out of hours.
- There were now 150 safeguarding champions throughout the trust. They supported staff and patients through the safeguarding system and since their development the number of alerts had increased.
- On 50% of the medical wards staff training in the safeguarding of vulnerable adults was below the trusts' target of 80%. The safeguarding lead for the trust was aware there were staff who required training and a plan was in place to improve attendance at the training provided.
- The development of care pathways to reduce the incidence of pressure ulcers had taken place through the pressure ulcer collaborative. On one medical ward there had been no grade 3 pressure ulcers since August 2014.
- One of the methods to protect patients from harm as a result of falls was the use of one to one care. On the wards for older people they used their own staff for this, requiring additional staff in order to provide the care. However on other wards we saw security guards were used to observe patients. They did not provide any care. Staff, including managers, were unable to confirm what training they had received. We were told an audit of the use and quality of this one to one provision was underway.

Mandatory training

- In14 of the 19 wards in the medical services staff were below the trust's target for completion of mandatory training. This training included health and safety, fire, manual handling, safeguarding and infection and prevention.
- In three wards only 57% of staff or below had completed the necessary training. This meant not all staff were up to date with training required for their role.
- Training in the care and support of patients living with dementia was part of the mandatory training in the trust. This included the medical staff who undertook the "virtual dementia tour" which gave them the opportunity to feel how dementia may affect the senses of a person.
- Doctors received "good support" from their clinical supervisors and an educational package for junior doctors included assessments of competence in core procedures such as cannulation.

- Staff spoke of the "learning hub" which was a resource for training and development on the trusts' intranet. This could be used to book training courses, access electronic learning and materials supporting the nurses' revalidation process.

Assessing and responding to patient risk

- Early warning scores (EWS) were used to identify if a person's condition was deteriorating. A clinical response team was contacted if a patient's score indicated their condition was deteriorating and a doctor would visit the ward and review the patient. Nursing staff reported this response was always without delay including at weekends.
- In the records we saw the EWS had been completed and reviewed as appropriate. Where a patient's score showed their condition was deteriorating the appropriate actions had been taken.
- All patients were seen hourly by a staff member in order that their condition and any needs they may have could be assessed (intentional rounding). Staff said they would escalate any concerns they had about a patient immediately at this time.
- From July 2014 to August 2015 slips, trips and falls were the highest cause of incident in the medicine division. All staff we spoke with were aware of this.
- An initiative to reduce the number of falls amongst patients had been developed through the falls prevention steering group. Actions such as non-slip socks and staff present in the ward bays at all times had been introduced and their success evaluated via this group. Whilst the actions had reduced falls with harm there was recognition that more work was required to make further improvements.
- When patients were admitted to a ward their needs and risks were assessed to ensure the necessary care was implemented. This included risk assessments for malnutrition, development of pressure ulcers, falls and the development of venous thrombo-embolism.
- Risk assessments for the use of bed rails were present in the records we saw. Where these had been completed the reason for the bed rail being in use was not always clear. One example was a tick by the point "patient would benefit" whilst "agitated" and "normal sleep pattern disturbed" were also ticked. There was no record of whether the patient would try to climb out of bed due to the agitation or why bed rails would be safe for this patient.

Nursing staffing

- Information provided by the trust showed that in the most challenging month which was April 2015 there were 1673 nursing shifts which needed to be filled with bank and agency staff in the integrated care group of which medical care was a part. Of these shifts 35% were covered by bank nurses, 27.5% were covered by agency nurses and 37.5% were unfilled. Information for July 2015 showed this had improved with the ward with most unfilled shifts averaging 29.84% for the month. This meant some wards were operating with nurse numbers below those required.
- Some areas of medical care had high vacancy and sickness rates of nursing staff. Gastroenterology was particularly affected with 24.4% vacancy rate and 13.4% absence. There was a high use of agency staff on these wards prior to new staff coming into post early in 2016.
- There had been six groups of newly qualified staff introduced to the trust with 56 having started in April 2015 and 63 in September 2015. Nurses saw this as a very positive move for the trust in introducing staff with new ideas onto their wards.
- Nurses were aware that a new cohort of nurses from overseas was due to start work in February 2016. They were looking forward to this increase in the nurses at the trust as they told us band 5 posts in particular were vacant.
- There were systems in place to assess the staffing needs of the medical wards several times during the day. This included a trust wide telephone conference at 9am with all divisions to discuss any nurse staffing issues. The movement of staff between wards and departments would then be discussed to ensure staffing was adequate to meet the needs of the patients.
- At 3pm each day the ward manager and the matrons met to discuss any gaps in staffing and agree how these would be met by using staff from other wards if necessary.
- NICE guidance was used to indicate red flag events which signalled an increase in staff numbers was required due to specific activity on a ward.
- A monthly report was completed which highlighted any staffing issues which had significant impact on providing patient care. This was then used in future planning.
- Average monthly use of agency nursing staff from April 2014 to March 2015 varied between the wards. The highest use was on a medicine for older people ward at

8.9% with the lowest on a respiratory ward at 0.2%. Less agency staff were used on wards with clinical specialities for which staff should have completed additional training.

- Agency staff we spoke with had been working on the same wards for several weeks and months which meant they were able to provide consistent care. They had received a thorough induction and felt part of the team.
- On the acute medical unit following the recent reconfiguration there were 15 nurse staff vacancies. Managers were aware and recruitment was underway. At present one area of the unit was not fully functioning therefore staff were redeployed throughout the unit. Agency staff were also being used, however because of the very recent move figures were not available.
- On the wards we visited most of the boards which displayed the staff numbers showed a shortfall in nurse staff numbers present. For example on the acute medical unit for the night there should have been nine qualified staff and there were eight. On a speciality medical ward there were four qualified nurses below the required number over a 24 hour period during the inspection. Managers and nurses said where possible these shortfalls were filled by staff working extra shifts or the use of bank and agency staff.
- Where additional staff could not be obtained an incident form was completed and concerns were escalated. One nurse told us they usually received feedback on their next shift about how the issues would be resolved.
- Handover of information from one shift to another was done between the qualified nursing staff. Whilst this information was then passed to the healthcare assistants on that shift we saw on one ward they had started to deliver care to the patients prior to getting any information about their current condition. This meant they may not be aware of their current care needs or those of patients newly admitted to the ward.

Medical staffing

- The number of junior doctors in the medical services at this trust was 32% of the total medical staffing. This compares to the England average of 22%.
- Some doctors were concerned that the medical cover on the newly appointed acute medical units was not adequate. The previous weekend there had been one junior doctor for the 40 patients on one of the acute medical units. This had been escalated to the medical director.
- On the acute medical unit four consultants were present in the morning and completed ward rounds from 8am to 12pm daily. There were additional ward rounds at 3pm and 10.30pm to ensure all patients admitted during the day were reviewed.
- Two consultants were present on this acute unit 1pm to 10.30pm with a junior doctor and physician on call overnight. This meant all patients received a clinical review every day.
- Nursing staff on all wards reported that they could access medical assistance quickly when required, including out of hours.
- Locum doctors were used when there were medical staff shortages. This ranged between the specialities with the highest being Cardiology consultants at 15.7% and the lowest Gastroenterology at 0.6%.
- Where locums were used they had been on the same ward for "several months" which provided continuity of care and more inclusion in team working.
- Less experienced doctors on medical wards were well supported by senior doctors, including out of hours.
- Medical handovers took place on all wards and included medical staff of all grades. When appropriate for the ward speciality these were multi-disciplinary for example they included the specialist nurse for that area.

Major incident awareness and training

- Some staff had completed major incident training 18 months previously whilst others had completed none and were not aware of the procedure they should follow. This represented a risk that not all staff would respond appropriately in the event of a major incident. The major incident policy was available for staff.
- Staff we spoke with were concerned about the escalation process when the hospital was at its busiest in the winter months. This was due to both lack of capacity and staff numbers. One ward was currently closed and some staff were aware this was to be used as an escalation ward, whilst others were not. Due to the very recent ward moves the escalation policy was being reviewed at the time of this inspection.
- Staff who would move between the wards to fill staffing gaps during the busy winter period had been identified.

Medical care (including older people's care)

Managers told us when they were moved their own ward was filled with an agency staff member which meant agency staff were not working together on the escalation ward.

Are medical care services effective?

Good

Summary

This inspection has resulted in a change of the rating from requires improvement to good in terms of being effective.

There was active participation in clinical and quality audits. Staff were aware of the audits on-going in their area and resulting action plans where applicable. There was a good understanding of the mental capacity act and deprivation of liberty safeguards with clearly documented decision making, plans of care and reviews. The multi-disciplinary working was inclusive of all health and social care practitioners and aided the patients' recovery and safe discharge. Patients had their pain levels assessed and managed. Patients were complimentary about the food provided and where necessary there was support for patients from a dietician.

The outcomes for patients with myocardial ischeamia and heart failure were better or the same as other trusts in the North West. However compared with the England average they were significantly worse for stroke and diabetes. Action plans were in place to improve those outcomes which were worse for patients. Half of the nursing staff were not up to date with an appraisal of their performance. There was insufficient input from the speech and language therapist for patients who had suffered a stroke.

Evidence-based care and treatment

- The review of guidelines in the medical care division to ensure they were meeting the latest NICE guidance was monitored by the patient safety and governance committee. At the meeting in July 2015 there were 9 outstanding NICE Guidance responses as of 13/04/2015. These ranged between 76-231 days overdue. This meant whilst most guidelines were in line with NICE guidance, some were not.
- On a care of older peoples ward audits were completed by doctors and nurses working together. These included management of catheters and urinary tract infections, use of cognitive assessments, antibiotic prescribing trends and administration of insulin. These audits were repeated with each rotation of new doctors to the ward and the results compared to those previously. Improvements could be seen and awareness of the correct procedures to follow had increased.
- The trust was participating in the relevant advancing quality audits. Where the scores did not meet the targets in heart failure and COPD (chronic obstructive pulmonary disease) action plans for improvement had been developed.
- On some wards staff were informed of the results of audits and any resulting actions as part of their safety huddle.
- A care pathway for naso-gastric nutrition had been developed by the nutrition steering group. This was based on best practice guidance and gave staff clear direction for the care of such patients.

Pain relief

- Patients told us they had received pain relief promptly if they had requested it.
- Nursing staff assisted patients to manage their pain. We heard nursing staff asking patients if they had any pain and then offering prescribed pain relief.
- Pain scores were recorded on the early warning score documents.

Nutrition and hydration

- Patients said the food was good and described it as warm and tasty. Some who had been in the hospital previously said it had improved.
- They had a menu with a choice of foods available which included special diets such as gluten free and texture modified foods. Cultural and religious needs such as halal were offered at every meal time.
- When a person had been assessed by a speech and language therapist the outcome of that assessment was easily accessible to staff being kept in the person's bed area. This meant staff could quickly check what food and drink a person could have.
- When a person was not allowed anything to eat or drink (nil by mouth) there was clear signage on the bedside table and above the person's bed.

- The records we saw for a person's fluid intake and output had been completed. However those for food intake had not been fully completed on every ward.
- Speech and language therapists (SALT) were only present three mornings per week on the ward for people who had suffered a stroke and we were told recently their time on this ward had been reduced. This meant patients whose swallow reflex may be impaired were not receiving sufficient assessment and review by this specialist.
- Referrals to a dietician were made for people at risk of malnutrition. The resulting assessments and care plans were easily accessible in the care records and had been reviewed.
- The dietetics team had developed their practices and were working to improve the service they provided. This included developing the provision of snack boxes for patients at risk of malnutrition, providing teaching sessions to the medical staff and the development of a dietetic celiac clinic.
- There was a chef to develop meals for patients with specific dietary needs. This included texture modified foods and fortified diets.
- When required, staff assisted patients to enjoy their meal. They helped the patient be in a comfortable position, washed their hands and encouraged them to eat and drink on a one to one basis.

Patient outcomes

- Mortality indicators for the trust were within the expected levels. The figures for mortality at weekends had improved and were within expected limits.
- Mortality and morbidity within the medical services was discussed at the monthly integrated care group divisional meetings. Information from this was then discussed at the monthly meetings of the mortality steering group where senior medical and nursing personnel were in attendance.
- Information provided by the trust as part of the Advancing Quality initiative showed in August 2015 they were meeting all of the targets for the care of patients with acute myocardial ischaemia.
- The SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service still needed to make improvements to the care and treatment of patients who had suffered a stroke. The latest audit results rated the hospital overall as a grade 'E' which is the lowest available score. This had remained unchanged since January 2014. The trust had put in place actions to improve the audit results. These included the recruitment of a stroke specialist nurse, a stroke pathway and the identification of multidisciplinary leads for stroke care.
- There were plans for the strategic development of the stroke care for local patients which had come from participation in the Lancashire and Cumbria stroke review. These included amalgamating current services to improve the quality of provision.
- The lack of speech and language input for patients following a stroke had contributed to the low score in the SSNAP data and was on the risk register. There were plans to increase the availability of this therapy in the near future as patients would currently not be assessed within 48 hours dependant on when they were admitted.
- The endoscopy unit was accredited by the Joint Advisory Group (JAG) on gastro intestinal endoscopy affiliated to the Royal College of Physicians. This meant they had met the required clinical, environmental and training standards.
- The trust was meeting seven of the eight measures in the heart failure audit. The performance against the target had improved from 50% being met in April 2015 to 89.7% in August 2015.
- The readmission rates were higher than the England average in elective medicine and the same as the England average in non-elective medicine.
- In the National Diabetes audit (September 2013) the trust scored worse than the England median for 12 out of 21 indicators. Improvements in diabetes care since this audit included daily consultant ward rounds for all diabetic patients, additional multi-disciplinary staff training and development of key senior roles for diabetes care and implementation of National guidelines.
- The recent changes to the acute medical unit were designed to increase the capacity of the unit therefore more patients could be treated and discharged from this unit. This would reduce the number of ward moves for people.

Competent staff

Medical care (including older people's care)

- 53% of the nursing staff in the medical services in the trust was up to date with their appraisal. This meant nearly half had not had the opportunity to discuss their performance and development within the agreed timescale.
- 86% of doctors in the trust had completed their annual appraisal.
- There was a 12 month preceptorship programme for newly qualified nursing staff. This included all areas of their work with supervision and mentorship to ensure they were supported within this time.
- In the endoscopy unit staff completed specialist training and had competence assessments completed.
- In areas where specialist medical diagnostic tests or treatment were provided staff with the relevant training and experience were employed.
- Staff with specialist training in a clinical area provided additional support and training to those in other areas such as respiratory nurses for staff in the Emergency Department.

