East Lancashire Hospitals NHS Trust

Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England

RAPID RESPONSIVE REVIEW REPORT FOR RISK SUMMIT

June 2013

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1. Introduction

This section of the report provides background to the review process and details of the key stages of the review.

Overview of review process

On 6 February 2013, the Prime Minister asked Professor Sir Bruce Keogh, NHS England Medical Director, to review the quality of the care and treatment being provided by those hospital trusts in England that have been persistent outliers on mortality statistics. The 14 NHS trusts which fall within the scope of this review were selected on the basis that they have been outliers for the last two consecutive years on either the Summary Hospital Mortality Indicator (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Definitions of SHMI and HSMR are included at Appendix I.

These two measures are intended to be used in the context of this review as a 'smoke alarm' for identifying potential problems affecting the quality of patient care and treatment at the trusts which warrant further review. It was intended that these measures should not be reviewed in isolation and no judgements were made at the start of the review about the actual quality of care being provided to patients at the trusts.

Key principles of the review

The review process applied to all 14 NHS trusts was designed to embed the following principles:

1) **Patient and public participation –** these individuals have a key role and worked in partnership with clinicians on the reviewing panel. The panel sought the views of the patients in each of the hospitals, and this will be reflected in the reports. The panel sought the views of the patients in each of the hospitals and also considered independent feedback from stakeholders, related to the Trust that had been received through the Keogh review website. These themes have been reflected in the reports.

2) **Listening to the views of staff** – staff were supported to provide frank and honest opinions about the quality of care provided to hospital patients.

3) **Openness and transparency** – all possible information and intelligence relating to the review and individual investigations will be publicly available.

4) **Cooperation between organisations** – each review was built around strong cooperation between different organisations that make up the health system, placing the interest of patients first at all times.

Terms of reference of the review

The review process was designed by a team of clinicians and other key stakeholders identified by NHS England, based on the NHS National Quality Board guidance on rapid responsive reviews and risk summits. The process was designed to:

- Determine whether there are any sustained failings in the quality of care and treatment being provided to patients at these Trusts.
- Identify:

i. Whether existing action by these Trusts to improve quality is adequate and whether any additional steps should be taken.
ii. Any additional external support that should be made available to these Trusts to help them improve.
iii. Any areas that may require regulatory action in order to protect patients.

The review follows a three stage process:

- **Stage 1** – **Information gathering and analysis**

This stage used information and data held across the NHS and other public bodies to prepare analysis in relation to clinical quality and outcomes as well as patient and staff views and feedback. The indicators for each trust were compared to appropriate benchmarks to identify any outliers for further investigation in the rapid responsive review stage as Key Lines of Enquiry (KLoEs). The data pack for each trust reviewed is published at http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/data-pack-eastlancs.pdf.

- **Stage 2 – Rapid Responsive Review (RRR)**

A team of experienced clinicians, patients, managers and regulators (see Appendix II for panel composition), following training, visited each of the 14 hospitals and observed the hospital in action. This involved walking the wards and interviewing patients, trainees, staff and the senior executive team. This report contains the findings from this stage of the review.

- **Stage 3** – **Risk summit**.

This brought together a separate group of experts from across health organisations, including the regulatory bodies. They considered the report from the RRR, alongside other hard and soft intelligence, in order to make judgements about the quality of care being provided and agree any necessary actions, including offers of support to the hospitals concerned. A report following each Risk summit has been made publically available.

Methods of Investigation

The two day announced RRR visit took place on Tuesday 4 June and Wednesday 5 June 2013 and an out of hours unannounced site visit on the evening of Thursday 13 June 2013 at the Royal Blackburn Hospital and the evening of Wednesday 19 June 2013 at the Burnley General Hospital. A variety of methods were used to investigate the Key Lines of Enquiry (KLoEs) to enable the panel to analyse evidence from multiple sources and follow up any trends present in the Trust's data.

The visit included the following methods of investigation:

- **Interviews**

Sixteen interviews took place with key members of the Board and other staff during the announced site visits on 4 and 5 June 2013. See Appendix III for details of the interviews undertaken.

- **Observations**

Ward observations enable the panel to see a ward undergo its day to day operations. It allows the panel to talk to current patients, and their families if the observations are scheduled during visiting hours. They allowed the panel to speak with a range of staff, observe the ward environment and review patient notes, staff rotas and training records and enabled the panel to analyse any observed handover processes within wards, to ensure that the staff that are coming on duty are appropriately briefed on patients.

Observations took place in 15 areas of the Royal Blackburn Hospital and 7 areas of Burnley General Hospital during the announced site visit on 4 and 5 June 2013 and in 11 areas of the Royal Blackburn Hospital during the unannounced site visit on the evening of 13 June 2013 and 3 areas of the Burnley General Hospital during the unannounced visit on the evening of 19 June 2013. See Appendix IV for details of the observations undertaken.

- **Focus groups**

Focus groups provided an opportunity to talk to staff groups individually, and for each staff group to discuss what they feel is the contributing factor to the Trust's high mortality scores and to provide an opportunity to explore further the key lines of enquiry and other issues raised by the staff groups. It also enabled staff to speak up if they feel there is a barrier that is preventing them from providing quality care to patients. A staff focus group, which was open to staff at all levels, was held at each site: Royal Blackburn Hospital and Burnley General Hospital.

As well as these focus groups, there were four drop-in sessions held across the two sites. These sessions provided both patients and staff with an opportunity to speak one-on-one with panel members. The attendance at both focus groups and the drop-in sessions was good.

The panel would like to thank all those who attended the focus groups and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the Trust.

- **Listening events**

Public listening events give the public an opportunity to share their personal experiences with the hospital, and to voice their opinion on what they feel works well or needs improving at the Trust.

Listening events for the public and patients were held on the evening of 4 June 2013 at Burnley Mechanics in Burnley and on the evening of 5 June 2013 at King George's Hall in Blackburn. The listening event in Burnley was poorly attended, where attendees expressed considerable anger at their perception of poor publicity prior to the event, consequently, the panel review team held a further listening event publicised by the Trust and the CCG. At Blackburn, the listening event was attended by approximately 30 members of the public, patients and members of the Trust staff where yet again the publicity prior to the event was criticised.

The panel would like to thank all those who attended the listening events and were open with sharing their experiences and balanced in their perceptions of the quality of care and treatment at the Trust.

- **Data review**

A number of documents were provided to the panellists during and after the site visit. Whilst the documents were not reviewed in detail, they were available to influence/verify findings as considered appropriate by the panellists. See Appendix VI for details of the documents available to the panel.

- **Unannounced site visit**

The unannounced site visit took place on the evening of Thursday 13 June 2013 at the Royal Blackburn Hospital and on the evening of Wednesday 19 June 2013 at the Burnley General Hospital. This visit focused observations in areas identified from the announced site visit, see Appendix VII.

Next steps

This report has been produced by Gill Harris, Panel Chair, with the full support and input of panel members. It has been shared with the Trust for a factual accuracy check. This report was issued to attendees at the risk summit, which focussed on supporting East Lancashire NHS Trust ("the Trust") in addressing the actions identified to improve the quality of care and treatment.

Following the risk summit the agreed action plan will be published alongside this report on the Keogh review website. A report summarising the findings and actions arising from the 14 investigations will also be published.

2. Background to the Trust

Context

East Lancashire Hospitals NHS Trust services a population of 521,000, which makes the Trust slightly larger than the size recommended by the Royal College of Surgeons. 8% of Lancashire's population belongs to non-White ethnic minorities, particularly Pakistani and Indians. Smoking in pregnancy and lack of breastfeeding initiation are among the most prominent health problems in Lancashire.

The Trust has two acute hospital sites: Royal Blackburn Hospital and Burnley General Hospital, as well as three community hospitals: Accrington Victoria, Clitheroe, and Pendle. The Trust became a Trust in 2003 and has a total of 946 beds. It has a 62% market share of inpatient activity within a 5 mile radius of the Trust sites. However, the Trust's market share falls to 56% within a radius of 10 miles, and 21% within a radius of 20 miles.

A review of ambulance response times shows that the North West meets the national 8min response target, but fails to meet the national 19 minute response target.

Finally, the Trust's SHMI level has been above the expected level for the last 2 years and therefore it was selected for this review.

Mortality

The Trust has an overall HSMR of 105 for the period January 2012 to December 2012, meaning that the number of actual deaths is higher than the expected level. However, this is statistically within the expected range. Further analysis of this demonstrates that non-elective admissions are the primary contributing factor to this figure, with an HSMR of 106, compared with a level of 61 for elective admissions.

Currently, the Trust has an overall SHMI of 114 for the period of December 2011 to November 2012, which is statistically outside the expected range. Non-elective admissions are seen to be contributing primarily to the overall Trust SHMI, with a SHMI of 114 for non-elective admissions.

The Trust has had two high mortality alerts for diagnostic groups since 2007.

The Trust developed five care bundles to improve the delivery of care in diagnostic groups with a high mortality rate, as part of its involvement with the Advancing Quality (AQuA) Mortality Collaborative. The Trust plans to develop more care pathways and care bundles and to continue to develop the Early Warning Score system to alert on patients at risk of deteriorating.

Leadership and Governance

The Trust Board is stable, with all Executive posts being substantive and the majority of members having been in post for at least three years.

There are two groups with direct responsibility for quality; these are the Governance Committee, and the Quality & Safety Board (which reports to the Governance Committee). The Governance Committee is chaired by a non executive. The Trust has also established a Mortality Steering Group.

A review of quality governance was performed by KPMG in July 2012. This review compared the governance arrangements in the Trust against Monitor's Quality Governance Framework. KMPG scored the Trust 1.5 (trusts must achieve a score below 3.5 to be authorised as a foundation trust).

Key risks for the Trust relate to staffing levels, working across the health economy, demand management, the discharge process and mortality.

Clinical and Operational Effectiveness

The Trust sees 95.9% of A&E patients within 4 hours which is just above the 95% target level. However, the percentage of patients seen within 4 hours has been falling over recent months. 92.8% of the patients start treatment within the 18 week target time which is above the target level. The Trust has been consistently performing above the target level since June 2012.

The Trust's crude readmission rate is one of the higher readmission rates nationally, at 13.2%, although the average length of stay is shorter than that of the national average.

Compliance with 12 key indicators for acute stroke is considered a good measure of clinical effectiveness. The Trust was outside the 95% control limit of stroke patients whose treatment was compliant with the 12 key indicators.

Finally, the PROMs dashboard shows that the Trust was an average performer overall. None of the indicators fell outside the control limits for the 3 years shown in the dashboard.

Patient Experience

Of the nine measures reviewed within Patient Experience and Complaints the Trust was rated 'red' on four separate measures.

On the cancer survey, the Trust was rated in the bottom 20% on a range of questions relating to hospital doctors and treatment as a day case or outpatient.

Around 70% of all complaints relate to clinical aspects of care, and this is unusually high. Almost two thirds of comments recorded on CQC's patient voice monitoring were negative, with comments focussing on communication and attitude of staff. There were suggestions that staffing levels were too low and that staff were too busy to answer the call bell.

Results from the patient environment action teams (PEAT) sometimes show results as 'acceptable' for environment. This is a low score in the context of this monitoring system, and Royal Blackburn has been marked at this level twice in recent years.

Safety and Workforce

The Trust is 'red rated' in two of the safety indicators: MRSA infection rates and clinical negligence scheme payments.

