Board of Directors

7 December 2023 | 1.00pm | Lecture Room 1, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 5 October 2023	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Interim Chief Executive's report	1.10pm (15mins: Q&A)	✓	Information	F Button
8.	Patient Story	1.25pm (10mins: Pres) (10mins: Q&A)	Pres	Assurance	J Howles/ A Hardyman
9.	Board Assurance Framework	1.45pm (10mins: Disc)	✓	Decision	S Regan
10.	**STRATEGY AND PLANNING**				
10.1	Annual Plan 2023-24	1.55pm (10mins: Q&A)	✓	Assurance	G Doherty
10.2	Clinical Services Strategy	2.05pm (10mins: Q&A)	✓	Decision	G Doherty
10.3	Social Value Strategy	2.15pm (10mins: Q&A)	✓	Assurance	J Wood
11.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
11.1	Safety and Quality Committee Chair's Report	2.25pm (10mins: Q&A)	✓	Information	K Smyth
11.2	Maternity and Neonatal Services report	2.35pm (10mins: Q&A)	✓	Assurance	E Ashton
12.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
12.1	Education, Training and Research Committee Chair's Report	2.45pm (10mins: Q&A)	✓	Information	P O'Neill
12.2	Workforce Committee Chair's Report	2.55pm (10mins: Q&A)	✓	Information	J Whitaker
12.3	**Report recommended for assurance**: (a) AHP Workforce Strategy (b) Guardian of Safe Working quarterly report (July to September 2023)	3.05pm (10mins: Q&A)	✓ ✓	Assurance Assurance	S Cullen N Pease

№	Item	Time	Encl.	Purpose	Presenter
13.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
13.1	Finance and Performance Committee Chair's Report	3.15pm (10mins: Q&A)	✓	Information	T Whiteside
13.2	Integrated Performance Report as at 31 October 2023 including Finance update *(considered by appropriate Committees of the Board)*	3.25pm (5mins: Pres) (10mins Q&A)	✓	Assurance	I Devji
14.	**GOVERNANCE AND COMPLIANCE**				
14.1	CQC Inspection Report including Well Led Review	3.40pm (20mins: Q&A)	✓	Assurance	S Cullen
15.	**ITEMS FOR INFORMATION**				
15.1	New Hospitals Programme Q2 Report		✓		
15.2	Date, time and venue of next meeting: *1 February 2024, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	4.00pm	Verbal	Information	P White

Board of Directors

5 October 2023 | 1.00pm | Microsoft Teams

Part I

PRESENT	06/04/23	01/06/23	03/08/23	05/10/23	07/12/23	01/02/24
NON-EXECUTIVE DIRECTORS						
Mr P White (Chair)			P	P		
Dr T Ballard				P		
Ms V Crorken	P	P	P	A		
Professor P O'Neill	P	P	Chair	P		
Ms A Pennell *(until 31 May 2023)*	P					
Ms K Smyth	P	P	P	P		
Mr T Watkinson	P**	P	P	P		
Mr J Whitaker	P	P	A	P		
Mrs T Whiteside	P	P	P	A		
EXECUTIVE DIRECTORS						
Ms F Button Interim Chief Executive Officer	P	P	P	P		
Ms S Cullen Chief Nursing, Midwifery and AHP Officer	P	P	P	P		
Professor N Latham Interim Chief People Officer		P	P	A		
Mr K McGee Chief Executive Officer	P	P	P			
Dr G Skailes Chief Medical Officer	P	P	P	P		
Mrs K Swindley Chief People Officer *(until 31 May 2023)*	P					
Mr J Wood Chief Finance Officer/Deputy Chief Executive	P	P	P	P		
IN ATTENDANCE						
Mrs K Brewin (minutes) Associate Company Secretary	P	P	P	P		
Mrs A Brotherton Director of Continuous Improvement	P	P**	P	P		
Mr I Devji Interim Chief Operating Officer				P		
Mr S Dobson Chief Information Officer	A	A	A	P		
Mr G Doherty Director of Strategy and Planning	P	P	A	P		
Mrs N Duggan Director of Communications and Engagement	P	P	P	P		
Mrs J Foote MBE Company Secretary	P	P	P	P		
ASSOCIATE NON-EXECUTIVE DIRECTORS						
Mr U Patel				P		
Mr M Wearden	A	A	P	P		
Mr P Wilson	A	P	A	A		

P – present | **A** – apologies | **D** – deputy | ** part meeting

***Quorum**: 4 Directors and must have at least 2 Executive Directors (one to be the Chief Executive or nominee) and 2 Non-Executive Directors (one to be Chair or Vice-Chair)*

- *Professor P O'Neill was Interim Chair up to and including 31 July 2023 and chaired the August meeting*
- *Mr P White appointed permanent Chair with effect from 1 August 2023*

Governors in attendance: S Barnes, S Brennan, S Doran, M France, S Heywood, L Lynch, J Miller, F Robinson and P Spadlo

Observers in attendance: Megan Cummings
Nicholas Dacres
Paul Faulkner, Lancashire Post and Blackpool Gazette
Martin Watts

IN ATTENDANCE TO PRESENT THE PATIENT STORY (Minute ref 197/23)	
Natalie Clough	Senior Bereavement and Donor Support Nurse
John Howles	Associate Director of Patient Experience and Engagement
Rachel Sansbury	Divisional Nursing Director for Medicine
Ann Tomlinson	Lead Cancer Nurse

IN ATTENDANCE TO PRESENT THE BOARD ASSURANCE FRAMEWORK (Minute ref 198/23) AND RISK MANAGEMENT STRATEGY AND RISK MANAGEMENT POLICY (Minute ref 211/23)	
Simon Regan	Associate Director of Risk and Assurance

IN ATTENDANCE TO PRESENT THE MATERNITY AND NEONATAL SERVICES REPORT (Minute ref 202/23)	
Jo Lambert	Deputy Director of Midwifery and Neonatal Nursing

190/23 Chair and quorum

Having noted that due notice of the meeting had been given to each member and that a quorum was present the meeting was declared duly convened and constituted.

191/23 Apologies for absence

Apologies for absence were received and recorded in the attendance matrix.

192/23 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting.

The Chair made a general declaration in respect of his role as Chair of the North West Ambulance Service.

193/23 Minutes of the previous meeting

The minutes of the meeting held on 3 August 2023 were approved as a true and accurate record.

194/23 Matters arising and action log

There were no matters arising and the updated action log was noted.

195/23 Chair's opening remarks and report

The Chair opened by reflecting on his first two months in post. Reference was made to the excellent people involved with the Trust trying their best to deliver services for the population and communities served. He felt privileged to be part of the organisation and had received a warm and supportive welcome. It was explained that the role of Chair would involve scrutiny and challenge where matters were not where they needed to be or where improvements could be made.

Reference was made to Board-level changes and a warm welcome was extended to Dr Tim Ballard (Non-Executive Director), Uzair Patel (Associate Non-Executive Director), and Imran Devji (Interim Chief Operating Officer) who had joined the Trust with effect from 1 October 2023. Congratulations were also extended to Faith Button who had been appointed Interim Chief Executive Officer following the retirement of the previous incumbent.

In summarising the contents of the Chair's written report, particular attention was drawn to the Board's response and summary points from the letter issued on 8 August 2023 following the verdict on the LL case. A range of reports included with the agenda focused on actions taken by the Trust to minimise such a criminal occurrence at the Trust. On behalf of the Board, the Chair advised that their thoughts and feelings were with the families affected by the actions of the individual, and recognised the potential psychological effect on NHS staff and the need to ensure appropriate support was available.

The report contained subject headings from the part II Board meetings on 3 August and 5 September 2023 and this would be a standing section in each Chair's report moving forward. In respect of the Chief Executive's appointment, it was confirmed that following a competitive interview process on 27 and 28 September 2023, Silas Nicholls (current Chief Executive of Wrightington, Wigan and Leigh NHS Foundation Trust) had been offered and had accepted the role. Further announcements regarding the start date would be made in due course. Thanks were extended to governors, stakeholder partners, and representatives from NHS England and the Lancashire and South Cumbria Integrated Care Service (ICS) who had all been involved in the recruitment process.

196/23 Chief Executive's report

The report provided an update on key national, regional, and local developments and highlighted a range of messages for information. Key highlights included:

- *National position* – current and ongoing strike action across the NHS was causing significant disruption to services across hospitals and particularly the recent consultant and junior doctors' strikes which had been held on the same day. There was focus on prioritising to protect urgent treatment and activities, such as cancer, trauma, and elective procedures, in addition to general medicine pathways. Work was also being undertaken to rebook and reprioritise patients although there would be an ongoing negative impact on the waiting list, financial position, and staff health and wellbeing across the NHS. The annual flu vaccination programme had commenced earlier than usual due to intelligence received regarding flu infection in the southern hemisphere, and Covid booster jabs were also being offered. Reference was made to the article on the strategy for diagnostic hubs across

Lancashire. It was positive to note that faster ambulance turnover times were being achieved and the Trust had moved from one of the poorest to the one of the highest performers across the NHS and within the ICS. The positive position of the Board in terms of disabled members was also highlighted along with the excellent work undertaken by Non-Executive Director K Smyth through the Disabled NHS Directors' Network. The NHS had launched its first Sexual Safety Charter and further information would be available over the coming months. Congratulations were extended to the Trust's Director of Continuous Improvement and Transformation (A Brotherton) on her appointment by NHS England to the recently established National Improvement Board.