Multidisciplinary working

- Discussions about each patient (board rounds) took place on the medical wards every morning. These were attended by the consultant, physiotherapist, occupational therapist, nurse and a member of the discharge team. This meant each person's condition and progress towards discharge was evaluated every day.
- A registered mental health nurse post had recently been introduced on the care of older people wards. They worked alongside the registered nurses to provide support and advice for patients with mental health issues and reduced mental capacity.
- Ward based therapists were working on some of the rehabilitation wards. They worked with specific patients to help them develop the skills they required to be safely discharged from the hospital. This included supporting them to be able to manage their own personal care, mobility and eating and drinking.
- The speech and language therapist and the dietician attended the care of older people's wards on a daily basis.
- A tissue viability nurse had assessed patients when required and recorded the outcome with a plan of care.
- In the records there were multi-disciplinary notes which contained a coloured sticker to denote which therapist had seen the patient. This meant at a glance specific information could be identified.
- Directorate meetings took place which included staff from all disciplines of various grades. Nursing staff described these as instrumental in the changes which had taken place within the organisation.
- Monthly meetings within the older people's wards included human resources to discuss the staffing vacancies and sickness. Plans for management of this resulted from these meetings.
- Ward managers had regular contact with managers on the other sites in the trust. This consisted of regular telephone contact and monthly directorate meetings.

Seven-day services

- Consultants were present on the wards on a daily basis. During the weekends their practice varied from a consultation with new patients only to seeing all patients under their care. Staff on all wards stated they could access senior medical input at the weekends should they need it.
- Pharmacy was open seven days per week. On Saturday and Sunday it was open 9am to 4pm.
- On the wards providing care for older people the physiotherapist and the occupational therapist provided therapy on the wards seven days per week.
- Patients on the stroke ward had occupational therapy five days per week only with no input on Saturdays or Sundays as the therapist on duty had to cover all of the wards.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- On the wards where records were stored on the computers not all staff who required access had the necessary security passwords.
- Policies and protocols were kept on the hospital's intranet and hard copies were available on the wards. This meant all staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and learning from incidents and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Staff had a good understanding of the Deprivation of Liberty Safeguards (DoLS) and when and how an application should be made. They reported good support from the safeguarding team and the trust lead for mental capacity and DoLS which included support resources and training materials on the wards.
- Staff had received training in the Mental Capacity Act as part of their induction.
- Medical and nursing staff understood when a mental capacity assessment should be done and how to make sure decisions were made in a person's best interests and involving others as required. Examples of appropriate inclusion of the patient's representatives were seen.
- Nursing records contained assessments of mental capacity and the resulting actions to be taken should a person lack capacity. This included input from specialists if required, for example the mental health team. These assessments were reviewed and up to date.
- Within the daily safety huddle staff discussed the mental health needs of a patient as part of their overall care. This included their safety and making relevant referrals to specialist services.
- Dementia link nurse roles had been developed and this role was open to all staff. They provided support to specific patients, carers and other staff on the wards when a patient living with dementia was admitted.
- We saw clear documentation of discussions with patients regarding their consent to treatment such as having a percutaneous endoscopic gastroscopy tube (PEG) fitted for feeding directly into the stomach. Patients were given clear options and their decisions were documented and respected. This consent included an assessment of the person's mental capacity to make that decision.

Are medical care services caring?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being caring.

Patients told us staff were kind, polite and friendly treating them with dignity and respect. The care was described as excellent and patients would recommend the hospital to their family and friends. Patients were involved in their care, could ask questions and felt staff including medical staff listened and took time to aid their understanding.

Emotional support was available for patients that included referral to specialist services and access to mental health nurses when required.

Compassionate care

- Nursing and medical staff were friendly, polite and kind. People said they were treated with respect and dignity. One patient told us they were treated as a person and not a number.
- One person said the care of their relative had been excellent and they couldn't fault anything. Another patient described staff as "great" saying "they would anything for you."
- We heard staff interacting with patients when providing assistance and support. However on two wards staff were talking to each other about employment issues whilst they were assisting people.
- People told us staff responded quickly when they rang their call bell.
- A four hour free therapeutic television service was available for patients living with dementia.
- In July 99% of patients who completed the Friends and Family test would recommend the medical services.

Understanding and involvement of patients and those close to them.

- Patients said they could ask any questions from the doctors and they clearly explained their care and treatment to them. One patient told us the doctor had explained in detail what was happening and why they needed the tests which had been done.
- Should patients wish to speak to a doctor they said their request was quickly responded to.
- Patients understood what was happening around their discharge from hospital or why they needed to remain in hospital.
- On one ward we saw senior nursing staff working with less experienced staff to help them understand the importance of assisting a person at their own pace.
- One patient who was ready for discharge had been given information leaflets about their condition and on-going care prior to discharge. They said they could ask questions and got prompt responses.

Medical care (including older people's care)

- On one ward visiting times had been extended as a result of listening to patients requests.

Emotional support

- Referrals were made to specialists who could provide additional emotional and social support for patients such as the drug and alcohol misuse nurses.
- Psychiatric nurses were available 24 hours per day through the mental health liaison team. They offered support and advice for patients with mental health needs.

Are medical care services responsive?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being responsive.

Two weeks prior to the inspection changes to the wards and departments had been made to assist in the flow of patients through the medical care wards. It was too early to evaluate the impact of these changes. Systems were in place to provide timely assessment of patients' needs for either transferring within the trust or discharge home with support. Strategies were in place to reduce the number of ward moves a patient experienced. The referral to treatment times met the recommended target in all specialities.

There were environmental changes to some wards to aid the orientation of people living with dementia. Staff knew what systems were in place to support patients with specific requirements. Systems were in place to reduce the number of complaints and manage them quickly to resolve the issues. Learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- Pathways for admission for teenage patients with complex needs had been developed. These were designed to avoid an admission through the emergency department, medical assessment unit and critical care for these patients who may have multiple admissions to the hospital.
- Actions to prevent future admissions for patients with multiple hospital stays were discussed at the daily safety huddle as part of their discharge plan.

Access and flow

- The development of the acute medical unit had increased the number of beds from 42 to 82 for patients admitted for medical assessment. These were provided on two separate units. The purpose of this unit was to reduce the number of unnecessary admissions to the medical wards by patients being treated and discharged directly from this unit. Patients could be admitted to this unit from the emergency department or directly from their GP or outpatient clinics.
- Patients who came to the unit were triaged by a qualified nurse and if they did not require a bed they may receive their treatment or diagnostic tests on the attached ambulatory unit. This meant inpatient beds were only used for those patients who required them.
- Consultants were present on this unit from 8am to 10.30pm which meant they could review patients and arrange discharges without delay.
- There was a rapid assessment team who would assess patients with a view to moving them from the medical assessment unit in a timely way to ensure the beds remained available for those patients who were unable to move to another ward or area.
- Systems were in place to facilitate timely safe discharge of patients from most wards. This included the integrated home support team who would assess patients to determine the level of support they would require to return home safely and the complex care manager who would involve other services such as social services at an appropriate time prior to discharge.
- There was a dedicated pharmacy team for the acute medical unit which could quickly provide medicines for discharge from the unit during the day. Out of hours a stock of medicines was available to aid rapid discharge.
- In the endoscopy unit there was a nurse led discharge pathway which meant the patient could be discharged when they were medically fit without waiting to see a doctor.
- The average length of stay was approximately 2 days shorter (better) than the average for all elective and similar to the average for all non-electives.
- Should a patient be accommodated in a ward which did not specialise in their own medical condition staff would ensure they were seen every day by their own

medical team. On most wards nursing staff reported there was no delay; however on others they said such patients could be "overlooked." This meant that in the main the treatment and discharge of these patients was not delayed.

- Staff in the cardiac catheterisation laboratory had won an internal trust award for reducing their waiting list from six months to zero. This meant patients could access this essential diagnostic test without delay.
- Patients were not discharged home after 10pm at night and staff said they made sure this was adhered to unless it was an emergency.
- Incident reports were completed for any patient moved between wards after 10pm. Between July 2014 and August 2015 there were 65 reported incidents of "inappropriate transfers" of which four were of patients being moved after 10pm. The majority of incidents were of missing or inaccurate handover information.
- Some patients were identified as not to be moved to the step down wards at the trusts' other site. This meant staff were clear if a patient should not be moved from the main site.
- There was a flow management team who identified throughout the day where the pressures for inpatient beds were and how these could be managed to aid the accommodation of patients.
- The referral to treatment times met the recommended time of within 18 weeks in all specialities.
- Referral to treatment was above (better than) the England average from April 2013 to April 2015**.**
- 2% of patients had moved wards four times or more between August 2014 and July 2015. 44% of patients had not moved wards during that time and the same amount had moved once. This showed the number of times a patient moved wards was not excessive for most patients.
- The majority of patients we spoke with had not experienced ward moves however one patient had been in one day and had moved three times including for an x-ray at 2am between one of the moves.

Meeting people's individual needs

- Should a person require a translation service there was a list of staff members who could speak specific languages if this was appropriate. Staff were aware of when it was not appropriate to use staff or a family member for translation.
- Should it not be appropriate to use a staff member for translation then a telephone service would be used.
- One person had been offered an interpreter however they declined as they said the doctors helped them to understand everything and listened when they explained their symptoms and concerns.
- There were no leaflets on display in languages other than English. Staff knew how to access written information in other languages should it be required.
- On the wards for the care of older people the physical environment had been adapted to be made more suitable for people with dementia. This included different wall colours to denote the various areas of the ward, information and pictures to help orientate people to their current environment and accessible signage including pictures.
- On one ward the relative of a patient with learning disabilities was included in their care and was accompanying the patient to diagnostic testing. This showed an understanding of how best to meet the individual needs of patients.

Learning from complaints and concerns

- The integrated care group of which the medical wards are a part had the most complaints in the year April 2014 to March 2015 with 43% of the total complaints.
- Should a patient raise a complaint the matron for that area was contacted in order that they could address the issues in the complaint immediately. Managers said this reduced the number of complaints which needed to be managed through the formal process.
- People told us they knew how to complain should they wish and written information about how to complain to the trust was present on the ward areas.
- Staff said learning from complaints was discussed as part of the safety huddle and at ward meetings.

Are medical care services well-led?

Good

Summary

This inspection has resulted in a change in the rating from requires improvement to good in terms of being well led.

Medical care (including older people's care)

Improvements had been made since the last inspection which included changes to the leadership of the service, staff engagement and the management of identified risks and subsequent improvements in practice. Risks were known by managers and mitigating actions were being taken and monitored. Action plans were in place to manage the nurse staff shortages and the poor outcomes in some audits such as that for stroke care; however it was too early in the implementation of these plans for documented assurance of positive outcomes to be available.

Staff were aware of the vision for immediate improvement in their clinical area. They also felt part of the wider trust, knowing the board members and seeing them in the hospital with direct access to senior managers should they want it. Staff talked of an open culture where they felt engaged and listened to. They spoke of significant positive changes in the past 12 months which had led to improved patient care and a better work environment. There was strong leadership in the service and opportunities for staff to develop.

Vision and strategy for this service

- Staff were aware that the vision for the medical services was to improve the outcomes for patients in light of the results of the national audit data and improve the patient flow through the acute medical unit and wards with the very recent ward moves.
- Most staff were aware of the wider vision of the trust and told us they felt there had been an investment in the staff as well as the work to improve the patient experience.

Governance, risk management and quality measurement

- The risks posed by the staffing were identified on the risk register and the recruitment and future plans in place to increase nursing staff numbers were being monitored on an ongoing basis.
- The poor results in clinical audits had been recognised however plans for improvement were in the early stages. These included the recruitment of specialist nurses, changes to the way data was gathered and proposed changes to service models. It was not possible at this inspection to assess the results of these changes.
- Monthly meetings were held within the specialities in the medical care group. These included respiratory, cardiology and gastroenterology. Senior doctors, nurses and managers from the speciality attended these meetings. Items discussed included complaints, updates on relevant NICE guidance, performance against national data and targets, issues such as staffing and developments for the clinical division. These meetings then fed into the monthly divisional integrated performance report where any actions for improvement were identified and reviewed.
- Ward managers were aware of the risks on the risk register for their specific area. They were involved in devising action plans and reviewing these risks regularly.
- An internal quality assessment programme had been instigated. This was a thorough assessment of all aspects of the service offered in each area. Wards were then rated as green, amber or red. If a ward was red they received assistance and guidance to make the necessary improvements prior to reassessment. Staff and ward managers told us this process was helpful in improving the quality of care provision and they saw the process as a positive one.
- There was a trust wide approach to reduce risks to patients which were identified through data collection. This included the development of the falls prevention steering group which had been set up in November 2014 with a remit to reduce the number of falls with harm by September 2015. Whilst there was recognition in this group that falls had been reduced there was also acknowledgment of more work to be done. Therefore the next stage had been agreed with the addition of interested staff in order to reduce falls further.

Leadership of service

- There was a newly formed management team for medicine services. The Deputy Chief nurse for the integrated care group had been in post for 12 months, the divisional director for six months and the group manager for six weeks. This team acknowledged that whilst many improvements had taken place there was more to do in order to embed them in practice and make further improvements in patient care.
- There was a band 7 leadership and development programme. Nurses at this level said they felt the trust had invested in them and they had benefitted from internal and external presentations to develop their leadership skills.

- There was a coaching network with opportunities to obtain coaching from individuals to assist with specific personal skills and development.
- The matrons who managed wards at more than one trust site organised their working so that they visited all sites they were responsible for on at least a weekly basis. Staff at the Royal Blackburn site said they saw their matrons regularly and could contact them should they need to do so.
- There was a monthly open forum with the director of nursing which the ward managers could attend. This was an informal meeting to discuss any issues and concerns or ideas they might have.
- There were monthly formal meetings for ward managers where learnings from complaints and incidents were discussed along with trust and clinical developments and changes.
- The meeting held for band 7 nurses was now run by two band 7 nurses and not a manager of a higher band. This had resulted in ownership of challenges on the wards and making the necessary changes.