The Trust recorded 102 incidents reported as either moderate, severe or death between April 2011 and March 2012. It also recorded one 'never event'. Between 2010 and 2012, the Trust's performance was in the lower quartile of the national distribution for its high rates of MRSA infection per bed day.

Throughout the last 12 months, the Trust has been consistently below the national rate and below the average of the selected 14 trusts in this review for new pressure ulcers. It is apparent that the prevalence rate of total pressure ulcers for the Trust has also been below the national average on all but 3 months.

The Trust's Clinical Negligence payments have exceeded contributions to the 'risk sharing scheme' over the last 3 years to a large degree. Payouts exceeded contributions by a total of £11m over this period.

The Trust is 'red rated' in 11 of the workforce indicators. It notably has a sickness absence rate above the national mean and has higher than average rates of medical vacancies. The Trust has a low score for the training of its doctors and is being monitored under the GMC's 'response to concerns process'.

Keogh review patient voice comments

The patient voice comments received directly to the Keogh review website (at the time of writing this report) identified the following themes from 8 emails and letters:

Positive	Negative
Helpful admin staff.	Staff shortages at weekends.
Skilled clinical staff.	Poor medicines management.
Treated with respect.	Treated in 'undignified' ways.
PALS supportive.	Poor discharge.
	Not patient focussed.
	Unsustainable services.
	Unsatisfactory experience with complaints process.
	Lack of care by nurses.
	Patient neglect.

3. Key Lines of Enquiry

The Key Lines of Enquiry (KLOEs) were drafted using the following key inputs:

- The Trust data pack produced at Stage 1 and made publicly available;
- The data submitted by the Trust;
- Insights from the Trust's lead Clinical Commissioning Group (CCG), and
- Review of the patient voice feedback received specific to the Trust prior to the site visit.

These were agreed by the panellists at the panel briefing session prior to the RRR site visit. The KLOEs identified for the Trust were the following:

Theme	Key Line of Enquiry
Governance and leadership	1. Can the Trust clearly articulate its governance structure and process for assuring the quality of treatment and care?
	2. How is the Board using performance information to drive quality improvement?
Clinical and operational effectiveness	3. What governance arrangements does the Trust have to monitor and address clinical and operational performance data at a senior level?
	4. How does the Trust deal with competing capacity drivers
Patient experience	5. How does the Trust engage with stakeholders?
	6. What processes does the Trust have to identify themes from patient feedback and ensure that learning is shared across the organisation?
	7. How does the Trust ensure that its mission statement and values are achieved within its clinical pathways?
Workforce and safety	8. In the context of this review, can the Trust describe its workforce strategy?
	9. How is the Board assured that it has the necessary workforce deployed to deliver its quality objectives?
	10. What assurance does the Board have that the organisation is safe?

4. Review findings

Introduction

The following section provides a detailed analysis of the panel's findings based on the evidence received in the Trust data pack, interviews, observations, staff focus groups and patient listening events. From the data gathered, the panel has identified some key areas the Trust must focus on to improve quality of care, patient safety and experience. These are summarised in the key messages below and are set out in more detail in the following tables.

Whilst these findings highlight a number of concerns around the quality of care provided by the Trust, it is important to note that the review team met many caring staff while at its hospitals. These staff are passionate, committed and want to do the best they can to care for their patients, albeit under frequently challenging circumstances. The CEO and Chair met the review team to hear the improvements identified by the review team to enhance the quality of the care they offer.

Key messages

The Trust was found to be coping with the current level of activity but it has no capacity to accommodate additional work and there were notable risks which may comprise the provision of safe patient care. There were consistent themes emerging during the RRR visit around the inadequacies of quality governance assurance systems, escalation processes and Board assurance of safe staffing levels. There were a number of urgent findings which the Trust needs to prioritise to improve the quality of care in the organisation, in particular an immediate review of still births and any related improvements required in maternity services, ensuring the escalation of clinical risks is consistent and a review of the discharge process and causes of high levels of readmissions.

Leadership and governance:

- **The review team felt the Board's quality governance processes were not cohesive and fails to use information effectively to improve the quality of care.** The governance systems are not providing the expected level of assurance to the Board and escalation of risks and clinical issues is inconsistent. The governance committee structure is onerous and provides insufficient challenge to enable decisive actions to be taken; consequently the Board is provided with insufficient intelligence on the quality of care, including mortality data and review findings. There is limited evidence to demonstrate that effective improvement ambitions are being agreed or action and monitoring of improvements is taking place.

  The review team observed that very few staff could articulate what risks to clinical quality and patient care existed within the organisation and therefore what was a priority for action. Whilst there was evidence of many audits, there is recognition in the Trust that better quality information is still needed. Further Board papers indicated that some quality issues have been considered in the private part of the board that could have been discussed in the public meeting to improve transparency on this important area.

- **The Board Assurance Framework is not being used as an effective strategic governance tool and the Board is not sighted on the Divisional CIP and quality impact assessments.** The Board could not share a strategic overview of the risks to quality and the BAF is not effective in supporting assurance with too many risks and inconsistent risk ratings. The Board does not review Divisional CIPs and the accountability and governance of Divisional performance is unclear and poorly monitored by the Executive Directors, as such it cannot be sure of the impact these initiatives are having on service performance. Given the weakness in the quality governance systems and in the escalation process to the Board, the panel consider that members are not sighted on the risks to quality at a divisional level.

  There is silo working in the divisions, especially with regard to sharing good practices or lessons learned (e.g. from mortality reviews). The review team did observe good practices within individual teams, but limited sharing between wards and departments. A consistent approach is required in selected areas, such as in response times and processes for complaints.

Clinical and operational effectiveness:

- **Existing capacity within East Lancashire NHS Trust could be used more effectively to improve quality and patient experience.** The review team noted a need to improve the relationships in the local healthcare economy so the Trust was working closely with partners in relation to care pathways for emergency and urgent care, as well as admissions and discharges.

  Capacity at the Royal Blackburn Hospital was fully utilised during the visit due to the number of patients presenting at the emergency department (ED). Reduced staffing levels are impacting on length of stay due to patients being discharged early, whilst in contrast, the review team observed empty beds in Burnley General Hospital. This was supported by evidence and complaints about early discharge levels and readmission rates. The review team noted a relatively short length of stay (which is positive) but also high levels of re-admission for some specialties and a high incidence of patients re-admitted for the same condition.

  The Trust should consider utilising beds at Burnley General Hospital as "step down" beds rather than beds at Royal Blackburn. It should ensure the flow of patients is managed more effectively to improve the use of each site and more consistently manage them as "hot" in the case of Royal Blackburn or "cold" in the case of Burnley.

  Workforce strategies within the Trust are based on national strategies and do not outline how it will develop its staff or address the skills gaps that will assist in overcoming its capacity issues, excessive clinical workload and improve employee morale. The review team considered the staff at the Trust to be a huge asset and individual areas of good and effective care was noted in caring for patients, often working at full capacity.

- **The Trust needs to understand its patient flow better to be able to deal with additional pressures**, for example, during surges in activity due to additional winter pressures. The review team noted a relatively short length of stay (which is positive) but also high levels of re-admission for some specialties and a high incidence of patients re-admitted under the same HRG chapter (i.e. admitted for the same condition).

  The review team was told by staff of clinical concerns that do not appear to have been addressed, including, known high mortality at the weekends and high levels of patients not ventilated in the Critical Care Unit (CCU) at the time of the announced visit. Other quality issues noted by the review team were the lack of understanding by staff of the ambition and trajectories for reduction levels of: pressure ulcers; falls, and ventilator acquired pneumonia. Additionally, the governance processes did not support the identification to the Board of exceptional events, for example, level of still born babies (8 recorded in a single month, March 2013). These need urgent review by the Trust.

  The review team also expressed concern over the appropriateness of the location of two close observation beds (referred to as high dependency beds by some staff) in the Delivery Care Centre in the maternity unit which were used for pre and post delivery pre-eclampsia. Monitoring of these patients can only be done at the side of the bed and not from the nursing station which put pressure on the midwifery staff. The review team noted issues with toilet and wash facilities which were found to be insufficient. Whilst some assurance was gained by the review team during the unannounced visit, concerns still remain over the use of these beds, including, the length of stay of some patients which could be up to 5 days (a shorter length of stay would normally be expected) and the impact on the capacity of midwifery staff to respond to periods of high demand.

Patient experience:

- **The review team considered the Trust's complaints process to be poor and lacking a compassionate approach.** As previously mentioned the complaints response times and the outcomes with respect to organisational learning or changes to practices appear to be lacking across the Trust. People are not offered face to face meetings with there being a preference for communication to be through formal written responses. Common complaint issues relate to; premature discharge; continuity of care; poor communication of information relating to care; poor provision of basic care adequate nutrition, hydration, provision of hygiene following

incontinence. These issues seem to be exacerbated through the high use of bank and agency staff. The review team also witnessed an insensitive conversation taking place regarding end of life care on the ward rather than in an appropriate area.

The public listening events provided evidence that patients and their carers/family members were not always treated appropriately when queries or concerns were raised about patient care. There were numerous examples where carers/family members felt they were treated with a level of condescension by medical staff when they enquired about the received or planned treatment. For instance a number of carers reported that where they expressed concerns regarding patients being moved to different ward areas or hospital sites, they were often overruled without sufficient explanation of whether it was appropriate or not.

The Trust has experienced poor press for an extended period of time and the publicity for the RRR review eliciting an initial angry public reaction at these events. The review team felt that the Trust could benefit from a more proactive and transparent approach to local communications with the public, including improving the relationship with the local media.

Workforce and safety:

- **The review team consider that staffing levels are low for medical and nursing staff when compared to national standards**. Particular issues regarding registrar cover (ST1 and 2) and medical staffing in the emergency department were identified by the review team. The review team also identified that within maternity, midwifery staff are operating at a ratio of 1:31 (midwives to births) and not the national standard of 1:28. This is particularly evidenced in the ante-natal and post-natal staffing ward levels. Staff reported that the level of Consultant cover and availability of allied health professions out of hours was a concern.

  The review team consider the ward staffing levels in some cases to be insufficient to meet the basic needs of patients, in particular, staffing levels on medical wards overnight. The observed impact on patients included delays for toileting, settling to bed and especially, delays in IV fluid or drug administration. Additionally, poor record keeping on some wards for example incomplete fluid balance charts and care plans was also a concern.

- **The review team consider that the nursing workforce needs more leadership, direction and support to achieve acceptable standards of care**. There were many examples of poor nursing processes and inadequate documentation, these included compliance with the controlled drug policy and a less than meaningful approach to intentional rounding. The review team were particularly concerned regarding the inability of front line staff to describe nursing goals regarding patient safety initiatives relating to pressure ulcers or falls. Whilst there was an established system for measurement of patient safety elements the review team could not find evidence that specific targets for improvement were established or understood.

  Band 7 and above nurses expressed strong working relationships with each other, but junior staff reported issues that were not expressed at more senior level, for example, the use of chairs in bays of wards for patients awaiting discharge so that extra patients could be admitted to the ward. This meant that there were additional patients within clinical areas without extra resource to care for them. The junior staff expressed concern regarding the closure of the discharge lounge but this was not highlighted by senior nurses.