- *System position* – good progress was being made on elective and cancer waiting times and focus was also directed at improving elective care performance levels. It was noted that East Lancashire Health Trust had been appointed as host organisation for the central services collaborative programme.

- *Local position* – a range of achievements were included in the report although particular attention was drawn to the movement of paediatric surgery to the Chorley and South Ribble Hospital site which was helping to reduce the waiting list for children across Lancashire and South Cumbria. Feedback from families about their experience had been extremely positive and the national team was interested in seeing how the service progressed. Finally, it was confirmed that the Trust had been successful in appointing the replacement Chief People Officer (Neil Pease) who would take up post from 1 December 2023.

Clarification was requested regarding the current situation with Covid infection levels, whether the Trust had clear guidance in terms of the conditions whereby mask wearing should be reintroduced, and what lessons had been learned from the southern hemisphere regarding their flu outbreak. In respect of Covid infection levels, there had been a slight increase in community prevalence with some infected patients being admitted to hospital, however, as the same testing regime from previous waves was not in place it was difficult to compare data. It was understood the current strain of Covid produced a relatively milder infection and the Trust had not admitted any patients to the Critical Care unit for some time suffering from Covid. With regards to mask wearing, there were clear trigger points in place and the position was considered by the Clinical Reference Group on a fortnightly basis and weekly by the Strategic Operational Group although specific areas could be identified for mask wearing and that was judged on a case-by-case basis. In terms of flu infection and lessons learned, the flu strain experienced by people in Australia had been particularly severe which had informed the Trust's decision to launch its annual flu campaign earlier than usual to try to combat infection levels.

Reference was made to the pathology clinical model and the intention to introduce a central facility alongside locally retained services. Clarification was requested on the location of the central facility, whether a capital bid would be required and whether next steps had been determined should the application for sufficient funds be unsuccessful. Clarification was also requested on the go-live date for the Pathology Collaborative. It was noted that the Pathology Collaborative was national policy and work was being undertaken around option appraisal. In respect of the location, it was noted that no decision had been reached at the present time and this was being looked at as part of the business case. The business case was being developed which would need to evidence significant transformation and benefits and some of the historical work already

undertaken would feed into the business case. There were robust processes in place to engage with staff and national teams and work was ongoing to recruit staff. Reporting on the Pathology Collaborative was through the PCB Joint Committee including discussions on any capital build and the overall governance would need to be determined, all of which would run in parallel to development of the business case.

197/23 Patient Story: Bereavement and Tissue Donation

The patient's wife (Julie) had elected to be filmed rather than attend the Board in person given the emotional impact of sharing her story. The story related to an end of life/bereavement experience as Julie's husband had sadly and unexpectedly passed away in front of her at home. The story outlined her experience of loss and bereavement and the eye donation service, including the support provided by the paramedic service, Chorley emergency department, and the bereavement and donation team. The experience was so distressing that Julie was diagnosed with both broken heart syndrome and post-traumatic stress disorder (PTSD). Despite this, Julie found the courage to share with the Board this most distressing time of her life because her husband was an organ donor and donated his tissue to help others and to also encourage others to consider being a donor. The story included a short video and was supplemented by a slide presentation outlining how the Trust responded to patient feedback.

The team outlined the processes involved for tissue donation, how the teams supported Julie, and how feedback received from Julie was acted on to ensure the service continued to improve its support to those in such situations. Some moving words were shared from those fortunate enough to benefit from organ and tissue donation along with a letter of gratitude from a patient who received a corneal donation. Reference was also made to 'Organ Donation Week – Race for Recipients 2023' and the Trust had been encouraging people to become donors for the first time by participating in activities that saw hospitals nationally compete against each other to count the number of miles of exercise undertaken.

Discussion was held regarding the importance of access for specialist services in the community, such as PTSD support, as opposed to general bereavement counselling. It was noted that there was support available and the team looked to signpost people to appropriate support services available in the community. A question was asked regarding whether there were services available in local authorities and whether they were distinct for the hospital services with no follow-up. It was explained that the team had close links with, for example, St Catherine's Hospice and Compassionate Communities. A Bereavement Group had also been established which included teachers, a person involved in the Manchester Arena bombing who had a wealth of experience, mortuary staff representatives, charities and local support groups, and the team was looking to identify additional community support services that could be involved. The Board asked for reflections from the team regarding whether there was more of an unmet need for bereavement support and family support for non-malignant deaths and end of life. In response, the team advised that there was an ambition that the central networking group would be able to help with looking at those gaps, particularly child support. There were a range of small charities that had come to light although it had been identified nationally that there was a lack of bereavement support.

The Board acknowledged the devastating effect of death and bereavement on families and explored the broader topic of staff health and wellbeing and how the team remained

resilient. It was explained that each member of the team had different coping mechanisms and if required they leaned on each other for support. A significant amount of clinical supervision was undertaken with links to the maternity team for external clinical support. There was also support available through the chain of command and from other senior managers who could be approached directly for support.

In response to a question regarding whether the same coverage by the team was available across both hospital sites, it was confirmed that the team was mainly based at Preston although team members did travel across sites. Where possible, a team member would base themselves at Chorley one day per week and the service was responsive as the need arose.

Reference was made to the key performance indicators outlined and discussion was held regarding the impact and unintended pressure such performance targets could place on patients, relatives, and the team. It was explained that it was about offering choice to families. If the patient was not suitable for donation the team would inform the family as to the reason why so they had awareness that donation had been considered and did not have unanswered questions. In response to a question regarding whether the team felt under pressure to ask people to donate, it was explained that a wrap-around support call was held with the next of kin to discuss practical issues and wishes, such as any personal requests (for example a lock of hair or fingerprint) and at the same time donation was explored to allow the family to consider holding the discussing. Conversely, if the family expressed their wish not to donate, then the family would not be approached again or feel under pressure to change that decision.

The Chair acknowledged the amazing work undertaken by the team and emphasised the importance of staff health and wellbeing. On behalf of the Board the team was thanked for the work they delivered. The Board was also unanimous in its praise for the powerful, emotional presentation and the work of the Bereavement and Tissue Donation team.

198/23 Board Assurance Framework

The report provided details of risks that may compromise the achievement of the Trust's high level strategic objectives. It was noted that the risks were scrutinised by Committees of the Board and the strategic risks detailed in appendix 2 were those that had been presented to Committees or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced. It was confirmed that there had been no changes to the risk scores since the August Board meeting. Three operational risks remained escalated to the Board relating to exit block (risk ID 23); elective restoration (risk ID 1125); and ongoing strike action (risk ID 1182).

A question was raised regarding the Consistently Deliver Excellent Care risk and the capacity position at Finney House at the present time as that facility was key to supporting hospital discharge. It was noted that Finney House continued to be well utilised with occupancy consistently at 90% or above. Patient experience was generally positive with fewer numbers of harms and adverse experiences when compared to an inpatient setting.

The Board noted a range of actions where the due date had been exceeded, no update had been provided on the reason for exceeding the action delivery date, and queried whether the delivery dates for some of the actions were achievable. As a general point

in relation to dates for completion of pieces of work, there was a need to ensure all boxes contained achievable delivery dates and a rationale for any extensions, which would provide assurance to the Board that progress was being made on risks. It was noted that the Chair would be meeting with the Associate Director of Risk and Assurance to discuss the structure of the report.

The Board RESOLVED that the updates to the Board Assurance Framework be approved.

199/23 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 28 July and 25 August 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- An outline of the early work of the Trust's Health Inequalities Delivery Plan.
- An overview of the findings and response to the Medicines and Healthcare Product Regulatory Agency (MHRA) inspection on 9 February 2023 of the Blood Bank at Preston to assess compliance with the Blood Safety and Quality Regulations.
- The annual Allied Health Professionals Staffing report.
- An update on progress against the project plan for thrombectomy expansion including details of the alternative options explored and the plan to expand services to 7-days (8am to 6pm) on 25 September 2023.
- An update following a High Court Clinical Negligence Trial ruling against the Trust in relation to a maternity case concluded on 28 July 2023.
- CQC maternity inspection high level feedback.

Attention was drawn to the negative escalation in respect of Clostridium *difficile* infection (CDI) levels and assurance was requested on the plan to move to an acceptable level. It was explained that an increase had been seen nationally in the number of CDI cases which, in part, was due to an increase in antimicrobial prescribing, although it was recognised the Trust had seen an increase above the national average. There had been a move to weekly oversight by the Executive team, national cleaning standards had been reinforced across the Trust, and discussions were being held with organisations in the ICS reporting positive results to see if lessons could be learned. However, the ability to clean the ageing estate and inadequate ventilation continued to negatively impact on the ability to control CDI levels within the hospitals. The increase in bed occupancy also contributed to the negative position. The Trust continued to engage with NHS England's regional teams to look at opportunities to improve the CDI position. An external review had been undertaken by NHS Improvement in December 2022 following which antimicrobial usage had changed which had realised improvements and it was expected that the results of the positive changes introduced would be seen during the next quarter. In response to a question regarding whether the position was reported at each monthly Safety and Quality Committee meeting, it was confirmed that was the case.

A question was raised regarding whether the Trust had any concerns regarding Reinforced Autoclaved Aerated Concrete (RAAC) in the hospital environment. It was confirmed that checks had been undertaken and RAAC had not been identified across any of the Trust's estate.