Culture within the service

- Staff told us there was an open culture within the service and this had developed over the past 12 months. They knew who the trust board were, saw them around the hospital and could contact them if they wished to do so.
- Nursing staff of all grades said the culture was supportive with good working links across all disciplines.
- Staff told us they were proud to work at the hospital and this had not always been the case. They said in the past 12 months things had changed and now "heads were held high in the corridor again."

Public engagement

- There were boards on the wards which displayed the information of what patients said they would like as part of their feedback and what actions had been taken (You said We did). An example of how this feedback had been used was one ward where visiting times had been extended.
- There were displays on the wards which showed feedback from patients, relatives, visitors and other professionals regarding the care provided. These were titled "glimpses of brilliance" boards and we saw comments including "I have received two years of 1st class treatment" and "staff are a credit."

Staff engagement

- There were several ways for staff to openly share their ideas and views. These included the "speak out safely" campaign where staff could anonymously provide feedback on any issues they wished and they had their own department and ward meetings where they felt able to discuss any concerns they may have.
- We were told about staff guardians by some managers; however other staff on the wards were not aware of their role. These had been set up as a peer support where staff could speak in confidence to an appointed staff member, about any issue, in order to get informal support.
- Doctors spoke about being encouraged to be part of the quality improvements which were underway. This included junior doctors being encouraged to participate in the quality improvement committee.
- Nursing staff talked about the chief executive's blog which they could read to be kept up to date with the organisations developments.
- There was a monthly newsletter which kept staff informed about changes and developments within the trust.
- A closed "facebook" site was also used by staff to communicate between each other as a form of informal communication.
- Mechanisms for including and involving staff in moving the wards between areas had been in place including staff workshops. However both managers and nursing staff said there was room for improvement in this engagement with some involvement happening late in the process.
- Staff felt able to challenge decisions made by the managers and said they had been listened to. One example was boards with staff names and photographs displayed which not all staff wanted. The decision not to proceed was made democratically involving all staff.
- Meetings for consultants from the various clinical areas were being re-instated in order that they could discuss issues at their level and agree the necessary changes.

Innovation, improvement and sustainability

Medical care (including older people's care)

- Ward managers told us they had a named financial lead whom they could contact to discuss budgets and this helped them work within the financial constraints they had.
- Staff on most wards spoke about opportunities to progress; however for some the business of the wards and the shortage of staff were seen as too much of a priority to become involved in other projects at this time.
- Several patients said they could see improvements in the care they received at the hospital. This included one patient who said the care was "infinitely better than any other time in 60 years."
- There was acknowledgement that the pace of change was fast, however staff and managers said it was manageable and changes were becoming embedded.

Surgery

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

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.

Hospital episode statistics data (HES) for 2014 showed that 44,231 patients were admitted for surgery at the trust. The data showed that, at Royal Blackburn Hospital, 35% of patients had day case procedures, 17% had elective surgery and 48% were emergency surgical patients.

As part of the inspection we visited theatres, the surgical day case ward, the surgical triage unit, ward B20 (ears, nose and throat), wards B22 and B24 (trauma and orthopaedics), wards C14 and C18 (General surgery) and ward C22 (urology).

We spoke with 13 patients, observed care and treatment and reviewed seven sets of records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, general managers, theatre managers, the assistant chief nurse, matron for theatres, health care assistants, physiotherapists, occupational therapists, ward clerks, housekeepers, the deputy chief nurse, the divisional director and the divisional general manager. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

We previously inspected surgical services at this hospital in April 2014 and rated the service overall as “Requires Improvement”. As part of that inspection, we identified issues regarding mattresses not being adequately cleaned, documentation not being well-managed, theatre equipment lists not adequately completed and a lack of patient’s dignity and privacy whilst in the theatre waiting area. There were also discrepancies as to how ward level risk registers were being reviewed and managed.

Surgery

Summary of findings

We rated the surgical services to be good although there were some areas of outstanding practice.

Since our last inspection the trust had made significant improvements, particularly focusing on strengthening their governance structures. Robust governance structures had been implemented, risk registers were fully completed and all staff were familiar with the risks for their areas. Regular governance meetings took place where lessons learned from complaints and incidents were discussed. Leaders were very visible to staff.

We saw evidence that incidents were being reported and staff we spoke with were aware of the incident reporting system and how to use it. We saw evidence of learning from incidents and how this learning was shared across the service and trust wide. We saw evidence of change to practice following learning from incidents.

Cleanliness and hygiene throughout the surgical department was of a high standard. Staff followed good practice guidance in relation to the control and prevention of infection.

Patients cared for in the surgical division were receiving care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were being completed and subsequent action plans implemented.

The trust participated in national audits including the hip fracture, bowel and lung cancer audits, which showed that overall the trust was achieving better than the National average.

At our last inspection we found that there was a lack of segregation in the theatre waiting area and subsequently patient's privacy and dignity were not always considered as male and female patients, wearing theatre gowns waited together. To address this, the trust has developed separate male and female waiting areas.

The hospital had consistently achieved better than the England average in respect of the 18 weeks target from referral to treatment between April 2014 and March 2015. Surgical procedures were sometimes cancelled at short notice but systems were in place to ensure patients were rescheduled within 28 days of the cancellation.

Leadership across the surgical division was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

At our last inspection we found discrepancies in how the local risk registers at ward level were being reviewed. There were concerns in relation to risks not being captured appropriately. However the trust has worked with the wards to ensure risk registers were well managed and maintained. Staff were familiar with the main risks for their area and local risk registers were on all staff notice boards.

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

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

Surgery

Are surgery services safe?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of protecting people from harm.

Safety Thermometer information between 1st June 2014 and 31st May 2015 showed there was had been a low number of pressure ulcers, falls and catheter acquired urinary tract infections.

Incidents were reported appropriately within the surgical division with the majority being of low or no harm to the patient. The top three reported incidents were displayed on staff and patient notice boards. Lessons learnt from incidents were shared with staff at weekly meetings.

Cleanliness and hygiene across the surgical division were of a good standard. There had been no cases of either MRSA or Clostridium Difficile between 1st June 2014 and 1st June 2015. Equipment was well maintained and the division held a medical devices register which identified the age, model and serial number of each piece of equipment.

Records were completed appropriately and we were able to follow and track patient care and treatment easily. However, records were kept in unlocked storage units behind the nurse's station.

Trust data showed that the completion rate for mandatory training was better than the trust target. All new staff within the division received a comprehensive induction programme and newly qualified staff nurses were given supernumerary status until they were passed as fully competent by the ward manager.

Staff were aware of the procedure to follow should a patients' condition quickly deteriorate. The division completed a 'track and trigger' audit which identified if the appropriate course of action was taken for patients whose condition deteriorated. This audit showed that patients were identified and a doctor was alerted and attended in good time when a patient's condition deteriorated.

However the audit also identified that appropriate interventions were carried out and documented in only 32% of patients However there was an appropriate action plan in place.

We found there was sufficient nursing and medical staff to ensure patient safety. Staffing levels and bed occupancy across the division was reviewed by the bed manager and matrons twice daily.

However, although medication, including controlled drugs, was stored and managed appropriately, the use of a computerised system was making administration very time consuming. This had been highlighted by ward managers and matrons and a solution had been identified but not yet implemented. The monitoring and recording of fridge temperatures also lacked consistency.

Incidents

- Incidents were reported using an electronic reporting system. Staff were knowledgeable about what types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- There had been 18 serious incidents within the surgical division requiring investigation between 1st April 2014 and 31st May 2015, including seven stage three pressure ulcers, six slips, trips and falls, three delayed diagnoses, a medical equipment failure and one which involved sub-optimal care of a deteriorating patient. All serious incidents were subject to an investigation using a root cause analysis approach and actions had been taken to prevent recurrence.
- Within the surgical division at the trust there were 5,118 incidents reported between 1st July 2014 and 31st August 2015 of which 4,080 were reported as no harm and 932 were reported as low harm. Communication problems was the highest number of incidents reported (626 in total). Senior leaders were undertaking work to identify what the communication incidents were and subsequently reduce the amount of incidents in this area.
- Staff were familiar with the top three reported incidents in their individual ward or theatre area and lessons learned from those incidents. They were clearly displayed on staff notice boards and discussed at weekly staff meetings, referred to as 'Feedback Friday'. Information discussed at these meetings was placed in

a ward folder for staff who were unable to attend. Additionally this information was displayed on prominent notice boards on entry to each ward for patients and visitors.
- Staff across the surgical division were familiar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and patients and relatives had been informed of incidents which had involved them.
- Multidisciplinary mortality review meetings took place monthly. These meetings helped learning from deaths in the division.

Safety thermometer

- Safety Thermometer information between 1st June 2014 and 31st May 2015 showed there had been a low number of pressure ulcers, falls and catheter acquired urinary tract infections with seven pressure ulcers, three falls and four catheter acquired urinary tract infections being reported during this period. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urinary tract infections (in patients with a catheter) and venous thromboembolism (VTE).
- Safety thermometer information was used to inform staff, during weekly ward meetings and shift handovers, of any identified shortfalls in harm free care and changes to practices as a result. We observed a safety huddle where all patients who had been identified as an increased risk of pressure ulcers, falls, urinary tract infections (in patients with a catheter) or venous thromboembolism were highlighted.
- Information about harm free care was displayed on boards at the entry to all wards and departments.

Cleanliness, infection control and hygiene

- Patients were being cared for in a safe environment in the wards and theatres we inspected.
- The wards, theatres and clinical areas were visibly clean and tidy. Staff were aware of, and adhered to, current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care. 'I'm clean stickers' were placed on equipment when it had been cleaned, including notes trolley, medication trolleys, computer stations and clinical equipment.
- Hand washing facilities, including hand gel were readily available in prominent positions, on entry to each clinical area.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- All patients were screened for Methicillin-resistant Staphylococcus aureus (MRSA). There had been no cases of either MRSA or Clostridium Difficile between 1st June 2014 and 1st June 2015.
- In all the surgical wards there were curtains between the cubicles which had labels identifying a date for the last and the next clean.
- At the last inspection we observed that nine out of 15 mattresses found in surgical areas had staining either on the covers or on the inside foam. However, we found at this inspection all the mattresses inspected were fit for purpose and had no visible stains, which clearly demonstrated the trust had undertaken work to address this issue.
- Hand hygiene audits were completed and data supplied by the trust showed that compliance ranged between 100% and 67% within the surgical division. An action plan was in place to improve compliance. In addition regular cleaning audits were completed and data supplied by the trust showed that compliance, across the surgical division ranged between 94% and 99%.

Environment and equipment

- The wards and theatre areas we visited were well maintained, with controlled access and provided a suitable environment for treating patients.
- Staff told us they had the equipment they needed to do their jobs and any repairs were completed in a timely way. The surgical division had an equipment register which logged the age, model and serial numbers as required by legislation.
- Emergency resuscitation equipment was in place and records indicated that it had been checked daily, with a more detailed check carried out weekly as per the hospital policy. However there was no tamper proof tag on the surgical day case unit resuscitation trolley which meant that items could be removed easily from it. When we checked this trolley, it was noted that some

equipment was missing, including needles, syringes and intravenous fluid. This trolley had been checked the previous day and checklist was signed, indicating that all equipment had been present.
- There were systems in place to maintain and service equipment. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date.
- There was a contract in place for pressure redistribution equipment and staff told us this equipment was delivered very quickly, usually within 30 minutes of ordering it.

· Medical device alerts were sent out via email and discussed at governance and weekly staff meetings to ensure that all staff were aware of the alert and the required action. Medical device alerts are the prime means of communicating safety information to health and social care organisations and the wider healthcare environment on medical devices. They are prepared and distributed nationally by the Medicines & Healthcare products Regulatory Agency (MHRA)and are distributed nationally for each healthcare setting to implement any requirements.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. The keys for the controlled drugs were kept separately for increased security.
- The controlled drugs were checked twice per day at shift change over and a register was kept and fully completed. All controlled drugs checked during the inspection were in date and accurately recorded.
- Fridge temperatures were checked and recorded daily on the wards that were inspected. However on wards B22 and the surgical triage unit the temperature had been recorded at 0.5 or 0.4 Degree Centigrade on a significant number of occasions for the three months prior to the inspection, which was against the trust policy. Ward managers felt this this was a recording error rather than an error with the fridge temperature.
- The temperature ranges of the medication fridges were not clearly documented on any of the wards visited. There was a tick placed in the box to suggest that the range had been checked but no temperature was written in. Some staff spoken to, including a ward manager, were unaware of how to do this and the significance of it.
- Medication was prescribed and distributed using a computerised system. However staff reported that this system was very time consuming, taking them up to three hours to complete a medication round. This had been highlighted by ward managers and matrons and a solution had been identified but not yet implemented.

Records

- We reviewed seven sets of patient records which were completed to a good standard. The hospital predominantly used paper-based records but was in the process of implementing electronic patient records. We found that patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- Each record contained a care plan that was completed electronically and printed and filed within the bedside record. Risk assessments such as risk of venous thromboembolism, pressure ulcer and falls were completed and updated appropriately.
- Records were stored in trolleys on the corridors of each ward. These trolleys were not locked and not all of them had the facility to be locked, making them accessible to patients or visitors to the ward.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. Safeguarding training formed part of the trust's mandatory training programme
- Data supplied by the trust showed that 83% of staff in the surgical division had completed safeguarding training which was better than the trust target of 80%.

Mandatory training

- Role specific induction was offered to all staff when they started work in the division. Newly qualified nurses received a period of supernumerary status until they were passed as fully competent by the ward manager.
- Staff received training in bullying and harassment, clinical record keeping, fire safety, generic consent, hand hygiene, risk management, health and safety, incident reporting and investigation, information governance and confidentiality, needlestick, sharps and accidental inoculation, safeguarding adults and children, safer handling, security, violence and

aggression, slips, trips and falls (patients and staff) , the patient experience, understanding dementia, valuing diversity and equality, waste management, early warning score and cardio pulmonary resuscitation, venous thromboembolism, medicines management and blood transfusion.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.
- Records showed the training completion rate among staff across the surgical services ranged between 100% (day surgery theatres) and 53% (B22) which was below the trust's target of 85% completion. Ward managers and matrons explained that there had been a high rate of sick leave and maternity leave on ward B22 which accounted for this training figure.