  The review team also consider that the staffing levels identified above provide evidence of limited support for nursing in terms of ensuring the right staff, in the right numbers with the right skills being available to meet the known needs of patients. Nursing staff either lacked the capability or the capacity to undertake tasks such as cannulation and administration of IV bolus medications. The impact on patients were delays to their necessary treatment and care which served to increase the workload of already overstretched junior doctors who were left to undertake tasks that in most other hospitals were undertaken by nursing or ancillary staff.

The following definitions are used for the rating of recommendations in this review:

Rating	Definition
Urgent	The Trust should take immediate action to respond to these recommendations and ensure improvement in the quality of care
High	The Trust should develop a response and action plan for these recommendations to ensure improvement in the quality of care
Medium	The Trust should implement these recommendations to ensure ongoing improvement in the quality of care

Leadership and governance

Overview

The three KLOEs in the area of leadership and governance were focussed on the governance processes for assuring the quality of treatment and care, including the use of performance information to drive improvements and the Trust's use of information locally. They were based on the template KLOEs for governance and leadership and tailored to the Trust.

The review panel sought to address the effectiveness of governance and leadership through reviewing documentation supporting key governance processes and interviews with key senior managers. The review panel also spoke to staff in focus groups and observed conditions in clinical areas to understand whether improvements in governance reported by management were having an impact in clinical areas and whether staff were benefiting from effective leadership.

Detailed findings

The governance process for assuring the quality of treatment and care

KLOE 1: Can the Trust clearly articulate its governance process for assuring the quality of treatment and care?

Good practice identified
A Morbidity Reduction plan has been developed, with accountable persons and timelines built into it. There are standardised morbidity-review forms that enable a consistent process to be followed when staff are contributing to the plan.
Non-executive director safety ward walks provide an opportunity for staff and patients to feedback directly.
The introduction of care bundles to address the known areas for improvement such as the treatment and care of a patient presenting with a cerebrovascular disease or chronic obstructive pulmonary disease (COPD).

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Gap between board and ward perceptions of performance and quality of care There is a gap between the Board's perceptions of staffing levels and what the review team were told by ward staff and patients and review of trust documentation: for example: • There were examples of clinical staff shortages (e.g. in maternity services) that were outlined to the review team by senior ward staff that were not recognised by the Deputy CEO or adequately reflected as an explicit risk in the Board Assurance Framework (BAF), or identified as ongoing concerns by the Board. • The review team were told during interviews with the Trust executive team that nurses are involved with mortality reviews (and also drive redesign pathways). However, review of the March 2013 minutes of the mortality review meetings appeared to contradicted these statements e.g. 'still awaiting nurses to be involved'. The review team also noted that quality initiatives that have been outlined by the Board, such as the 'productive ward' or care bundles, are not being consistently applied across the organisation.	None the panel was notified about	The Board should assure itself that there are adequate numbers of staff available to provide safe care and a dignified patient experience. The Trust needs to review lines of reporting, involvement and engagement between the board and its divisions / services. Board members need to be more visible within the services. Adopt a consistent approach to care bundles within the Trust underpinned by training and education and obtain assurance that these are being implemented. A communication strategy to help raise awareness of key initiatives within the trust such as "productive ward" and to facilitate the learning from examples of poor and best practice. This will require more effective leadership, focussed implementation and effective performance management.	Urgent High Medium Medium Medium
Deficiencies within the risk management process to provide board assurance of quality care It is unclear that the process by which risks are rated or escalated is either universally understood or used. The Trust's Board Assurance Framework (BAF) does not reflect all strategic risks identified by the review team during the RRR visit (see below). In addition the BAF contained too many risks for it to be a readily useable document to track performance against key risks during board meetings; the	None the panel was notified about	The Trust needs to establish a consistent approach to the identification and management of risks. Substantial review of the Trust's Corporate Risk Register (CRR) and BAF document is required. The Trust should review the CRR and BAF at sufficient frequency in order to understand whether progress is being made to	High High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
panel noted several duplicates amongst it too. The BAF is a key governance tool and whilst risks are linked to strategic objectives and have Executive ownership, there is little evidence that impact of controls are effective and progression is being made. In many cases the residual risk score is the same as the initial risk score. The Trust needs to prioritise its risks and actions better, for example in response to the recommendations contained within the Francis report a comprehensive GAP analysis was performed but this did not include any prioritisation of key actions.		address risks, where appropriate. Risk arising from the Francis gap analysis should be included on the register as appropriate. This should include mitigations and improvement actions agreed and implemented with the required performance management arrangements in place.	High
Deficiencies within the risk escalation process to provide board assurance of quality care Evidence of a significant number of deaths is highlighted by Healthcare Evaluation Data (Jan 2010 – Nov 2012) which records that the Trust had 26 stillbirths over this period, during which there were 20 months where no still births were recorded. The highest number of recorded still births in a month was three and during the period there were three months when this occurred (Jan 2010, Nov 2010 and July 2012). This makes a figure of eight still births in a single month all the more relevant and something that we would expect to have been escalated to the Board. The panel was informed that any risk that was rated at 15 or above would be escalated to the Board. However, the panel was informed by midwifery staff of concerns raised about a staffing issue relating to 80 incidents of midwife shortages in the previous year with a risk rating of 20. However, this was not reflected in the Board's BAF. Furthermore, during the interview with the Deputy Chief Executive it was not clear that it was known to the Board. The review team interviewed the Divisional Director for Women and	None noted	The Board should undertake an immediate investigation into still births and the failure to escalate the level of deaths. The Board should consider seeking an independent review of the maternity unit's processes. The Board should review its divisional schemes of delegation and performance management. This should include assurance that effective management controls and systems are in place. Divisional risks should be reviewed for consistency on a quarterly basis by the Head of Quality and Governance.	Urgent High Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Children's due to the issue of eight still births (as described above) reported in March 2013. This highlighted that the Divisional Management delegation and escalation processes need to be reviewed to ensure that significant risks to quality get escalated to the Board.			
Quality impact assessments and CIPs CIPs are only signed off by the Medical Director and Nursing Director if they have a risk score of 15 or more and these are self-regulated at a Divisional level. The panel were unable to find evidence that after sign-off the quality impact of CIPs are measured for any variance against their predicted impact following implementation. Additionally, there are no processes in place for the Trust to consider divisional risks at an aggregated corporate level.	None the panel was notified about	All CIPs should be signed off by the Medical Director and Nursing Director to ensure SMART actions, that include a QIA that contain identified quality indicators and baseline measure, the ongoing monitoring and reporting of the potential impacts on quality should be clear. Risks should be considered for their compound effect at an aggregated corporate level.	High High
The Trust divisions are working in silos Elements of good practice exist within the trust organisation but the trust is not ensuring effective working across divisions including the sharing of good practice and learning. Executive and Clinical Directors have recognised that services and divisions need to work together more effectively (for instance between MAU and ED).	Verbal plans articulated agreed to share cost saving plans but no dates for this have been set.	The Board should set the cultural tone for effective collaboration and organisational learning. A framework for divisional sharing of best practice between division and at a Directorate level, including, lessons learned from patient feedback, serious incidents, innovations as well as financial savings initiatives.	Medium
Non executive director (NED) understanding of assurance NEDs have admitted to having limited levels of personal assurance, or understanding of what assurances they should be receiving. Several NEDs stated they receive their assurances from external agencies such as the CQC and NHSLA and also internal audit or through verbal updates from the Medical Director.	None the panel was notified about	A review of NED governance capability including the ability to interrogate quality intelligence should be undertaken and an appropriate training provided. Recommendations already made will strengthen the assurance system and process.	Urgent High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
There was clear evidence that NEDs are not sighted on the care experiences of patients or issues facing staff and have insufficient knowledge of the quality measurement systems in place, for example the safety thermometer. This means that NEDs are unable to provide the required level of scrutiny to have sufficient assurance on the Trust's performance in providing safe and dignified care to patients.		The Board would benefit from commissioning an independent external review of its quality governance systems. A comprehensive programme of safety walk about and, visits that form part of a triangulation and assurance process for NEDs should be established. The Panel expects that this would include NEDs using quality performance data from board dashboards relating to issues such as mortality and harm from pressure ulcers, VTE etc. The Board needs to examine and interrogate mortality figures and gain assurance from other methods than just external audits or the safety thermometer. The Board members should each undertake their own unannounced visits to wards and other clinical areas to understand the priorities of the staff and patients.	High High

Use of information to drive improvements in the quality of treatment and care

KLOE 2: How is the board using performance information to drive improvements?

Good practice identified
The standard of documentation is generally good in terms of it being easy to find and with a logical flow to how it is organised. In both ITU and Emergency Department paperwork was completed very well.

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Board Business Intelligence Board reports contain a lot of data but analysis and interpretation, assurance and progress reporting is lacking. It is not clear that decisions are revisited after approval to ensure that the initial decisions were sound and that risks are being appropriately addressed, as outlined in KLOE 1. Additionally, the Board is not using performance information to set SMART quality improvement within plans. For instance: • In the Maternity incidents reports there were no action plans detailing leads and timeframes, or updates on previous actions. This goes to the Board quarterly. • Some actions are carried over with no commitment to resolution, or are discussed at other forums. For instance a report to the Executive Management Board on 23rd May 2013 outlined that head Injury management discussions had been going on for over a year, - i.e. that there had been consultation but no action (Item EMB/2013/009). • Board reports from Quality and Safety board minutes dated 18/2/13 and 18/3/13 showed that actions in minutes are not properly tracked and in some cases there are no obvious owners for the actions. The Director of Service Improvement outlined a number of planned improvements in a report to the Board, but could provide little evidence of what had been achieved. The actions that were contained in improvement plans that were shared were very non-specific. Examples included (in relation to the falls prevention agenda) “monitor themes”, “discuss with sisters”; another said “actions to be agreed at the directorate level” rather than outlining specific progress targets with reporting timelines and trajectories for service improvements. Review of the meeting minutes and supporting business intelligence reinforces that the Board should undertake a more robust review and challenge of management processes and or	There was a comprehensive service improvement plan although synonymous with other reports much of this was in the very early stages of development.	Commission an independent review of the quality governance framework to assess all gaps and implement quality reporting. Develop a systematic approach to improving clinical quality through the use of improvement science to assess baseline performance define aspirations and agree trajectories with clearly defined monitoring and reporting arrangements. The involvement of patients and staff are key to successful change management and this needs to be included when developing the Trust’s methodology.	Urgent Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
divisional performance. The review team observed that there is a "hunger for information" from the Board but assurance can be limited because actions, the lead accountable person, and monitoring information is missing.			
Board transparency The review of Board papers by the review team suggests a lack of transparency (and thereby accountability) to the public as many of the agenda items in part 2 (private) should be in part 1 (public). For instance the following items may be considered suitable for public discussion, but were not, from Board discussions in 2013: • In the January 2013 meeting at least 4 items could be public including: the ED data; the CQC report; Deanery; and Budget setting reports. • There are no patient stories in Part 1 of the Board meeting.	None the panel was notified about	The publishing of performance information in public would focus on quality and outcomes and encourage greater transparency.	High
Non-elective admissions and high mortality It is unclear how the issue of the causes of mortality is being addressed within the Trust, in particular whether the mortality review team is tackling this issue specifically. From our review of the mortality group minutes and interviews it appears that the mortality review team is conducting an analysis but not providing meaningful action plans for the Trust to review and update its processes. The junior doctors or outreach team were unaware of the review team. Consequently, the review team felt there was limited of evidence or information regarding the action the Trust is taking to address this either individually or collectively with partner organisations. See also KLOE *9* - How is the Board assured that it has the necessary workforce deployed to deliver its quality objectives.	Use of HED and Aqua to understand high mortality.	The Trust needs to improve its approach to mortality reviews and address its high non-elective indicators. This includes working with the health and social care economy wide approach to reduce the number of emergency admissions, including providing alternative support in the community, empowering and aiding patients to effectively manage their long term conditions at home and to promote healthy living to stay well.	High
The Trust has relatively short lengths of stay, high readmissions rates and potentially unsafe discharges	Readmissions audit undertaken which concluded further	The Trust needs to review the causal factors behind its readmission rate and length of stay. Once these factors are	High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Healthcare Evaluation Data (Jan 2012 – Dec 2012) indicates that the Trusts average length of stay is lower than the national average at 3.95 days and the crude readmission rate is above average at 13.2%. Further, patient feedback suggests that both short length of stay and high readmission rates are as a result of premature or inappropriate admissions and discharges (for example patients with Urethral catheters being sent home with no agreed care plan, or discussion with support services; another patient was discharged from Blackburn to Burnley in pyjamas on shuttle bus). In the current model, the emergency department does not need to refer via the medical SpR to admit patients - provided they are stable they get sent straight to the ward. This can result in patients being inappropriately admitted to MAU due to time and bed pressures in A&E. The review team considered that the lack of alternative services within the wider health economy may be a key factor in relation to inappropriate discharges. This was supported through interviews with ambulance staff. Additionally, the level of emergency pressures is the driver for premature discharges.	collaboration with community services is required.	better understood then an action plan, performance management and monitoring system can be established that will then provide assurance for the Board of effective clinical care and safe discharges. Care pathways should be reviewed to avoid delayed discharges. Outpatient services could support specialist nurse follow up rather than delay discharge. The Trust needs to establish whether the current model of admittance to MAU is as effective as it could be. For example, some Trusts have begun to employ a medical SpR based in A&E in order to prevent unnecessary admissions.	High Medium Medium