200/23 Patient Safety Investigation Response Framework (PSIRF) Implementation Plan and Policy

The report, accompanied by a slide presentation, provided an update on the implementation of the Patient Safety Incident Response Framework (PSIRF) which was a key component of the new National Patient Safety Strategy and would replace the NHS Serious Incident Framework. As part of transition to PSIRF, all Trusts were required to produce a PISIRF Policy and a Patient Safety Incident Response Plan (PSIRP). An overview was provided of the arrangements for transition to PSIRF from 6 November 2023, along with the implementation plan and critical steps that must be achieved, to ensure that PSIRF was fully embedded by 31 March 2024. Both the PSIRF Policy and Plan had been included in the report and would be published on the Trust's website following Board approval.

Discussion was held regarding whether the timescales for delivery by the end of March 2024 were realistic particularly as winter season was approaching. It was explained that the ask of NHS England was for the NHS to implement PSIRF in autumn 2024. Transition arrangements were more fluid and there was some flexibility to move from the Serious Incident Framework. There was confidence that a critical mass of the workforce would be trained by November 2023 with a plan in place to deliver training on an ongoing basis including Board members at the end of November. It was recognised that this was a significant programme and risks during the winter season were recognised although through PSIRF there would be a reduction in unnecessary repetitive investigations which would release time to focus on other pressures.

Reference was made to how patients and families would be informed of the outcome of investigations. It was noted there would be no standard completion deadline and timescales would be negotiated with families which could cause a backlog therefore it was felt a KPI on whether the ambition was being met would be helpful. In addition, clarification was requested on the process for families raising issues or concerns outside of the five local patient safety priorities outlined in the PSIRP and how those issues or concerns would be managed. It was explained that all issues or concerns raised would be dealt with although not necessarily through the PSIRF framework at this point. The five local priorities had been agreed for in-depth reviews to be undertaken and the intelligence obtained would help to deliver improvements on a broader scale. Engagement with patients and families would be critical and through the engagement work with local patient groups it had been determined that patients and families did not feel the current process of investigations was helpful and was felt to be daunting. It was apparent that families wanted to know that the Trust was taking their concerns seriously and improvement actions were being introduced. A programme of improvement around the concerns would be developed clearly describing the actions that would be taken and the action plan would be shared with families. The PSIRF framework would not remove or replace the current process for investigating complaints and concerns and there would be continuing specific focus on such matters through the Patient Experience and PALS team.

A question was asked regarding whether Board members required more in-depth training. It was noted that to date this had been undertaken by the Chief Nursing Officer and Chief Medical Officer but further opportunities would be explored in due course.

Reference was made to how the Board would be updated on PSIRF moving forward. It was confirmed that an annual report would be scheduled at the April Board meeting which would provide six months to implement the framework.

In summarising the discussion, the Board noted the comments regarding the national requirements and the five local priorities identified. It was emphasised that public perception and understanding would need to be as clear and straightforward as possible with strong communication and learning. It was recognised that at a point in the future the Board would need to look at live examples to evidence patients and families had been listened to and appropriate action taken. In terms of wider key stakeholders and governors, there would be a need to understand how PSIRF operated to ensure people supporting the Trust had sufficient understanding to help navigate and signpost members of the public.

The Board RESOLVED that:

1. **it was assured of the actions to commence transition from the Serious Incident Framework to PSIRF from 6 November 2023.**
2. **the PSIRF Policy and Plan be approved for submission to the ICB Quality Committee on 18 October 2023 for approval.**
3. **responsibility be delegated to the Safety and Quality Committee to approve any critical changes to the Policy and PSIRP throughout the year.**

201/23 Mortality Annual Report

The annual report was presented to provide assurance that the Trust had robust governance arrangements in place to review, report and learn from patient deaths. The report had been considered by the Mortality and End of Life Committee and scrutinised by the Safety and Quality Committee on 30 June 2023.

Discussion was held regarding Learning Disabilities Deaths, Reviews (LeDeR) and the continuous improvement work undertaken to support national and local learning. During the year Structured Judgement Reviews (SJRs) had been completed for 50% of deaths against a minimum benchmark of 20% and key learning from SJRs had been shared. A range of initiatives had been delivered or commenced, such as a regional Inquest Training Day in 2022 and an Engineering Better Care project to improve the management of complex investigations into a death. Deep dives had also been undertaken into the data during the year to ensure persistently low mortality rates were existent and nothing was being missed to provide the required assurance that appropriate figures were being reviewed and the data was correct. It was noted that the Medical Examiner Service had been a positive introduction with all deaths within the hospital scrutinised by the service. Through the Medical Examiner Service and Bereavement team all bereaved families were contacted and concerns addressed, if required, through SJR. The Trust was also in the process of rolling our Medical Examiners to review deaths occurring in both hospital and community settings.

The Board observed that action plans to address concerns in some areas were referenced in the report however the negative themes on the action plans were not clear. It was confirmed that the structure of the report would be reviewed and negative themes included in future reports. It was noted that the majority of key themes were being taken through the Always Safety-First programme with dashboards and proactive flags to ensure patient observations and concerns were addressed. Work was being undertaken around DNAR and delays encountered to ensure those discussions were

held proactively and earlier in the patient pathway to allow informed decisions to be made; this was a community-wide piece of work.

The Board RESOLVED that it was assured of the robust arrangements in place relating to the management of patient deaths.

202/23 Maternity and Neonatal Services Report

The report provided an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report detailed progress against work streams relating to the ten Clinical Negligence Scheme for Trusts (CNST). The Deputy Nursing and Midwifery Director jointed the meeting and provided an overview of the contents including other high level service updates.

It was noted that an action tracker was being developed and would be included in future reports to ensure the Board was sighted on progress and issues. Safety action standards 6 and 8 remained at risk due to multiple additional requirements and the updated projected position would be shared with the Board in December. Reference was made to the slight increase in perinatal mortality although this was within the expected range. Attention was drawn to the maternity red flag data by category and it was confirmed no red flag incidents had resulted in patient harm. Reference was also made to the national maternity visit undertaken on 13 September 2023 and the positive feedback received from the Deputy Chief Midwife for England.

Attention was drawn to training compliance which remained off target and clarification was requested on whether the Safety and Quality Committee scrutinised training metrics and whether additional assurance in this area could be provided. It was explained that the Safety and Quality Committee scrutinised training data on a monthly basis. It was recognised there had been a slight reduction in performance which related to medical and anaesthetic colleagues impacted by strike action, and planned training days had been prioritised along with considerations around anything that could be introduced to maintain the 90% compliance rate.

Clarification was requested on the reason for high sickness rates along with an update on international recruitment. In respect of sickness, the service was currently undergoing peer review and challenge due to the pressures on staffing levels experienced for some time. With regards to international recruitment, the service had welcomed 10 colleagues and the programme was progressing well.

The Board RESOLVED that:

1. **the Maternity Service update be approved.**
2. **the CNST update report and recommendations be noted.**
3. **the associated action plans for information, oversight and assurance be received.**
4. **the positive escalation and feedback from the national and regional maternity NHS England visit be acknowledged.**

203/23 Response to Letby Report

The report was presented to provide assurance following the case of LL and the learning that could be drawn from the case whilst the statutory public enquiry was undertaken. The Board had held a Workshop on 5 September 2023 which provided an opportunity to

discuss and reflect on the case alongside a letter from NHS England to all ICB and NHS Trusts. The Board would continue to have the opportunity to reflect on the findings of the case as information became available.

The report set out the arrangements for leadership, oversight and engagement and identified a range of mechanisms to look at and listen to patient and staff feedback, speak up arrangements and patient and staff outcomes. At the September Board Workshop it had been identified that there were good levels of assurance in a range of areas and functions and further identified several areas that the Trust would now focus on strengthening to ensure learning was implemented from the case. Progress against that work would be reflected within the Freedom to Speak Up reports to Board.

The Board acknowledged the crucial nature of scrutinising and triangulating information as part of awareness and learning and to safeguard against people who may seek employment in vocational roles in order to do harm to others. The importance of speaking up was also emphasised particularly for staff in lower-level roles and how their voice was heard. The Trust had robust arrangements in place as part of the Freedom to Speak Up programme and there was a need to ensure the processes were easily accessible and clearly understood to ensure all staff played their part and were encouraged to speak out.

During discussion the Chief Nursing Officer agreed to forward existing information to the new Associate Non-Executive Director regarding raising concerns, whistleblowing and how grievances were captured to help with understanding the Trust's processes.

The Board RESOLVED that it was assured of the measures in place and planned developments as outlined in the report.

204/23 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 8 August 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Detailed conversations with the four clinical divisions as part of the annual review of their education and training programmes, including successes and challenges.
- The strategic risk remained high which had increased some months' ago due to several factors although it was recognised the Trust was in a better position with the announcement of the newly appointed Chief People Officer and realignment of the research and innovation portfolio to the Director of Continuous Improvement and Transformation.
- Positive work undertaken with the Chief Finance Officer and Finance team to ensure compliance with financial procedures.
- Discussions on the work required to ensure the Trust was the leading teaching hospital for Lancashire and South Cumbria which linked to the New Hospitals Programme.
- Consideration of some concerns raised within the GMC survey around education and training for some postgraduate trainees and the need to ensure excellent training provision for all staff.

In response to a question regarding the themes raised within the GMC survey, it was noted that the issues related to support provided to postgraduate trainees and clinical areas experiencing specific workload pressures. The Education, Training and Research Committee Chair and Chief Medical Officer agreed to pick up a discussion outside the meeting with the new Non-Executive Director to provide a more detailed overview.