Assessing and responding to patient risk

- There were reliable systems, processes and practices in place to keep patients safe.
- We observed staff using the World Health Organization's (WHO) surgical safety checklist and the '5 steps to safer surgery' approach in theatres. Safety checks before, during and after surgery were completed, this demonstrated a good understanding of the five steps to safer surgery procedures. Trust data shows that compliance with the checklist ranged from 99.7% to 100% for the period 1st June 2014 to 31st June 2015. This was a significant improvement from our last inspection where we found that these checklists were not always fully completed.
- All patients had a preoperative assessment undertaken prior to their surgical admission. This ensured that any patients at an increased risk of having surgery were identified.
- Theatre recovery and nursing records included an early warning score chart to alert staff if a patient's condition was deteriorating. We observed these had been fully completed in the records we inspected. Staff were aware of the procedure to follow should a patients' condition quickly deteriorate. This included calling for out of hour's emergency assistance. The division completed a 'track and trigger' audit which identified if the appropriate course of action was taken for patients whose condition deteriorated. This audit showed that patients were identified and a doctor was alerted and attended in good time. However the audit also identified that appropriate interventions were carried out and documented in only 32% of patients.
- Nursing staff described the use of the early warning score system, which was used to monitor a patient's condition following their surgery. The scoring system was used to enable staff to identify concerns before they became serious and to get support from medical staff. We saw the early warning score system in use in the patient records we reviewed.
- There was a critical care outreach team at the trust which was a protective workforce (could not be used to cover staffing shortages in other areas). This team provided 24 hour, emergency cover for patients whose condition was deteriorating.

Nursing staffing

- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The nursing staff vacancy rate ranged from 5.2% to 5.4% for the period 1st April 2015 to 1st July 2015 which was slightly worse than the trust target of 5%.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients received the right level of care. Staffing rotas that we reviewed confirmed that staff numbers and staffing skill mix were appropriate to meet the needs of patients.
- Managers told us that staffing rotas were completed several weeks in advance to enable appropriate cover to be in place. The rotas were completed electronically and any gaps in the rota would trigger bank or agency staff cover. The wards tried to cover with their own staff prior to covering with agency. Staff told us there was very little agency staff used.
- Some innovative work was being completed within theatres to assist with the recruitment process including supporting existing staff through development opportunities, attending high school careers evenings to promote working in theatres and running open days.
- Ward B22 (orthopaedic) had experienced nursing staffing challenges in the months prior to the inspection, with 14 staff out of 34 staff having previously been on

sick leave or maternity leave. This had been covered effectively managed by the temporary ward manager who had received a trust award for her management approach with these staffing difficulties.
- The surgical division had recently recruited newly qualified nurses. The fair distribution of new staff across the wards had ensured they received the correct level of support and preceptorship.

Surgical staffing

- The medical staffing for consultant cover was slightly worse than the national average at 39%, compared to 41% nationally. However the percentage of junior doctors was 22% compared to 12% nationally.
- The junior doctors raised concerns in respect of the inflexibility of their rotas. They told us that, at the time of the inspection, they were unable to request any specific days off or have any control over their off-duty. They had raised their concerns with senior leaders but no changes had yet been implemented. The senior leaders were in the process of implementing a change to these rotas
- The surgical division was in the process of training nurse practitioners within various specialities to provide support to the medical team. The nurse practitioners that we spoke with told us they were well supported and valued as part of the medical team. There was also a programme in place to increase the number of theatre assistant practitioners to assist surgeons in theatre.
- Surgical and anaesthetic consultant cover was provided 24 hours for each speciality.

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. Staff members were aware of how to locate this in the case of a major incident.
- The hospital occasionally utilised the surgical day case to relieve bed pressures at times of bed pressures. This was well managed with a risk assessment in place.

Are surgery services effective?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being effective.

Patients cared for in the surgical division were receiving care in line with current evidence-based guidance and standards supported by accessible policies and procedures. Care was delivered by competent staff who worked in a strong multidisciplinary way.

Frequent local audits were being completed and subsequent action plans implemented. The trust participated in National audits including the hip fracture, bowel and lung cancer audits, which showed that the trust was achieving better than the National average in many areas. In the hip fracture audit 2014 the trust scored better than the England average for nine of the 10 indicators. The lung cancer audit results for 2014 showed they was preforming better than the England average with 99% of patients receiving computerised tomography (CT) scan before bronchoscopy compared to 91% nationally. The National Emergency Laparotomy audit (2014) showed that the trust was preforming similar to the England average. However there remained some areas for improvement. PROMs performance was improving in line with national improvement.

Pain was well managed and recorded and this was supported by a dedicated pain team. Consent protocols were adhered to and all staff we spoke with were clear in relation to the mental capacity act and deprivation of liberty safeguards.

Appraisal rates for staff were lower than the trusts' target. There were clear induction processes for new staff which included competency assessments however; the nursing appraisal rates were lower than the trust target.

Evidence-based care and treatment

- Policies and procedures were in place and could be accessed via the trust's intranet. Staff were aware of how they could access them.

- The service used a combination of National Institute for Health and Care Excellence (NICE), and Royal College' guidelines to determine the care and treatment provided.
- It was evident from the care records we reviewed and from our discussions with staff that NICE guidance on falls prevention, pressure area care and venous thromboembolism was being followed.
- Regular audits were completed across the surgical division, including hand hygiene, blood culture contamination, antibiotic compliance and various infection prevention audits. These audits demonstrated overall good compliance.
- Care pathways were in place that followed NICE guidance, for example the fractured neck of femur. Staff received training on a new care pathway once it had been developed and its use was audited.

Pain relief

- Pre-operative assessments of pain were carried out for all patients. Anticipatory pain relief was prescribed to ensure there was no delay should a patient require this post operatively.
- Pain relief was reviewed regularly on wards and patients were involved in pain assessments. We observed that pain relief was offered to patients when they needed it.
- There was a dedicated pain team, led by an anaesthetist, who assisted ward staff to support patients with acute pain.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition in ward settings. We reviewed care records and found that this tool had been completed, and included appropriate recording of the patient's weight. We found that actions were taken to refer patients to a dietician for specialist advice when required.
- Ward staff identified that patient flow made it difficult to identify how many meals were required throughout the day; however additional meals were obtained as required to ensure each patient received a meal of their choice.
- A red tray system was in operation across the trust to highlight patients who required additional support with meals. Alerts were also evident behind the patient's bed to highlight to staff that additional support was required.
- The surgical division risk register identified the challenges staff faced when patients attended for morning theatre lists and the list priority changed or the list time over ran. Subsequently patients were sometimes nil by mouth longer than was necessary.
- Three patients identified that the food was not hot or not very appetising with limited choice.

Patient outcomes

- Overall the trust was matching the improvement seen nationally in Patient Recorded Outcome Measures (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the England average.
- In the hip fracture audit 2014 the trust scored better than the England average for nine of the 10 indicators. However the hip fracture audit data showed the hospital was worse than the England average for the mean total length of stay. We were told that this was directly related to the fact that community rehabilitation facilities sit within the Trust.
- In the bowel cancer audit the trust was worse than the England average for patients being seen by a clinical nurse specialist and also for discussion at a multidisciplinary team meeting. However the lung cancer audit results for 2014 showed that the trust was preforming better than the England average with 99% of patients receiving computerised tomography (CT) scan before bronchoscopy compared to 91% nationally. The National Emergency Laparotomy audit (2014) showed that the trust was preforming similar to the England average. However there remained some areas for improvement.
- The rate of readmission following surgery was worse than the England average. The higher areas for risk of readmission were both urology and vascular surgery which were both worse than the England average for elective admissions.

Competent staff

- Trust data for the surgical division at Royal Blackburn Hospital showed that 78% of staff had received their appraisal which was worse than the trust target of 95%. Trainee medical staff stated they were well supported and had an appraisal and revalidation process in place with good training opportunities.
- There were clear induction processes for staff which included competency assessments for procedures such

as administration of medicines, infection control and discharge of patients. Newly appointed nursing staff told us they had received good support when they started in post from all members of the team.
- A learning and development lead nurse was in post across the trust's theatres who was responsible for identifying and leading on training within the unit.
- There was a strong focus on career progression within theatres. Managers were in the process of completing a business case for health care assistants to work towards NVQ levels two and three.
- Staff were passionate about training and student nurses told us they experienced a positive, supportive placement. The surgical day case unit had won an award from a local university for best student placement.

Multidisciplinary working

- Good multidisciplinary working was evident in all areas visited.
- Discharge letters were sent electronically to the patient's GP and district nurse, if appropriate, following discharge home. We reviewed a selection of discharge letters; we found there were a number of abbreviations which potentially would not be understood by the district nursing team.
- There were good links and inter-trust working with other neighbouring trusts. Examples of good inter-trust working were given across vascular surgery, paediatrics and the hepato-pancreatic-biliary service. Consultant surgeons told us they had a good history of working together with other trusts across Lancashire and worked within the Lancashire and South Cumbria network.
- Physiotherapists and occupational therapists completed joint assessments with patients. This ensured a joined up approach, prevented patients having to repeat information previously given to another professional and also reduced nursing time when mobilizing the patient. It also relieved time on both services as only one professional was required to write the patient records.
- Weekly multidisciplinary team meetings were held on surgical wards. This included physiotherapists and occupational therapists along with the trauma co-ordinators who would discuss each patient's care and any planned transfers or discharges.

Seven-day services

- Daily ward rounds took place on all surgical wards in the hospital. At the weekend the consultant on call would complete a ward round and contact the named sub specialist if required.
- There was access to a physiotherapy service at the weekends. This was a reduced service with input based on a needs assessment for example specific days following surgery.
- Diagnostic services were available 24 hours a day, seven days a week.
- To alleviate waiting lists, operations regularly took place at weekends. Between 1st October 2014 and 31st September 2015 a total of 206 additional theatre sessions, across the trust, had taken place.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were ample computers available on the wards we visited which gave staff access to patient and trust information.
- Policies, protocols and procedures were kept on the trust's intranet and staff were familiar with how to access them. In addition there were mobile computers on the wards to support ward rounds, where patients' x-rays and blood results could be brought up easily.
- Electronic discharge letters were sent to the GP and district nurse, if required, to ensure continuity of care following discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment. We observed consent forms within patient records which were completed correctly.
- Staff had a good understanding of the Mental Capacity Act and also Deprivation of Liberty Safeguard. They were aware of the MCA lead for the trust and how to contact them. Mental Capacity Act and Deprivation of Liberty Safeguard training was provided to all staff as part of mandatory training.

Are surgery services caring?

Surgery

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being caring.

All staff we observed were caring, professional and friendly. Patients were involved in their care and treatment and encouraged to ask questions. We saw patients were supported emotionally before, during and immediately after their procedure.

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

At our last inspection we found that there was a lack of segregation in the theatre waiting area affecting patient's privacy and dignity. However the trust had undertaken work in this area and had developed separate male and female waiting areas.

Compassionate care

- The NHS Friends and Family Test conducted between February 2014 and February 2015 showed the percentage of patients that would recommend the hospital to friends and family ranged between 75% and 100%. The response rates (59%) were significantly higher than the England average (37%) indicating the scores were more likely to be representative of the opinions of the patients receiving care at the trust.
- On the wards we observed cubicle curtains and doors were closed during consultations to maintain privacy.
- We observed many examples of compassionate care given to patients and those close to them based on individual needs. Staff provided reassurance and comfort to parents who were anxious or worried.
- We observed on a ward handover that patients were referred to as bed numbers rather than their name, to protect their identity. The ward manager explained that this was for confidentiality reasons as the handover was completed at the nurse's station where there were single rooms in close proximity.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they had received good information about their condition and treatment. They had also received sufficient information prior to, as well as after surgery.
- Visiting time was open on the ward to enable family members to take an active part in supporting their relatives.
- Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.

Emotional support

- Nurse specialists provided specific support for patients, for example the stoma nurses following colorectal surgery resulting in a colostomy.
- Patients told us that the nursing staff would answer call bells promptly, and provided good support during their stay on the ward.

Are surgery services responsive?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being responsive.

The facilities and premises in surgical services were appropriate for the services that were planned and delivered. Specialist areas to enhance the patient experience were evident for example the "hot clinic" in surgical triage and a trauma team who assisted the coordination of care for this group of patients. Late changes to surgical lists were being addressed through the trial of a "lock down" of the lists.

The hospital had consistently achieved better than the England average in respect of the 18 weeks target for referral to treatment between April 2014 and March 2015. Surgical procedures were sometimes cancelled at short notice but systems were in place to ensure patients were rescheduled within 28 days of the cancellation (only three patients had had to wait longer than the 28 days).

We found that the trust had numerous systems in place to assist people who used the service. Computer software was available on each ward area that enabled staff to translate information into any language and print it out for the

patient. The hospital had a dedicated dementia team and used the butterfly scheme, where a blue butterfly is used on records to let staff know that the patient may require additional help because of dementia.

Theatre staff actively engaged patients with learning difficulties who were due to have an operation. The theatre ran open days where patients were invited to visit the theatres and take part in interactive sessions such as role play keyhole surgery and hand hygiene techniques. The NHS Friends and family test had also been adapted for people living with a learning difficulty.

There was a system in place for the investigation, management and resolution of complaints and we found evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The facilities and premises in surgical services were appropriate for the services that were planned and delivered.
- The surgical triage unit had a 'hot clinic' where patients were referred to from a number of routes, including their GPs, the emergency department and specialist nurses. This unit was well utilised and well-staffed.
- There was a trauma team within the hospital who coordinated the care of patients admitted following a trauma. The team arranged beds, investigations, outpatient appointments, scans and theatres for patients as well as managing the orthopaedic outliers (orthopaedic patients that were not nursed on an orthopaedic ward due to bedding shortages). This ensured the service could better manage patients at busy times.
- Matrons held meetings twice daily to look at bed management and staffing for the day and night shifts. This ensured that the movement and flow of patients was closely monitored.
- Flexible visiting times were offered on all the surgical wards to support patients and those close to them.

