

East Lancashire Hospitals NHS Trust

Burnley General 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)

Requires improvement



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, surgical and end of life services.

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 aggregated 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 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 on-going 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.
- 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 board and executive team contributed greatly to the culture of continuous improvement.
- Leadership across the departments was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.
- The mortality rates had improved and were now within expected limits.
- 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.

We saw several areas of outstanding practice including:

- Theatres ran interactive open days where they invited selective audiences, such as young people from the local high schools and people with learning difficulties. This initiative was to help break down some of the barriers between the community and hospital theatres. It also helped patients with learning difficulties become familiar with the theatre settings to help alleviate their anxieties around having surgery.
- A band 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.
- Each ward and theatre area held weekly staff meetings called 'Feedback Fridays.' These meetings were a two way process and covered all significant governance issues pertinent for their area, including lessons learned from incidents and complaints, the risk register for their individual areas and feedback from matron and governance meetings.

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

Importantly, the trust must:

- make sure the records on the acute medical unit of controlled drugs which patients have brought in themselves are accurate.

Summary of findings

- take action to ensure that patients in the Rakehead centre are enabled and supported to make, or participate in making decisions relating to their care or treatment to the maximum extent possible.

In addition the trust should:

Urgent Care

- Work to improve the levels of staff training in Mental Capacity Act and Deprivation of Liberty Safeguards training where these are low.
- Review resuscitation trolleys regarding the provision of neck breathing resuscitation equipment.

Medicine

- The trust should ensure that staff in the Rakehead centre adhere to infection prevention and control measures with regard to the use of personal protective equipment and the management of soiled linen.
- In the Rakehead centre the trust should ensure that medicines are correctly stored and hazard signage is in place for the safe storage of oxygen.
- The trust should ensure the provision of rehabilitation physiotherapy in the Rakehead centre is sufficient to meet the needs of patients.
- The area in the Rakehead centre for the promotion of independent living should be accessible to patients.
- The trust should ensure that the systems for assessing the mental capacity of patients and acting according to the outcome of that assessment are used in the Rakehead centre.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

At the last inspection in July 2014, we rated the service as requires improvement. Improvements were required in areas such as managing the public's expectation of urgent care services, transfer times between sites and delays for assessments of patients with mental health needs.

At this inspection we found improvements had been made in four of the five domains (caring maintained a good rating).

Access and flow through the department was good. Targets set by the Department of Health were being met. Assessments were generally completed within 15 minutes. In July 2015 99% of patients were admitted, transferred or discharged within four hours and in August 2015 the figure was 98%. Less than 5% of patients left prior to being seen in July (3%) and August 2015 (3.5%).

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 generally 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. Staff used national guidance to provide evidence-based care and treatment.

Patients received extra support from physiotherapists and Age UK. Age UK provided adult patients with support and advice relating to shopping, cleaning, food provision and pensions and referred patients for help with physiotherapy, mental healthcare provision and social services. Staffing was adequate and agency staff rarely used despite there being some vacancies, due to sickness, maternity leave and promotion. Medical cover was adequate despite vacancies in the division. Middle grade doctors provided on site cover 24 hours a day, seven days a week and consultants were available during the day or on an on call basis.

Summary of findings

Children were cared for in the Children's Minor Injury Centre between the hours of 10am and 8pm Monday to Friday, and midday until 8pm at weekends with the final admission received at 6pm each day. The centre was staffed by medics, advanced paediatric nurse practitioners and paediatric nurses. Outside of these hours at least one trained nurse with advanced paediatric life support training was always on duty, and staff had links with medics from the children's ward based on site. Additionally, all nursing staff completed intermediate paediatric life support annually.

Staff felt supported and appraisal systems were in place. 14 out of 32 nursing staff had received their annual appraisal since May 2015. Training was managed by practice educators in the department, including core mandatory training and additional training including plaster skills 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. There was a culture of being open, sharing learning and seeking feedback to promote improvement. Risks, incidents, complaints and performance were reviewed through monthly clinical governance meetings. A risk register was in place which covered relevant topics. However some risks had been on the register for a number of years with no reference to when actions to mitigate them were instigated. Staff spoke positively about their roles and felt supported and encouraged by leaders. Engagement took place with the public to source their views and manage their expectations of the UCC and how this differed from the trust's main Emergency Department.

Medical care (including older people's care)

Requires improvement



At the last inspection medical services at Burnley General Hospital were rated as good. At this inspection some improvements were required in the Rakehead rehabilitation unit however services in other parts of the hospital were good. Staff were involved in learning from incidents, complaints and results of audits. They were caring, kind and respectful to patients and involved them in their own care. There was good record keeping and

Summary of findings

on the wards infection prevention and control measures met guidance. Systems were in place to detect deterioration in a patient's condition and measures were in place to obtain medical assistance. Nursing and medical staffing was adequate in all areas and there was a low reliance on agency staff. Staff felt part of the wider trust and were positive about improvements in the past 12 months.

In the Rakehead rehabilitation centre some improvements were required with regard to the provision of therapy services, infection prevention and control measures and medicine storage. Staff in this unit were not working within the guidance of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

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 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.

Summary of findings

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 theatre open days to break down barriers between community and operating theatres and the positive use of social media.

End of life care

Good



The EOL care service at the Royal Blackburn hospital was rated good overall with no domain requiring improvement. Although there were few deaths at the

Summary of findings

hospital, the SPCT team managed end of life care effectively. Staff attended full team meetings with the consultants from the EOL team and with the palliative care lead nurse.

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. The nursing staff ensured that they were up to date with policies and procedures for EOL care and asked for advice from the SPCT if necessary. Staff we spoke with were aware of the EOL care lead and the trust EOL strategy.

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 unregistered staff in EOL care. Staff in the SPCT 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 services were responsive and death certificates were issued in a timely way to meet the needs of different religions. Porters were respectful of patients when they took them to the mortuary.

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

Summary of findings

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.

Burnley General 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

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Background to Burnley General Hospital

Burnley General Hospital is part of East Lancashire Hospitals NHS Trust. The trust was established in 2003 and is a major acute trust located in Lancashire. Burnley General Hospital has 267 beds.

In 2013 the trust overall was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the medical director for NHS England) as part of the Keogh Mortality Review in July 2013. After that review, the trust entered special measures. 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. Burnley is a district in Lancashire. Census data shows that Burnley has a decreasing population and a lower than England average proportion of Black, Asian and minority ethnic residents. Life expectancy is lower for men and women in the most deprived areas of Burnley than in the least-deprived areas of the country.

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.

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?

Detailed findings

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 Burnley General 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.







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:

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

Information about the service

Urgent care services are provided at Burnley General Hospital by the urgent care centre (UCC), which is run under the trust's integrated care group division. The UCC was re-designed in 2007 from an Accident and Emergency (A&E) Department. The UCC moved into a new building in January 2014 which is shared with a GP out of hours service. Services operate 24 hours a day, seven days a week 365 days a year. Between January and October 2015, the UCC saw 43,226 patients (including 12,812 children) averaging 150 patients each day.

Burnley UCC provides treatment for illnesses or injuries which are not life threatening, but require treatment quickly such as minor head injuries, suspected broken bones, cuts, scrapes and eye problems. Whilst patients generally make their own way to the UCC, approximately seven per day are brought in by ambulance under strict criteria. There is a designated entrance for these patients.

Self-presenting patients at the UCC are directed to the adult or children's waiting area. The children's area and service is managed by a separate division within the trust called the family care division. This division provides paediatric services between 10am and 8pm each weekday. However the waiting area is accessible to UCC patients 24 hours a day seven days a week.

Patients then receive assessment in one of two triage rooms, followed by care and treatment in one of 14 treatment/consultation rooms. One room is used as a plaster room for patients with fractured limbs. Two rooms are designated for children.

Suitable patients can be referred to GPs who work in the UCC between 2pm and 11pm Monday to Friday, and between 11am and 11pm on weekends and bank holidays. Patients requiring emergency care are transferred to emergency departments (ED) in other local hospitals. The nearest ED is at the trust's other site, Royal Blackburn Hospital, which is also run under the trust's integrated care group division. Patients with minor injury or illness could also be seen at the trust's minor injury unit (MIU) in Accrington. The MIU was approximately seven miles away from the trust's ED unit and eight miles away from the Burnley UCC. We did not inspect this service.

During the inspection we spoke with 11 patients and 16 staff from different disciplines including doctors, nurses, matrons, cleaners and allied health professionals. We also reviewed ten patient records and observed day to day 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 managing the public's expectation of urgent care services, transfer times between sites and delays for assessments of patients with mental health needs.

At this inspection we found improvements had been made in four of the five domains (caring maintained a good rating).

Access and flow through the department was good. Targets set by the Department of Health were being met. Assessments were generally completed within 15 minutes. In July 2015 99% of patients were admitted, transferred or discharged within four hours and in August 2015 the figure was 98%. Less than 5% of patients left prior to being seen in July (3%) and August 2015 (3.5%).

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 generally 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. Staff used national guidance to provide evidence-based care and treatment.

Patients received extra support from physiotherapists and Age UK. Age UK provided adult patients with support and advice relating to shopping, cleaning, food provision and pensions and referred patients for help with physiotherapy, mental healthcare provision and social services

Staffing was adequate and agency staff rarely used despite there being some vacancies, due to sickness, maternity leave and promotion. Medical cover was

adequate despite vacancies in the division. Middle grade doctors provided on site cover 24 hours a day, seven days a week and consultants were available during the day or on an on call basis.

Children were cared for in the Children's Minor Illness Unit between the hours of 10am and 8pm Monday to Friday, and midday until 8pm at weekends with the final admission received at 6pm each day. The centre was staffed by medics, advanced paediatric nurse practitioners and paediatric nurses. Outside of these hours at least one trained nurse with advanced paediatric life support training was always on duty, and staff had links with medics from the children's ward based on site. Additionally, all nursing staff completed intermediate paediatric life support annually.

Staff felt supported and appraisal systems were in place. 14 out of 32 nursing staff had received their annual appraisal since May 2015. Training was managed by practice educators in the department, including core mandatory training and additional training including plaster skills 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. There was a culture of being open, sharing learning and seeking feedback to promote improvement.

Risks, incidents, complaints and performance were reviewed through monthly clinical governance meetings. A risk register was in place which covered relevant topics. We saw that some risks had been on the register for a number of years with no reference to when actions to mitigate them were instigated. However, the trust assured us that the risk register was regularly reviewed at directorate meetings where actions to mitigate risks were discussed and agreed.