205/23 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 12 September 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The overall vacancy rate was falling across the Trust and the organisation was generally in a good position in respect of registered nurse staffing levels.
- Sickness levels had increased in July and August.
- Increasing trend in violence and aggression incidences (both patients and family members to staff and staff to staff) and the Committee focused on and reviewed the three-year strategy on a regular basis. A focused event on violence and aggression was also planned.
- A positive staff story was received from Ward 5 which illustrated the strong leadership within that team which could be replicated in other areas.
- Scrutiny and review of the annual report on appraisal, revalidation and medical governance which was recommended to the Board for approval. It was recognised there were good levels of compliance overall, 15 out of 16 doctors had justified reasons for not completing their annual appraisal, and the remaining doctor had now completed the revalidation exercise.

The Chair referred to some general work that was being undertaken to understand growth and shrinkage of the workforce that may be required to meet financial challenges and requested clarification on where progress was being reported. It was confirmed that progress would be monitored through the Finance and Performance Committee in terms of right-sizing the workforce establishment. A new Workforce Task and Finish Group had been established to consider workforce supply in the market and the Trust's controls. The output from those discussions would be reported through the Finance and Performance and Workforce Committees and be included on their cycles of business.

206/23 Appraisal, Revalidation and Medical Governance Annual Report

The report was presented to provide assurance that appraisal systems were robust, supported medical revalidation and were operating effectively whilst acknowledging that there were further improvements to be made. The report had been compiled using the NHS England reporting template and covered the period 1 April 2022 to 31 March 2023 and formed part of the Chief Medical Officer's duties as Responsible Officer. The report was scrutinised by the Workforce Committee on 12 September 2023 and was recommended to the Board for approval prior to submission of the report to NHS England, including sign-off of the Compliance Statement, by 31 October 2023.

Clarification was requested regarding the process where deferral of revalidation was recommended to the GMC and how the Trust supported medics to reach the required level for revalidation. It was explained that the revalidation process was undertaken on a five-yearly cycle with an annual appraisal with a trained appraiser undertaken each

year and one 360-degree feedback completed during the five-year period. The Trust had recently introduced a new 360-degree feedback provider which had caused some technical challenges therefore there had been a higher number of deferrals this year for the minimum four-month period and medics were being supported through that process. A review had also been undertaken of the reminders and prompts sent to medics which it was expected would improve the process over the coming 12 months.

The Board RESOLVED that:

1. **the report provided assurance regarding medical appraisal and revalidation within the Trust.**
2. **the report be approved for the Chair to sign the Statement of Compliance (section 9) prior to submission of the return to NHS England by the deadline of 31 October 2023.**

207/23 Finance and Performance Committee Chair's report

The Chair's reports from the Finance and Performance Committee meetings on 25 July and 22 August 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Continued improvement on meeting cancer and elective performance targets. It was recognised significant work was required to deliver operational targets and the position was scrutinised in detail at each Committee meeting.
- Good progress was being made with the Digital strategy with several positive programmes of work in that space.
- The Emergency Preparedness, Resilience and Response (EPRR) core standards annual assurance report was approved at the part II Board meeting on 5 September.
- The Trust's financial position and continued pressures around delivering the agreed financial target for 2023-24 and subsequent years. The Committee recognised the need for greater assurance around the programmes that would deliver for the Trust along with clarification on the final figures and the longer-term sustainability plan. It was recognised that the information was being developed and the Committee would receive further details in due course.
- Work was continuing with the system and colleagues across the ICS to deliver some of the changes that would assist the Trust both operationally and financially.

The Chief Finance Officer highlighted two significant issues being managed which were negatively impacting on the financial position, i.e. the impact of industrial action on the Trust's financial and performance plan; and, more significantly, transformation and change. The Board was reminded of the additional infrastructure introduced to meet the needs of care pathways during Covid and it had a responsibility to de-escalate those plans rapidly to meet the financial plan for 2023-24.

208/23 Integrated Performance Report as of 31 August 2023

The integrated performance report as of 31 August 2023 provided an overview of key performance indicators aligned to the Big Plan. Detailed scrutiny of the metrics aligned to the four ambitions was undertaken by respective Committees of the Board. Key messages identified from the report, in addition to those already reported by respective Committee Chairs, included:

(a) ***Consistently Deliver Excellent Care*** – ambulance handover times continued to report positively and the Trust was keen to ensure traction continued. The Trust was on track to deliver on the 4-hour emergency care standard of 76% by March 2024 with 72.6% delivered in August 2024. Steady progress was being made in the Emergency Department regarding patients waiting over 12-hours with a reduction seen when compared to last year. There was ongoing focus on timely discharges from wards and the Chief Medical Officer, Chief Nursing Officer and Interim Chief Operating Officer were discussing de-escalation and plans for winter to ensure the safety component and confidently de-escalate with appropriate mitigation. The positive cancer position was recognised in terms of the 28-day faster diagnostic standard to ensure those who did not have cancer were informed earlier, so focus was directed to treating patients with cancer. The backlog position for 62-days was within trajectory and on track to meet the target by March 2024. The Trust was on track to date all over 65-week waiters by March 2024 although the position would be negatively impacted by further strike action.

In respect of safety and quality measures, there were early indications that a positive shift may be occurring relating to pressure ulcer incidences however this remained an area of risk. Improvement work continued within the Always Safety-First Improvement Programme for both pressure ulcers and falls. The data was demonstrating continued raised levels of CDI and weekly oversight meetings were in place to focus on cleaning, movement of patients, training and education, and developing greater understanding of further actions that may improve the CDI rate. In addition, the work to reduce antimicrobial prescribing/consumption had resulted in the anticipated reduction.

Reference was made to hospital admission avoidance and clarification requested on the actions being taken to increase the number of patients that could be admitted onto virtual wards, including whether referrals were being made for both admitted patients (step down) and the Emergency Department (step up). It was explained that as part of mitigation there was increased utilisation around virtual wards. In the next report to Board drill down information would be included as the Trust progressed with that transitional model and a lengthier conversation on that topic would be helpful at the December Board meeting if time allowed.

(b) ***Great Place to Work*** – there had been an increase in violence and aggression incidences and actions had been introduced to address the issues in the three areas with the highest prevalence, including general support and wellbeing and zero tolerance to ensure safety at work was also being emphasised.

Reference was made to sickness and it was noted that sickness absence levels had increased during the summer months and seasonal viruses were expected over the coming months therefore clarification was requested on the actions being taken overall to reduce the sickness rate. It was recognised that the Trust was reporting above the national average for sickness levels and the Executive team focused on sickness absence rates at Divisional Improvement Forums (DIFs) and scrutinised targeted actions developed by divisions to tackle long and short-term sickness absence, including the two key factors for highest sickness levels (musculoskeletal and stress). The ambition remained to reduce sickness absence below the 5% national target and the newly appointed Chief People Officer had referred to some positive actions that would be delivered to improve the position.

It was further clarified that the additional vacancy controls introduced by the ICB for roles band 5 and above (those impacted by central services) and band 8b and above, related to non-clinical posts.

(c) ***Deliver Value for Money*** – the Trust was reporting a month 5 deficit position of £28.6m against a £18.7m deficit plan with the £9.9m variance attributable, in the main, to the system support gap; under-delivery of the Cost Improvement Plan; double running nursing costs; the cost of strikes and the impact of strike action on activity; a shortfall in pay awards; and the net restoration adverse impact offset by operational underspends. An overview was provided of the capital and cash positions, cost improvement programme, and use of resources as outlined in the report.

The Chief Finance Officer noted that there were fundamental issues relating to the cash position. The Trust was spending more cash than was available and it was fair to say the NHS overall was struggling with cash. The position was not unknown in the NHS and the Trust was working with colleagues to remedy in the short-term. There was a need to manage sickness levels down so there was not a reliance on additional pay expenditure, and ensure sufficient cash was available to pay suppliers. The Board would be kept updated on the position.

The Chair reflected on the integrated performance report and welcomed the Interim Chief Operating Officer's view on how the report could be improved moving forward. It was noted that as part of governance the Board focused on what was not going well although consideration should also be given to positive performance, such as cancer and elective activity. At the same time, the Board recognised the difficult discussions that would be needed around matters such as finance with the same rigour around finances as that directed to other metrics. Thanks were extended to colleagues for the improvements being made under difficult circumstances and the context in which staff were operating.

The Board RESOLVED it was assured in respect of the actions being taken to improve performance.

209/23 Audit Committee Chair's report

The Chair's report from the Audit Committee meeting on 21 September 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Significant focus during the meeting on previous internal audit reports and progress with recommendations for improvement. Executive Director leads for each of the reports were invited to the meeting to provide an update and the Committee received a lot of assurance that the recommended actions were being delivered.
- In respect of the Theatre List Management audit report, the Committee felt that focus on the recommendations needed strengthening therefore a further update would be provided to the Committee on 18 January 2024.
- The Finance and Performance Committee was charged with oversight of finances although the Audit Committee requested additional assurance from the Chief Finance Officer on the controls and assurances in place.

- There had been an increase in the number of single tender waivers and the Committee had requested additional oversight in that area in addition to the increased amounts of overseas debt that had been written-off.

In respect of the Theatre List Management recommendations, it was noted that theatre utilisation had been increasing although it was not yet at the required standard. The electronic system had been introduced last year and lessons around implementation had been learned. There had been some difficult problems to overcome during the initial period and the IT team was working with the division to optimise the processes. In response to a question regarding whether information on lessons learned was gathered from large-scale implementation programmes, it was confirmed that was the case and there was currently a major EPR implementation on the horizon which would be helped by previous issues raised regarding the Theatre Management System.