Access and flow

- The hospital had met the 18 week target for referral to treatment for patients. They were better than the England average between 1st April 2014 and 31st March 2015.
- NHS England advises that patients whose operation is cancelled should be offered another date within a maximum of 28 days. The percentage of patients whose operation was cancelled by the hospital for non-clinical reasons and were not treated within 28 days was consistently better than the national average. Trust data showed that only three patients, between 1st April 2014 and 28th March 2015, did not have treatment within 28 days.
- To alleviate waiting lists, operations regularly took place at weekends. Between 1st October 2014 and 30st September 2015 a total of 206 additional theatre sessions took place across the trust.
- The average length of stay for elective and non-elective surgery was similar or better than the England average.
- There was a focus on patient discharge planning. Staff discussed discharges at the daily safety huddle and at the bed management meeting. Discharge letters were sent to general practitioners and the patient also received a copy.
- Patient flow meetings were held three times per day which were attended by matrons and the bed management team. These meetings reviewed and planned bed capacity and responded to acute bed availability pressures.
- Staff told us the operating list for elective day surgery was not "locked down" at any time. This meant it was open to change and patient's allocated time for their surgical procedure could change at short notice. Staff from theatre were working hard to keep patients fully informed of any delays.
- Bed occupancy across the surgical division ranged between 80.5% and 86.9% for the 12 month period prior to the inspection. The National Audit Office advises that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care acquired infections.

Meeting people's individual needs

- The hospital used a bedside alert system to notify staff of patients who had additional needs or where risks had been identified. This included patients that were at increased risk of falls, pressure ulcers, or venous thromboembolism (VTE). It also included patients that required assistance at meal times. Staff were familiar with this system.
- Translation services and interpreters were available to support patients whose first language was not English.

Staff confirmed they knew how to access these services. In addition, the majority of wards had staff members who were multi-lingual and, where appropriate, assisted with translation.

- Computer software was available on each ward area that enabled staff to translate information into any language and print out for the patient. This ensured that information was readily available in any language.
- The hospital had a dedicated dementia team to ensure the needs of dementia patients were met whilst they were using hospital services. The trust had a scheme in place for dementia patients called the butterfly scheme, where a blue butterfly is used to let staff know that the patient may require additional help because of dementia.
- Wards B22 and B24 had higher levels of patients who suffered with dementia. These wards provided one to one nursing care when required and also maintained a one to four nursing bay. This was to minimise the risk of patient falls and also to reduce anxiety. Activity boxes were used in these areas that included memorabilia and historic objects to engage the patients in activities.
- Theatre staff actively engaged patients with learning difficulties who were due to have an operation. The theatre ran open days where patients were invited to visit the theatres and take part in interactive sessions, such as role play key hole surgery and hand hygiene techniques. This was to relieve anxiety in these patients.
- The NHS Friends and family test had been adapted for people living with a learning difficulty, which included pictures to make it easier to understand and complete.
- Vegetarian and halal menu options were available but there was no code on the menu to make this easily understood to patients. These meals were only identified by the letters 'h' and 'v'. In addition menus were only given out in English and ward staff or family members would translate for the patient, where English was not their first language.
- There were male and female changing rooms with lockable cubicles and lockers in surgical day case, which ensured patient's privacy and dignity. Patients were given a unique lock code to ensure the locker was secure.
- Multi-faith facilities were available for patients and those close to them.

Learning from complaints and concerns

- Patients and those close to them knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints made about their own ward or department and any subsequent learning.

Are surgery services well-led?

Outstanding ☆

Summary

This inspection has resulted in an improved rating from requires improvement to outstanding in terms of being well-led.

The vision and values of the trust and the division were clearly embedded within practice across the surgical division. Staff were energetic and motivated by the clarity of the strategy for surgical services which was explicit with the trust's operational development strategy.

Governance and performance management arrangements were proactively reviewed and reflected best practice. There was a robust governance structure within the division which ensured lessons learned from incident and complaints were appropriately shared with all staff. There were monthly multidisciplinary governance and quality meetings led by the clinical lead for each speciality, referred to as 'share to care' meetings.

A systemic approach was taken to working with other organisations to improve care outcomes and tackle health inequalities. An example of this was the joint working of the clinicians within the North West theatre network where shared learning and benchmarking was a key focus.

Each ward and theatre held a local risk register containing risks for their area which fed in to the divisional risk register and staff were very familiar with the main risks for the division. The risk register was displayed on staff notice boards and discussed at weekly team meeting. All staff

were knowledgeable about the key risks and control measures for their area. This was a significant improvement from our last inspection where we found discrepancies with how local risk registers at ward level were reviewed.

Staff were proud of the organisation as a place of work and there was a strong climate of positivity with high levels of staff satisfaction. The trust ranked in the top 100 places to work in the NHS in an external health journal poll. Staff and patients told us they felt well engaged and their views were valued. Staff at all levels were actively encouraged to raise concerns.

Innovative approaches were used to gather feedback from people who use services, such as a text messaging service to ask patients to complete the NHS Friends and Families test and also the use of a blog within theatres.

The leadership was driving continuous improvement and staff were accountable for delivering change. We saw several examples of safe innovation across the surgical division, including robotic surgery, theatre open days to break down barriers between community and operating theatres and the use of social media.

Vision and strategy for this service

- The strategy for surgical services was aligned with the trust's operational development strategy and staff were aware of the trust's vision and values. The trust's vision was to be widely recognised for providing safe, personal and effective care. Work that was completed within the division was centred on this vision.

The trust vision was displayed in all areas that we visited. The trust vision was to be widely recognised as a provider of safe, personal and effective care. We saw this was very evidence within practice in the surgical division. All staff were very knowledgeable on the trust's strategy on how they should achieve this vision and we observed they were very focused on delivering it.

Governance, risk management and quality measurement

- There was a standardised approach across the division in terms of overall management and governance.
- The surgical division held an overarching risk register and local risk registers were held by each ward and theatre area. These were found to be fully completed with good control measures in place. The risk register was clearly displayed on notice boards within staff rooms and discussed at weekly staff meetings. Therefore, staff were very familiar with the risks for their area and actively worked towards minimising them. This was a significant improvement from our last inspection where we found discrepancies with how local risk registers at ward level were reviewed.
- The trust performed assessments of each ward and theatres, known as performance assessment frameworks. Staff were very positive about these assessments and felt that they improved the quality of care for each area. Staff were passionate about showcasing the good practice on their area and felt this framework helped them to achieve this in addition to identifying areas for improvement.
- Matrons completed daily checks on wards and theatres to ensure the quality of care on the wards. These checks looked at areas including environment, equipment, quality, documentation and the 15 steps challenge. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience. The challenge is a ward walk-around, seeing the ward through a patient's eyes.
- Staff within the surgical division showed good evidence of learning from a recent never event that had taken place in a different division of the trust. All staff were very familiar with this incident and shared lessons that had been identified. Evidence was seen of actions taken. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- Monthly governance and quality meetings were held within each clinical speciality of the division led by the clinical lead. These were multidisciplinary meetings and addressed areas including clinical effectiveness, safety and performance, patient experience and training. The meetings were discussed with all staff at weekly staff meetings and the minutes were readily available.
- A monthly ward managers meeting took place to provide support, shared learning and to discuss governance. This information was then shared with ward staff within weekly meetings.
- Matrons had regular one to one meetings with their manager to discuss specific issues within their teams. Matrons told us they valued these meetings.

- Theatres had a policy of the month, where a policy would be highlighted and discussed with staff. This was to raise awareness of new or altered policies.
- Theatre representatives attended a North West theatre network and attended joint meetings on a monthly basis which looked at sharing lessons from incidents and complaints. The group benchmarked against best practice across the network and also policy development.
- There was a systematic programme for clinical and internal audit. The results of audits were discussed at departmental governance meeting and subsequent action plans were implemented.

Leadership of service

- Leadership within the surgical division was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care. This was a big improvement since our last inspection as the surgical division had new senior leadership in place who had made a lot of positive changes to the service.
- There was a standardised approach across the division in terms of overall management and governance. However staff and ward managers were also encouraged to develop new initiatives more locally. Good practice and innovation was shared and rewarded.
- Staff spoke highly of the executive team and told us they felt very valued by senior managers and the trust board. They felt the board were very visible and approachable.
- We heard of examples of staff feeling comfortable with raising concerns with a trust director and where this had been acted upon. We also heard of positive achievements being highlighted with the board and an example of where a staff member received an award, which was presented to her by the chief executive at a ward handover.

Culture within the service

- There was an open and honest culture within the service. Staff we spoke with were candid throughout our inspection about their service and the areas were they wanted to do better.
- Throughout the service we found that staff thought of the two hospitals as one trust with one ethos.
- Staff were very passionate about working in the organisation and were committed to providing high quality patient care.
- There was a low staff turnover rate within the surgical division, which ranged from 7.9% to 9.4%. This was better than the trust target of 12%.
- The divisional staff sickness rate ranged from 4.2% to 5.4% with the upper figure being worse than the trust target of 5%.

Public engagement

- The surgical division was actively seeking the views of patients and their relatives by asking them to complete the NHS friends and family test, which they had adapted to ask patients additional questions to help shape future improvements. The results of this test were displayed on prominent noticeboards on all wards across the division. There was also a new initiative for patients to complete this test following discharge by being sent a text message to their mobile telephone.
- Theatres were actively working with the local community with initiatives such as theatre open days and working with local high schools.
- Theatres were using a blog on the trust's internet site where they encouraged the general public to post their views and suggestions on any issues or new ideas they wish to raise. This blog was reviewed and found to be very interactive with staff responding to posts from the public.
- The trust used patient-led assessments of the care environment (PLACE). These assessments involve local people assessing how the environment supports patient's privacy, dignity, food, cleanliness and general building maintenance.

Staff engagement

- Staff within theatres gave examples of team building exercises, such as fundraising ventures that enabled good team working. The staff had jointly raised money for the local hospice. A team of staff from theatres also travelled to India on a yearly basis for a two-week period to repair cleft palates. This was a joint venture with a neighbouring trust.

Innovation, improvement and sustainability

- Staff and mangers within surgical services were continually striving to improve the care and treatment

patients received. Staff and ward managers were encouraged to develop new initiatives more locally. Good practice and innovation was shared and rewarded.

- Staff were actively encouraged to take part in innovation and encouraged to suggest new and innovative ways for improvement. We saw several examples of where staff had suggested change in practice and these had been successfully implemented.
- The surgical division has recently submitted a business case for an improvement grant to receive support from the armed forces. The focus of this would be to gain experience from the armed forces in safety and team work.
- An example of innovation was seen on ward B20 where the ward manager had set up a page on a social media site for staff. The page gave staff the opportunity to thank each other for hard work and achievements and also where they could post points for learning. This initiative had been started because there was a young workforce on the ward and the manager felt this would reach out to staff. The page was well received by staff.
- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.
- The urology department had invested in robotic assisted surgery for the treatment of prostate cancer. The trust was the first in Lancashire to invest in this technology and was the only trust in Lancashire offering this type of surgery at the time of our inspection. This type of surgery has clinical benefits for patients with improved cancer outcomes as it gives the surgeon the opportunity to remove the prostate gland with a high degree of precision, which subsequently results in less pain, a shorter recovery period and hospital stay due to the surgery being far less invasive.
- A band three member of staff from theatres ran a painting competition for children and young people who had learning difficulties and medical conditions. The resulting art work was displayed in the patients' waiting area. This innovation was looking at working closely with these young people and easing their anxiety about undergoing surgery.
- As part of the on-going recruitment drive, staff from theatres were going into local high schools for careers evenings to help raise the profile of working in theatres and for the trust.
- The ward manager of theatres had developed a blog on the trust's internet site to reach out to the public. This was a very interactive page where patients, staff and the public were encouraged to write about their experiences.

End of life care

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

Information about the service

We visited the Royal Blackburn hospital as part of our announced inspection on 19, 20 and 21 October 2015 where patients with end of life (EOL) care needs were nursed on the general wards across different divisions and specialties.

There were 1862 deaths across the trust in 2014. The Specialist Palliative Care Team (SPCT) received 80-90 referrals a month. About 15% of these were non–cancer referrals.

On the 19 October we met with a member of the hospital (SPCT) who was deputising for the palliative care lead nurse who was on annual leave. We also met with the clinical director of the SPCT, the bereavement co-ordinator, the business manager and the chief medical officer for the trust (the medical division of the trust). These meetings gave us an overview of the role of the SPCT and the EOL and palliative care service.

On the 20 October we met with other staff involved in EOL and palliative care. These included the mortuary manager and two porters, the facilities manager, the EOL care facilitator, the bereavement care manager and the clinical lead for EOL care. We also met with four of the clinical nurse specialists from the SPCT and six health professionals from the wards. On 21 October we attended the EOL care strategy and operational group to observe the leadership and the implementation of the strategic aims of the service. We also met with the non–executive director who was the lead on the trust board for EOL care.

During this inspection we visited eight medical inpatient wards where EOL may be provided. We visited the hospital mortuary including the viewing room and the relatives' room. In addition we visited the spiritual centre and the bereavement office, including the relatives' rooms. We observed care and reviewed records for seven patients and we spoke with four patients and eight relatives. We looked at trust policies and procedures; we received information about the performance of the trust and reviewed comments from people who attended our events and feedback from a range of sources.

End of life care

Summary of findings

The end of life care service was rated good overall with no domain requiring improvement.

The clinical leadership in the specialist palliative care team was effective. There was a strategy and a vision for the end of life service and effective reporting mechanisms to the trust board. All directorates were engaged in the delivery of good quality end of life care.

Staff were enthusiastic and caring and enjoyed working for the trust. They said that the last few years had been difficult but the stability of the current board and executive team contributed greatly to the culture of continuous improvement.

Systems were in place to keep people safe and incidents were reported by staff through effective systems. Lessons were learnt and improvements were made. An integrated care plan had been launched which was comprehensive and staff had been trained to use it. The plan identified priorities for patients in the last few days and hours of their lives. Patients and their relatives were involved in the planning of their care.

The service had a well-developed education programme for medical staff, nurses and unqualified staff in EOL care. Staff in the specialist palliative care team and on the wards were committed to providing good compassionate care for patients and their relatives. There were good audit systems in place and the outcomes of these were used to improve the service.

The bereavement service showed care and compassion to those attending the bereavement centre. There were bereavement champions who worked in a range of departments and across directorates to deliver good care after death for patients and their relatives. The chaplaincy was part of the holistic care of the patient and family at the end of life, giving spiritual and religious support to people of all faiths.

Mortuary staff and porters were compassionate and respectful with patients following death and with relatives who were using their services.

However consultant cover for out of hours and seven day working was not always available. The specialist palliative care telephone advice line for out of hours was answered by a nurse and referred to a doctor if necessary. This doctor was not always a consultant in palliative medicine and could be a GP. This did not fully meet the National Institute for Health and Care excellence (NICE) quality standards for end of life care.