Staff spoke positively about their roles and felt supported and encouraged by leaders. Engagement took place with the public to source their views and manage their expectations of the UCC and how this differed from the trust's main Emergency Department.

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 for safety in the urgent care service.

There was a culture of reporting, learning and making changes following incidents. The areas and equipment we inspected were visibly clean and tidy. Equipment was not always visible such as adult circular airway masks for patients with a tracheostomy. Staff also told us they could not administer some antibiotics when patients presented with symptoms indicative of sepsis because they did not have infusion pumps to enable them to administer them.

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 had access to the trust safeguarding team during office hours and a duty team outside of these hours.

There were plans in place and staff were trained to take action during major incidents.

Staff used tools to manage risk when assessing and monitoring patients and actions were taken during busy periods to improve patient experience by maintaining access and flow through the department.

The trust used a tool to accurately calculate the right number of staff required to care for patients. Although two vacancies were expected, we were told that staffing levels were adequate within the UCC and figures for nursing establishment confirmed this. Staff moved between sites to cover deficiencies. 5.5 consultants were employed within the division and worked across the two sites at Blackburn and Burnley. However, the establishment required ten consultants. The vacant positions were being filled by regular locum consultants.

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.
- 192 incidents were recorded for the division between April and July 2015. Of these 185 were graded as low or no harm.
- Incidents were shared at senior level and disseminated to staff in daily, weekly or monthly meetings depending upon the issues identified.
- Changes occurred as a result of learning. For example, portable heart monitoring equipment was provided for the UCC after two patients deteriorated in the department.
- 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 that have led to moderate or significant harm. 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. Training records showed that only two staff had dates recorded for completed training. However, staff described being open in their approach to patients when errors were made.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy with hand sanitizers available around the department. We observed staff following hand hygiene guidance when moving around the department, washing hands before and after treatment and using gloves and hand gel when required in line with good practice guidance.
- Hand hygiene, commode cleanliness and equipment decontamination audits were completed monthly. Hand hygiene and equipment decontamination audits showed, 100% compliance between April and July 2015. Commode cleaning audits showed 100% compliance in April 2015, only 67% in May and June 2015 and 100% in July 2015.
- Cleaning staff knew the department well, and told us what their routine was. Some cleaning schedules for consultation/treatment rooms were written on whiteboards. However, we did not see any overarching cleaning routines or recorded cleaning activity. Cleaning staff told us they did not have any records of what had been cleaned or when cleaning had taken place.

Urgent and emergency services

Environment and equipment

- The environment was light and spacious and patients told us the area looked 'very tidy'.
- Treatment/consultation took place in large rooms with frosted glass to ensure privacy for patients.
- There was a separate secure waiting area for children which had a range of toys to play with and television to watch. The waiting area led to two separate children's consultation rooms with secure access.
- We noted that the department had no hoists for assisting patients who were not mobile. However senior staff told us that hoists were rarely required (once or twice annually) and were borrowed from a specified ward if required.
- There was a room designated to care for patients with mental health needs. The room had two doors with no ligature points. Items such as chairs were fixed to prevent them being used for harm.
- The UCC had specialist equipment for ophthalmology, and ear, nose and throat patients.
- Resuscitation equipment was securely sealed and checked once weekly or whenever the seal was broken. Certain equipment was checked daily. We found some of these items (laryngoscope blades and airways) which should be sealed to keep sterile, were found to be open and were therefore no longer sterile.
- We checked the paediatric resuscitation trolley. Here we found equipment in a range of sizes to suit growing children and circular masks for tracheostomy patients. Again we found that some equipment which should be sealed was open.
- Whilst there were circular masks (for patients who breathe through a tracheostomy) on the paediatric resuscitation trolley, there were none on the adult resuscitation trolley. The National Patient Safety Agency recommended action to ensure that all resuscitation trolleys in Emergency Departments included appropriate equipment to administer oxygen effectively and manage the airway of a neck breather in March 2005(issue 2). Whilst the UCC was not an ED, staff told us that resuscitation was occasionally undertaken in the department.
- Nursing staff told us that there were times when they could not start treatment for sepsis because they did not have access to the equipment required to provide them intravenously (infusion pumps). In these case

patients would be transported to the main ED at the Royal Blackburn Hospital. Between November 2014 and October 2015, ten patients who attended the UCC were given a diagnosis of sepsis.

Medicines

- Staff used a combination of Patient Group Directives (written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available) and prescriptions to give medicine to patients.
- Medicines and controlled drugs were stored securely on site. These were checked and replenished three times per week by a pharmacy team.
- We checked the medicines and controlled drugs in the UCC and found the stock balances were correct and within expiry date. However some medicines used for children (paediatric syrups) were found to be open with no 'opened' date recorded.
- A range of medicines were stored in the UCC for patients to take home with them. These were available for patients between 5pm and 8am when pharmacies were closed.
- A robust system was in place to ensure the correct use of 'take home' medicines. Records were signed by two staff and copies of prescription forms kept. Nursing staff told us that the records were checked by pharmacy staff who would not replace stock if prescriptions were found to be missing. They gave us an example when this had occurred.
- 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. Archived records were also stored securely in a storeroom.
- We reviewed 10 patient records (five of which were children's records) which were clearly completed.
- We saw evidence that triage was well documented with observations and pain scores recorded.
- Child risk assessments were completed in all the paediatric records.

Safeguarding

Urgent and emergency services

- 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.
- All nursing and medical staff were required to complete level 3 safeguarding training on a three yearly basis as part of their mandatory training. We asked the trust to provide us with training figures for staff but were only provided with training figures for nurses. These showed all nursing staff were up to date. We were provided with trust wide figures for staff safeguarding training which showed that in June 2015, 78% of staff were up to date.
- Staff responsible for assessing children knew what triggers to look for which might indicate safeguarding issues, and were aware of current topics such as child exploitation and female genital mutilation.
- Using the department's child risk assessment tool also helped staff identify safeguarding issues.
- Staff told us that the UCC had access to a local register which highlighted children already identified as being at risk.
- Staff also told us that relevant school nurses were informed about concerns identified in the UCC.

Mandatory training

- 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.
- Staff told us that they were allocated protected time to complete mandatory training.
- Practice educators and matrons used a training matrix to maintain knowledge of nursing staff training requirements. This showed dates for when staff received training on the different topics. The matrix showed that 94% of staff were up to date with mandatory training. We were unable to obtain medical staff training figures for UCC, however training figures for all staff across the trust was reported as 73% in June 2015.

Assessing and responding to patient risk

- The UCC 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.
- Patients were triaged comprehensively and within the department of health target of 15 minutes with a range of questions including the nature of the problem, pain, past medical history, medications, allergies and next of kin.
- 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.
- Staff used risk assessment tools when assessing children and patients with mental health care needs. Support was available for staff caring for paediatric patients via the children's ward, situated on the same site.
- Reception staff were aware of the need to notify staff if patients arrived with particular problems such as chest pain.
- At times (during the night) the reception area was manned by one member of staff who could observe people waiting. However, staff found it difficult to leave the reception area (which would leave it unmanned) because of the risk that patients waiting may require assistance or unwell patients may enter the department.
- The department worked closely with specialist mental health teams, who deployed staff to provide one to one care for patients if required. This occurred approximately once a month and staff told us the response time for the team was usually between one and two hours. Staff were also able to contact a psychiatrist who worked on site if they were concerned about a particular patient.
- Strict admission criteria were in place for patients brought in by ambulance. Only those that fit the criteria could be brought directly to UCC rather than an ED. This helped to ensure that only patients well enough to receive urgent rather than emergency care were brought to UCC.
- The UCC had two portable heart monitors to care for patients who deteriorated whilst in the UCC or required emergency care upon arrival.

Urgent and emergency services

Nursing staffing

- The UCC assigned different grades of nursing staff to different areas such as triage or treatment. These included staff nurses and emergency nurse practitioners.
- Staff rotated between the Burnley UCC and a minor injury unit based in Accrington approximately nine miles away.
- The department had previously used a recognised workforce planning tool called the 'Baseline Emergency Staffing Tool (BEST)' to ensure staffing levels were adequate in the UCC. The matron told us that staffing was adequate and this was supported in figures the trust provided. Despite this there were two nurse vacancies following promotion to new roles, and four staff absent due to long term sickness and maternity leave. These issues were discussed at monthly governance meetings and we saw evidence that recruitment took place to fill posts.
- To manage shortfalls the UCC and ED staff moved between trust sites and used bank staff as well. The matron told us that agency staff use was rare. A process was in place to ensure any temporary staff received an induction to the department. Bank and agency staff received comprehensive induction to the department.
- Nurse handover of information took place twice daily at set times.
- Dedicated paediatric staff worked in the paediatric minor injury unit next door to the UCC. Additionally, at least one nurse with advanced paediatric life support training was on duty at all times.

Medical staffing

- There were 5.5 whole time equivalent substantive consultants who provided cover for the ED at the Royal Blackburn Hospital and the UCC at Burnley Hospital. However the establishment was for 11 consultants. The short fall was filled by three regular long term locum staff but there was still a 1.5 whole time equivalent shortage. The trust said 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.
- Consultant cover at the UCC was available between 9am and 5pm each weekday. Outside of these times consultants were available on an on call basis.

- Middle grade doctors provided cover in the UCC 24 hours a day seven days a week. Medical staff rotated between Blackburn and Burnley hospital sites as well as across different disciplines such as acute medicine and intensive care.
- A clinical fellow worked between 8am and 4pm each weekday. (A clinical fellow is a junior doctor gaining experience in a speciality but not in a formal training post).
- Junior doctors worked between midday and midnight, seven days a week.
- The trust was unable to provide figures relating to medical training for paediatric life support or advanced paediatric life support. However nursing support was available in the department as well as paediatric staff from the on-site children's ward.

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.
- The UCC was not a 'receiving site' for major incident patients and as such did not keep major incident equipment. However, staff knew what actions to take if a major incident was declared by the trust or another local agency.
- Staff in the UCC were trained how to manage patients presenting with Ebola or Middle East Respiratory Syndrome (MERS). Ebola and MERS are serious viruses originating in other countries. As these patients would require care and treatment in an ED, UCC staff were limited in what care they could provide. However, they explained the process for keeping the patient segregated from others prior to transfer to an ED.

Urgent and emergency services

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 trust participated in national audit programmes by the College of Emergency Medicine (CEM) division. The UCC received details of audits undertaken and worked in conjunction with ED colleagues to improve outcomes. Some plans for improving sepsis care were in progress but treatment for sepsis (that NHS England guidance recommends is given within one hour) was not available at the UCC. Pain relief was offered to patients and pain scores were routinely recorded. Not enough staff were trained in the Mental Capacity Act or Deprivation of Liberty safeguards.