210/23 Charitable Funds Committee Chair's report

The Chair's report from the Charitable Funds Committee meeting on 19 September 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- An ethical and legal debate on the acceptable use of charitable funds.
- Decision to approve charitable funding for a two-year fixed-term Early Pregnancy Bereavement Nurse.
- The Committee considered the charities investment policy against the Trust's green agenda and was comfortable with the current level of exposure. The ethical dilemma of investments in sectors such as fossil fuels or anti-environmental technologies was acknowledged and the balanced approach adopted was endorsed.
- The 2022-23 annual report and accounts for the Lancashire Hospitals Trust and Rosemere charities were approved for submission to the Charity Commission.

The Board recognised the critical importance of keeping up-to-date with legal requirements of charities as the pressures on charities to step outside and fund things not within their gift was immense. It was positive to hear about the Committee's scrutiny in that area and thanks were extended to the Company Secretary for her expert advice and guidance.

211/23 Risk Management Strategy (2023-26) and Risk Management Policy

The report presented the new Risk Management Strategy (2023-26) and the updated Risk Management Policy for approval as well as outlining the introduction of a new Risk Management Group. The Strategy and updates to the policy specifically supported the achievement of two actions developed in response to recommendations from an externally commissioned Risk and Assurance Review conducted in November 2022.

Clarification was requested on the intention to create the new Risk Management Group and the value to be added through creating this additional hierarchy. It was explained that currently the Board focused on high strategic risks and other risks within divisions were not sighted. Therefore, the Risk Management Group would provide the opportunity to undertake deep dives and the group would be supporting reducing risks to allow the Senior Leadership team to drive the strategy without losing sight of divisional risks.

It was noted the Audit Committee had received the document on 21 September 2023 with a request for recommendation to the Board for approval. Given that further work was required to provide greater clarity on the control framework, the recommendation from the Audit Committee was for the document to be presented to the Board in three months so the changes were clearly articulated within the document.

The Board RESOLVED that:

1. **the Risk Management Strategy be ratified on the basis that the amendments to provide greater clarity on the control framework were included and the document re-presented to the Board on 1 February 2024 to ensure all Audit Committee member comments had been reflected.**
2. **the updates to the Risk Management Policy be ratified.**
3. **the introduction of a new Risk Management Group be noted.**

212/23 Implementation of Kark Recommendations: Fit and Proper Persons Test (FPPT) Policy

The Board received the revised policy updated to reflect the adoption of the NHSE Framework on the Fit and Proper Person Test.

It was noted that the framework had been utilised for the recent Board appointments (i.e. the Chair, Non-Executive and Associate Non-Executive Directors, the Chief People Officer, and the Chief Executive). There would be a requirement for all Board members to complete a FPPT declaration annually and arrangements would be put in place with reporting through the Audit Committee. A separate report would be presented to the Council of Governors on 2 November 2023 outlining governors' responsibilities under the framework.

The Board RESOLVED to adopt the FPPT Framework and approve the FPPT Policy as presented.

213/23 Items for information

The following report was received and noted for information:

(a) Data Quality Assurance Report – it was agreed that the report would in future be presented to the Audit Committee and arrangements would be made to schedule the report on the cycle of business. The current report would be presented to the Audit Committee at its meeting on 18 January 2024.

214/23 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 7 December 2023 at 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, PR2 9HT.

Signed: _____

Chair

Date: _____

Action log: Board of Directors (part I) – 5 October 2023

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	211/23	5 Oct 2023	*Risk Management Strategy (2023-26)* – strategy to be updated to provide greater clarity on the control framework (as agreed at the Audit Committee meeting on 21 September) and be included on the Board agenda in February.	Associate Director of Risk and Assurance	1 Feb 2024	

COMPLETED ACTIONS ***(for information)***

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	107/23	1 Jun 2023	*Annual Plan 2023-24* – the plan would be presented to the Board in six months to show refinements, iterations, and movement on the plan.	Director of Strategy and Planning	7 Dec 2023	**Completed** **Update for 7 December 2023** – report included on the agenda.
2.	200/23	5 Oct 2023	*PSIRF Implementation Plan and Policy* – annual report to be scheduled at the April Board meeting.	Chief Nursing Officer	4 Apr 2024	**Completed** **Update for 7 December 2023** – report scheduled for April Board meeting.

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	7 December 2023
Report of:	Chair of the Trust	**Prepared by:**	Peter White/Rebecca Black
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during October and November by the Trust Chair.

It is recommended that the Board receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

Chair's Report

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during October and November.

Annual Members Meeting

Our Annual Members Meeting took place on the 11th October 2023. Whilst members were able to join the meeting on-line, this was also the first in person AMM since before the pandemic and gave members the opportunity to hear from the Trust's Executive Team as they presented the 2022/23 Annual Report and Accounts. Steve Canty, Medical Lead for Lancashire and South Cumbria New Hospitals Programme and Paul Brown, Deputy Director of Research and Innovation (Operations) presented on the New Hospitals Programme and Research and Innovation respectively and these topics were well received. Overall 166 people either attended on the day, joined on-line or watched the session back in their own time.

HSJ Awards

Richard Barker, CBE, Regional Director (North West) has written to Trusts to acknowledge the achievements of NHS organisations across the North West that have been recognised at this year's Health Service Journal (HSJ) Partnership Awards. In particular, the **Clinical Leader of the Year "Highly Commended"** was LTHTR's Dr Mohammed Munavvar, Consultant Respiratory Physician and Interventional Pulmonologist. The HSJ Partnership Awards helps drive improvements in culture and quality across the NHS so this is well deserved recognition for Dr Munavvar and our teams who strive to deliver excellent patient care.

CQC Report

The Care Quality Commission (CQC) inspection team published their findings on the 24th November and overall the Trust has been rated as Requires Improvement – the same rating received after the 2019 pre pandemic inspection. Whilst this is not where we all want to be, we believe that this is a fair reflection of our position and the challenges facing us.

This will be covered in more detail elsewhere on the agenda, however I wanted to take a moment to thank colleagues across the organisation for their efforts and dedication, not only during the inspection, but every single day during what continues to be a very challenging period for the NHS.

As a health system in Lancashire and Cumbria we have an ambition for all Providers to be rated as good overall by the CQC. The Trust has more work to do to achieve this across our hospitals, but I firmly believe that we have strong plans in place the right teams to deliver them, ambition to delivering services that are rated as Good' and ultimately Outstanding.

2. Part II Board of Directors' meetings on 5th October and 22 November 2023

The items discussed at the October part II Board meeting are outlined below along with a brief resume of the discussions. The Board also held two Special part II Board meetings in November which have also been summarised below:

5 October 2023:

1. **Challenging Decisions Report** – the Board discussed a range of schemes that could contribute to bringing the Trust into financial balance and approved three recommended schemes.
2. **New Hospitals Programme** – the Board received two update reports on progress with identifying a site for the new hospital build along with the output from a data gathering exercise undertaken in July and August 2023.
3. **Financial Improvement Plan** – the Board received an update on the Trust's FIP and delivery as at month 5 (August 2023).
4. **Lancashire Hospital Services (Pharmacy) Limited** – the Board received an update on the Trust's subsidiary.
5. **Ward 8 Report** – the Board received the report presented to the Safety and Quality Committee on 25 August 2023.
6. **Maternity Serious Untoward Incidents Report** – the report was presented to Board in line with Ockenden recommendations.
7. **Staff Suspensions Report** – the Board received the quarterly report on the status of staff suspensions.
8. **Charities Annual Report and Accounts 2022-23** – the Board received the reports for the Lancashire Teaching Hospitals and Rosemere Charities which had been adopted by the Charitable Funds Committee on 19 September 2023.
9. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

November 2023:

1. **Financial and Operational Delivery Allocations** – the Board met to discuss the plan to address significant financial challenges following confirmation by NHS England of financial and operational delivery allocations, and approved the Trust's submission.

2. **CQC Inspection Report** *(embargoed)* – the Board received the final CQC Inspection report under embargo and discussed the findings of the 2023 CQC Inspection prior to formal publication of the report on 24 November.

3. Chair's attendance at meetings

a. Details below are the meetings attended and activities undertaken during October and November 2023.

Date	Activity
October 2023	
4 October	LTHTR Board Agenda Brief
	1:1 – Company Secretary
5th October	Non-Executive Director Meeting
	LTHTR Board of Directors Meeting
	1:1 – System Collaborative Business Manager
6th October	1:1 – Non-Executive Director
	1:1 – Associate Director of Risk and Assurance
	Introductory Meetings – Non-Executive Directors
9th October	Chairs, Deputy Chairs and Lead Governor Meeting
	1:1 – Chief Executive
	1:1 – Company Secretary
	AAC Consultant Interviews
10th October	ICB Chair and Provider Chairs Meeting
	Chief Executive/Company Secretary Meeting
	1:1 – Non Executive Director
	HR Team Meeting
11th October	1:1 – Non-Executive Director
	Annual Members Meeting
16th October	Introductory Meeting – ELHT Chair
17th October	1:1 – Non-Executive Director
	Board Workshop – Chorley & South Ribble Hospital

	System Recovery & Transformation Board
18th October	1:1 – Director of Finance/Deputy CEO
	1:1 – Director of Strategy
19th October	Provider Collaboration Board
	Introductory Meeting – CEO, WWL
23rd October	1:1 – Chair, LSCFT
24th October	1:1 – Director of Procurement
	NHP Strategic Oversight Group
26th October	Black History Month – Celebration Event
	1:1 – Executive Chief Nurse
	1:1 – F2SU Lead (Freedom to Speak Up)
30th October	AAC Consultant Interviews
31st October	1:1 – Chair, MBHT
November 2023	
2nd November	1:1 – Company Secretary
	1:1 – Interim Chief Executive
	Council of Governors Meeting
	Governor Elections Working Group
16th November	1:1 – Interim Chief Executive
21st November	1:1 – Associate Non-Executive Director
	System Recovery and Transformation Board
22nd November	1:1 – Director of Finance/Deputy Chief Executive
	LTHTR Board of Directors Meeting
27th November	Mr Speakers' Lancashire Day – Westminster

4. Financial implications

a. There are no financial implications associated with the recommendations in this report.