End of life care

Are end of life care services safe?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being safe.

The trust had reported no never events or serious incidents in the last year. Staff were encouraged to report incidents and to do so through the trust system. Lessons were learned and this learning was disseminated to staff.

Staff were aware of safeguarding procedures and there was a trust lead for safeguarding who provided information and support for staff. There was comprehensive training in all aspects of end of life and palliative care for all grades of staff including doctors and this was well attended. Safety huddles were used in teams and on the wards to identify any patients at end of life ensuring good continuity of care.

The porters were aware of the signing in processes when bringing patients to the mortuary. The mortuary manager attended major incident meetings at the trust and at county level to ensure mortuary capacity in the event of a major incident.

The syringe driver prescription was incorporated into the syringe driver administration and recording chart and not recorded in the medication administration record. There were some discrepancies in the recording of medicines delivered through a syringe driver for one patient which were dealt with before we left the inspection.

We looked at seven do not attempt cardiopulmonary resuscitation (DNACPR) records; five of these had been completed correctly. Discussions with health professionals, patients and families were clearly documented and signed and dated appropriately. There were shortfalls in the other two DNACPR records with signatures and dating of the records.

The specialist palliative care telephone advice line for out of hours was commissioned from a local hospice; it was answered by a nurse and referred to a doctor if necessary. This doctor was not always a consultant in palliative medicine and could be a GP.This did not fully meet the National Institute for Health and Care excellence (NICE) quality standards for end of life care.

Incidents

- The Trust had reported no never events or serious incidents in the period between August 2014 and July 2015. (Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented).
- Incidents were reported on the trust incident recording system. Staff knew how to report incidents and said they were encouraged to do so. Staff knew how to escalate incidents to managers if necessary.
- Incidents were discussed at ward meetings and were standing agenda items at the EOL strategy and operational group meetings. There was a significant event audit reflective template which was used as a tool to learn from the event/incident. The minutes of the meetings were disseminated to the palliative care team and any learning and actions were highlighted in individual team meetings.
- Actions from the EOL strategy and operational group were standing agenda items on the monthly directorate meetings and an EOL report was produced monthly. Performance and actions from the directorate meeting were reported into the divisional quality safety board.
- Staff we spoke with were aware of the duty of candour and could demonstrate their individual responsibility to be open and honest with patients and families when something went wrong.

Medicines

- Anticipatory end of life care medicines were prescribed appropriately. The medicines were kept on the wards that we visited ensuring that patients could receive effective symptom control in a timely way. There were clinical guidelines on anticipatory medicine prescribing for medical staff. Support was also available from the consultants and the staff in the specialist palliative care team.
- Staff were aware of how to use syringe drivers effectively. In 2011 the National Patient Safety Agency recommended that all Graseby syringe drivers should be replaced by the end of 2015. The trust has replaced them with McKinley syringe drivers that can deliver subcutaneous medication. Staff accessed the syringe drivers from the equipment library and said that they were always available.
- There was a syringe driver prescription, administration and recording chart which included observations for

checking the needle site, the battery life, any crystallisation of the medicines and the volume of infusion left in the syringe. A minimum of two observations a day were required with a signature and a time checked. We checked the syringe drivers for two patients, they were both fully functioning, and both were kept in a locked box and were clearly labelled with the medicines. Both syringe drivers had good battery life.

- We saw seven of these records and six were completed appropriately. One of the records showed that the syringe driver was delivering medicine to the patient at a set flow rate. The volume in the syringe driver was recorded twice with a time interval of several hours but the fact that the volume of medicine delivered was less than it should have been was not noted or acted upon. This indicated either a recording error or maladministration of the amount of medicine that the patient needed to control their symptoms.
- On the same chart a medicine had been prescribed to control two symptoms but it was unclear from the patient's medical record and care plan if the medicine had been effective in the management of either of the symptoms. Best practice advises that medicine used to control two different symptoms should be prescribed separately so that there is clarity about the doses for each medicine and the efficacy against the symptoms.
- These issues were raised with the ward manager before we left the ward. We were told that a doctor would review the patient's medicines and the incident was referred to the specialist palliative care team before we left the site that evening.
- Symptom management information was available on the trust intranet site and staff were aware of how to access this information

Records

- The trust used paper based records. The specialist palliative care team (SPCT) made entries into the medical notes of patients. This information was then faxed on a secure fax to the palliative care team office. Entries by medical staff were also faxed to the office. The records in the palliative care team office were stored securely.
- Stickers were used in the notes following a visit from the SPCT. The stickers had contact numbers for in hours and out of hour's advice.
- We reviewed seven patient records which were legible, accurate, signed and dated. Notes were well documented with clear comprehensive plans in place. However, in one set of patient records a number of the sheets were not securely fastened into the notes with a risk of them falling out or getting lost.
- The trust had a "do not attempt cardio pulmonary resuscitation" (DNACPR) policy which was available to staff on the intranet. The DNACPR documentation was on coloured paper to identify it in the medical notes.
- We reviewed seven DNACPR records on the medical wards. Five of the records were clearly labelled with the patient identifier and the reason for the DNACPR was clearly documented. Discussions with relatives, the names and signatures of the health care professional making the decisions were clear and legible. Stickers in the notes indicated when a review had taken place.
- One of the records had a signature and a date but there was no name or designation and no GMC number. The other record was dated but not timed and the verification section of the record was incomplete.
- We spoke with two patients and their relatives on the dementia friendly ward about their discussions about the DNACPR decision. One patient and their relatives had initial discussions with the medical consultant which they described as "disappointing". They said that they had not received all the information that they needed to make the DNACPR decision. The patient was referred to the SPCT and had further discussions with a consultant from the team; these discussions were described as "outstanding" and alleviated many of their concerns and uncertainties. The other patient said that their discussion about DNACPR was not thorough. The discussions were not with a member of the SPCT.
- DNACPR forms followed the patients on discharge home or to a different location. The patients' GP's were informed of the DNACPR decision.
- A paper based and electronic recording system was in place in the mortuary to record the details of patients admitted. Patients were brought to the mortuary by the porters in a dignified way and signed in. Patients were given a unique mortuary number and their information was transferred onto an electronic register by the mortuary staff. When patients were collected from the mortuary they were signed out by the mortuary staff and the funeral director.

End of life care

- In hours the notes were sent directly to the bereavement centre. Out of hours the medical notes accompanied the patients to the mortuary.

Safeguarding

- Policies and procedures were accessible to staff on the trust intranet for safe-guarding vulnerable adults and children.
- There was a head of safeguarding and staff we spoke with knew how to access the safeguarding service for advice and information.
- Staff received training in safeguarding children and vulnerable adults. Mandatory training included the following: safeguarding vulnerable adults, safeguarding children, the Mental Capacity Act 2005 and Deprivation of Liberties safeguards.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and were aware of the process for reporting safeguarding concerns.

Mandatory training

- Staff in the SPCT were 100% compliant with their mandatory training that was part of an annual rolling programme.
- The trust had achieved a commissioning for Quality and Innovation (CQUIN) target for 2014/5. This was based upon attendance figures at the training offered by the SPCT clinical nurse specialist team. A target of trust staff attending 60% of the 540 available places was agreed. Attendance at scheduled medical teaching was also included. Overall there was 61.6% attendance at the training. These training sessions were evaluated and recommendations were taken to the palliative care education steering group.
- The trust had introduced an "individual plan of care and support for the dying person in the last days and hours of life." (IPC). Training had been given to ward staff about completion of the IPC and over 200 staff had attended training over a two month period. A train the trainer model had been used and nine link nurses were able to deliver training to other staff. An A5 laminated card had been developed for staff and was called "priorities for care of the dying patient" to support the training.
- The palliative medicine consultants provided education sessions as part of the trust's medical trainee teaching programme, the medical grand round and on request by teams. Care of the dying sessions were delivered most frequently to support the changes to caring for dying people.
- There were regular training and review sessions for staff that used syringe drivers. The SPCT had conducted an audit of the matrons to find out the preferred model for staff training for syringe drivers. This information will be used in the delivery of further training.

Assessing and responding to patient risk

- Early warning scores (EWS) were used to identify if a person's condition was deteriorating. A clinical response team was contacted if a patient's score indicated their condition was deteriorating and a doctor would visit the ward and review the patient. Nursing staff reported this response was always without delay including at weekends.
- We spoke to nursing staff who said that they always had a good response from the SPCT which was always on the same day. They knew how to access information out of hours. Staff knew how to make a referral to the SPCT.
- All of the SPCT were located in the same office so there was good communication in the team.
- The safety huddle was used both on the wards and in teams to plan the work of the team for the shift. All patients approaching the EOL or in the last few days of life were identified on a daily basis and any information about these patients was communicated through the huddle. We observed a safety huddle for the SPCT and saw it was an effective and well run meeting.
- There was an alarm system for monitoring fridge temperatures in the mortuary to ensure maintenance of the correct temperature.

Nursing staffing

- Care for people at EOL was the responsibility of all staff and was supported by the SPCT.
- The SPCT included a lead nurse, five whole time nurse specialists, an end of life facilitator and administration support. There was a vacancy for an electronic palliative care co-ordination system (EPaCC's) clinical co-ordinator. This is an information system for EOL and is due to commence in December 2015. The SPCT used bank staff infrequently and these staff were former members of staff from the SPCT team.

End of life care

- A business case to two clinical commissioning groups had resulted in an increase of nurse staffing in the hospital specialist palliative care team by three members of staff.
- Ward staff told us that they always prioritised care for a patient at EOL and if necessary additional staffing could be brought in to provide this care.
- A patient told us that he was not impressed by some of the agency staff though he was very complimentary about the "regular" nurses. He also said he felt that at times he felt that there were not enough nurses and they couldn't always respond promptly to the call bell. The patient was dependent on the nursing staff for most of his needs.
- The trust were developing a band 5 competency framework for nurses to include an EOL care domain.

Medical staffing

- There were three specialist consultants in the SPCT including the clinical director and the clinical lead of end of life care.
- There was currently a vacancy for a consultant in the SPCT. The consultants should have provided six sessions in the hospital to support EOL patients. They provided just less than five sessions per week. The consultants said that it did not affect patient care
- The consultant vacancy was on the risk register for the SPCT though not on the directorate risk register.
- A specialist palliative care telephone advice line for out of hours was commissioned from the local hospice. This was answered by a nurse and referred to a doctor if necessary. This doctor was not always a consultant in palliative medicine and could be a General Practitioner.

Major incident awareness and training

- There was a trust major incident plan that was available on the trust intranet.
- The mortuary manager attended major incident meetings at the trust and multi-agency County meetings.
- We met with the mortuary manager who discussed the capacity for the mortuary and the additional capacity available on site. When the mortuary capacity was reduced, usually over a bank holiday, weekend or during some of the winter months, patients would be moved from the mortuary to another onsite facility. The porters were responsible for monitoring the capacity of the mortuary and were aware of the process to contact mortuary staff as necessary.

Are end of life care services effective?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being effective.

The service no longer used the Liverpool care pathway for the dying. This was removed in 2014 and replaced with the individual plan of care and support for the dying in the last days and hours of life. Training had been given to staff in the use of the document.

The service contributed to the national care of the dying audit of hospitals to compare end of life care provision with that of other healthcare providers. Though the trust had not performed well in the 2013-14 audit which had taken place in May 2014, there was evidence to show that action had been taken to improve the service.

The trust had undertaken an internal care of the dying audit every three months across the divisions to highlight the importance of improving care for dying people across the trust.

There was an EOL care facilitator/educator who provided a rolling programme of education for staff across the trust including health care assistants. The bereavement service had developed an education plan to support the bereavement care strategy with training for all grades of staff. This was based on national end of life care strategy.

Multidisciplinary team working was good and meetings were held to review the patients and to address the needs of the patients and their carers.

Evidence-based care and treatment

- East Lancashire Hospitals NHS Trust had participated in the National Care of the Dying audit of hospitals (NCDAH) for 2013-2014. The trust had submitted data for the 2014-2015 audit in September.
- In the NCDAH 2013-2014 the Royal Blackburn hospital did not achieve five out seven of the organisational key

performance indicators. The hospital scored lower than the England average on eight out of ten clinical key performance indicators. Action plans had been put in place and interval audits have demonstrated improvement. They did score 100% on the review of number of assessments undertaken in the last 24 hours of life. The hospital scored higher than the England average for care after death. We saw that priorities had been developed and implemented through the end of life strategy and operational group to address the Key Performance Indicators that had not been achieved and to progress those that had.

- As part of the locally negotiated Commissioning for Quality and Innovation (CQUIN) requirement for end of life care for 2014/15 the trust developed and implemented a regular care of the dying audit to be undertaken by the different divisions in the trust. The audit took place every three months and showed the importance of improving care for dying people across the trust. It identified areas of good practice and areas that needed improvement. The audit will continue in 2015/16 as part of the trusts overall commitment to improving care.
- The trust audited the systems for DNACPR decisions. An audit tool was used on each ward by the matrons to review DNACPR decisions. This involved checking the numbers of patients with DNACPR orders in place and the quality of the care record. The matrons also checked whether the DNACPR order required review or was indefinite and whether all the necessary information had been provided regarding the DNACPR decision.
- In September 2015, 60% of wards and departments took part in the audit and this number was expected to increase. The audit showed that 15 of the 16 wards could evidence that patients with DNACPR's were identified in the safety huddle. 13 of the wards clearly identified if the DNACPR was indefinite or required review. 76 of the 86 patients included in the audit had the DNA decision discussed with them or their next of kin where appropriate.
- The audit identified areas for improvement. Information leaflets about DNACPR decisions should be provided to patients and next of kin and this must be documented in the care records. Also when a DNACPR had been started in a different location but the decision of the patient and/or relative had not been documented, it needed to be discussed with the patient or next of kin on the ward.
- The trust and the SPCT had received two years funding to implement the AMBER care bundle. This was in response to the Department of Health's National End of Life recommendations. The AMBER care bundle provides a simple approach to manage the care of hospital patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months. It was successfully rolled out over 10 wards but when the funding recently ceased it was agreed at the EOL steering group that a different approach would be used. The principles of the AMBER care bundle were embedded into the culture of some of the wards with examples given by staff.
- The SPCT worked in line with the National Institute for Health and Care (NICE) to provide its EOL service.
- The trust worked in line with the national end of life care strategy and General Medical Council guidance
- There were guidelines for symptom management and care of the dying. Training was available in these areas.