Staff felt supported by their managers and there were appraisal systems in place. We saw evidence that regular staff appraisals took place.

Evidence-based care and treatment

- Staff followed trust guidelines issued by NICE and had locally defined guidelines, protocols and care bundles. These were included in on line handbooks covering adult and paediatric care. Hard copies were also available at the nurse's station. They included information about falls care, dementia care, safeguarding, 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.

- 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 weekly or monthly basis. These included use of the child risk assessment tool, patient record completion and the storage and use of controlled drugs. Findings were shared through presentations. For example, an audit in July 2015 assessed the use of the child risk assessment tool when triaging patients. The results showed improvements since previous audits in January 2015 and May 2014 with 100% of assessments being completed. We saw an example of a random audit of the controlled drug storage in the UCC completed in January 2015. This showed a number of required elements were actioned, including drugs being stored and locked in an approved cupboard, writing in the storage record book was accurate and legible, and balance checks were being undertaken at least once weekly.
- We saw a range of algorithms in rooms to support staff. These covered issues such as triaging patients and calculating early warning scores in paediatric patients.
- Physiotherapists were part of groups with specialist interests in upper or lower limb, and spinal care. They helped develop pathways for specialist care in limbs.

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 during initial assessment.
- Pain scores were recorded in patient records and we observed patients being offered medicine to ease pain.

Nutrition and hydration

- A vending machine was available for patients, relatives and visitors which was regularly replenished.
- We spoke to 11 patients and found six of them had not been offered anything to eat or drink. However, in July and August 2015 the average time spent in the department was one and a half hours and two hours 11 minutes respectively.

Urgent and emergency services

Patient outcomes

- The Department of Health target for less than 5% of patients to re-attend within 7 days was met in July (1.8%) and August 2015 (2.4%).
- The trust's integrated care division participated in national audit programmes by the College of Emergency Medicine (CEM) and action plans were generated to improve performance as a result. We reviewed the latest audit and action plans. The audit of assessment of mental health patients in the ED (2014/15) showed that an examination of a patient's mental state was only assessed and recorded in 30% of cases against a target of 100%, risk assessments were completed and recorded in only 76% of patient records and previous mental health history was recorded in 84% of patient records. The only action recorded against these results 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 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. Findings were due to be presented in November 2015.
- The Matron informed us that results of CEM audits and action plans were disseminated to UCC staff and work to improve outcomes for patients was done collaboratively within the division.
- The trust told us that following the results of an audit in 2014, improvements were required to improve the care of patients with sepsis. Sepsis criteria and information about the 'sepsis six bundle' (a range of therapies designed to reduce mortality relating to sepsis) were displayed for staff.

Competent staff

- Staff told us they received appraisals annually and nursing records showed that 14 staff had received an appraisal in the last 6 months.
- Reception staff were trained to manage different scenarios through role play, however the majority of training was experience based. The reception staff we spoke to had over ten years' experience in the role.

- Nurse practitioners were given the opportunity to complete individual modules at masters level. Other nurses requested further training in plaster skills and a workshop was put together which allowed them to do this. Bespoke training was reviewed by the trust's learning and development team prior to being implemented.
- Physiotherapists were keen to enhance their qualifications but were told there were currently no funds to allow this.
- In the last inspection we identified that not enough staff were trained to care for very unwell children. Since then the UCC had increased paediatric staffing to two qualified paediatric nurses. Senior staff told us that all nursing staff of NHS band 6 grade were trained in advanced paediatric life support (APLS). One staff member had been 'trained to train' and further training was being cascaded to the rest of the nursing team.

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 were transferred from Burnley UCC to Blackburn ED if required. The local ambulance service NHS trust provided the resource for transfers but transfers were managed by the trust. Between July and October 2015 the ambulance trust transferred between two and 11 patients daily.
- Staff worked together to care for patients. We saw examples of nurses, physiotherapists and doctors seeking assistance from each other when they were unsure.
- Age UK were based in the UCC, accepting referrals from medical staff. They provided adults with support and advice relating to shopping, cleaning, food provision and pensions. They were able to refer patients for help with physiotherapy, mental healthcare provision and social services. They were included in daily meetings with organisations including the trust, the local ambulance service
- Work with the local ambulance service NHS trust took place to ensure the criteria for bringing patients directly to UCC was adhered to.
- The UCC worked closely with a neighbouring NHS trust to care for patients with mental health needs. Should

Urgent and emergency services

patients require admission to hospital under the Mental Health Act, this was done by the neighbouring trust that provided a response 24 hours a day, seven days a week. Staff told us the response time was between one and two hours.

- GP's worked within the UCC providing support for patients with minor injuries This area was managed by the UCC. They were available between 2pm and 11pm on weekdays and from 11am to 11pm on weekends and bank holidays.
- GPs worked on site for separate organisations and were able to request assistance from nursing staff if required.
- Five physiotherapists worked in the UCC supporting staff and patients through the assessment of limb and spinal injuries and back pain. They liaised with doctors and consultants when requesting scans or for support with treatment plans. They also liaised with local community teams such as the falls team for patients requiring support at home or social care. Nursing and medical staff were able to refer patients to the physiotherapists.
- Play specialists worked in the UCC to help children by using distraction techniques when undergoing tests or treatment.
- Physiotherapists were also able to refer patients for specialist treatment for neuro or plastic surgery at other local NHS trusts.

Seven-day services

- During the inspection in July 2014, we noted there were plans to extend the physiotherapy service to a seven-day a week. During this inspection we saw that this had not yet been done. Physiotherapists working Monday to Friday told us plans were in place to expand the service to weekends from January 2016.
- Middle grade doctors, junior doctors and Age UK representatives worked in the UCC seven days a week.
- Security staff worked in the UCC 24 hours a day, seven days a week.

Access to information

- Staff were able to access the information required to care for patients. This included diagnostic reports, guidelines and care bundles. The guidelines and 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.

- Nursing staff told us x-ray reports were usually received within 20 minutes under a 'hot reporting' scheme, available during office hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The UCC training matrix showed Mental Capacity Act and Deprivation of Liberty Safeguards training was in place. However, we were unable to decipher which staff were selected for, or had completed the training except for two staff out of 32 who had completion dates listed. Senior staff acknowledged that only a few staff had undertaken this training.
- Although training records covered a range of topics, consent training was not listed. Despite this we saw evidence that staff understood the principles of consent when asking the parents of a young child for consent to take blood.

Are urgent and emergency services caring?

Good

Summary

This inspection has resulted in no change to the rating of good for caring in the urgent care service.

The UCC provided a caring and compassionate service to patients and those accompanying them. We observed staff treating patients with privacy, dignity and respect and patients told us this was the case.

Patients felt involved in their own care and were given time to ask questions and discuss treatment. We saw relatives being involved in the process.

Staff working for the division were 'champions' for dementia and safeguarding which enabled them to offer support to these patients in particular. Play specialists worked in the UCC.

Compassionate care

- The UCC used NHS Friends and Family questionnaires and incorporated these into their own more detailed patient satisfaction survey. This was the case during our last inspection in 2014, but since then the response rate

Urgent and emergency services

had increased from 3% to approximately 25%. Staff continued to improve the response rate by placing the questionnaires in prominent places and encouraging completion.

- The feedback received in September 2015 showed that 97% of patients were given privacy and 98% of patients felt they were treated with dignity and respect.
- Patients we spoke to described staff as 'lovely, polite and friendly'.
- Staff introduced themselves to people during the triage process. They built a positive rapport and interacted well with children.

Understanding and involvement of patients and those close to them

- The UCC patient satisfaction survey for September 2015 showed that 96% of patients felt care and treatment was fully discussed with them, and they were given time to ask questions about care.
- We saw evidence of staff informing relatives that a patient was being cared for in the UCC.

Emotional support

- Having individual consultation/treatment rooms allowed for a more private environment for patients or families who were distressed.

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

Good



Summary

Children were catered for in a designated waiting area 24 hours a day seven days a week. Translation was available for patients whose first language was not English. Sign language was also available. Patients living with dementia were supported with dementia friendly signage. For patients with mental health needs there was a place of safety available whilst they waited for specialist help to arrive. Although fit for purpose, staff agreed that the room was stark with no pictures and the acoustics produced an echo which was less than ideal.

Treatment was usually provided in a timely way with few breaches of the Department of Health target to admit, transfer or discharge patients within four hours of arrival. Targets to commence and complete treatment were also met.

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 able to wait in the paediatric waiting area and were seen in one of two rooms designed for children with pictures on the walls and toys to play with. Although this area was not managed by the UCC, access was provided 24 hours a day seven days a week.

Meeting people's individual needs

- The UCC used a hearing loop for patients and visitors with hearing problems. Sign language interpreters were requested via the main switchboard if required.
- Staff were aware of different ethnic groups in the local area.
- For patients for whom English was not their first language, staff used a translation book endorsed by the British Red Cross. Telephone translation called 'language line' was also available. The hospital switchboard also kept details of staff who spoke different languages to assist if required.
- 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.
- There was a room in the department designed to keep mental health patients safe. The room had windows which allowed monitoring to take place, fixed furniture and no ligature points. In addition there were two exits to maintain the safety of staff. Staff agreed that although the room was fit for purpose in terms of safety it was stark, with no pictures on the walls and poor acoustics.
- The trust had access to request particular staff to come and care for patients with mental health needs on a one to one basis if required.
- Special signage for patients living with dementia or learning disabilities was used on toilet doors and Age UK were based in the UCC to assist adult patients.

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- The UCC had two bariatric wheelchairs and a trolley for bariatric patients to use if required.

Access and flow

- The Department of Health target for urgent care centres is to admit, transfer or discharge patients within four hours of arrival. The matron informed us that breaches rarely occurred in the UCC. This was supported by figures which showed that 99% of patients in July 2015 and 98% in August 2015 were admitted transferred or discharged within four hours.
- The UCC met the department of health target to treat patients within an average of one hour in July and August 2015. They also met the target that less than 5% of patients should leave the department before treatment.
- The department of health target to commence initial assessment of patients within 15 minutes was also met in July 2015 (on average 6 minutes) and August 2015 (on average 7 minutes).
- The trust funded one ambulance to transfer or discharge patients which helped maintained flow through the UCC.
- The UCC usually used one room to triage patients, but we saw them open a second room to triage patients when numbers waiting started to rise.
- The department employed nurse practitioners to provide assessment and care for patients. This improved the skill mix of staff.
- Physiotherapists working in the department completed mobility assessments for patients, to confirm patients were safe to be discharged.
- Some nursing staff were able to refer patients for x-ray and provide pain relief which reduced delays and maintained the flow of patients through the department.
- Up to two UCC staff worked in the reception area during the day and one at night time with another receptionist working separately who was co-located with the GP service. Staff told us queues formed at times during the day which they found difficult to cope with.