5. Legal implications

a) There are no legal implications associated with the recommendations in this report.

6. Risks

b) There are no risks associated with the recommendations in this report.

7. Impact on stakeholders

c) There is no impact on stakeholders associated with the recommendations in this report.

8. Recommendations

It is recommended that the Board received the report and notes the contents for information.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report

Report to:	Board of Directors	**Date:**	7 December 2023
Report of:	Interim Chief Executive	**Prepared by:**	Naomi Duggan, Director of Communications and Engagement
Part I	✓	**Part II**	

Purpose of Report

For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The Interim Chief Executive's report provides an update to the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

The Board is requested to receive the report and note its contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

INTERIM CHIEF EXECUTIVE'S REPORT

1. INTRODUCTION

a. The purpose of this report is to update the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

2. UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

a. National Headlines

i. Victoria Atkins replaces Steve Barclay as new Health Secretary

Victoria Atkins MP replaced Steve Barclay MP as secretary of state for health and social care following a cabinet reshuffle on Monday 13 November.

Victoria Atkins has been the Conservative MP for Louth and Horncastle in Lincolnshire since 2015 and is now the fifth appointment in just under two and a half years with Steve Barclay MP now becoming the Environment Secretary.

The Secretary of State is responsible for the work of the Department of Health and Social Care, including overall financial control and oversight of NHS delivery and performance and oversight of social care policy.

She was previously Financial Secretary to the Treasury between 27 October 2022 and 13 November 2023, and Minister of State at the Ministry of Justice and Minister for Afghan Resettlement between September 2021 and 6 July 2022.

ii. New Health Secretary aiming to build 'brighter future for our NHS'

Two days after her appointment, new Health Secretary Victoria Atkins suggested she will take a fresh approach to dealing with NHS strikes and plans to find a "fair and reasonable resolution".

In a video message to the NHS Providers' annual conference in Liverpool, she told delegates she is "an optimist" and plans to work with staff to overcome the challenges in the health service and "take the long-term decisions that will build a brighter future for our NHS".

She added: "This is the approach I will take to industrial action. I'm acutely aware of how the strikes have disrupted patient care and I'm committed to getting around the table, because I want to see a fair and reasonable resolution."

iii. BMA and HCSA to put forward offer to consultants

On Monday 27th November the Government announced it has put forward an offer that it says will modernise the consultant contract and reform consultants' pay structure which the British Medical Association and Hospital Consultants and Specialists Association will put to their memberships.

Agreement by union members would see the end of consultant strike action and you can read more about this on gov.uk here. The BMA say that 'while this offer does not deliver all that the they have asked for, significant progress has been made and they expect to put this formally to members via a referendum that will likely open in mid-December and run until late January 2024'.

iv. NHS pledge to eliminate cervical cancer by 2040

On the same day the new health secretary addressed the NHS Providers' annual conference, the NHS pledged to eliminate cervical cancer by 2040 for the first time ever.

Speaking at the conference in Liverpool, NHS chief executive Amanda Pritchard outlined how the health service can achieve the goal for elimination by making it as easy as possible for people to get the lifesaving Human Papillomavirus (HPV) vaccination and increasing cervical screening uptake.

England is among the first countries in the world to set this elimination ambition within the next two decades.

As part of new plans to put the NHS one step closer to eliminating the HPV virus, which causes up to 99% of cervical cancers, health and care professionals will be supported to identify those who most need the vaccine, through targeted outreach and offering jabs in more convenient settings.

Read more on the NHS website.

v. Artificial intelligence to help boost NHS winter response

Artificial intelligence (AI) will spot patients at risk of needing to go to hospital so community NHS teams can get to them first and reduce pressures on A&Es, as part of a range of tech and data solutions being rolled out across the NHS ahead of winter.

Four GP practices in Somerset are trialling an AI system which can highlight registered patients with complex health needs, at risk of hospital admission or who rarely contact their GP and reach out to them for conversations about their health.

People most at risk will then be contacted by health coaches, nurses, or GPs, who can provide a range of preventive care such as offering vulnerable patients food parcels, escalating care to specialist doctors, putting in support to avoid falls, or link them up with a local voluntary group to help avoid loneliness.

In Buckinghamshire, the NHS is using AI linked to electronic sensors on kettles and fridges that spot changes in patients' eating and drinking habits. These are then flagged with a non-clinical Onward Care team who speak to patients, solving 95% of their issues or escalating anything clinical. Read more on the NHS website.

vi. New NHS software to improve care for millions of patients

The NHS will roll out new software from spring next year to deliver better joined-up care for millions of patients, help tackle waiting lists and reduce hospital discharge delays.

The software will bring together existing NHS data, making it easier for staff to access key information to provide improved and more timely patient care.

The new tool, known as the Federated Data Platform, will join up key information currently held in separate NHS systems to tackle some of the big challenges the health service faces coming out of the pandemic.

By bringing together real time data, such as the number of beds in a hospital, the size of elective waiting lists, staff rosters, the availability of medical supplies and social care places, staff can plan and maximise resources such as operating theatre and outpatient clinic time to ensure patients receive more timely care - read more.

vii. One-year waits reduce for patients as record demand for NHS emergency care continues

NHS staff are managing record demand across emergency care ahead of winter, with new data showing Type 1 A&Es and ambulance services experienced their busiest month this year in October.

New data published today shows more than 2.2 million people attended A&Es last month (2,219,618), making it the busiest October on record, and the busiest month so far this year for Type 1 attendances (1,413,560). There were 547,586 emergency admissions – the highest number since January 2020 (559,058).

Ambulance services also saw their busiest month this year for category 1 (83,326) and category 2 (393,724) ambulance callouts, while more than 850,000 calls to 999 were answered last month – the highest figure this year so far.

Read more on the NHS website.

viii. Hundreds of thousands of NHS patients to be offered the chance to travel for treatment

Hundreds of thousands of NHS patients who have been waiting the longest for treatment will be offered the opportunity to travel to a different hospital, if it means they could be seen sooner.

From 31st October, any patient who has been waiting longer than 40 weeks and does not have an appointment within the next eight weeks will be contacted by their hospital via letter, text, or email, as announced by the NHS and government earlier this year.

As part of the ambitious NHS elective recovery plan, offers will be sent to up to 400,000 eligible patients who will then be able to submit their details including how far they are willing to travel – 50 miles, 100 miles or nationally. NHS teams can then identify whether any alternative hospitals have capacity to see them sooner.

In some instances, the patient's request will be uploaded to the NHS' innovative hospital matching platform – the Digital Mutual Aid System – to see if NHS or independent sector providers elsewhere in the country can take on their care - read more.

ix. NHS virtual wards to treat thousands of patients with heart failure at home

Thousands of patients with heart failure will now be treated from home as the NHS expands its world-leading virtual wards scheme. The expansion means people can remain active and maintain their independence in their own home, while undergoing medical treatment.

New NHS clinical guidance published at the end of October asks local health systems to expand their use of virtual wards to include heart failure patients who often spend a lot of time in hospital and can now get specialist care from the comfort of their own homes. Read more on the NHS website.

x. NHS dementia diagnosis rates at three-year high

The NHS is diagnosing tens of thousands more people with dementia since the start of the pandemic, thanks to NHS recovery efforts.

NHS staff have diagnosed 475,573 people with dementia in September – up more than 52,000 than the same time last year, with diagnosis rates now at a three year high.

Speaking at NHS Providers annual conference, NHS chief executive Amanda Pritchard said that the NHS is committed to continuing this diagnosis drive so that more people get the help they need as soon as possible.

NHS England launched new pilots in December to increase diagnosis rates with health professionals going into care homes to assess older adults who may have missed checks during the pandemic.

Heath chiefs are expecting the ambition of diagnosing 66.7% of people over 65 will be met in the next year. Read more on the NHS website.

3. INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

i. Interim Chief Executive, Faith Button's meetings in October and November 2023:

Date	Event
October	
9th	P White, Chair
10th	A Cummins, Lead CEO, LSC Provider Collaborative
	Executive Directors meeting
11th	Executive Management Team and Senior Leadership Team
13th	JLNC Meeting
16th	Weekly Executive Briefing
17th	NW System Leaders
	Board Workshop
	System Recovery and Transformation Board
18th	Executive Team Meeting
	Lancs & South Cumbria (LSC) Chief Executives
19th	CEO and Consultants
	Provider Collaboration Board
	JNCC
30th	Weekly Exec Briefing
	Monthly Executive Q&A
	Consultant Interviews – Neuropathology
31st	Integrated Respiratory Team Steering Group
	NW System Leaders
	Medical Staff Committee
November	
2nd	Board Agenda Setting
	Council of Governors
	P O'Neill, Vice Chair
3rd	M Girach, Programme Director (Primary and Community Integration)
	NW Talent Pool (Inspiring Leaders)
6th	Weekly Exec Briefing
	M Oldham, Chief of Transformation & Recovery / Deputy CEO – ICB
	K Lavery, ICB Chief Executive
	NHS England Visit (Richard Meddings and Sir David Behan)
7th	Board Workshop and Trust Board
	NHS England ICB & CEO Webinar
8th	Consultant Interviews
	Senior Leadership Team
9th	CEO and Clinicians Meeting
10th	ED Safety Forum

13th	Weekly Exec Briefing
14th	Transformation and Recovery Board
15th	Inclusive Leadership Graduation, Evaluation and Learning
	Executive Management Team
	Chief Executive's weekly meeting
16th	Provider Collaboration Board
	P White, Chair
17th	Clinical Strategy Configuration Event
20th	Weekly Exec Briefing
21st	P Wilson, Associate NED
	Central Lancs Executive Group
	System Recovery and Transformation Board
22nd	Special Board of Directors
	Executive Management Meeting
	LSC CEO Meeting
23rd	K Lavery, ICB Chair
	N Duggan, Director of Communications & Engagement
	C DeGoede, Consultant Paediatrician and visit to Department
	Media Call
	Divisional Finance Review Meeting
24th	L&SC Pathology Service Board
	Divisional Finance Review Meeting
	NIHR Manchester BRC Governance Board
27th	Weekly Exec Briefing
	N Latham, Interim Chief People Officer
28th	S Nicholls, Chief Executive, Wrightington, Wigan and Leigh Trust

ii. Trust receives Care Quality Commission report

Lancashire Teaching Hospitals NHS Foundation Trust has received its Care Quality Commission (CQC) report on 24th November following inspections in May, June and July of this year.

Unannounced inspections took place at urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, as well as medical care, and surgery at Royal Preston Hospital. A focused inspection of maternity services was also undertaken as part of CQC's national maternity services inspection programme before inspectors also looked at how well-led the trust is overall.

Overall the Trust was rated as requires improvement. Safe, effective and responsive domains maintained requires improvement ratings; well-led moved from good to requires improvement and caring was re-rated as good.

Of the 17 domains inspected at Preston, seven have maintained their rating as good with five areas remaining as requires improvement. Three areas, including responsive in surgery, effective in urgent and emergency services, and safe in maternity, saw their rating go from good to requires improvement with surgery (effective) and medical care (well-led) improving from requires improvement to good.

At Chorley, of the seven domains inspected, five areas maintained their good rating and maternity (safe) and urgent and emergency services (safe) are now rated as requires improvement.

The report recognises that staff across the Trust felt supported, respected, and valued, services were promoting equality and diversity in daily work, and the Trust was providing opportunities for career development.

The CQC also found areas of outstanding practice across the Trust, particularly in maternity services at both Royal Preston and Chorley & South Ribble Hospitals and within the emergency department at Royal Preston

and noted the outstanding work of our Team Development and Engagement (TED) tool, which has been recognised by NHS England as an example of excellent practice for leadership development and continuous improvement.

As part of their visit, the inspectors went to have a look around Finney House, but it was not inspected upon this occasion. However, the inspectors acknowledged that this was an innovative and positive way of addressing some of our challenges around the amounts of patients not meeting the criteria to reside (NMC2R).

Our focus now is to ensure we enact all the recommendations of the CQC report; rapidly spread the learning from the areas that have maintained or improved their rating and continue to build a learning and improvement culture within the organisation to deliver excellent care with compassion for patients accessing all of our services.

Read more on the Trust website or a link to the report is available on the CQC website.

Upon receipt of the report we issued internal communications to staff as well as holding a number of engagement sessions for them and also briefed our membership and other stakeholders.

This item is covered in detail later on the agenda, but I would like to take a moment to thank all our staff for their incredibly hard work and acknowledge the ongoing aspiration for all our services to be rated good and ultimately outstanding.

iii. Provider Collaborative Board

The Provider Collaborative Board (PCB) met on 16 November 2023. It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on several key programmes of work as agreed with Trust Boards. Updates on the One LSC leadership team, the Clinical Programme Board and the Pathology Network Board were discussed under Joint Committee Working items. Please see Appendix I for the full summary.

iv. Kevin Lavery's Chief Executive report – ICB Board Meeting – 8th November

On 8th November the Lancashire and South Cumbria Integrated Care Board held their last Board meeting of 2023 with Chief Executive, Kevin Lavery, outlining the current challenges that the ICB is facing in relation to delivering an ambitious recovery and transformation plan, and focusing on what needs to be in place in order for the plan to be achieved.

In the report Kevin highlights there has not been enough progress in relation to the agreed recovery plan and the month six position means that it is now necessary to prepare for intervention from NHS England. Intervention should add value and help to improve the year-end position and future transformation.

Kevin's full paper is available in Appendix II and you can watch the last ICB Board meeting on their website.

v. Improving Health and Care at scale – system noted for Engineering Better Care and Core20Plus5 work

NHS England has outlined plans to develop an improvement approach known as NHS IMPACT to support continuous improvement. There are also ambitions for integrated care systems (ICSs) to become 'self-improving systems'.

The Health Foundation, NHS Confederation and the Q community have recently reviewed the experience of a number of ICSs identified as being at the forefront of this work, focusing on the approaches they have taken and the results achieved**.**

The November publication of 'Improving health and care at scale' report features an eight page case study (see page 55) of Lancashire and South Cumbria's recovery and transformation programme featuring Engineering Better Care and Core20Plus5 work.

You can read the full report on the NHS Confederation website. Well done to everyone involved.

vi. UK Disability History Month – 16th November to 16th December

UK Disability History Month runs until 16 December with this year's theme focussing on the Experience of Disablement amongst children and young people in the past, now and what is needed for the future.

UKDHM 2023 provides an opportunity for all councils, service providers, education establishments, youth, play and sports organisations, health providers and employers to examine their approaches to disabled children and youth, and you will see communications from our EDI team throughout the month about any events they have planned.

Also to mark the month, Kate Smyth, Non-Executive Director at the Trust, has written a blog for NHS Providers on 'Redefining ability: A Director's journey through disability and leadership in the NHS'. In the blog, Kate shares her story of overcoming adversity, championing diversity in the NHS and co-founding the Disabled NHS Directors Network (DNDN). Her experience is not just about facing the challenges of living with multiple sclerosis (MS), but about transforming obstacles into opportunities for advocacy and leadership. You can read it here.

Kate has also contributed to a video produced by the DNDN about what it's like to be a disabled director in the NHS, where she highlights her role, what she enjoys and also her frustrations. Kate was recently asked by NHS employers to chair a panel at their Disability Summit on 29th November and was a keynote speaker at the Trust's Living with Disability Staff Ambassador Forum on Wednesday 6 December between 2pm-4pm as part of a hybrid event in the Education Centre.

I would personally like to thank Kate for her inspirational work in this area – she really is a fantastic ambassador for disability within the NHS and of course our Trust.

In recognition of DHM, the Trust has lit up its main entrance at Royal Preston Hospital purple and Board members were asked to today wear something purple to show their support. #PurpleLightUp is a global movement that celebrates and draws attention to the economic contribution of the 386 million disabled employees around the world. Purple also supports the UN International Day of Persons with Disabilities (IDPD) held annually on 3rd December to drive the momentum for disability inclusion.

vii. Women urged to take up offer of vital cervical screenings as attendance drops across Lancashire and South Cumbria

Women are being urged to accept NHS cervical screening invites after new figures show three in 10 of those eligible for screening do not take up the potentially life-saving offer.

The NHS Cervical Screening Programme, England 2022-2023 annual report, published by NHS England, found that 68.7 per cent of 25 to 64 year-olds had attended screening within the recommended period of time, compared to 69.9 per cent the previous year.

Attendance in Blackburn with Darwen (63.1 per cent) and Blackpool (64.8 per cent) is significantly lower than the national average, and while Cumbria (75.1 per cent) and the Lancashire local authority area (70.3 per cent) are above the average, they are both seeing lower figures in 2023 than in 2022. Read more on the ICB website.

viii. Final call to book a COVID-19 autumn booster ahead of the festive season

Health chiefs in Lancashire and South Cumbria are urging eligible people who haven't yet had their autumn booster to come forward to avoid missing out.

The last date to book a COVID-19 vaccine on the National Booking Service is expected to be Thursday 14 December, after that date there will still be some walk-in and outreach clinics offering vaccinations.

The local vaccination helpline 0300 7906 856 is available for more information and help with finding a vaccination service near to where you live.

By calling the number (between 9am and 5pm, Monday to Friday), you can also access more information about the COVID-19 vaccine.

ix. Expanded NHS support available for patients in GP practices across North West

Patients in the North West are benefiting from expanded GP services thanks to thousands of healthcare staff working across the region to support the new GP access recovery plan and help patients get the right care when they need it.

More than 3,400 additional staff have been recruited into healthcare roles at general practices in the region since 2019, with community health teams, including pharmacists, mental health practitioners, paramedics, physios, and social prescribers now available to patients in addition to seeing their GP or practice nurse.

This comes as part of a national campaign to make sure the right help is available as record numbers of people are seeking support from their family doctors. With one in five GP appointments in England being for non-medical reasons such as loneliness or seeking advice on housing or debts, it's important to have a wide range of professionals available to offer support.

A patient can always see their GP, be it face to face, over the phone or a virtual consultation. More than 700 staff from practices across the North West have been trained, and a further 400 places are available for new roles until the end of March 2024, to better assess patients' needs when they first contact their practice so they can be seen by the right health professional. For example, if a patient has muscular pain, they will be booked straight into see a physiotherapist. Read more on the ICB website.

x. Ambitious strategy to tackle smoking in Lancashire and South Cumbria announced

The Tobacco Free Lancashire and South Cumbria Strategy 2023-28 is an ambitious five-year plan to address smoking rates, and meet the NHS Long Term Plan target of less than five per cent smoking rates across the country by 2030.