Pain relief

- The service had performed lower than the England average national for the prescription of medicines for the five key symptoms for the end of life. (National Care of the Dying Audit 2013/2014).
- Anticipatory end of life care medicines were prescribed appropriately. The medicines were kept on the wards that we visited ensuring that patients received effective symptom control in a timely way. There were clinical guidelines on anticipatory medicine prescribing for medical staff. Support was also available from the consultants and the staff in the specialist palliative care team.
- Staff we spoke with had a good understanding of anticipatory prescribing and knew how to access information on the intranet. They reported that they could always access syringe drivers including out of hours.
- Patients had their pain needs assessed and reviewed through the early warning scores (EWS).
- All of the patients and relatives that we spoke with said that their pain needs were assessed and reviewed though one patient told us that an agency nurse had not responded to his pain needs. He reported this to another nurse and was immediately given appropriate pain relief.

End of life care

- We saw a leaflet the SPCT had designed as a result of NICE guidance on opioids. NICE CG 140 (Opioids in Palliative care). This was a patient information leaflet that would be given when a patient began opioid treatment. The guidance stated that patients and carers should be given both verbal and written information on opioid treatment. The team did not currently audit if the leaflet was given to patients.
- On the dementia friendly ward the Abbey pain scale was used as well as observation for patients with reduced cognitive function. The Abbey pain scale is used for patients with dementia who cannot verbalise. This meant that patients with dementia would receive appropriate pain relief.

Nutrition and hydration

- The nutrition and hydration assessment was part of the individual plan of care and support for the dying (IPC) in the last days and hours of life. We saw that patients and relatives were involved in these discussions. There was consideration about the benefit and burden of clinically assisted nutrition and hydration. Patients were supported on oral fluids and food as long as they were able.
- Staff would respect the dying person's choice to eat and drink even though they were at risk of aspiration this was respected by the staff. Staff would try to minimise the aspiration risk.
- Regular mouth care was part of the IPC and the trust had a policy on mouth care. We observed that a patient had good mouth care provided by staff.
- The speech and language therapists at the trust were developing guidance on feeding at end of life. Dieticians were available for advice.
- Patients we spoke with said that hot and cold drinks were always available and that there was a good choice of food. One younger patient commented that the food was poor and his father was bringing food into the hospital for him.

Patient outcomes

- The trust had stopped using the Liverpool care pathway three years ago and had developed a new document. This was approved in December 2014 and was the "individual plan of care and support for the dying person in the last days and hours of life." (IPC) This had been developed by a local strategic clinical network and a working group from end of life care strategy and operational group. The IPC was an individual plan of care used by staff on the wards which was discussed openly with patients and those identified as important to them. These plans were reviewed on a daily basis.
- The IPC identified five areas for the care of the dying patient, the recognition of likelihood of dying, sensitive communication, involvement in decision making, support –the needs of families and others close to the dying patient and plan and do- the individual plan of care. The plan was not mandatory for all patients at the end of life and currently about 25% of appropriate patients were assessed using this care plan The other 75% patients were assessed on the general care plan.
- The IPC contained information on specialist palliative care, advice and support both in hours and out of hours. It also contained information about the chaplaincy team and emergency marriages in hospital.
- The care plans had a section on spiritual care and religious needs that was completed by patients and relatives. Members of the chaplaincy team would support these discussions if required.
- The IPC was not going to be formally reviewed until after publication of the NICE clinical guidelines for the care of the dying due to be published in December 2015/ January 2016.
- There were care plans if appropriate e.g. wound care, falls assessment, manual handling and use of bed rails. These care plans could not be individualised and contained actions for the nursing staff that were unnecessary for that patient's care. This issue was also raised by nursing staff as time-consuming as all sections needed to be completed. The care plans we saw were up to date.
- We saw that there was good detailed documentation in the multi-disciplinary team progress notes before being transferred to the IPC plan.
- Some ward staff were unaware of the referral criteria for the SPCT and referred to them if the patient wanted input from the team or if they had complex symptoms. The SPCT were described as responsive and supportive.
- We spoke to patients and relatives who had good discussions about their care plan. This was well documented and reviewed daily however we spoke to one patient and their relatives who were unsure about what their plan of care was. They said that some of the medical communication was poor and the DNACPR

discussion was not thorough They reported limited feedback from the multi-disciplinary team meeting but felt the nurse from the SPCT was supportive in trying to co-ordinate care and was organising a transfer to a local hospice.
- Staff on the wards participated in a safety huddle three times a day and all patients with a DNACPR order were identified in the safety huddle. The matrons monitored whether this information was passed on through the safety huddle.
- The department were developing a policy for deactivation of implantable cardiac defibrillators. When a patient is nearing the end of life it is usually recommended that any implantable device is deactivated. This should be discussed when the DNACPR is completed.

Competent staff

- There was an EOLC facilitator/ educator who was part of the SPCT. There was a rolling programme of training including a number of topics including care of the dying patient and symptom control in palliative care. There was training for health care assistants which was very well received.
- We spoke to nursing staff who said that EOL care was well demonstrated on their ward and that all staff took responsibility for shared learning. They had a good relationship with the SPCT and were well supported by the team. These staff said a debriefing following a death would provide additional support and aid their learning.
- The wards had EOL link nurses who provided an additional resource and support for ward staff and for patients at EOL. The link nurses were involved in the induction of new staff onto the wards and were able to pass on information about EOL through this process. There was also a link nurse for the accident and emergency department.
- On the dementia friendly ward there was an excellent resource folder and end of life box with comfort packs for patient's relatives. The comfort packs contained a toothbrush, toothpaste and other toiletries for relatives who wished to stay overnight with a patient.
- On one of the wards much of the information in the EOL resource folder was out of date including the symptom management guidelines. There was a copy of the Liverpool Care pathway in the folder.
- 100% of the nurses on the SPCT had an appraisal in the last twelve months.
- All nursing members of the SPCT received clinical supervision.
- There was an education plan for the bereavement care strategy. This education was aimed at all staff in the trust and was based on the national End of Life care strategy. The training included spiritual, religious and cultural needs of the local population, verification and certification of death and communication skills.
- The trust provided bereavement care workshops, as part of the bereavement care strategy, which covered a range of care practices relevant to death. This included the physical care of the deceased, the implications of tissue donation and care of the patient's property. It also included religious and cultural needs, communication skills and verification and medical certification of the cause of death and stillbirth. The workshops were open to anyone in the organisation. Following attendance at the workshops staff would become a bereavement champion. The bereavement champions met monthly to reflect on practice. There were over 50 bereavement champions in the trust.

Multidisciplinary working

- There were two multi-disciplinary team meetings (MDT) every week. All new patients were discussed at these meetings. Advice to other healthcare professionals on palliative care was provided to improve the quality of the care for patients. The meetings were used to co-ordinate the patient's pathway and to signpost to other staff or teams as appropriate. They were also used to provide information to patients and carers.
- The MDT meetings involved staff from the community SPCT service and from the local hospices.
- The consultants held a weekly caseload review meeting. This provided an overview of all patients on the caseload of the specialist palliative care team and provided medical leadership for the team
- Specialist palliative care representation was provided at a number of oncology meetings on a weekly basis. This was monitored for the purposes of cancer peer review.
- Nursing staff on a respiratory ward described good MDT working with the SPCT and the respiratory consultants.
- We saw MDT progress notes in the patient's medical record to update staff about their treatment plan

Seven-day services

End of life care

- The SPCT delivered a 9am -5pm service Monday to Friday. Out of hours there was an advice line staffed by a nurse who had access to a doctor. This doctor was not always a consultant in palliative care and could be a GP. The NICE quality standards for end of life care state that there should be provision of specialist palliative care advice at any time of the day or night which may include telephone advice. The trust was not meeting this quality standard.
- The bereavement centre ran an open service so that patients did not have to make an appointment. This was available five days Monday-Friday a week. Arrangements could be made if a death certificate was required urgently.
- The mortuary staff were available seven days a week, twenty four hours a day.
- The chaplaincy service was available seven days a week, twenty four hours per day and a minister from most religions could be provided.

Access to information

- The trust intranet provided information and guidance for staff. This included a palliative care section that included symptom management guidelines and anticipatory prescribing. Staff felt this was a useful resource.
- The SPCT staff had access to national policies and clinical guidelines. The team were co-located with the consultants providing easy access to clinical knowledge and advice.
- The appointment system on a shared drive and staff had access to clinical lists. SPCT clinics were very rarely cancelled.
- The electronic palliative care co-ordination system (EPaCC's) was to be based in the hospital from December 2015. The system would be used to record and share people's care preferences and information about their end of life care. One of the consultants from the palliative care team was the clinical lead for the project and there was a task and finish group for the health economy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff received training for the mental capacity act, the care act and learning disabilities.
- There was a mental capacity act and Deprivation of Liberty safeguards (DOLS) lead who worked full time in the trust.
- A patient was given five days to regain mental capacity when they were admitted to hospital before a DOLS application was made. Staff would discuss the application with the safeguarding team.
- For two of the DNACPR forms we saw, the record showed a mental capacity decision was recorded including family involvement.
- The trust had a consent policy that could be viewed on the intranet.

Are end of life care services caring?

Good

Summary

This inspection has resulted in no change of the rating of good in terms of being caring.

The ends of life and bereavement care services were provided by compassionate caring staff. Staff were sensitive to people's personal, cultural and religious needs.

Ward staff provided practical support with open visiting and meals and refreshments for relatives. There was free parking and this included parking for those coming to collect a death certificate. Comfort packs were provided if relatives wished to stay overnight.

The bereavement co-ordinator had completed a bereavement survey to promote improvements. There were workshops on bereavement care and following attendance at one of these workshops members of staff became bereavement champions. Staff at the bereavement centre understood the need for timely death certificates for the funeral rites of a number of religions and every effort was made to facilitate this process. The staff at the bereavement centre and the mortuary had worked with local religious leaders to seek their advice and guidance in these matters.

The chaplaincy provided religious and spiritual support for a number of different religions and was proactive in working on the spiritual and religious section of the individual plan of care and support for the dying person in the last days and hours of life. (ICT)

End of life care

The porters brought the deceased to the mortuary from the wards. They were respectful and afforded the deceased privacy and dignity.

Mortuary staff were compassionate and supported relatives who had been bereaved.

Compassionate care

- Patients were treated with dignity and respect from the ward to the mortuary. A patient and their relatives said they were treated with respect and dignity by the ward staff. Nurses and care assistants introduced themselves by name and designation.
- We spoke to a patient and his relatives who described his care as exceptional, everyone from the cleaning staff to the doctors and nurses. His past experience of the hospital had been very poor when his wife died last year. He had been worried about returning to the hospital but all his worries and concerns had been alleviated during his stay. He commented that the hospital was much cleaner than when he last visited.
- The staff we spoke with said that they respected people's personal, cultural and religious needs.
- The SPCT were committed to providing patients with sensitive, personalised care while respecting their choices at the end of life.
- There was open visiting for relatives and they were allowed to use patient showers and facilities as necessary. Meals and refreshments were also provided for relatives who did not wish to leave a loved one. Comfort bags made by local school children contained items for relatives who might want to stay at the hospital. They contained toothbrushes, toiletries and other items.
- The trust had a bereavement care service that included the bereavement co-ordinator, the bereavement centre and the chaplaincy. It was managed by the deputy chief nurse. The service had undertaken a bereavement survey. In the period July - October 2015 the service had given out 178 surveys, of these 70% were returned.
- An action plan had been produced using the information from the survey results. This had clear actions, outcomes and timescales.
- Members of the bereavement care service had arranged for a patient's relative to stay in an unoccupied bungalow in the doctor's residence so she could be on site to respond to any deterioration in her relative's condition.
- The bereavement centre had two relatives' rooms. They were comfortably furnished but there were no religious or faith icons to ensure it was relevant to anyone who needed the facility. Refreshments were provided for relatives when they came to collect the death certificate. Patient's belongings were sent to the bereavement centre so that relatives did not have to return to the ward. 99% of people who completed the bereavement survey said that their relatives' belongings were returned to them in a way that showed that the staff had respected these items until they could be returned.
- We observed two families who attended the bereavement centre and were shown into the family rooms. They were given information on how to register their relatives' deaths. Both were treated with compassion and respect. Staff were calm and knowledgeable. 95% of people who had completed the bereavement survey said that they were given the medical certificate of cause of death in a suitable environment.
- We spoke with the chaplaincy and bereavement care manager who told us that the chaplaincy is part of the bereavement service and there were three full time chaplains and five sessional Muslim imams.
- There were services at the chaplaincy for a number of religions and there was a prayer room and washing facilities that were used for staff and patients. There was also a quiet room, available for patients and their relatives and staff, and refreshments were available. The quiet room contained information about many different religions and their funeral rites
- One of the patients we spoke to told us that he had attended a service while in hospital.
- There were about forty volunteers, of different faiths, who visit the wards. Some took communion to patients and others chatted with patients and supported families. Leaflets were available about the chaplaincy service, though only in English.
- When a patient was put onto the end of life care pathway the chaplain was included in the meeting with patients and relatives to help to address spiritual needs. The chaplaincy also had links to the bereavement midwife. An advocate was also available to support patients and their relatives.
- The trust had begun to audit the recording of a patient's religion on admission to hospital to help to support spiritual and religious needs. At the time of the inspection there were no outcomes of this audit.

End of life care

- We visited the mortuary and we spoke with staff that showed a caring and respectful attitude to deceased patients. We spoke to porters who told us how patients were taken from the ward to the mortuary after death. There was a comfortable viewing room where relatives could view their deceased relative. Relatives could stay as long as they liked and mortuary staff would try to facilitate out of hours viewings as necessary. 50% of responses from the bereavement survey of relatives said that they were not informed about the visiting arrangements in the mortuary. Of those that visited the mortuary, 64% were satisfied with their care.
- The staff in the mortuary would try to facilitate the needs of relatives when viewing bodies. If they were disfigured in any way, staff would provide advice and support to prevent further distress to relatives.

Understanding and involvement of patients and those close to them

- The individual plan of care and support for the dying person in the last days and hours of life (IPC) contained a section about the needs of carers and their understanding of the diagnosis. Carers were asked if they wanted to participate in the care of their relative so that staff could facilitate this. Concerns and fears of carers were recorded and also their own religious and spiritual needs. This was reviewed on a daily basis.
- We saw documented discussions of updates in their care and treatment with patients and their families.
- We spoke with patient's relatives who were confident to leave the patient in the care of the hospital staff while they went home to rest. There was a handover at bedtime when the night staff ensured that all contact numbers were correct.