Learning from complaints and concerns

- The UCC used a designated email folder system to filter complaints from the trust complaints team.

- However, if possible staff told us that they tried to deal with complaints at the time they occurred by summoning a senior staff member to deal with the issues raised.
- Leaflets were available which explained the complaints process to patients should they wish to make a formal complaint.
- All formal complaints were seen and investigated by the matron.

Are urgent and emergency services well-led?

Good



Summary

This inspection has resulted in an improved rating from requires improvement to good for leadership in the UCC.

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 and complaints. 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.

Vision and strategy for this service

- The trust's vision was visible in the UCC and staff were clear about the services offered, and what needed to be improved. They were able to tell us what plans were in place for the future.
- Staff had undergone a period of change following change to infrastructure and were keen to promote the scope of the UCC to local residents. This was being done with the help of the trust's communications team.

Governance, risk management and quality measurement

Urgent and emergency services

- Monthly governance meetings took place where a range of regular topics were discussed. These minuted and available for all staff on the trust system.
- Mortality and morbidity was discussed at these governance meetings where lessons for learning were identified. A UCC risk register was in place which cited issues, actions to mitigate, and review dates. However, some risks had been open since 2008 and the way the details were presented meant we could not see updates or reviews to show whether the actions to control risks were effective.
- Security staff were present in the department to maintain safety 24 hours a day seven days a week.
- CCTV was used to monitor patients in real time (not recorded). Signs were displayed to inform visitors that CCTV was in use in some areas. CCTV was not used in consultation/treatment rooms to maintain privacy and dignity.
- The room assigned for patients with mental health needs had a fixed panic alarm and staff carried personal alarms with them at all times.

Leadership of service

- Staff felt supported and well informed in their roles. They also felt encouraged by staff responsible for training them.
- Staff described managers as approachable and they felt able to raise concerns with the matron who had a visible presence in the department.
- Staff described the board as 'stable' and there being a 'clear chain of command' within the trust.
- Managers were visible and the matron described working with the team to provide clinical support when the UCC was under pressure.

Culture within the service

- Staff spoke positively about their roles and the services they provided for local people.

- Staff described an open culture where they enjoyed work and felt part of a wider team.

Public engagement

- Following the change from a local A&E department to a UCC the trust communications team had worked to educate the public about the function of the service. This message was reinforced one year later in local newspaper articles.
- Senior staff reported that more needed to be done by continuing to manage public expectation that patients attend the nearest ED for emergency care or treatment.
- Staff sourced opinions from patients through use of the 'Friends and Family' test and a UCC patient experience questionnaire. Response rates were improving.
- The UCC staff produced monthly health promotion displays on noticeboards. During the inspection the noticeboard displayed information about firework safety.







Staff engagement

- Staff spoke highly of the chief executive and told us trust executives were visible and communicated with staff regularly via a blog.
- Staff had the opportunity to discuss concerns or queries in daily meetings.
- An Employee Engagement Sponsor Group was in place which in 2015 organised 12 group meetings called 'big conversations'. 720 staff attended these meetings to give their views about the service.

Innovation, improvement and sustainability

- The trust were part way through plans to enhance clinical skills of staff and improve the transfer times for patients between the UCC and the ED at the Royal Blackburn Hospital.

Medical care (including older people's care)

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

Information about the service

We visited Burnley General Hospital as part of our announced inspection of East Lancashire Hospitals NHS Trust on 19 and 20 October 2015. The medical care services at the hospital provided care and treatment for a patients who had were receiving rehabilitation following more intensive care and treatment at Royal Blackburn Hospital or those who had been transferred as they no longer required acute medical care but were not ready to return home. Some patients needed changes to their social circumstances before they could return home. There was a day unit where patients could have blood tests or procedures that did not require an overnight stay. Rakehead rehabilitation unit was a separate building in the hospital grounds, where neuro-rehabilitation was provided for patients following illnesses which resulted in physical and mental impairment. This included strokes, multiple sclerosis and acquired brain injury.

During the inspection we visited ward 16, ward 23, 28 the endoscopy unit and Rakehead rehabilitation centre.

We reviewed the environment and staffing levels and looked at eight care records. We spoke with two family members, seven patients and 14 staff of different grades, including nurses, doctors, ward managers, matrons and housekeepers.

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 medical services at Burnley General Hospital were rated as good. At this inspection some improvements were required in the Rakehead rehabilitation unit however services in other parts of the hospital were good.

Staff were involved in learning from incidents, complaints and results of audits. They were caring, kind and respectful to patients and involved them in their own care. There was good record keeping and on the wards infection prevention and control measures met guidance. Systems were in place to detect deterioration in a patient's condition and measures were in place to obtain medical assistance. Nursing and medical staffing was adequate in all areas and there was a low reliance on agency staff. Staff felt part of the wider trust and were positive about improvements in the past 12 months.

In the Rakehead rehabilitation centre some improvements were required with regard to the provision of therapy services, infection prevention and control measures and medicine storage. Staff in this unit were not working within the guidance of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Medical care (including older people's care)

Are medical care services safe?

Good



Summary

Medical care services at Burnley General hospital were good in terms of being safe. However there were some issues which required improvement in the Rakehead rehabilitation centre. The issues we found in Rakehead rehabilitation centre were discussed with the trust at the time of the inspection. They responded by carrying out an assessment of the quality of care provided and developed an action plan for improvement.

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; however we saw some practice which did not meet guidance in the Rakehead Centre. Equipment was checked within expected timescales. Medicines management was in line with guidance except for two storage issues in the Rakehead Centre.

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. Nurse staffing was appropriate with low agency use and medical staffing provided adequate clinical support including out of hours. Most of the staff in the medical services were up to date with their mandatory training.

Incidents

- The highest number of incidents at the trust, 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 additional measures to reduce falls including the use of technology to alert staff to patients at risk.
- At the last inspection 40% of incidents were pressure ulcers grade three or four. At this inspection this had reduced to 7%.
- The number of recorded incidents in the medical services had fallen from 649 in July 2014 to 494 in July 2015. The largest number of these 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. This was trust wide data and not specific to the wards in Burnley General Hospital.
- Staff knew how to report incidents and were confident to do so if required. They received information at the monthly ward meetings about incidents which included any themes and learnings with any agreed changes to practice.
- 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 made as a result were discussed.
- Safety huddles were used to discuss any incidents which required immediate dissemination of information.
- 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.
- Managers knew how to follow the duty of candour regulations when any incident occurred.
- 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.
- 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 discussed at the monthly meetings of the mortality steering group where senior medical and nursing personnel were in attendance.

Safety thermometer

Medical care (including older people's care)

- 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 data included information about pressure ulcers, falls and catheter acquired urinary tract infections
- The information about harm free care, such as the number of falls per month, was displayed at the entrance to each ward. Staff told us this was discussed during the share to care meetings in order to measure their safety performance and identify areas for improvements.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy. Patients told us the wards were clean and they had no concerns about the cleanliness of the environment or equipment.
- Between April 2014 and March 2015, there were no cases of MRSA in the medical services and one case of Clostridium Difficile.
- On the wards staff adhered to infection control guidance by washing their hands between patient care and wearing personal protective equipment. However on the Rakehead unit we saw staff carrying used linen in their arms along a corridor wearing gloves and apron. They then returned to the patients' room wearing the same protective clothing. This does not meet with infection control guidance.
- In the Rakehead unit the holders on the walls to store personal protective clothing within close proximity to the patients were empty. This meant this equipment was not readily available for staff.
- 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 agreed if any ward was not meeting the required standard. In the past four months only one ward had not met the trusts' target of 95% compliance scoring 93% on one occasion.

Environment and equipment

- The resuscitation equipment had been checked in line with the trusts' policy and these checks were recorded.
- Equipment such as hoists and mobile scales had been checked in line with the manufacturer's guidance and these checks were recorded.

- There was a variety of physiotherapy equipment available for patients use in Rakehead centre. This included a therapy bed, exercise balls, stairs and walking bars.
- There was a variety of entertainment equipment in the Rakehead unit which patients could use. This included computers and games.
- On one ward the hoist for safely moving and handling patients had recently become out of order. Staff were able to ensure temporary equipment was provided to safely move patients and said that such items were usually repaired quickly.
- Clear access to a fire exit was blocked in the Rakehead unit. A hoist was plugged into the wall opposite fixed seating which meant there was no space for wheelchair access to the fire exit in that area. This presented a risk to patients and was discussed with the staff at the time of the inspection. Other fire exits were accessible within the area.

Medicines

- In most of the wards and units the medicines were securely stored.
- In the Rakehead unit there were loose strips of tablets which were not in boxes in one of the cupboards. This did not meet with safe storage of medicines guidelines.
- The controlled medicines we checked were stored securely and accurate records were checked. This included records when patients had their own medicines which they then took out of the unit when they returned home for short visits.
- The fridges used to store medicines were locked and the temperatures had been checked and recorded. These were within the safe temperature limits.
- In the Rakehead unit there were no hazard warning signs on the door where oxygen was kept. This did not meet with fire prevention regulations.
- Staff received medicines management training as part of their induction and were asked to read the trust policy on medicine management. There was no further training or assessment of competency unless 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.

Records

- Most nursing records had been completed with detailed information about a patients care needs and how these

Medical care (including older people's care)

should be met. However in some areas records of food intake and the frequency of checks for a patient's skin that was at risk of developing a pressure sore had not been kept up to date.

- There were documented assessments for the risk of malnutrition and developing a venous thromboembolism. There was a multifactorial assessment for the risk of falls. This included cognitive impairments, medication and any continence issues. Those we saw had been reviewed and were up to date.
- Nursing care plans included goals for rehabilitation when appropriate and reviews of progress towards meeting those goals.
- There had been a recent move from paper to electronic records. The records which had been printed from the electronic system were clear and fully completed.
- Not all staff had passwords to access the electronic system. This meant some staff including therapists could not record their input on the new system.
- Records were stored securely and in a way which protected patient confidentiality.