Further findings not fully investigated

Due to the length of the visit and the number of matters identified, the panel did not have the opportunity to fully investigate all issues identified. These additional matters are listed below. We recommend that the Trust reviews these matters further:

- It is unclear to the panel whether or not clinical coding has been accurately conducted within the organisation.

Clinical and operational effectiveness

Overview

The review into clinical and operational effectiveness focused on how the Trust is implementing actions to monitor mortality performance and identify areas where clinical effectiveness is potentially impacting patient quality and safety, this included the following:

- How the Trust reviews deaths to understand if trends can be identified and lessons learned
- How clinical effectiveness is monitored
- How actions to improve mortality performance are implemented in the Trust

The panel used the mortality and other clinical data in the data pack, as well as other intelligence, for example, that provided by the CCGs to prepare for the review. This insight was then used when conducting interviews with management, examining the Trust's documentation and observing conditions on the wards.

Detailed findings

Governance arrangements for clinical and operational performance

KLOE 3: What governance arrangements does the Trust have to monitor and address clinical and operational performance data at a senior level?

Good practice identified
The Outreach Team providing a rapid response to patients whose condition is deteriorating.
Surgical Triage Unit has been so successful that the Trust is expanding this facility.

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Understanding of corporate or divisional ownership Whilst decision making is devolved it is not clear what Divisional Directors are accountable for, nor is it clear which areas should be owned corporately. This has been covered under governance and leadership above especially in relation to ownership of service and divisional risk registers. Further there are instances of clinical practice that should, where possible and appropriate, be standardised across the services and Divisions, as things stand currently there are potential gaps within performance monitoring or performance reporting to the Board. For instance: • The continuity of medical cover and care seems to vary greatly depending on the consultant and ward. This is impacting on patient experiences of care, for example, a patient on Ward C2 reported to the panel that they had "a different doctor every day of the week" during their in-patient stay and at the weekend the doctor who came to see the patient had not read their notes at all. The patient wanted continuity of care. However, this contrasts with patients reporting good quality of care in Ward C4. • Nursing performance indicators are not well understood across the wards visited during the announced and unannounced visits, for instance, pressure ulcer and falls targets were not well understood and nursing staff appeared to have only a general impression that they were meeting these targets. (See also "Clarity of quality improvements" below). • Nursing staff are not involved in the Mortality Steering Group. Interviews undertaken at the trust also suggests that nursing staff and junior doctors are not involved in the process of reviewing a patient's death within the trust. Further, nursing staff were not aware of improvements to practices that had come about in response to external mortality concerns. There was evidence of significant decisions being taken without the	Divisional Directors admitted that there is been recognition that cross- divisional savings have a lot of potential value in them and the divisions are planning to share ideas by presenting them to one another.	The Trust needs to ensure that there is appropriate delegation of authority to the division, including that of professorial advice. Develop an updated, single, cohesive quality strategy that takes account of external reports, mortality concerns, feedback from patients and staff, clinical audit recommendations, current identified risks and current Trust performance. As part of this, agree quantifiable and measurable improvements.	High High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
input of relevant Executive Directors. For instance, the Deputy Chief Executive, also the Chief Nurse at the Trust, was not initially consulted on a significant reduction in the nursing establishment within the Medical Division a number of years ago. The Board needs to assure itself that it has received the correct level of professional clinical advice regarding decisions that it is accountable for in respect of clinical safety and patient experience. Interviews with non-executives identified that some relied on verbal updates provided by the Medical Director for their assurance about efforts to combat higher than expected mortality.			
Clarity of quality improvements As noted earlier, whilst front line nursing staff are aware of and understand the national 6C's of nursing, there was poor understanding of specific targets that would support the delivery of this initiative. It was described that senior staff had taken one element of the 6C's each and were planning initiatives for roll out across the organisation but this had not yet happened. Nursing staff of various levels of seniority and in various clinical locations throughout the Blackburn and Burnley sites, when asked about the exact number of falls or pressure ulcers within their locations, could not provide specific answers. Further examples included staff at both sites who were unable to articulate a trajectory for C Difficile infections, pressure ulcers or falls – or specific numbers for VTE compliance, MRSA within their areas or as a Trust. Therefore the panel concludes that trust governance arrangements to monitor and address some elements of clinical performance are inadequate, given poor knowledge of quality improvements targets and staff inability to articulate how their clinical areas were performing against these targets.	None the panel was notified about	See previous recommendation regarding improvement science. Staff should have specific knowledge about what improvement ambitions apply to their clinical area, their relative prioritisation and the actions required to deliver improvement in care.	Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Inadequate staff understanding of clinical safety procedures During the announced and unannounced visit the panel become aware of a number of issues relating to the delivery of care in an appropriate environment and the application of generally expected clinical standards. These included: • Two close observation beds in the maternity unit (Burnley) had no telemetry or immediate nearby toileting facilities. Therefore it was unclear as to level of acuity of patients in these beds, and whether the beds had the appropriate support to deliver effective. At the unannounced visit staff reported that patients requiring level 2 care would be managed in that environment. • During discussion with CCU staff it was stated they had decided not to use the ventilator acquired pneumonia (VAP) bundle as "so many improvements were being done at the same time"., However, other staff on the unit indicated that they introduced the use of chlorhexidine products to reduce the incidence of VAP. This suggests inconsistent application of practices. • Across a number of clinical locations it appeared to the review team that controlled drug registers were not reviewed and signed of as frequently as would be expected. • Beds in the escalation areas are resourced predominantly by agency nursing staff. • There was evidence at the unannounced visit that Trust staff had given a patient, awaiting amputation, the wrong consent form (one for parental consent for child or young adult), staff did not appreciate the gravity and potential consequences of this incident. • There were a number of ward areas observed with an inappropriate case mix of patients, including diabetics, cancer patients, and a patient with alcohol related illnesses, these included wards C2 and C10.	None the panel was notified about	The Trust should review the criteria for patient placement, make explicit service improvement priorities and support the delivery of these and address the shortcomings in the level of nursing. An independent review over the close observation beds in the Maternity Unit should be undertaken including a review of case notes of patients using the close observation beds.	Urgent High

Good practice identified
Many staff believe that the concentration of elective activity on the Burnley site is very positive.
Burnley general hospital has mental health trained staff on site, employed by the Trust – including a nurse at the Urgent Care Centre.
The Trust has commissioned Public Health analytical support to better understand demand on capacity.
Staff appear to be pulling together to reduce risks from escalation.
The introduction of the surgical triage unit has improved patient access to treatment and saved money, according to the Triage unit nurse. However, the Trust needs to ensure it is adequately resourced.
There are areas of good practice throughout the Trust, for instance a patient on Ward C4 praised the nursing staffing as absolute angels. They had also had the same doctor throughout the stay, who was able to sit beside the bed and take the time to talk to the patient. He listened and was open to patient input into their treatment.

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority (urgent, high or medium)
Imbalance in capacity and demand across Royal Blackburn Hospital (RBH) and Burnley General Hospital sites. Nursing and medical staff have indicated that there are capacity issues within RBH, the hospital is struggling to deal with the number of patients attending the emergency department and the pressure this creates throughout the hospital. This impacts upon the flow of patients within the hospital and is compounded by issues relating to the delay in discharging medically fit patients, including the availability of medication on discharge and community care packages. Hospital Evaluation Data (Jan 2012- Dec 2012) indicates the Trust had 179,535 A&E attendances (first attendances only) making it amongst the busiest emergency departments in the country. Further, 48,385 are ambulance attendances, the vast majority if not all of which will be to the Royal Blackburn Hospital (RBH). This means that approximately half of all	Strategy involves increasing attendances at MAU and Ambulatory Care Unit. The trust is looking to recruit overseas ED consultants.	Linked to the strategy recommendation previously raised, the Trust needs to urgently review the imbalance in demand and act upon findings, before the next set of winter pressures arrive. As part of this investigation the Trust should benchmark the numbers of attendees against similar sized trusts and also benchmark the staffing profile of these. Additionally, the Trust should review the scope available to relieve bed pressures at Blackburn by using beds in Burnley differently. The Trust needs to enhance its strategy to recruit emergency department consultants and also feedback to NTDA that there are significant difficulties with recruiting to these posts. Care pathways for primary medicine are not being	High Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority (urgent, high or medium)
A&E attendances at the RBH arrive by ambulance. The ability to deal with high demand within the emergency department is affected by the Trust's inability to recruit middle grade doctors and consultants into their emergency department. The panel review team observed and staff reported under utilisation of beds at Burnley General. The split of services between sites appears to be creating inequity of services as the system is not working as an effective whole – especially as patients do not seem to know how to navigate through the services.		used effectively. There needs to be a whole healthcare economy effort to educate the public and to configure services so that patients have access to services at the right place and right time.	Medium
Inappropriate use of clinical areas The panel was informed that endoscopy and day surgery areas were used as escalation areas. The use of these beds as escalation areas could have a potentially adverse impact on cancellations for endoscopy and day case procedures. As previously noted, given that escalation areas are predominantly resourced with agency staff, the appropriateness and safety of using these beds as inpatient areas is questionable. Additional issues within these settings include • Day surgery patients who are not discharged stay on the day surgery unit overnight. • The length of stay in these escalation areas was reported by staff to be up to four days. The review team understand the policy to be no more than 23 hours. • Junior doctors informed the panel that escalation ward patients are supposed to be medically stable, but often they are not. • Often drugs and resources to effectively treat these patients are not available. • There is a lack of continuity of care due to a high use of agency and locum staff. • Toilet and bathing facilities are not optimal in these areas.	None the panel was notified about	The Board should assure itself immediately that patients are clinically safe and receiving a dignified experience, particularly in escalation areas. Escalation arrangements should be reviewed in association with ECIST support. The revised escalation arrangements should ensure that: • No patient stays longer than 18 hours in an escalation area; • The case mix of patients admitted to those areas is clearly defined and any breach of the case mix criteria is reported and investigated as a serious incident; • A clear strategy model is in place to flex staff in support of additional capacity. This should ensure that areas are not staffed solely by agency staff.	Urgent High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority (urgent, high or medium)
Limited provision of a 24 hour service and concerns about out of hours rostering The Trust sometimes struggles to provide out of hours cover; several patients that the panel met reported a delay to their discharge because the relevant service (for example, a specific health practitioner) was not available that day. Some services are not doing enough to reduce clinical workload and, in some cases, are slowing discharges. For instance: • Band 5 and 6 nurses reported that prescriptions for patient discharge were typically delayed and waits of up to 8 hours were not uncommon. • A member of staff in one of the escalation areas stated that on occasions full nursing assessments were not completed until transfer to a ward, which resulted in pressure ulcer and falls assessments were not being undertaken. • Nursing and medical roles appear to be outdated within the trust, for instance there is no access to phlebotomy in the emergency department or Medical Admissions Unit, which would free up medics and nurses to focus on other more skill appropriate tasks. The additional pressure on the Blackburn site is impacting on staff. Issues raised by staff include the following: • Community service managers are participating in the acute hospital on-call rota and are often in work until very late (e.g. 2-3am). They are finding this difficult when allied with an expectation that they are still required to work the next day. • An FY1 was required to lead a ward round without adequate supervision, due to a lack of available consultant support. • Junior doctors also considered there is not a ward round rota that is effective for night cover, resulting in them having to cover too many ward areas. • Junior doctors have concern about the rota, especially for weekend cover. Rotas seem to work against continuity of care. There is an	None the panel was notified about	Skills mix needs to be reviewed on rotas and to be taken to the July 2013 board – to examine both junior doctor and nursing skill mix levels. This links to the recommendations for nursing and workforce strategy. The Trust should review its discharge planning to ensure that this commences on admission and allows patients to be discharged on a timely basis. Specifically, this should include expected date of discharge (EDD) so that both communications with patients regarding discharge is improved and improved arrangements for discharge can be delivered. The Trust should consider the provision of services across its two sites (including pharmacy, physiotherapy and dietetics) to ensure that the configuration of services supports timely discharge. This links to the recommendations around clinical strategy and workforce.	Urgent High High