Emotional support

- The staff on the wards referred to the specialist palliative care team (SPCT) for psychological support for patients. They said that the palliative care consultants were good at speaking to patients and families**.**
- The bereavement centre had information on counselling services, organ and tissue donation. A booklet called care after death was given to relatives about registration of death. Ward staff said that they gave the booklet to relatives and were fully aware of bereavement services. 97%of relatives who filled in the bereavement survey said that they found the booklet easy to understand.
- There were thirteen staff working in the bereavement service. Each death was allocated to a named individual. We saw staff at the bereavement centre supporting relatives in a sensitive way.
- There was bereavement support at the local hospice. This could be accessed by anybody living in the catchment area of the hospice.
- Staff were supportive of each other. A member of the SPCT had recently had bereavement and was supported by the palliative care lead nurse. One of the porters who was a bereavement champion had supported a team member who had lost a relative. A small number of porters were uncomfortable dealing with the deceased and the other porters on the shift always covered this aspect of the work.
- There was a regular memorial service for those who had died on the intensive care unit at the hospital. This was attended by members of the executive team.

Are end of life care services responsive?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of being responsive.

The EOL services were responsive to the needs of the local population and were providing good personalised palliative and end of life care to patients.

There was a rapid discharge pathway to transfer those in the last few days and hours of life to their home or to a care home dependent on choice. This was supported by arrangements with patient transport services. There was a good triage system, patients were prioritised and urgent patients were visited within the day by the SPCT. Others were seen within two days. Consultants would do home visits if necessary for patients with complex needs at the end of life.

There were good services to support those with a learning disability or autism from the safeguarding team at the trust.

End of life care

Staff from the team would support the ward staff and the patients during treatment. Staff knew how to access translators but there was very little written information available in any language other than English.

The porters were responsive and were auditing the time from patient's death to arrival in the mortuary. They were trying to reduce this to less than three hours. The mortuary services were good with a comfortable relative's room and viewing room. There were facilities in the mortuary for bariatric patients.

Work had been undertaken with the mortuary and the bereavement centre to produce a death certificate in a timely way. This was to meet the needs of a number of religions who preferred that funeral arrangements are made as soon after death as possible.

Service planning and delivery to meet the needs of local people

- The trust was not collecting data about the numbers of patients dying in their preferred location or patients discharged within 24 hrs. of death. The electronic palliative care co-ordination system (EPaCC's) would collect this data when the system was implemented in December 2015
- There was a triage system for the assessment of patients by the SPCT. Information about the patient would be faxed to the SPCT office. Urgent referrals would be seen within the working day, moderate referrals by the end of the next working day and non-urgent within two working days. This was audited and in the period May to July 2015 there was 100% compliance with these response times. If the patient could not be seen, telephone advice was offered.
- There was a rapid transfer discharge pathway for the dying patient in the last few hours and days of life which had a multi- disciplinary approach. This was to support the rapid, safe transfer of care to home or a care home dependent on the patient's choice. There was a tool to facilitate this; both the pathway and the tool were being reviewed by the trust due to changes in national and local end of life care. The SPCT recognised that the pathway had trust wide educational requirements that the review would address There was a rapid transfer ambulance arrangement with a dedicated phone number that allowed a two hour response to transfer a patient in the last days of life.
- The mortuary had a relative's room and a viewing room which were comfortably furnished with abstract pictures and subdued lighting.
- There were suitable facilities in the mortuary to accommodate varied physical needs, including bariatric patients?
- Some religions require that the funeral takes place as soon as possible after death. Staff at the bereavement centre and the mortuary had liaised with the Muslim Council, local imams and funeral directors in order to assist with the timely release of patients and paperwork had been developed to facilitate this process. There was an out of hour's process to support the transport of a deceased patient out of the country.
- New doctors and student doctors were trained in the completion of death certificates and were encouraged to complete these in a timely manner. We observed a doctor completing a death certificate. Following training and a competency assessment some nurses at the trust could complete a death certificate for an expected death and the certification of the death would be completed by the doctor. This was in line with the trusts' "verification of expected death" policy. There was draft guidance for all nurses if a patient died out of hours and there was the need for an urgent funeral service. We were not told when this would be approved
- The coroner's office was based on site alongside the bereavement centre and the coroner was sensitive to cultural needs. A registrar of deaths was available two days per week but if a deceased patient needed to be collected quickly there was access to an on call registrar of deaths.
- There was a lower uptake of EOL services from the local ethnic populations than the white British population. The clinical director was aware of this and action was planned to understand the reasons for this.

Meeting people's individual needs

- The consultants conducted home visits for complex patients and applications for continuing health care were fast tracked when the patient was in the last year of life.
- Staff knew how to access interpreters for face to face contact and language line. Due to the diversity of staff in the trust many different languages were spoken, staff were used as interpreters if necessary and where

appropriate. Staff could also access British Sign Language services for patients who were deaf or hard of hearing. Very few information leaflets that we saw were available in any other languages than English.

- There was a specialist nurse for patients with a learning disability and autism. Patients were flagged on the electronic patient system so the nurse was aware that they were in the hospital. They would try to visit them and was available to provide information and support to the ward staff. If a patient was a planned admission staff would work with the patient and their carers before the admission
- We spoke with staff on a dementia friendly ward. There was awareness that there was an increase in the needs and support required for patients with dementia or reduced cognitive function at end of life. Ward staff had developed a bereavement folder that was maintained by the link nurse and the ward manager. The ward used volunteers to support relatives on the ward with refreshments and quiet spaces to sit.
- All the SPCT had received training in advanced communication skills. The bereavement champions had also received additional training in communication skills
- Patients were nursed in side rooms if available, though on some wards there were only two side rooms that were prioritised for patients with infections. If a side room was unavailable patients were located in calm and quiet areas of the ward with easy access for relatives and close to the nurses' station.
- When a patient died the ward staff would prepare them appropriately dependant on their infection control risk.
- The patient was escorted to the mortuary in a discreet manner.
- There were facilities for the washing of bodies in the mortuary but this was usually done at one of the local mosques. When a Muslim person dies it is the responsibility of the family to wash them according to Islamic rites to prepare them for burial; if a body could not be released quickly, prayers could be said in the mortuary.
- The notification of death was done on the ward and the porter would log the patient and time of arrival at the mortuary. The patients' belongings were sent to the bereavement office unless the patient had died out of hours or in the accident and emergency department in which case they were stored securely in the mortuary.

Access and flow

- Referrals for the SPCT were made via faxed by post. Referrals for the SPCT were received and the information was entered onto the Community Patient Administration System (CPAS) All the new referrals were reviewed and prioritised on a on the same day for hospital patients or by the next working day for patients in the community. For urgent referrals the team was contactable by phone.
- Nursing staff were aware of the rapid discharge home to die and said that they usually managed to facilitate this if it was the wish of the patient.
- Funding was available to support patients who needed to be discharged over the weekend period. This funding without prejudice ensured that patients could die at their preferred place of care
- The mortuary were auditing the time taken to transfer to the mortuary. They were trying to reduce this from four hours to less than three hours. The chaplain would work with relatives and carers following a death to help to facilitate the transfer of a patient to the mortuary.

Learning from complaints and concerns

- The SPCT received few complaints and these were generally dealt with informally.
- We saw an example of an incident where the patient felt that they had received unsatisfactory care. They were unhappy that their spirituality needs were not met and that the carers needs had not been met. The reflective template had been completed with actions and learning and a section on what could have been done better. An apology had been sent to the patient and their carer.

Are end of life care services well-led?

Good

Summary

This inspection has resulted in an improved rating from requires improvement to good in terms of being well-led.

There was executive and non-executive leadership for the end of life service (EOL). There was good leadership from the clinical director of the service and from the members of the specialist palliative care team. A cross-divisional EOL

care strategy and operational group had been set up with reporting links to the board ensuring that EOL care was a priority for the trust. The group was effective with an action plan that was closely monitored.

The specialist palliative care team were respected by staff on the wards because they were responsive and supported staff to care for those at the end of life.

Staff were motivated, enthusiastic and proud to work there. They felt that they had come a long way in the past two years since the Board had gained stability.

All aspects of the bereavement service were well run and the service was focused on the experiences of both the patient and the relatives of the bereaved.

Vision and strategy for this service

- There was an executive and a non -executive lead for EOL care. The executive lead was the Director of Nursing.
- There was an EOL care strategy and operational group that met monthly. The group was chaired by the chief medical officer for the trust and the director of nursing was a member of the group. The group had identified six key priorities from the Pennine and Lancashire EOL care strategy and developed an action plan which was managed by the group.
- The EOL care strategy and operational group had implemented the good practice guidance and actions for care of the dying patient and the three monthly divisional audit was launched in the first three months of 2014. A position statement had recently been agreed which will go to the EOL care steering group in November 2015 There was a vision for EOL care for the trust. The SPCT were aware of this vision although some of the ward staff were not aware of its existence.

Governance, risk management and quality measurement

- The non-executive lead for EOL was the chair of the patient safety and governance committee which was a committee of the board.
- The EOL care strategy and operational group reported to a subsidiary committee of the board. The minutes from these meetings went to the patient safety and governance committee. We attended the EOL care strategy and operational group. It was a well-structured meeting that had processes for ensuring that actions were taken and performance managed.
- The SPCT were part of the integrated care group management structure and had become a directorate in its own right. This had significantly raised their profile in the organisation There was a block contract and was mainly used for staffing.
- The trust board received a report on end of life care every year. This report included the results of the care of the dying audit, themes of complaints and numbers of trust staff attending EOL training
- Action plans from the three monthly care of the dying audits were developed at divisional level and discussed at quality and safety meetings.
- The EOL care action plan was a standing agenda item on each of the monthly directorate meetings.
- There was a risk register for the SPCT; risks that scored above nine were reported on the directorate register although here was nothing on the directorate risk register at the time of the inspection. The consultant vacancy was recorded on the risk register but the consultant out of hours cover was not Risks related to end of life care that were identified by divisions were recorded on their own risk registers.

Leadership of service

- There was good clinical leadership from the consultant who was the clinical director for the service.
- The service had developed considerably in the last twelve months since becoming a directorate within the division. This was supported by one of the consultants having a designated clinical director position. This allowed them to better engage with other consultants in the trust.
- The SPCT team demonstrated effective leadership and were respected by the staff on the wards.
- The bereavement co-ordinator showed good leadership which was reflected by the development of the bereavement service. The bereavement care co-ordinator was pro-active in the delivery of the service and was striving for the chaplaincy to become pivotal addressing cultural, religious and spiritual needs.

Culture within the service

End of life care

- The staff were proud of their improvements in end of life care.
- The SPCT had a culture of continual improvement. All staff were enthusiastic about the service they delivered and were continually striving to improve all aspects of their service
- Nursing staff said the culture on the wards was open and inclusive. One said that the ward ethos was one of care and support for patients requiring EOL care.
- All staff were enthusiastic about the service they delivered and were continually striving to improve all aspects of their service.
- The bereavement service worked with patients and their relatives to provide the best service they could to make the bereavement process as seamless as possible.
- The mortuary manager described the porters as the backbone of the organisation. All staff in the mortuary and the bereavement service worked together to provide good end of life care for patients and their relatives.

Public engagement

- There was a patient experience group and a patient experience survey was undertaken every month. Five patients were invited to participate. We saw the results for August and September 2015. There was 100% satisfaction from participants.
- There were two patient representatives who were members of the EOL care strategy and operational group. This showed that the patients had a voice at the highest level.

Staff engagement

- There was a culture of team working in the SPCT which supported patients receiving end of life and their relatives.
- The minutes for the EOL strategy and operational group meetings were shared at the palliative care team meetings.

Innovation, improvement and sustainability

- The EOL strategy and operational group has worked to improve EOL and palliative care services across the trust. There have been significant improvements in services and future improvements will be driven by this group.
- The SPCT are working to embed the strategy into all divisions and specialties in the trust. The education programme for all staff had improved education and training in this area.

Outstanding practice and areas for improvement

Outstanding practice

The leadership of the surgical division was proactive in terms of their governance and performance management arrangements. There was a systemic approach to working with other organisations to improve care outcomes and tackle health inequalities. An example of this was the joint working of the clinicians within the North West theatre network where shared learning and benchmarking was a key focus. There was a strong climate of positivity with high levels of staff satisfaction. The trust ranked in the top 100 places to work in the NHS in an external health journal poll. Staff and patients told us they felt well engaged and their views were valued.

Innovative approaches were used to gather feedback from people who use services, such as a text messaging service to ask patients to complete the NHS Friends and Families test and also the use of a blog within theatres. The leadership was driving continuous improvement and staff were accountable for delivering change. We saw several examples of safe innovation across the surgical division, including robotic surgery, theatre open days to break down barriers between community and operating theatres and the use of social media.

Areas for improvement

Action the hospital MUST take to improve

Ensure safe and accurate medicines administration and documentation particularly in terms of;

- the recording of controlled drugs which patients have brought into the acute medical unit.
- oxygen prescribing and documentation on the medicine prescription and administration record.

Ensure the safe access and use of electronic patient records in terms of;

- all staff having access when required
- maintaining the confidentiality of records particularly in communal areas.

Action the hospital SHOULD take to improve

In Urgent and Emergency Care;

Work to improve the frequency staff assess and record a patient's mental state following findings that this was only done in 30% of cases

In Medicine;

Consider how medicine storage fridge temperatures could be accurately recorded and action taken where they are not within the correct range.

Improve staff uptake on the medical wards of mandatory training.

Consider improving staff awareness of their role should a major incident occur.

Improve the services for patients who had suffered a stroke including the input from speech and language specialists.

Nursing staff on the medical wards should be up to date with an appraisal of their performance.

In End of Life;

Work with commissioners to provide a seven day service.

Consider re-audits of DNACPR records to ensure that all records are correctly completed and all discussions with patients and families are documented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(g)** The hospital must make sure the records on the acute medical unit of controlled drugs which patients have brought in to hospital are accurate.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2) (c)** The hospital must maintain securely an accurate, complete and contemporaneous record in respect of each service user. This will not always be possible if some staff do not have the access required to complete records.