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 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.
- Training for staff in the safeguarding of adults was above the trusts target of 80% on all medical wards and units at this hospital site.
- 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 three 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, as additional staff were required to provide the care. However on other wards we saw security guards were used and 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.

- Bay nursing had been introduced in response to the number of patients who had fallen. This was when a member of staff was based in the ward area where the beds for patients were situated in order to provide additional observation.

Mandatory training

- One of the two medical wards and Rakehead unit were 100% compliant with the core mandatory training. The other ward was 91% compliant which was just under the trusts' target of 95%.
- On one ward the manager had identified a week when no staff could take holidays in order for all staff to complete their mandatory training. This meant that ward was 100% compliant. This was to be repeated this year.
- In the Rakehead unit seven staff were overdue with basic food hygiene training. They told us this was due to the competence assessment element of the training not being completed. Staff on this unit assisted patients with eating and drinking therefore the knowledge and skills of this training were an essential part of their work.
- Staff told us about the "learning hub" which was a resource for training and development on the trust's intranet. This could be used to book training courses, access electronic learning and materials to support the nurses' revalidation process.

Assessing and responding to patient risk

- The patients accommodated at this hospital had been assessed by doctors at another hospital site and their condition did not require acute medical intervention. They were medically fit to receive rehabilitation therapy or were awaiting social interventions such as changes to their accommodation, before being discharged home. Their condition was monitored for any signs of deterioration through routine nursing assessments and observations.
- Staff saw all patients hourly to assess their condition and ask if they needed any help or support (intentional rounding). Patients said they did see staff every hour and they found this supportive.
- There was no direct nurse access to the acute medical unit at Royal Blackburn Hospital. Should a patient's condition deteriorate whilst an inpatient at Burnley

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General Hospital and they required urgent care an emergency ambulance would be called to transport the patient to the Emergency Department at Royal Blackburn Hospital. Staff said this happened rarely.

- There was a specialist nurse available between 7pm and 7am to give advice to staff on the wards should a patient's condition deteriorate. They would then triage the patient to either the on call doctor at Burnley or to Royal Blackburn Hospital via an ambulance.
- There were physiotherapists available to administer respiratory physiotherapy 24 hours per day seven days per week.
- In the nurse led day admissions unit there was a clear protocol to follow if a patient's condition deteriorated and medical input was required.
- There was no critical care facility on site at Burnley General Hospital. Patients with a tracheostomy (an artificial opening in the windpipe which is held open by a tube) could be accommodated in the Rakehead unit. There was a critical care outreach nurse who would visit the unit to assist with non-urgent care to patients with this procedure should it be required.

Nursing staffing

- 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.
- 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
- Information from the trust showed a low use of agency staff in the medical wards at this hospital. The highest was an average of 0.4% between April 2014 and March 2015.
- Most of the wards had the actual number of staff on duty they needed to meet the needs of the patients.
- There was one ward which did not have a manager as they had been seconded to Blackburn and no replacement had been employed. Staff were unaware of the plans for replacement.
- One medical ward had four full time vacancies for qualified nurses; however the nurse in charge said they usually could fill those vacancies with their own staff who worked extra hours.

- On one ward there were four full time vacancies. The ward manager had changed the shifts of permanent staff to ensure there were competent experienced staff available to work with the bank staff that were used to fill the staffing vacancies.
- The handover of information was thorough with all staff present to receive information and participate in the discussions.

Medical staffing

- Doctors reported that improvements had been made in the last year to some of their systems of work. This included multidisciplinary handovers, better information sharing with nurses and more protected time for junior doctors training.
- Junior doctors had received educational input from their supervisors in both a formal and informal way on a frequent basis.
- Doctors reported good support from their senior colleagues both between 9am and 5pm and out of hours. This included a registrar and consultant on call out of hours to provide support and advice when required.
- In the evenings and at weekends there was one doctor on duty for the hospital. They had access to senior doctor support if required however if a patient's condition deteriorated significantly they would use emergency services to admit them to Royal Blackburn Hospital.

Major incident awareness and training

- Staff had not received training in their role should a major incident occur. They were aware there was a policy but had not completed training or a drill. This meant staff may be unaware of the actions they would need to take should a major incident occur.

Are medical care services effective?

Requires improvement



Summary

Medical care services at Burnley General hospital required improvement in terms of being effective.

In the Rakehead rehabilitation centre there was a lack of therapy provision which impacted on patients'

Medical care (including older people's care)

satisfaction with the service and ability to achieve their goals in a timely way. There was also one area of the building out of use which significantly impacted on the rehabilitation of patients who were returning to independent living. On the wards staff had a good understanding of the Mental Capacity Act and how to work within it. However in Rakehead rehabilitation centre records showed staff had not worked within the principles of the Act or the Deprivation of Liberty Safeguards.

Patients had their pain well managed and were provided with good food. There was good multi-disciplinary working and staff had access to doctors out of hours. Guidelines were accessible and in line with best practice however they were not all up to date. Two wards were below the trusts' target for completion of staff appraisals.

Evidence-based care and treatment

- The review of guidelines in the medical care division of the trust 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.
- 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.
- Practices in the Endoscopy unit were audited quarterly in line with the JAG accreditation.
- The policy for providing one to one care was being reviewed and the ward managers had been asked to provide information and be involved in this review.

Pain relief

- Patients received pain relief promptly when required.

- We heard staff ask patients if they required pain relief in a kind and respectful manner.
- Records included an assessment of a patient's pain which was monitored following the administration of pain relief.

Nutrition and hydration

- Most patients said the food was good, hot and tasty.
- Food charts were fully completed and where it was not necessary to complete fluid intake and output charts these had been recorded as not applicable.
- One patient who attended the day case ward told us they had not been offered a specific diet to meet their cultural needs.
- In the Rakehead rehabilitation centre the food was cooked on the premises and served by the housekeepers. Patients said it was good, tasty and hot. They had 24 hour access to snacks from a vending machine in the communal dining room.
- In Rakehead centre there was one weekly menu which rotated. This meant for patients who were in the unit for a number of months they had the same meals on offer each week. Take away meals were offered at weekends when the occupancy decreased.

Patient outcomes

- 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.
- There was a lack of physiotherapy in some wards and departments. There were eighteen hours provided on the wards and each patient in the Rakehead rehabilitation unit received physiotherapy a maximum of three times per week. Some patients and staff were concerned that the reduction in physiotherapy provision had a negative effect on the rehabilitation of patients and increased their length of stay.
- In the Rakehead unit there was a self-contained residential area allocated for the use of patients who had completed their treatment and were having rehabilitation to return home. This was awaiting refurbishment and had been out of use for six months. This meant patients were not getting the opportunity to be supported in their independence as part of their rehabilitation before they returned home.

Medical care (including older people's care)

- There was no heating in one of the rooms used for occupational therapy in the Rakehead unit. This room was too cold for use at the time of the inspection and had been reported to the maintenance department one week earlier. This meant another part of the unit was out of use for patients.
- One of the ward managers told us they rarely admitted patients who were medically unstable however if this did happen they would return to Royal Blackburn Hospital.
- The relative risk of re-admission at Burnley General Hospital was higher than the England average for elective patients and lower than the average for non-elective.

Competent staff

- There was a 12 month preceptorship programme for newly qualified staff. This included all areas of their work with supervision and mentorship to ensure they were supported within this time.
- One of the ward managers had recognised the value of specialist nurses and therapists by providing training and support for staff on the wards. This was for the prevention and management of pressure ulcers and providing adequate nutrition.
- 14 staff in the Rakehead rehabilitation centre, who managed the care of patients with a tracheostomy, had completed training for the management of patients with this in place. Information provided by the trust showed 12 of these staff had completed this training between April and September 2014 with one having completed it in 2012. Two staff members had updates booked in November 2015. Staff told us there was no system in place to monitor their competence to deliver this care. This meant staff may not be up to date with this aspect of care and did not have their competence assessed.
- The trusts target for staff appraisals was 95%. This had been exceeded at Rakehead centre with 100% of nursing staff being up to date. 88% of staff on ward 28 and only 44% on ward 16 were up to date. This meant on these wards not all staff had received an appraisal in a timely way.

Multidisciplinary working

- 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 with personal care, mobility and eating and drinking.
- The speech and language therapist and the dietician attended wards when required to review patient's care and provide advice and support to patients and staff.
- Multidisciplinary teams which included specialist physiotherapists worked with various clinical specialisms including cardiology.
- The psychological impact of ill health was understood and support was offered for patients with cardiac problems.
- Ward managers had regular contact with managers on the other sites in the trust. This consisted of regular telephone contact and monthly directorate meetings.
- There was a community rehabilitation team which consisted of physiotherapists, occupational therapists and rehabilitation support workers. They assessed patients and referred to other services if required and delivered therapy and treatment to aid them to remain in the community or access inpatient intensive services as required.

Seven-day services

- Physiotherapy was not available on Saturday or Sunday. Some patients and staff said they thought this impeded progress for rehabilitation and resulted in a longer stay. There had been six written and two verbal complaints made about the reduction in the physiotherapy time at Rakehead rehabilitation unit.
- A doctor was available during the night and at weekends if they were required.

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.

Medical care (including older people's care)

- On the wards where records were stored on the computers not all staff that 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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.
- Staff on the wards understood their role in the management of patients with impaired mental capacity. This included the need to refer for Deprivation of Liberty Safeguard authorisation if the patient needed one to one care and lacked the capacity to consent to this themselves.
- Senior nursing staff in Rakehead rehabilitation centre did not have a good understanding of the need to assess a patient's mental capacity or how to do this. We saw a variety of completed documents for recording the mental capacity of patients to make their own decisions. These ranged from questions to assess orientation to a question which had a simple yes or no answer regarding their ability to make decisions. For one patient it was recorded their mental capacity could not be assessed due to their inability to verbally communicate despite it being recorded they could appropriately use written communication.
- In the Rakehead centre there was no consistency of management of patients with impaired mental capacity when they had transferred from another unit. One patient had a Deprivation of Liberty Safeguard in place at another hospital with documentation stating there was reduced mental capacity. However this had not been reviewed and there was no documented assessment of their capacity since being accommodated at Rakehead centre. Despite this staff had documented this patient had given verbal consent for care and treatment to be delivered.
- In the Rakehead unit the records for one patient had documentation that they "lack memory and are disorientated to time, place and person" and had refused personal care due to being "very disorientated." However an invasive procedure had been carried out for this patient for which it was recorded verbal consent

had been obtained. There was no evidence that this patient had been assessed with regard to their mental capacity to give this consent which was contradictory to the previous documentation. There was no record this had been carried out in their best interests in line with the mental capacity act. This meant staff were not delivering care and treatment in line with this legislation.