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority (urgent, high or medium)
impression that the group are unable to get to know patients and are 'task driven'. • The FY1 rota has been described as 'abusive' and with inadequate support to that group provided by nurse practitioners and phlebotomy. It is considered that rotas are made 'without compassion' and there are long term gaps that are not being filled. Further comments include: • Two clinicians (one at each of the Blackburn and Burnley sites) remarked that they thought that public remarks made recently by the Member of Parliament for Burnley about having apparently 'saved' the Burnley ED [although it was actually a UCC] had led to increased demand at Burnley and consequently Blackburn, with patients needing to be transported from Burnley to Blackburn. Consequently service changes may have influenced patient behaviour.			

Further findings not fully investigated

Due to the length of the visit and the number of matters identified, the panel did not have the opportunity to fully investigate all issues identified. These additional matters are listed below. We recommend that the Trust reviews these matters further:

- It is unclear whether or not the cause of capacity constraints is exclusively as a result of the level of A&E attendances or whether there are also patient flow issues due to patients changing their behaviour. Evidence provided to the panel and recorded again *KLOE 5, Engagement with the healthcare economy partners,* supports that view that there are inappropriate attendances but the panel was unable to determine patient flow issues conclusively.

Patient experience

Overview

The three KLOEs in this area consider how the Trust engages with patients and how it is responding to the challenges relating to the duty of candour. This KLOE was tested by speaking to patients and family on wards (where appropriate) and during the patient / public listening events.

How the Trust deals with complaints and how it responds to emerging issues were explored during these sessions, as well as interviews with management.

Detailed findings

Engagement

KLOE 5: How does the Trust engage with stakeholders?

Good practice identified
The review team met many caring staff whilst at the hospitals in Burnley and Blackburn, who are passionate, committed and want to do the best they can to care for their patients, albeit under frequently challenging circumstances. This was confirmed by stories from patients which described excellent care provided by the Trust, despite low staffing levels, at the public listening events and patient “drop-in” session held in Blackburn.
Patient safety walks by executives offer an opportunity to gain insights at a ward level.
Some changes have been made as a result of staff and patient feedback, including: • Improvements made to the fractured Neck of Femur ward e.g., separating patients with different needs. • C4 ward had examples of using new trolleys to transport patients more safely. • New pressure relieving mattresses across the organisation

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Poor communication with patients A recurring theme from the patient listening events was poor communication, with complaints being handled with indifference and without compassion. Examples of this included patients not being fully informed of potential complications in their care, relatives not being told a patient was transferred to another ward and poor communication to patients awaiting transfer from one site to another.	None the panel was notified about	A comprehensive public engagement strategy is developed that clearly indentifies how the board will engage with the public, so that public expectations regarding communication and the required duty of candour and standards are met. Identify an Executive lead to address issues with communication to patients.	High High
Engagement with healthcare economy partners (including Social Services) There has not been robust evidence to suggest that a range of strategic issues are being jointly addressed with healthcare economy partners. An issue for the Trust is that engagement with primary care needs to be addressed around patient flows so that the first point of contact with health service is appropriate. Patient feedback suggests they don't know how to navigate their way through services. Other examples of issues about the wider healthcare economy that the Trust needs to be working with its partners on, include: • Child and Adolescent Mental Health Services **(**CAMHS**)** staff group feel they struggle as deprivation and mental health of adults are affecting children; there is a lot of self harm within the local population and there are deficits within voluntary services in the community that can deal with these. • The panel were told by staff in ED that patients presenting with a mental health issue have poor support, with extended waits to be seen. • There are no mental health trained clinicians on-site at Royal Blackburn Hospital, meaning that access to appropriate advice or interventions is restricted. • Staff at the trust indicated that the availability of social services	None the panel was notified about	The Trust needs to engage with the health economy in response to pressures within the Urgent and Emergency care pathway; the trust is at the mercy of other providers. Acute care pressures need to be addressed through a whole economy response to ensure that effective health and social care needs of the local population are provided. Work with Lancashire Care to improve patient's experiences and see how some support can be given to these patients. The Trust needs to liaise with social services to have the ability to reinstate care packages as soon as possible.	High Medium Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
is an issue for some patients; if a patient is admitted for 24 hours then social service will not reinstate their services for 72 hours meaning that the trust doctors feel unable to discharge patients until these services are reinstated. One patient relayed a story, based on their experience of having an acute hypoglaecemic episode, during which ambulance staff appeared unsure whether services were available in the community.			
Lack of action with regards to patient and public complaints Several themes were prevalent in patient and public feedback sessions, including: • A lack of continuity of care with patients being moved between wards and sites with patient-clinician relationships affected, often via inappropriate ward admissions. • Delayed or inappropriate time of discharge and place of discharge (e.g., an elderly lady was discharged at 3am, with the place of discharge being decided by the hospital without reference to patient choice). • Problems with clinical decision making by junior doctors in ED (for instance where x-rays were not requested and patient subsequently lost sight in one eye). • Significant delays in the availability of medicines, resulted in patients being kept on wards unnecessarily, for example, the panel were informed of patients delayed as prescriptions were not available due to reductions in pharmacy hours. • 'Suspicious' increases in cleanliness immediately prior to the review. Compounding the concerns about the patient complaints process is the lack of evidence about an effective, systematic response to complaints or proof that the organisation is able to provide assurance about learning from these themes. For example the 2012/13 Aggregated Learning report contains a long list of planned actions but no sense of a consistent approach across the	None the panel was notified about	Provide real time complaints monitoring; introduce a system whereby the Board can provide itself with assurance about actions being taken to address deficits; introduce a lessons learned forum; appoint a Board lead to report on this on a monthly basis. Patient safety walkabouts need to target wards that are raised in patient complaints and be unannounced. There were a number of specific complaints raised to the review panel during public listening events. These have been shared with the Trust and action taken needs to be shared via the CCG. The Trust should establish formal routes for sharing lessons learned from patient feedback throughout the Trust (see also KLOE 6) – both positive and negative. The trust should separate out and record complaints and comments on a hospital by hospital basis and use this as the basis for sharing lessons learned across the trust. Undertake specific complaints procedure training for ward champions. The Trust should	Urgent Urgent Urgent High Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
organisation to the "top 5 primary themes emerging from complaints" (3.4 in report) or an approach by which to monitor progress and ensure that changes have happened to working practises or that changes are effective. Other concerns include: • The Governance Committee in January 2013 admission that divisional response times were not as good as they should be (but no action to rectify this). • Complaints raised in January 2013 were only addressed during the week of the announced visit through a first formal letter response (first week in June). • The NHS Choices website comments page does not appear to be covered by PALS. • The Governance Committee meeting in January 2013 was examining complaints for July-September of 2012 i.e. Q2 2012/13 but there was no evidence of a follow up to actions in the next meeting in March 2013 or additional evidence of patients' complaints for the subsequent period. In general terms it is not clear how a complaint is escalated and investigated, nor what sort of complaint would go to the Board or how the Board responds to these – most especially with regards to organisational learning and action. For instance, the panel was verbally informed that patient stories were relayed by the Risk and Governance Manager at Board meetings, but there was no evidence of this in the formal minutes. Patient stories are also supposed to be discussed at a business forum, which is made up executive and non-executive directors, but, there was no evidence supplied to provide assurance of how this forum feeds into the full Board. Conversely, where there is positive patient feedback and experiences of both treatment and care (for instance at a patient focus group) there does not seem to be a process or system to feed back into the Trust.		consider targeted approaches to training following never events or serious incidents that are outlined in patient feedback. There needs to be a framework to deliver an evidenced action plan from complaints combined with learning properly cascaded through the hospital. This may be through specific forums, by appointing ward level champions or by adding it to the agenda of existing ward level meetings. Consider using safety newsletters to feed back additionally.	Medium

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Lack of action with regards to internal incidents Internal incident procedures do not appear to be operating consistently. For example. a Junior Doctor reported putting in an IR1 (Incident Reporting) form about a patient being 'surged' i.e., moved to Bed 15 on ward C9, known as "the cupboard". The doctor was told it was a 'one-off' due to the policy that no one is turned away from the hospital when they felt this was not the case. There appeared to be a common theme from staff interviewed that they did not always get a response from feedback on organisational issues.	None the panel was notified about	The Trust should review the internal incidents management function and processes. In particular, consideration should be given to the lessons emanating from the Francis enquiry. The Board should assure itself that there are no outstanding lessons learnt from actions that require implementation.	High High
Response targets and style of response Divisions have been asked to respond to complainants within an internal target of 25 days, but, there is no data to corroborate performance. The Trust reported it to be 100% in Quarter 1 but the panel considered that this may not have been accurate based on recent complaints raised at public listening meetings. Letters seen by the review team did not offer patients an opportunity to meet staff involved in their care and the letter does not encourage resolution.	None the panel was notified about	There needs to be a paradigm shift in the behaviour of those charged with this process from one of administrating the process to one that recognises the need to recognise empathy and compassion and listen to patients.	High

Learning from patient and public feedback

KLOE 6: What processes does the Trust have to identify themes from patient feedback and ensure that learning is shared across the organisation?

Good practice identified
None identified.

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
The processes for cross organisational learning are ineffective The Trust provided little evidence in the way that it is a 'learning organisation'. Discussions with the Deputy Medical Director, NEDs, Clinical Director, emergency department staff all identified issues with a lack of consistency in lessons learnt between divisions. Where changes are proposed there was no evidence provided to the panel that there was a robust quality assurance about this process. Issues that are being raised (for instance through patient complaints) are not being satisfactorily addressed, because processes for sharing learning as a result of complaints or critical incidents are not clear across the divisions or hospital sites. There is some feedback about incidents, via matrons, but advice to staff is of the nature of "follow the pathway" rather than specific changes to aspects of the pathway that could be addressed. Furthermore, information is not aggregated at the organisational level. There is an absence of positive evidence to suggest that changes are never more than localised and there is not a systematic system of improvement. During the visit the review team were informed that regular night shift workers (including Bank staff) are not engaged fully in the learning culture or opportunities. Additionally, on the unannounced visits, nurses interviewed felt that night shift staff were not included in the learning culture. One nurse stated that although they encourage patient and family feedback, there does not appear to be any learning from the output. The other said that they had never been asked to participate in staff feedback. *See KLOE 5 Action with regards to complaints* and *Lack of action with regard to patient and public complaints.*	Sharing of learning from issues identified in blue light alerts and through aggregated learning reports.	The Trust should establish formal routes for sharing lessons learned and this needs to be shared both internally and externally with all stakeholder groups such as Clinical Commissioning Groups, Area Team and Local Authorities.	Urgent

Governance arrangements for clinical and operational performance excellence

KLOE 7: How does the Trust ensure that its mission statement and values are achieved within its clinical pathways?

Good practice identified

The Trust values were reflected in some patient stories:

- The Endoscopy unit in Burnley is reported as being clean, tidy and well run. There was evidence of positive patient feedback in relation to it as well as JAG accreditation in place. There are also clear escalation processes.
- Patients on planned admissions ward (in Burnley) felt well cared for by doctors and nurses – this was echoed by patients on Ward 23.
- The Day Surgical Unit in Burnley was also seen to be very clean, tidy and well run with clear policies and procedures in place.
- Patients provided evidence of consistent consultant cover on C3 wards at Blackburn.
- Patients provided evidence in Burnley of: caring midwives, continuity of care, professionalism, 'exceptional' staff at the fertility clinic, 'phenomenal care' at the birth centre.
- Two parents were very complimentary about the experience of being treated in both ED and the CMU; they were seen within 15-20 minutes by a 'fantastic doctor', before being moved straight to CMU where they got immediate attention. "Staff on both wards were wonderful and friendly". When staff changed they all introduced themselves and were equally friendly.
- Another patient reported "wonderful" experiences at Ward 15 in Burnley – especially around communication. Everyone explained who they were, what would happen next. There was information about what staff did, what you can expect in the hospital, the values and this carried on even into theatre. They seemed happy. They had been together for a long time, which was reflected in the care back.
- A patient in MAU had come in for blood tests, referred by GP, and was seen in same day and "wouldn't be here without them".

There are proud, committed and loyal staff at the Trust, many of whom described enjoying working there in drop in sessions.

The 6C values are displayed on each ward and are known about within nursing.

The Neck of Femur ward has put in place innovation – splitting the ward to care for dementia patients more effectively – which has led to positive feedback about the quality of care received.

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
There is limited assurance that organisational values are practised consistently across the two sites Whilst there was evidence across both Royal Blackburn and Burnley General Hospital sites of excellent patient care, there was also limited evidence that staff were aware of and understood the Trust's values. One value focuses on respecting individuals but many practices that were observed during the panel visit contradicted this. For instance there was a lack of dignity being afforded to patients waiting in ED after hours, where many patients were lined up along the corridor without any privacy whilst awaiting x-rays. See also *KLOE 3 Clarity of quality targets.*	None the panel was notified about.	The Trust should review how it can communicate and embed the organisation's values and quality priorities in both hospital sites.	High

.

Workforce and safety

Overview

The panel sought to understand the Trust's workforce strategy in the context of the review, and themes from staff engagement, through a review of data on staffing, the staff survey, interviews with management and discussions with staff at focus groups, drop-in sessions and on wards. The panel was also able to observe actual staffing levels and skill mix on ward observations.

Detailed Findings

Key themes from staff engagement

KLOE 8: In the context of this review, can the Trust describe its workforce strategy?

Good Practice identified
The nurse focus group said that permissions to attend mandatory training were not a problem.
Junior doctors said that the paediatric support and the training were 'very good' in the Children's Medical Unit, as well as in Anesthetics which has a good training set up for junior doctors.
Foundation level 1 junior doctor teaching on Thursdays is done well, with locum cover provided.

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
Nursing Strategy and workforce planning needs improvement to ensure safe deployment and effective training The panel was concerned at the number of issues that were identified that relate to staffing and the ability to provide safe clinical care and a dignified patient experience. Detailed and comprehensive evidence is provided below. The panel are of the view that insufficient dedicated Board leadership and professional advice has resulted in a situation where there are insufficient numbers of nurses, an inadequate skill mix and consequently poor standard of care. The nursing strategy was presented by the Chief Executive at the January 2013 Board meeting, but the Director of Nursing was not present at this meeting and this role is currently vacant. This plan agreed the approach for adopting a national strategy rather than a local nursing strategy. The nursing workforce review papers were received after the review but a number of the panel members have reviewed these papers and a conference call interview with the Deputy Chief Executive was held on 26 June. Importantly, this interview occurred after the Trust had had the opportunity to comment on the draft report and after the paper had been presented to the Board of East Lancashire NHS Trust, earlier the same day. This interview confirmed that: • The working papers for medicine, that identified a significant shortfall in nurse staffing was prepared after the Deputy CEO had reversed the workforce reduction enacted (without her permission) by the Divisional Management team some twelve to eighteen months earlier. • The Board had taken note of the comments regarding maternity and agreed to fund the planned two extra midwives plus an additional six, not requested in the initial paper.	None the panel was notified about.	The Chief Executive and Chairman should expedite the recruitment to the Director of Nursing position to enable effective leadership of the improvements required. The Board needs to assure itself that staffing skill mix and levels does not present any immediate risk to patient care or staff welfare. The Board should consider immediate interim support to complete this action. The Board should closely track the implementation of these newly agreed staffing increases. As a matter of urgency, the skill mix of night staffing should be addressed. To develop senior effective nurse leadership to monitor and ensure the successful implementation of the strategy. As part of a divisional accountability agreement put in place formal arrangements for performance management and assurance process for nursing care in and out of hours. The Board should monitor closely the impact of the less than 60:40 ratio in all areas and consider addressing at the next workforce review in six months' time. Bi-annual workforce review in line with Francis with consideration of a dynamic acuity monitoring	Urgent Urgent Urgent Urgent Medium Medium Medium

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
• The Board approved the plan to recruit thirty RN and thirty Non RN staff for Medicine Division. However, the panel note: • The Board paper submitted did not identify the actual shortfall of staff across the organisation, where the gaps were most significant nor the risk that these gaps posed or the financial cost of rectification; nor was there a recommendation for the timescale within which the staffing shortfall should be addressed. The Deputy CEO confirmed that she supplied this information verbally to the Board. In isolation, the Board paper provides insufficient information for assurance purposes, particularly for Non-Executives. • The Medicine Division working paper identified a need for 30 wte registered nurses (RN) and 52 Non-registered nurses. The Board has approved 30 Non Registered. • Even with the now approved increase in establishments the skill mix on Medical wards falls short of the 60:40 RN/Non RN ratio endorsed by the former CNO for England as the minimum for general wards, the exception being some types of 'step-down' or rehabilitation wards. Of the twenty two Medical wards the proposed staffing levels have only three wards meet, or exceed, this ratio and eleven wards will be at 55:45 or less. • Despite the recognition that the existing two days/week supervising time for ward managers, is not routinely achieved in some areas, the Francis Report recommendation that ward managers have full supervisory status has not been addressed as part of this workforce review. There exist only plans to pilot in two areas with the expectation of productivity benefits. The panel feel that this is a missed opportunity. • The most concerning aspect of the ward observation was the		tool being implemented at ward level. Ensure Ward Managers have dedicated supervisory status.	Medium

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
inadequate qualified nursing staffing establishment at night in the Medical wards. The Board paper or supporting Divisional working papers do not address this. The Deputy CEO confirmed that she will look to address this. Finally, the nursing model at the Trust appears to be outdated, with little innovation (for instance adhering to traditional boundaries about roles, such as canulating or applying catheters to treat incontinence).			
Lack of strategy to deal with staffing deficits There are significant gaps within the workforce, especially with regards to Junior Doctors (7 of 21 Specialist Registrar positions are unfilled) and Nursing staff (as observed during site visits – especially in wards B2, B4, C10, C11, C18 and C22 which were very busy very late into the night on the relatively 'quiet' night that the unannounced visit occurred on i.e. 13 June 2013). This is especially pronounced out of hours. The organisation has the feel of being 'just adequately' staffed providing that there are not surges in attendances or whilst nothing goes wrong in a ward (especially at night). Staffing deficits are not being addressed in a timely manner or there doesn't appear to be evidence of a workforce strategy to address them. In some instances (e.g. Emergency Department) gaps are filled with agency staff which can compromise the quality of care and in other areas (e.g. ITU), staff cover one another's shifts which is resulting in an unsustainable workload over time. During the unannounced visit one junior doctor was observed to be shared across multiple wards and struggled to cope with the pressures resulting from this (the observation was made in C18 (Vascular) Ward. The Deputy Chief Executive mentioned that they did not have any concerns about staffing issues, and yet: • The Risk Register for March 2013 showed ED medical staffing at 20 and	The Trust is looking to recruit from other EU countries.	Linked to the previous recommendation, the Trust needs to conduct a full staffing review, considering clinical outcomes and costs, in order to identify staffing recruitment priorities. This should examine the use of agency staff and their impact on patient quality and safety. See also the need for an improved workforce plan in the previous recommendation.	High

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
Maternity staffing at a risk score of 15. • Temporary staff on ward 23 (Burnley) have been employed on it since the ward opened. • In MAU there are 2 SHOs on weekdays and 1 SHO on weekday nights, but no SHOs on weekends resulting in huge pressures on the FY1s. • The panel was told by a junior doctor that there are not enough trained junior doctors. • At the junior doctors focus group the panel were told consider there is not a clear plan for when the hospital reach capacity. • Multiple staffing groups commented that there is not enough staff to cover annual leave, sickness or teaching commitments. The review team noted that there is a lack of focus on addressing workforce issues through its review of Board papers and this was recognised in an interview with the Director of HR. The review team also identified additional concerns: • That only the biggest 5-6 risks are reviewed by the Board (and that these are basically standard HR metrics like vacancies, sickness rates, absence rates). • There is a high use of locums. • That a workforce review for the organisation has reportedly been completed but the panel were unable to verify who completed it or indeed when it was completed. • There are cultural issues remaining as a legacy of the merger of the organisation in 2004, although progress has been made in the last four years.			
Training concerns A number of training requirements have been flagged to the panel. These include: • The junior doctor group felt that more nurse training locally is needed as they have become 'deskilled' as a result of not fully carrying out nursing duties (like blood tests or cannulating. They also thought that newly qualified nurses have difficulty using EWS appropriately and are not recognising sick patients.	None the panel was notified about.	The Trust needs to review its training policies and consult with medical training facilities to ensure that training needs are being met. This should be innovative and respond to Junior Doctors needs to help bring additional numbers of junior doctors to the Trust.	Medium