- Staff on the wards gave an example of when a best interests meeting had been held in order to ensure that a planned discharge was safe for a patient.
- Staff monitored patients whose behaviour may challenge staff or present potential safety issues for themselves or others. For one such patient there were recorded triggers for the behaviour and care plans for the management of it.

Are medical care services caring?

Good



Summary

Patients were complimentary about the staff describing them as helpful, caring and kind. On the wards patients told us their call bells were answered promptly however in Rakehead rehabilitation centre call bells rang for long periods of time without being answered and we observed one example of undignified practice in that unit which was brought to the attention of the trust. Observations of care in other medical services in the hospital showed staff to protect the dignity of patients.

The results of the friends and family test were consistently high for patients who would recommend the hospital. Patients had access to various means of emotional support and were given the information they required both verbally and in writing.

Compassionate care

- Patients told us staff did respect their privacy and dignity. Curtains around a patients' bed had "Do not disturb" signs in place when they were closed and the patient was receiving care from staff. This increased their dignity and privacy.
- On one ward staff had started to provide small amounts of essential toiletries for those patients who were admitted without these.

Medical care (including older people's care)

- Most patients on the main wards in the hospital reported that if they needed to use a call bell it was answered promptly. In the Rakehead rehabilitation unit we heard call bells sounding for long periods of time before being answered by staff. This meant patients in this unit were not receiving prompt attention.
- On the Rakehead unit we observed one patient being assisted in the corridor in a manner which did not respect their dignity or protect their feet from harm. This meant this patient's care was not managed in a compassionate or caring manner. Other patients on that unit said the staff did treat them with respect and dignity giving examples of knocking on doors and using their preferred name.
- The percentage of patients who would recommend the hospital in responses collated in the friends and family test were consistently 100% between March 2014 and February 2015.

Understanding and involvement of patients and those close to them

- Patients said they got the information they required. They told us their questions were answered promptly and if the person could not provide the answer they found another person to help or returned with the answer.
- In one unit two patients out of four we spoke with told us they had difficulty understanding the language of the doctor they had seen. They had asked for further explanation and that had been given.
- Patients were given written information in the form of leaflets which they said were helpful.

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.
- Additional psychological support was available through a referral system. This included for patients receiving rehabilitation for long term conditions.
- A chaplaincy service was available should patients wish to access this.

Are medical care services responsive?

Good



Summary

Medical care services at Burnley General hospital were good in terms of being responsive.

Systems were in place to provide timely assessment of patients' needs for either transferring within the trust or discharge home with support. There was additional support to aid the timely and safe discharge of patients with complex health and social care needs. The referral to treatment times met the recommended target in all specialities. The length of stay was comparable to the national average except in rehabilitation services where it was longer.

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

- There was recognition that the trust services covered a large geographic area and some services, such as the cardiac rehabilitation service, held clinics in various localities to aid attendance.
- In the planned admissions unit staff had worked with another trust in the area to provide daily treatment for a patient who would otherwise have to make an eight hour round trip. This showed staff worked to meet the needs of people who lived locally.
- The planning of the use of space was based on the needs of the patients. On one ward where there was a shortage of space a doctors meeting room was now used as a therapy room in order to provide physiotherapy and occupational therapy to patients

Access and flow

- The average length of stay for patients receiving rehabilitation services was longer than the England average at 57 days for this hospital as opposed to 30 days for the England average. No comparative data for

Medical care (including older people's care)

Rakehead rehabilitation centre was available due to the specific nature of the rehabilitation provided; however staff told us the length of stay had increased following the reduction in provision of therapy services.

- There was capacity for patients on the general medical day unit to stay overnight if required. This unit was open five days per week. Should patients be unable to be discharged on a Friday they would be accommodated on another ward over the weekend. Staff said wherever possible they tried to avoid inappropriate admissions that may lead to this occurrence.
- Staff on the inpatient medical wards at Burnley said where possible they would accommodate patients from various wards at Royal Blackburn Hospital to try to ease the pressure during busy periods. This could include patients from a specialist clinical area such as ophthalmology. They would not do this unless assessments showed they could deliver the necessary care.
- Unless it was an emergency there were no transfers of patients from the medical wards in Burnley after 10pm.
- There was a complex care discharge team who were integrated with the intensive home support service. They worked across all disciplines and used the same systems. The aim of this service was to ensure discharge arrangements were in place to facilitate the safe discharge of patients with complex health and social care needs.
- The community rehabilitation team would reduce the waiting time for patients by using a multidisciplinary approach to assessment and therapy where possible. This meant that those waiting longer than the target of two weeks for an appointment could be seen by either a physiotherapist or an occupational therapist for their assessment.
- Referral to treatment was above (better than) the England average from April 2013 to Jan 2015.

Meeting people's individual needs

- One patient told us they had been offered translation services however they had declined and everything had been clearly explained to them.
- There were no leaflets on display in languages other than English. Staff knew how to access written information in other languages if it was required.
- Staff could access a telephone translation service should this be required.

- Staff were aware of the needs of people living with dementia and had received specific training in the delivery of their care.

Learning from complaints and concerns

- The integrated care group of which the medical wards were a part, had the most complaints in the year April 2014 to March 2015 with 43% of the total complaints.
- If a patient raised 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?

Requires improvement



Summary

Medical care services Burnley General hospital were good in terms of being well led.

Staff at this site felt part of the wider trust. They knew the board members and saw them in the hospital and had direct access to senior managers should they want it. Mechanisms were in place to assess and monitor improvements through action plans and review risks. However the governance and risk assessment systems had not identified the concerns we found in Rakehead unit. Following the inspection actions were taken to assess the quality of care and subsequently improve the outcomes for patients.

Staff talked of an open culture where they felt engaged and listened to. They spoke of significant positive changes in the past 12 months. There were opportunities for leadership development. There were mechanisms in place for staff and public engagement.

Vision and strategy for this service

Medical care (including older people's care)

- 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.
- There was uncertainty amongst some staff we spoke with about the vision for the future of the type of rehabilitation service provided at Rakehead centre.

Governance, risk management and quality measurement

- The matrons of the medical services attended the monthly meetings held within the specialities in the medical care group. 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.
- This internal quality assessment process had only been in place for the past six months and had not been applied to Rakehead unit. The governance systems in place had not identified any concerns with the provision of care, including rehabilitation therapy, at this unit. The risks we identified with regards to mental capacity assessment had not been identified. This meant the governance arrangements had not been effective in relation to Rakehead unit. Following our inspection an internal assessment of the quality of the service was completed and support provided for improvements to be made
- 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 further reduce falls.

Leadership of service

- 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 both trust sites we visited 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.

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; they had visited 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.
- Both nursing and medical staff said the communication and cross site working between Blackburn and Burnley had improved in the past 12 months. They described a good working relationship.

Public engagement

Medical care (including older people's care)

- On the Endoscopy unit users of the service were invited to regular meetings to discuss their experience and explore any ideas for change to improve the practices in the unit.
- In the Rakehead unit there was a monthly focus group where patients were invited to discuss any suggestions and ideas for the management of the unit.
- There were monthly focus group meetings at Rakehead unit to obtain patient and relatives views and suggestions. Recent changes as a result of this were a review of the menu and the availability of the table tennis equipment.
- A closed “Facebook” site was also used by staff to communicate between each other and as a form of informal communication between them.
- Each department set up team meetings to fit with the availability of staff. An example of this was the Endoscopy unit where staff team meetings were held at 8pm monthly.
- One staff member described the trust as “on a journey of positive change” and said they felt included in that journey.
- The community rehabilitation team based at Rakehead unit said they did feel part of the wider trust team and did not work in isolation.

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 and they had their own department and ward meetings where they felt able to discuss any concerns they may have.
- They talked about the chief executive’s blog which they could read to be kept up to date with the organisation’s developments.
- There was a monthly newsletter which kept staff informed about changes and developments within the trust.

Innovation, improvement and sustainability

- Ward staff told us there was a “much better feeling in the trust” in the past 12 months. They had seen board members in their areas and said previously they would not have known any directors of the trust.
- 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.
- Some staff from the rehabilitation wards had spent time working in the newly built Clitheroe Hospital and had shared good practice on their return.

Surgery

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

Information about the service

The Burnley General Hospital provided a small range of routine surgical services, which included trauma and orthopaedics, ophthalmology as well as having a surgical day case unit. There were 14 theatres, including day surgery.

Hospital episode statistics data for (HES) 2014 showed that 44,231 patients were admitted for surgery at the trust. The data showed that, at Burnley General Hospital, 88% of patients had day case procedures, 12% had elective surgery and no patients had emergency surgery.

As part of the inspection we visited theatres, the surgical day case ward and ward 15 (trauma and orthopaedics).

We spoke with five 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 “Good”. As part of that inspection, we identified issues regarding poor

documentation of theatre equipment lists, areas of non-compliance in areas of the WHO checklist, theatres were not used to their full potential and there was a lack of privacy and dignity within theatre reception areas.

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 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.

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 positive use of social media.

Surgery

Are surgery services safe?

Good



Summary

We rated surgical services as good for being safe.

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.

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 31st May 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 patient's 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 action plan in place to deal with this.

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.

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.

Surgery

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 the wards that we visited.

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 safe 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 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.
- 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.

Surgery

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 ward BG15 the temperature had been recorded at 0.5 or 0.4 Degree Celsius on seven occasions out of a possible 19 on the month of the inspection, which was against the trust policy. The ward manager felt this was a recording error rather than an error with the fridge temperature.
- The temperature ranges of the medication fridges on ward BG15 were not clearly stated. There was a tick placed in the box to suggest that the range had been checked but no temperature was written in.

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 unlocked trolleys behind the nurses' station on ward BG15.

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%.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.

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 overall training completion rate among staff across the surgical services was 100% which was much higher than the trust's target of 85% completion.

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. There was only trust level data which showed 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.

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- 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 patient's 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 when a patient's condition deteriorated. 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.

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.
- 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, in that they told us that, at the time of the inspection, 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 been implemented yet.
- 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 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.

Are surgery services effective?

Good



Summary

We rated surgical services as good for being effective.

Surgery

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 were performing better than the England average with 99% of patients receiving computerised tomography (CT) scan before bronchoscopy compared to 91% nationally. 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 pathway. 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.

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.