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
• There are mixed views about the quality of junior doctor teaching; there are pockets where it works well, but many junior doctors are concerned about the quality of teaching on the wards because of the shortage of staff, the timing of ward rounds and the time available for consultants who also have outpatient clinic responsibilities. The quality of training appears to depend on the area to which they are assigned. Often training is too short to allow for proper explanation of patients or to deal with queries. • Junior doctor training is not appropriately focussed – e.g. not enough on clinical skills, but instead on other training such as smoking cessations which are three-hours long (three one-hour sessions was quoted as being more suitable) and took too much time away from clinical areas. • The night shift feel that they are not included in the learning culture and feel disconnected; leading them to feel undervalued. • Outputs from patient's feedback are not shared or resulting in organisational learning. The panel was informed that the medical and surgical divisions are the main problems. Consultants there have very little time to undertake training. Specialist consultants are considered to have more time to teach, whilst the medical registrars are very good. Junior doctors also feel frustrated and powerless, as they are not provided with cover to go to their lectures in a timely fashion. If a FY1 arrives late for a lecture because of an urgent clinical commitment they are marked as 'late' which affects their certification. There is no leeway with this but this is not a standard practice in other hospitals.			
High use of locum and agency staff The organisation has a high number of temporary staff which compromises the quality of care for patients. During the unannounced visit ED had 3 out of 8 nurses on the night shift that were agency staff (albeit some that had	None the panel was notified about.	The Trust needs to review its training and induction policies to ensure all locum and agency staff receive appropriate induction and training so that all staff apply a consistent approach to quality and other initiatives. This	Medium

Outstanding Concerns including evidence	Planned improvements	Recommended Action	Priority – urgent, high or medium
worked there before). Temporary staff cannot be involved routinely with safety initiatives or will have less knowledge of quality targets (and organisational approaches to ensuring that they are met).		is linked to "Training concerns" above".	

Workforce strategy

KLOE 9: How is the Board assured that it has the necessary workforce deployed to deliver its quality objectives?

Good practice identified
It was apparent during ward visits that the majority of staff in the hospitals are very hard working and intent on delivering good care.
The Outreach team are very highly regarded and nurses feel that they knew who to call (i.e. escalation processes are effective for them).

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
The Board receives limited assurance on workforce and quality improvements The panel considered three pieces of evidence as crucial in terms of the Board's ability to be assured:	None the panel was notified about.	As previously noted the Trust should commission an independent review of the quality governance framework to assess all gaps and implement quality reporting.	Urgent

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
• Evidence provided in KLOEs 1, 2 and 8 focussed on a lack of board assurances in the implementation of the strategies and lessons learned from patient feedback or critical incidents. • Clinical quality improvements are not known by many staff at a ward level. • There is a lack of understanding within some of the NED group about what assurances they should be providing or how this may be provided.			
Inadequate clinical staff available to provide safe and effective care The review team noted "hotspots" of issues known within the Trust that are not being addressed by the clinical leadership. For example: • During the unannounced visit the review team noted that three of eight night staff where agency staff within Emergency Department. • Midwifery staffing at Burnley General Hospital is below the suggested national target of 1:28 (midwives to births) with a ratio of 1:31. • Staffing on the post-natal wards is at very low levels and pressure on staff due to flexing i.e. moving staff from wards to address capacity issues on other wards is a major concern to staff due its impact on patient care. • Access to consultant and allied health cover out of hours is inadequate. • Registrar cover is low with numerous vacancies i.e., 7 out of 21 posts are currently vacant.	None the panel was notified about	The Board needs to assure its self that staffing skill mix and levels does not present any immediate risk to patient care or staff welfare. The Board should consider immediate interim support to complete this action. Develop a workforce strategy to support the clinical strategy and as part of this undertake an evidence based nurse staffing review to ensure safe standards of care and dignified patient experience is achieved. To develop senior effective nurse leadership to monitor and ensure the successful implementation of the strategy.	Urgent High Medium

Good practice identified
There is a multidisciplinary mortality and morbidity team and audits – there are action plans with responsible names and dates (seen in the Women's health audit minutes in May 2013).

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
The Board cannot be assured that the organisation is safe Based on the evidence provided in previous KLOEs a number of factors provide evidence that the Board cannot be adequately assured about organisational safety. This evidence included: • There is an absence of SMART actions driving improvements and no clear process by which the board or executives monitor or address discrepancies in planned improvements against actual performance. • Not all members of the Board seem to understand what assurance should be or how to get it. • Whilst the Governance Committee considers quality and safety not all Board members know what is going on there and feel removed from its outputs. This suggests that its outputs are unclear or information from it is not shared with the board. • There is evidence through the panel review team's review of Board and other committee minutes of an overwhelming amount of information presented to the Board. Information that is presented to the Board focuses on an aggregated picture but cannot, therefore, provide specific insights into problem wards. • There is an issue of how risk is managed within the organisation. The Board does not prioritise risks and how to mitigate them. Additionally there is no consistent application of risk definitions across divisions. • The panel has seen significant evidence to suggest that staffing levels are inadequate to provide clinically safe and dignified care.	None the panel was notified about.	The Trust should commission an independent review of the quality governance framework to assess all gaps and implement quality reporting, including: • Review lines of reporting, involvement and engagement between the Board and its divisions / services. This should include putting in place procedures and review periods to review organisational development and risk mitigation. • A consistent approach to the identification and mitigation of risks at both corporate and divisional level. • A review of NED governance capability including the ability to interrogate quality intelligence and appropriate training provided.	Urgent

Outstanding concerns including evidence	Planned improvements	Recommended action	Priority – urgent, high or medium
Mortality Group effectiveness According to the Patient Safety Report the Surgical Division analyse unexpected deaths, but other specialities don't follow the same processes. Whilst the Deputy Medical Director informed the panel that *"all deaths should be reviewed"* it was clear that this was not always the case. It is unclear how these reviews feed into the Mortality Group. Attendance at the Mortality Group is not representative of all staffing groups. As outlined in KLOE 1 the panel were informed that nurses are involved with mortality reviews, further of the Deputy Chief Executive who had suggested that nurses are involved in mortality reviews. However the minutes for the March 2013 Mortality Group meetings, stating *'Nurses still to be involved'*. Junior doctors also reported to panel members that they felt left out from mortality reviews and this was a significant learning opportunity that is missed. The mortality reduction target for the trust was to reduce HSMR by 5 points in the previous year, this was not achieved. There is no evidence of feedback to medical frontline staff as a result of any changes to practises that may arise as a result of the mortality review.	None the panel was notified about.	Review the governance of mortality improvement to bring rigour and pace to a comprehensive and coherent programme of work such that mortality reviews are of adequate depth to produce recommendations. Ensure that there are clear lead responsibilities and full involvement of the multi-professional team.	High Medium

5. Conclusions and action plan

Conclusions

The review identified some good areas of practice across the Trust, with some examples of excellent care being delivered to patients. The review also identified a number of areas of outstanding concern across all 10 key lines of enquiry which will require urgent or high priority action to address as identified in the detailed findings section. The panel recommends the Trust quickly develops action plans to address all these concerns. A number of these areas are recommended for discussion at the risk summit to consider what support may be required from the Trust to address these concerns.

Action Plan

This section summarises the immediate actions arising from the review.

Urgent and High Priority actions for consideration at the Risk Summit

Problem identified	Recommended action for discussion	Support required by the Trust
Governance and leadership	a. Commission an independent review of the quality governance framework to assess all gaps and implement quality reporting (p19, 20, 47 and 49) including: • Review lines of reporting, involvement and engagement between the Board and its divisions / services, to strengthen assurance processes. This should include putting in place procedures and review periods to review organisational development and risk mitigation as well as escalation processes so issues, such as, the level of still births are escalated appropriately. (p16, 17) • Substantial review of the Trust's CRR and BAF and a consistent approach to the identification and mitigation of risks at both corporate and divisional level as well as risks arising from the Francis gap analysis. (p16, 17) • A review of NED governance capability including the ability to interrogate quality intelligence and appropriate training provided. (p18) • Performance information should be made more public to focus on quality and outcomes and encourage greater transparency. (p21) b. CIPs should undergo full quality impact assessments which are signed off by the Medical Director and Chief Nurse. These should be assessed for their aggregated impact on the trust. (p18) c. The Board needs to examine and interrogate mortality figures and gain assurance from methods other than external audits or the safety thermometer. This needs to manifest itself into explicit action and monitoring. The Board members should each undertake their own unannounced visits to wards and other clinical areas to understand the priorities of the staff and patients. (p19)	

Problem identified	Recommended action for discussion	Support required by the Trust
Local Capacity	a. There needs to be a health and social care economy wide approach to reducing the number of emergency admissions, by providing alternative support in the community, empowering and aiding patients to effectively manage their long term conditions at home and to promote healthy living to stay well (p21). b. Care pathways should be reviewed to avoid delayed discharges and a review of the causal factors behind its readmission rate and length of stay needs to be undertaken. Once these factors are better understood and an action plan put in place this will provide assurance for the Board (p22).	
Clinical and operational effectiveness	a. The Trust needs to ensure that there is appropriate delegation of authority to the division, including that of professorial advice (p25). • Develop an updated, single, cohesive quality strategy that takes account of external reports, mortality concerns, feedback from patients and staff, clinical audit recommendations, current identified risks and current Trust performance. As part of this, agree quantifiable and measurable improvements (p25). Linked to this, the Trust needs to urgently review the imbalance in demand and act upon findings, before the next set of winter pressures arrive. As part of this investigation the Trust should benchmark the numbers of attendees against similar sized trusts and also benchmark the staffing profile of these. Additionally, the Trust should review the scope available to relieve bed pressures at Blackburn by using beds in Burnley differently (p28). b. The Trust should review the criteria for patient placements, make explicit service improvement priorities and support the delivery of these addressing shortfalls in nursing levels (p26). c. An independent review over the close observation beds in the Maternity Unit should be undertaken including a review of case notes of patients using the close observation beds (p27). d. The Board should assure itself immediately that patients are clinically safe and receiving a dignified experience, particularly in escalation areas. Escalation arrangements should be reviewed in association with ECIST support. The revised escalation arrangements must ensure that patients stay no longer than 18 hours in an escalation area; the case mix of patients admitted is appropriate; and clear strategy model is in place to flex staff in support of additional capacity (p29). e. The Trust should review: • Skill mix on rotas, • Discharge planning; and • Provision of specialist services across both sites (p30).	
Patient experience	a. A comprehensive public engagement strategy should be developed that clearly identifies how the board will engage with the public, so that public expectations regarding communication and the required duty of candour and standards are met. The Trust should identify an Executive lead to address issues with communication to patients (p33).	

Problem identified	Recommended action for discussion	Support required by the Trust
	b. The Trust needs to engage with the health economy in response to pressures within the Urgent and Emergency care pathway. Acute care pressures need to be addressed through a whole economy response to ensure that effective health and social care needs of the local population are provided (p33). c. Provide real time complaints monitoring and introduce a system whereby the Board can provide itself with assurance about actions being taken to address deficits; introduce a lessons learned forum and appoint a Board lead to report on this on a monthly basis (p34). d. Patient safety walkabouts need to target wards that are raised in patient complaints and be unannounced (p34). e. There were a number of specific complaints raised to the review panel during public listening events. These have been shared with the Trust and action taken needs to be shared via the CCG (p34). f. The Trust should establish formal routes for sharing lessons learned from patient feedback throughout the Trust (p34). g. The Trust should review the internal incidents management function and processes. In particular, consideration should be given to the lessons emanating from the Francis enquiry (p36). h. The Board should assure itself that there are no outstanding lessons learnt from actions that require implementation (p36). i. There needs to be a paradigm shift in the behaviour of those charged with this process from one of almost grudgingly administrating the process to one that recognises the need for empathy and compassion (p36). j. The Trust should establish formal routes for sharing lessons learned with all stakeholders internal and external (p37).	
Workforce and safety	a. The Board should assure itself that there are adequate numbers of staff available to provide safe care and a dignified patient experience (p16). b. The Trust needs to conduct a full staffing review, considering clinical outcomes and costs, in order to identify staffing recruitment priorities (p43). c. The Board needs to assure itself that staffing skill mix and levels does not present any immediate risk to patient care or staff welfare. The Board should consider immediate interim support to complete this action (p48). d. Develop a workforce strategy to support the clinical strategy and as part of this undertake an evidence based nurse staffing review to ensure safe standards of care and dignified patient experience is achieved (p48). e. Review the governance of mortality improvement to bring rigour and pace to a comprehensive and coherent programme of work such that mortality reviews are of adequate depth to produce recommendations (p50).	

Problem identified	Recommended action for discussion	Support required by the Trust
Nursing	a. The Chief Executive and Chairman should expedite the recruitment to the Director of Nursing position to enable effective leadership of the improvements required (p41). b. The Board needs to assure itself that staffing skill mix and levels does not present any immediate risk to patient care or staff welfare. The Board should consider immediate interim support to complete this action (p41). c. The Board should closely track the implementation of these newly agreed staffing increases (p41). d. The skill mix of night staffing should be addressed (p41).	

Appendices

Appendix I: SHMI and HSMR definitions

HSMR definition

What is the Hospital Standardised Mortality Ratio?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

How does HSMR work?

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 specific groups (CCS groups); in a specified patient group. The expected deaths are calculated from logistic regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

How should HSMR be interpreted?

Care is needed in interpreting these results. Although a score of 100 indicates that the observed number of deaths matched the expected number; in order to identify if variation from this is significant confidence intervals are calculated. A distribution model is used to calculate 95% and 99.9% confidence intervals and only when these have been crossed is performance classed as higher or lower than expected.

SHMI definition

What is the Summary Hospital-level Mortality Indicator?

The Summary level Hospital-level Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the general standardised mortality ratio; a measure based upon a nationally expected value. SHMI can be used as a potential smoke alarm for potential deviations away from regular practice.

How does SHMI work?

1) Deaths up to 30 days post acute trust discharge are considered in the mortality indicator, utilising ONS data
2) The SHMI is the ratio of the Observed number of deaths in a Trust vs. Expected number of deaths over a period of time

3) The Indicator will utilise 5 factors to adjust mortality rates by
    a. The primary admitting diagnosis
    b. The type of admission
    c. A calculation of co-morbid complexity (Charlson Index of co-morbidities)
    d. Age
    e. Sex
4) All inpatient mortalities that occur within a Hospital are considered in the indicator

How should SHMI be interpreted?

Due to the complexities of hospital care and the high variation in the statistical models all deviations from the expected are highlighted

Some key differences between SHMI and HSMR

Indicator	HSMR	SHMI
Are all hospital deaths included?	No, around 80% of in hospital deaths are included, which varies significantly dependent upon the services provided by each hospital	Yes all deaths are included
When a patient dies how many times is this counted?	If a patient is transferred between hospitals within 2 days the death is counted multiple times	1 death is counted once, and if the patient is transferred the death is attached to the last acute/secondary care provider
Does the use of the palliative care code reduce the relative impact of a death on the indicator?	Yes	No
Does the indicator consider where deaths occur?	Only considers in hospital deaths	Considers in hospital deaths but also those up to 30 days post discharge anywhere too.
Is this applied to all health care providers?	Yes	No, does not apply to specialist hospitals

Appendix II: Panel Composition

Panel Role	Name
Panel Chair	Gill Harris
Deputy Panel Chair and Senior Regional Support	Teresa Fenech
Lay Representative	Geraint Day
Lay Representative	Trevor Fernandes
Lay Representative	Jenny Cairns
Lay Representative	Howard Naylor
Lay Representative	Gill Stone
Junior Doctors	Andrew Collier Bethan Graf
Doctor	Alan Paul
Doctor	Graham Cooper
Student Nurse	Lucy Giles
Senior Nurse	Joanne Todd
Board Level Nurse	Mandy Bailey
CQC Inspector	Robert Taylor
Senior Trust Manager	Fleur Blakeman
Senior Regional Support	Jon Develing

Appendix III: Interviews held

Interviewee	Date
Mark Brearley, Chief Executive and Hazel Harding, Chairman	4 June
Liz Sedgely, Chair of Audit Committee and Non-executive Director, Dr Ian Stanley, Member of Patient Safety Board and Deputy Medical Director and Charles Thomson, Clinical Director Emergency Medicine	4 June
Lynn Wissett, Deputy Chief Executive and John Fletcher, Representatives from Patient Safety Group	4 June
Rineke Schram, Medical Director	4 June
Jonathan Wood, Director of Finance	4 June
Maire Morton, Divisional Director of Surgery and Anaesthetics Services, Damien Lynch, Divisional Director of Medicine and Duncan Gavin, Divisional Director of Diagnostic and Clinical Support	4 June
Anita Fleming, Head of Nursing and Midwifery	4 June
Ian Brandwood, Director of Human Resources	5 June
3 X Matrons	5 June
Martin Hodgson, Director of Service Development and Jon Dean, Associate Medical Director for Service Integration	5 June
Shahzad Sarwar, Non-executive Director	5 June
Alan Crowther, Divisional Director of Community	5 June
PALS and Complaints team	5 June
Simon Hill, Divisional Director of Family care	5 June
Martin Hill, Non-executive Director	5 June
George Boyer, Non-executive Director	6 June

Appendix IV: Observations undertaken

Item	Location	Date
C2	Royal Blackburn Hospital	4 June
C4	Royal Blackburn Hospital	4 June
B18	Royal Blackburn Hospital	4 June
C9	Royal Blackburn Hospital	4 June
Surgical Unit	Royal Blackburn Hospital	4 June
C14	Royal Blackburn Hospital	4 June
Day Care unit	Royal Blackburn Hospital	4 June
A&E	Royal Blackburn Hospital	4 June
MAU	Royal Blackburn Hospital	4 June
ITU	Royal Blackburn Hospital	4 June
B2	Royal Blackburn Hospital	4 June
B6	Royal Blackburn Hospital	4 June
B8	Royal Blackburn Hospital	4 June
Handover in B14, B20 - Surgical Triage	Royal Blackburn Hospital	4 June
Medical Handover in CCUB	Royal Blackburn Hospital	4 June
Surgical Day Case unit	Burnley General Hospital	5 June
Endoscopy and Elective Surgery Day unit	Burnley General Hospital	5 June
Ward 16 and 23 - Urgent Care unit	Burnley General Hospital	5 June
Neonatal Intensive Care and Women's Health unit	Burnley General Hospital	5 June
Maternity	Burnley General Hospital	5 June

Appendix V: Focus groups held

Focus group	No of attendees	Date
Junior nurses (Bands 5 & 6)	20	4 June
Junior doctors (Below registrar)	14	4 June
Senior nurses (Band 7 & above)	16	4 June
Consultants and Senior Registrars	27	5 June

Appendix VI: Information available to the RRR panel

Board Quality strategy (incorporating Patient Safety, Patient Experience and Clinical Effectiveness)	Governance and committee structures and terms of reference for assuring quality including mortality
Board Assurance Framework and Trust Risk Register	Trust Board (private and public) papers and minutes for the last 2 months
Clinical Audit plans for 2013/14 and latest Clinical Audit Annual Report	Board sub-committee with delegated responsibility for assuring quality and safety. Papers and minutes for last 2 months (public and private)
List of all Cost Improvement Programmes for 2012/13 and 2013/14 and details of the process for assessing the quality impact of these	Mortality review group papers and minutes for the last 2 months
Most recent self assessment or external assessment of quality governance (against Monitor's Quality Governance Framework or equivalent)	Summary of key performance measures for 2012/13 including finance, performance, quality and patient experience
Organisation structure CVs of Executive team	Annual plan submission to Monitor or equivalent for NTDA for 2013/14
CQC Mortality alert action plans and implementation	National Inpatient and Outpatient surveys and the National Staff Survey
Any independent reviews of quality within the last year	Latest RAG Report rating each QIPP & CIP scheme
Mortality Steering Group Papers for March/April	Quality Impact Assessments
Nursing Strategy	Trust Controlled Drugs Strategy
Analysis of bank & agency staff by ward versus overall establishment	2013/14 CIP Programmes that have been signed off by the Board

Attendees for urgent care & A&E split by site	Medical staff rotas
Complaint responses for the last month	6 monthly monitoring data produced by (DRS or ZIRCADIAN) - Core medical rota, surgical rota and obs and gynae
Readmission Data for last year	Top 10 Reasons for readmissions
Template for Safety walkabouts to record information - and what where the outcomes from last 3	History of the Safety Crosses
Primary and secondary reviews of deaths for last 2 months	Nurse Bank by Ward
Mortality reduction strategy	Complaints Quarterly Report that goes to Governance Committee (Most Recent)
Complaints procedure/policy	Midwife ratio cover currently & over last 12 months on a monthly basis by area
Number of transfers between Burnley and Blackburn	Details on SUIs
Emergency pathway for Obstetrics with regards to mothers	The discharge and escalation policies
DNR policy	Trust goals in relation to falls and pressure ulcers for 2013/14 and the year end for 2012/13
Liverpool Care Pathway Policy	Non-elective admissions documentation
Information on five care bundles and future planned bundles	Nurse staffing information (post-announced visit)

Appendix VII: Agenda for unannounced visit

Item	Location	Date
ED	Royal Blackburn Hospital	13 June
MAU	Royal Blackburn Hospital	13 June
ITU	Royal Blackburn Hospital	13 June
B20 – Surgical Triage	Royal Blackburn Hospital	13 June
B22 – Orthopedic Hip Fractures	Royal Blackburn Hospital	13 June
C18 – Surgical (General and Vascular)	Royal Blackburn Hospital	13 June
C22 – Surgical (Urology)	Royal Blackburn Hospital	13 June
B2 and B4 – General Medical (Elderly wards)	Royal Blackburn Hospital	13 June
C4 – General Medical	Royal Blackburn Hospital	13 June
B18 – General Medical (Cardiology)	Royal Blackburn Hospital	13 June
C10 and C11 – Gastroenterology, Respiratory, Cardiology and General Medical (Gastroenterology)	Royal Blackburn Hospital	13 June
Maternity Unit: • Delivery Care Centre • Birth Centre • Post Natal Wards	Burnley General Hospital	19 June