Surgery

- 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 performing better than the England average with 99% of patients receiving computerised tomography (CT) scan before bronchoscopy compared to 91% nationally.
- The rate of readmission following surgery was worse than the England average. The higher areas for risk of readmission were both urology and vascular surgery which were both worse than the England average for elective admissions.

Competent staff

- Trust data for the surgical division at Burnley General 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 and paediatrics. 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.

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 specialist consultant if necessary for additional support or advice.
- 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

Surgery

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?

Good



Summary

We rated surgical services as good for 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. Patients were positive about the way staff had cared for them.

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

Compassionate care

- The NHS Friends and Family Test conducted August 2015 to December 2015 showed the percentage of patients that would recommend the hospital to friends and family ranged between 99% and 100%. The

response rates (49%-63%) 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.

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.
- Three patients on ward 15 complained about the lack of internet connection on the ward. They also did not have access to a television as there was no day room on the ward and the patient bed side televisions were reported to be expensive. The ward manager informed us that plans were in place to convert a room on the ward into a day room with a television.

Emotional support

- Patients told us that the nursing staff would answer call bells promptly, and provided good support during their stay on the ward.
- Multi-faith facilities were available for patients and those close to them.

Are surgery services responsive?

Good



Summary

We rated surgical services as good for being responsive.

The facilities and premises in surgical services were appropriate for the services that were planned and delivered.

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.

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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.

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.

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.
- 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 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.

- 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 theatres were working hard to keep patients fully informed of any delays.
- 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 all elective and non-elective surgery was better than the England average. In addition, the percentage of patients whose operation was cancelled and were not treated within 28 days was consistently 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 daily which were attended by matrons and the bed management team. These meetings reviewed and planned bed capacity and responded to acute bed availability pressures.
- NHS England advises that patients whose operation is cancelled should be offered another binding date within a maximum of 28 days. The percentage of patients whose operation was cancelled by the hospital for non-clinical reasons and were not treated within 28 days was consistently better than the national average. Trust data showed that only three patients, between 1st March 2014 and 28th February 2015, did not have treatment within 28 days.
- There was discrepancy in relation to theatre lists in that theatre staff raised concerns in relation to the lists frequently over running, which mainly related to two particular lists per week. This had an effect on flow through theatre and patients waiting longer prior to their surgery. However a consultant surgeon was in the process of trialling a new ‘lock down’ of theatre lists where no alterations or additions could be made to the list on the day of surgery. Senior leaders told us there was a lock down process already in place relating to the elective list of for day surgery.
- 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

Surgery

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.
- 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.
- Three patients on ward 15 complained about the lack of internet connection on the ward. They also did not have access to a television as there was no day room on the ward and the patient bed side televisions were reported to be expensive. The ward manager informed us that plans were in place to convert a room on the ward into a day room with a television.

- 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.

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

We rated surgical services as outstanding for 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

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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.

Surgery

- Matrons were offered 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 to staff. This was to raise awareness of new or altered policies.
- Theatre representatives attended a North West theatre network 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.
- 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 where 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.
- The divisional staff turnover rate ranged from 7.9% to 9.4% which 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.

Staff engagement

- The trust ranked in the top 100 places to work in the NHS in an external health journal.
- There had been a change in the senior management structure within the surgical division. Staff spoke very positively about this change and felt the senior managers were much more visible than they had previously been.
- 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 travel 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 managers within the 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.

Surgery

- 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 completed 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.
- 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.
- The trust ran a 'hip and knee' school which focused on education sessions for patients prior to them undergoing surgery for hip or knee replacements. This had been audited and had identified that patients had an enhanced recovery.

End of life care

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

Information about the service

We visited Burnley hospital as part of our announced inspection on 21 October 2015 where patients with end of life needs were nursed on the general wards. There were three wards that provided end of life (EOL) care, ward 16 (medicine for older people) a rehabilitation ward and the gynaecology ward. There were few deaths at the hospital, less than six in the year till October 2015.

On the 21 October we met with the specialist palliative care team (SPCT) at Burnley hospital to get an overview of the service. The SPCT at Burnley hospital covered community EOL care, but as there were few deaths at the hospital they managed EOL care on the wards. The team were fully integrated with the team at Blackburn and policies and procedures were shared across both sites.

During the inspection we met with eight members of the SPCT, four nurses and one health care assistant on the wards and a number of porters who gave us access to the cold store (mortuary). We also spoke with staff in the general office. There were no patients at end of life on any of the wards so we were unable to speak to any patients or their relatives. We looked at documentation in patient's records and 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.

Summary of findings

The EOL care service at the Burnley hospital was rated good overall with no domain requiring improvement. Although there were few deaths at the hospital, the SPCT team managed end of life care effectively. Staff attended full team meetings with the consultants from the EOL team and with the palliative care lead nurse.

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. The nursing staff ensured that they were up to date with policies and procedures for EOL care and asked for advice from the SPCT if necessary. Staff we spoke with were aware of the EOL care lead and the trust EOL strategy.

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.

End of life care

The service had a well-developed education programme for medical staff, nurses and unregistered staff in EOL care. Staff in the SPCT 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 services were responsive and death certificates were issued in a timely way to meet the needs of different religions. Porters were respectful of patients when they took them to the mortuary.

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 service was commissioned through a local hospice. This did not fully meet the National Institute for Health and Care excellence (NICE) quality standards for end of life care.

Are end of life care services safe?

Good



Summary

The Royal Burnley hospital was rated good for the safety of their EOL service. Staff were encouraged to report incidents and to do so through the trust system. Lessons were learned and this learning was disseminated effectively.

Staff were aware of safe-guarding 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 specialist palliative care telephone advice line for out of hours was commissioned through the local hospice and 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

- Staff knew how to report incidents and were encouraged to do so through the trust system. Lessons were learned and this learning was disseminated effectively.
- Staff were aware of safe-guarding procedures and there was a trust lead for safeguarding who provided information and support for staff. Safety huddles were used in teams and on the wards to identify any patients at end of life ensuring good continuity of care.
- 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 an 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.

End of life care

- 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 to were fully aware of the duty of candour and were able to describe when they had applied it in their practice.

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.
- 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.
- Staff were aware of how to use syringe drivers effectively. In 2011 the National Patient Safety Agency recommended that all syringe drivers of a specific make should be replaced by the end of 2015. The trust has replaced them appropriately.
- Staff were familiar with syringe drivers and used the syringe driver checklist when in operation. The SPCT provided regular training updates for staff. If ward staff had not used the syringe driver for three months they would contact SPCT to refresh competencies.
- If patients were being transferred to another location they were prescribed a supply of medicines for a week until a prescription could be issued.
- 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 hours advice.
- 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.
- On one of the wards there were two patients with a DNACPR in place. One was fully completed, dated and signed though there was no documented discussion with the family. This was highlighted at the safety huddle on the ward. The other DNACPR was fully completed dated and signed.
- If patients were admitted to the hospital with a DNACPR in place, this would be reviewed with the patient and their relatives.
- Patients on the rapid discharge pathway with a DNACPR in place did not have a review of the DNACPR.
- There were clear processes for the documentation of patients who were brought to the mortuary. 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.

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.

End of life care

- 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.
- All the porters had undertaken moving and handling training for the safe moving of patients.

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.

- The ward staff held a safety huddle at the beginning of every shift. Any patient at the end of life would be discussed at the huddle and information was communicated through the huddle.
- The SPCT held a daily safety huddle to plan the day’s work and to identify those at end of life in the hospital.
- The SPCT would see urgent patients within 24 hours on the wards. They could be contacted by telephone when out in the community.

Nursing staffing

- Care for people at EOL was the responsibility of all staff and was supported by the SPCT.
- There were good staffing numbers on the wards and the escalation policy could be used for additional staff to increase staff numbers for EOL care.
- The SPCT at Burnley hospital had nine point two whole time equivalent members of nursing staff with one vacancy and a full time administration support. These numbers did not include the palliative care lead nurse. The low numbers of referrals at Burnley hospital did not impact on the community caseload.
- 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 palliative medical consultant in the SPCT.
- A specialist palliative care telephone advice line for out of hours was provided 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. This did not fully meet the National Institute for Health and Care excellence (NICE) quality standards for end of life care.

Major incident awareness and training

- There was a trust major incident plan that was available on the trust intranet.

End of life care

- The mortuary manager attended major incident meetings at the trust and multi-agency County meetings.

Are end of life care services effective?

Good



Summary

Burnley General Hospital was rated as good for the effectiveness of their EOL care.

The service no longer used the Liverpool care pathway for the dying. This was 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. This supported evidence-based care and treatment. The trust had undertaken an internal care of the dying audit every three months across the divisions which had resulted in improvements. Pain relief and dietary needs were managed well.

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

- 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.
- Staff we spoke to had accessed the training provided by the EOL care facilitator and knew how to complete the individual plan of care and support for the dying person in the last hours and days of life. (ICP). There were no patients on the wards supported by this plan at the time of the inspection. If an ICP plan was in place it was reviewed three times daily with bedside handovers.
- 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 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 but when the funding recently ceased it was agreed at the EOL steering group that the principles of the AMBER care bundle would continue.
- The SPCT worked in line with the National Institute for Health and Care (NICE) guidance 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.
- On one of the wards there was a bereavement box. This was a resource for staff and had been put together by the EOL care link nurse on the ward. It contained comfort packs for any relatives who wished to stay with a patient. The comfort packs included toothbrushes and toothpaste and other toiletries. The box also contained the baseline assessment for bereavement care, the syringe driver checklist, a guide to anticipatory prescribing for the community, information about the bereavement champions, the bereavement care booklet and information about what to do after death.

End of life care

- On the same ward was a palliative care folder that contained prescribing guidance, EOL care guidance, the EOL care bereavement policy, the rapid discharge pathway guidance and the hospice referral form.
- 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.

Pain relief

- Patients had their pain needs assessed and reviewed through the early warning scores (EWS).
- 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 knew about anticipatory prescribing and the guidelines were on the trust intranet palliative care pages.
- There were no patients at end of life at the time of inspection and there was no anticipatory prescribing of medicines for the treatment of symptoms at end of life. Wards had stocks of medicines used in anticipatory prescribing giving immediate access if necessary.
- Syringe drivers were kept on the wards. We checked two syringe drivers; both were clean and within service dates. The hospice ran training updates for the syringe drivers
- 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.

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. 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.
 - The speech and language therapists at the trust were developing guidance on feeding at end of life. Dieticians were available for advice.

Patient outcomes

- 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.
- 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 East Lancashire Hospitals NHS Trust had participated in the National Care of the Dying audit of hospitals (NCDAH) for 2013-2014. The data submitted was for the Royal Blackburn Hospital. We saw that priorities had been developed and implemented

End of life care

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. These priorities were implemented across the trust.

- 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
- Audits of the ICP's were undertaken on the wards. They were audited every three months and the results sent to the EOL care facilitator/ educator. A copy of the audit was seen and an action plan was to be developed for the division following the audit. Staff said that the audit would enhance care and that good communication between patients and their relatives and staff was the key to good EOL care.
- The service had undertaken a bereavement survey. In the period July 2015- 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 surveys. This had clear actions, outcomes and timescales.

Competent staff

- There was an EOLC facilitator/ educator as 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.
- The SPCT band seven staff had monthly meetings with the palliative care lead nurse.
- There were regular appraisals from the palliative care lead nurse for the band seven staff. The band seven staff appraised the band six staff. 100% of the nurses on the SPCT had an appraisal in the last twelve months.
- The trust was recruiting clinical supervisors for the nursing staff on the SPCT team. This would support the development of the nurses and the team.
- We spoke to the SPCT about the fact that there were low numbers of hospital patients at EOL. They didn't have any concerns because of the MDT meetings and support from other team members.
- There was an end of life care champion/link nurse on each ward where EOL care was delivered who provided advice and support for the ward staff about EOL care.

- On one ward, 16 of the nursing staff had undertaken care of the dying course, this was the majority of nursing staff who worked on the ward. 50% of HCA's had also completed the course. Most ward staff had completed the symptom control course.
- There were monthly band six nurse meetings on the wards, the outcomes of which were fed back to night staff
- All staff on one ward had undertaken training on the EOL care plan
- There was a rolling programme of multi-agency education sessions in a range of end of life care topics for both hospitals, the community hospital, the community staff, hospices and nursing homes
- The nurses on the SPCT were provided with supervision by members of their peer group
- 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 was a weekly multi-disciplinary team meetings (MDT) which took place at Pendleside hospice which was attended by the SPCT. 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.

End of life care

- The MDT meetings involved staff from the Royal Blackburn hospital 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.

Seven-day services

- 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.
- There was some concern from the team about the working hours. The team would have liked to be more responsive with more flexible hours.
- Staff on the wards told us that they knew how to access help out of hours for help and support if necessary.
- The bereavement centre ran an open service so that patients did not have to make an appointment. This was available five days a week Monday-Friday. 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 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.
- The trust had a consent policy that could be viewed on the intranet.

Are end of life care services caring?

Good



Summary

End of life services were rated as good with regards to 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.

There were workshops on bereavement care and following attendance at one of these workshops members of staff became bereavement champions. The staff at the bereavement centre and the mortuary had worked with local religious leaders to seek their advice and guidance.

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)

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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.
- The staff we spoke with demonstrated 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 were available and contained items for relatives who might want to stay at the hospital. They contained toothbrushes, toiletries and other items.
- Many patients elected to stay on the gynaecology ward for their end of life care as many had been patients there for many years and knew the staff. The ward had a homely atmosphere and patients were encouraged to use the day room for meals and refreshments.
- There were concessions for the payment for the television if requested by patients and their relatives; there were also radios and DVD players available.
- The hospital allowed pets to visit those at the end of life.
- Staff helped patients at EOL to prepare bereavement keepsake boxes for relatives.
- The gynaecological ward was used for those women whose baby had died or who had suffered a miscarriage. Women who had lost a baby or had a stillbirth were supported to prepare a memento box which contained keepsakes of their baby.
- There was no time limit for relatives to stay on the ward following a death but they were encouraged to allow the patient to be moved as soon as possible.
- 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

- Staff knew how to access the bereavement centre at the hospital.
- 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.
- 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.
- 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

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.
- One of the wards held a tea party to provide peer support for relatives of patients who were at the end of life. The ward provided refreshments and staff brought in cakes.
- One of the wards said that they had joint discussions with the consultants from the SPCT and the families as the patient's condition began to deteriorate. An EOL plan was developed with patients and their relatives.

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.
- Wards had quiet areas available for relatives.
- The bereavement centre had information on counselling services, organ and tissue donation. A

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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 was religious and spiritual support from the chaplaincy who visited the wards frequently. Staff were aware of how to access different faith groups.
- There was bereavement support at the local hospice. This could be accessed by anybody living in the catchment area of the hospice.
- One of the wards had debriefing sessions for staff as many of the patients were long term patients of the service. The trust funded a number of counselling sessions that were available to staff.
- Staff on one ward said that there was good peer support following a death.

Are end of life care services responsive?

Good



Summary

End of life services were rated as good with regards to 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. 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.

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.
- The preferred place of care was documented though many attending the hospital preferred to die at the community hospital or at one of the local hospices. The exception to this was the gynaecology ward where patients were known to staff as they had been attending the ward for long periods of time to receive treatment.
- 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.
- Ward staff provided practical support with open visiting and meals and refreshments for relatives. There was free parking and concessionary television if relatives requested it. Comfort packs were provided if relatives wished to stay overnight.

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- 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 hours process to support the transport of a deceased patient out of the country. The matron on call could contact the coroner if a body needed to be released quickly.
- New doctors and student doctors were trained in the completion of death certificates and were encouraged to complete these in a timely manner. Following training and a competency assessment some nurses at the trust could complete a death certificate for an expected death and this would be completed by a doctor. This was in line with the trusts' "verification of expected death" policy. Priority was given to faith groups that required early burial.
- The bereavement room was used to give the death certificates to relatives. This was a quiet room with comfortable soft furnishings. Good information leaflets were available.
- There was draft guidance for all nurses if a patient died out of hours and there was the need for an urgent funeral service. We were not told when this would be approved.
- There was a cold store at Burnley hospital and all post mortems were carried out at the Royal Blackburn hospital. Relatives could request a viewing of a relative, though this was a rare occurrence. Mortuary staff could organise this if necessary.
- There was good liaison between the cold store and the mortuary at the Royal Blackburn Hospital and transport was arranged if necessary to move patients between the sites. There were no bariatric storage facilities at Burnley hospital and so all bariatric patients were taken to the Royal Blackburn hospital.
- The bereavement centre was open five days a week so that relatives could obtain a death certificate. Death certificates could be obtained out of hours for the quick release of some patients. The coroner's office was based on site alongside the bereavement centre and the coroner was sensitive to cultural needs.

- The chapel at Burnley hospital had stained glass and a number of statues and faith icons. In the prayer room religious texts were available. The female side of the prayer room appeared unclean and the washing facilities available were part of the toilet area.
- There was a lower uptake of 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 patients with complex needs and applications for continuing health care were fast tracked when the patient was in the last year of life.
- Staff knew how to access interpreters for face to face contact and language line. Due to the diversity of staff in the trust many different languages were spoken, staff were used as interpreters if necessary and where appropriate. Staff could also access British Sign Language services for patients who were deaf or hard of hearing. Very few information leaflets that we saw were available in any other languages than English.
- There was a specialist nurse for patients with a 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
- All the SPCT had received training in advanced communication skills. The bereavement champions had also received additional training in communication skills.
- We saw on one of the wards, hourly rounding when the staff visually checked every patient. This was done every two hours at night.
- Ward staff were aware of how to contact SPCT and they said they always got a good response usually within 24 hrs. Out of hours staff would contact the hospice for advice. Staff had never needed the palliative care consultant but aware of how to contact the consultants if necessary.
- Staff said there was good availability of side wards at the hospital. There was prioritisation of side rooms as far as possible, for those at end of life and additional beds/

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recliner chair for relatives could be put into the rooms. On the gynaecology ward the manager said that they had always managed to nurse EOL patients in a side room. The canteen was available for food and refreshments for relatives. Ward staff would make drinks for relatives.

- Staff had worked with the bereavement team to provide comfort bags for the patients' relatives. These comfort bags contained a toothbrush, toothpaste and other toiletries to allow relatives to stay overnight.
- Staff had discussions with patients and relatives about how they wished to be treated following death.
- There was concessionary car parking for relatives of patients at the end of life.
- Staff were looking to redesign the property bags for the patients as these were green plastic bags. Staff felt that they were undignified.
- When a patient died the ward staff would attend to them appropriately dependant on their infection control risk.
- The patient was escorted to the mortuary in a discreet manner.
- The notification of death was done on the ward and the porter would log the patient and time of arrival at the mortuary.

Access and flow

- Referrals for the SPCT were made via fax or 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 and triaged on a daily basis by members of the SPCT and allocated to a member of the team as appropriate.
- Nursing staff were aware of the rapid discharge home to die process 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 staff 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 facilitate the transfer of a patient to the mortuary.

- Staff said that sometimes they felt there was pressure to ask for patients to be moved following death to free up the bed.

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

The well-led aspect of end of life care services at Burnley hospital was rated as good

There was executive and non-executive leadership for the end of life service (EOL). There was effective 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.

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- There was an EOL care strategy and operational group that met monthly. The group was chaired by the chief medical officer for the division and the director of nursing attended the meeting. 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.
- Work to improve care for the dying was underway in the trust. The EOL care strategy and operational group had implemented the good practice guidance for care of the dying patient and the three monthly divisional audit was launched in the first three months of 2014. A position statement on the NCDAAH had recently been agreed which will go to the EOL care steering group in November 2015.
- There was trust vision for EOL services.
- Staff on the wards were aware of the EOL care strategy.

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 which was mainly used for staffing.
- The trust board received an annual report on end of life care. 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 there 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 effective 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.
- Staff were aware of the EOL care strategy and knew who was the EOL care lead for the trust.

Culture within the service

- 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.

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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

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

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

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

Urgent Care

- Review the requirement for the delivery of antibiotics for sepsis in line with the trust's efforts to improve sepsis care for patients.
- Work to improve the levels of staff training in Mental Capacity Act and Deprivation of Liberty Safeguards training where these are low.
- Review resuscitation trolleys regarding the provision of neck breathing resuscitation equipment.

Medicine

- The trust should ensure that staff in the Rakehead centre adhere to infection prevention and control measures with regard to the use of personal protective equipment and the management of soiled linen.
- In the Rakehead centre the trust should ensure that medicines are correctly stored and hazard signage is in place for the safe storage of oxygen.
- The trust should ensure the provision of rehabilitation physiotherapy in the Rakehead centre is sufficient to meet the needs of patients.
- The area in the Rakehead centre for the promotion of independent living should be accessible to patients.
- The trust should ensure that the systems for assessing the mental capacity of patients and acting according to the outcome of that assessment are used in the Rakehead centre.