The plans were endorsed at a recent ICB board meeting and now work will begin on bringing together local authorities, the wider NHS, service providers and communities to help achieve its goals.

The Government recently announced proposed legislation that will make it an offence for anyone born on or after 1 January 2009 to be sold tobacco products – effectively raising the smoking age by one year each year

until it applies to the whole population – and while the Tobacco Free Lancashire and South Cumbria Strategy was agreed before those targets were announced, it will complement those proposals - read more.

4. Consistently Deliver Excellent Care

i. Professor Munavvar 'Highly Commended' at the HSJ Awards

Congratulations to Professor Mohammed Munavvar, Consultant Chest Physician, who received a highly commended award in the 'Clinical Leader of the Year' category at this year's HSJ Awards 2023.

The HSJ awards are one of the most prestigious and coveted awards across the NHS. They highlight best practice and excellence within the healthcare sector and provide the opportunity to recognise the fantastic achievements of the people working in the UK's healthcare workforce. A massive well done to Professor Munavvar on his award!

A big well done also to the Lung Vision team, who were shortlisted in the 'Modernising Diagnostics' category for their fantastic work introducing the Lung Vision Navigation Bronchoscopy System to our hospitals. Lancashire Teaching Hospitals are one of the first hospitals in the UK to benefit from the system, which is already helping to transform diagnostic services for lung cancer patients in Lancashire and South Cumbria. Read more on the Trust website.

ii. New breast pain clinic launched by the Trust in Central Lancashire

The NHS in Lancashire and South Cumbria has launched a new breast pain clinic to support people in Central Lancashire. The new specialist service provides examinations and advice to patients suffering from breast pain in Preston, Chorley and other parts of Central Lancashire and is run by Lancashire Teaching Hospitals NHS Trust.

The Preston-based clinic aims to reduce anxiety and worry for many patients who might otherwise have been unnecessarily referred for hospital tests on a cancer pathway.

There are no mammograms or scans in the breast pain clinic. Instead, it focuses on finding the cause of the pain and identifying ways to help manage it.

Most women will experience breast pain at some stage in their life and there are different ways in which women describe the sensations in their breasts including pain, discomfort, a bruised sensation, tingling/itching behind the nipple, and tenderness. Read the full story on the ICB website.

iii. 'Tea for Two' initiative aims to improve patient experience in Trust Discharge Lounge

Lancashire Teaching Hospitals recently introduced a 'Tea for Two' initiative in its Discharge Lounge to help improve patient experience and staff wellbeing for patients using the service who are waiting to go home.

The new programme encourages staff working in the Discharge Lounge to pull up a chair and have a cup of tea and a chat with patients, providing support, answering questions and giving the opportunity to get to know patients better to ensure the final part of their stay at the Trust is comfortable.

Naomi Rowley, Discharge Lounge Lead Nurse, explained: “I saw a similar initiative at another Trust that encouraged nutrition, hydration, and social interaction through having a cup of tea with patients. As the Discharge Lounge Lead Nurse, I am extremely passionate about continuous improvement and patient care being the top priority.

So far the initiative has been a great success and you can read more on the Trust website.

iv. Lancashire Teaching Hospitals welcome three Patient Safety Partners

Lancashire Teaching Hospitals welcomed three new Patient Safety Partners (PSPs) in November as part of their work to support and enhance patient safety and experience.

The brand-new role, which has been developed in line with NHS England and the Patient Safety Framework, will offer support to staff, patients, families and carers to influence and improve safety across the Trust’s full range of services.

The PSPs – Ben Heal, Rane Comley and Jacqui Pendlebury - visited the Trust to meet with Sarah Cullen, Chief Nursing Officer, and Catherine Gregory, Deputy Director of Nursing, Midwifery and AHPs.

The PSPs will communicate rational and objective feedback focused on ensuring patient safety is maintained, improved and remains a priority - this may include attendance at governance meetings reviewing patient safety, participation in investigation oversight groups, review and analysis of safety-related information and contributing to documentation, including policies, investigations, and reports. Read more on the Trust website.

5. A great place to work

i. Trust Clinical Nurse Tutor admits invite to Buckingham Palace was ‘dream come true’

Lancashire Teaching Hospitals’ Clinical Nurse Tutor, Meettu Koshy, was commended for her contribution to International Nursing and Midwifery at a special ceremony at Buckingham Palace in November, hosted by His Majesty The King.

Meettu, who is part of the Professional Education Development Team at the Trust, admitted it was “a dream come true” to be invited to the reception, as she joined a group of nurses from the North West at the Palace, along with Steven Colfar, Regional Director of Nursing at NHSE.

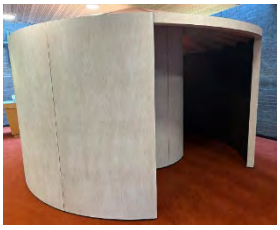
The reception was to celebrate the contribution of Nurses and Midwives, notably International Nurses and Midwives, working in the UK's Health and Social Care Sector, with Meettu being nominated to go by the Trust's HR department, who wanted her work mentoring international nurses to be recognised.

Following her work as a nurse, Meettu become a Pastoral Support Nurse for International Nurses, and said receiving the formal invite to the Palace was a career highlight. Read the full story on the Trust website.

ii. Unique 100 voices sound installation

100 Voices - an immersive sound installation created from five months of research, workshops and conversation with staff, patients and visitors in 12 hospitals across four NHS Foundation Trusts, including Lancashire Teaching Hospitals – visited Royal Preston Hospital between Monday 20 November – Thursday 30 November.

The unique installation was located in the Chapel and gave audiences a 360-degree audio experience, immersed in the voices of 100 people from different hospital communities reflecting on their daily lives and work, their challenges, joys, inspirations and losses.



In the year of the NHS's 75th anniversary, it was something of a tribute to everyone's contribution, with four operatic songs voiced by fictional characters of the Midwife, the Porter, the Patient and the Manager, exploring what it means to have a voice, how we make ourselves heard and how we listen to others. Read more on the Trust website.

iii. Mayor of Preston joins Royal Preston Hospital to celebrate Black History Month

The event, which was held in the Education Centre at Royal Preston Hospital, focussed on highlighting the importance of Black History Month – celebrating the contributions of black individuals throughout history. Alongside speeches from the Mayor and executives, it also featured cultural performances, exhibitions, and discussions on black history and its impact on local communities.

One of the highlights of the event was a local dance group that performed a routine showcasing the vibrant spirit of Caribbean dance. The group's performance served as a reminder of the amazing culture in the black community. You can read more on the Trust website.

6. Deliver value for money

i. Double national recognition shows Cancer Patients and "Not Cancer" patients all get excellent care

Lancashire Teaching Hospitals is proud to have achieved their best ever scores for patient experience, as well as winning highly commended at the prestigious HSJ Patient Safety Awards for their work with patients who are referred on a cancer pathway.

The Rosemere Cancer Centre has always offered excellent patient care for those who are diagnosed and being treated for cancer, and this year the Trust has excelled itself, achieving the most positive results they have ever had in this national survey, published in July. The overall Patient Experience score was a commendable 9/10, and with no scores below the national average, leading the way across the four local Trusts.

In addition, Lancashire Teaching Hospitals is also pioneering a dramatically different approach to cancer diagnostics, with their 'Tell People Quickly That They Don't have Cancer' initiative recognised at the HSJ patient safety awards in September.

The HSJ award recognises that the safest way to manage patients is to put them at the centre of their care. The colorectal team at LTH has recently embedded a new compassionate, patient-centred cancer diagnostic pathway, led by a team of expert nurses, Advanced Clinical Practitioners (ACPs), who put patients at the centre of decision making from their very first contact in a virtual clinic. This transformation and culture change programme has resulted in the Trust making the largest improvement nationally in 62-day performance targets. Read the full story on the Trust website.

7. Fit for the future

i. Finney House celebrates its first anniversary

The Trust marked the first anniversary of the opening of Finney House in November, one year on from becoming the CQC-registered provider of services.

Since opening, the Trust has taken on all 96 beds within the facility, two floors acting as a Community Healthcare Hub with Orchard Floor continuing to provide care for Local Authority and private residents.

The Community Healthcare Hub has been a huge success, acting as a step-down facility for patients no longer requiring specialist hospital care, but needing support before transitioning back home.

The initiative has helped improve flow within Royal Preston Hospital and the local healthcare system, and continues to support discharge, patient flow and ease pressure on ambulance crews with over 1,500 admissions and 70% of patients able to return home with support since opening last year.

As well as freeing up beds across both hospital sites in Preston and Chorley, spaces are available to encourage patients to become involved in a variety of activities and socialisation, as well as a garden to the side and back of the building, and a community library. Read the full story on the Trust website.

ii. Trust cancer research nurse recruits first UK patient to clinical trial

Lancashire Teaching Hospitals' Cancer Research nurse, Haiyan Huang, has been successful in recruiting the first UK patient to the HeredERA clinical trial, which aims to find better ways to give treatment to breast cancer patients.

The trial, which is sponsored by F.Hoffmann La Roche Ltd, looks at a small subset of breast cancer patients (Her2- Positive, Estrogen Receptor Positive), and is an opportunity to look at a new drug which can be taken orally, replacing the need for a deep, intramuscular injection every four weeks, which isn't pleasant or comfortable.

During the trial, breast cancers can be viewed under a microscope and tested for a sensitivity to Estrogen, and another marker, a human epidermal growth factor receptor, Her2. The study aims to develop a hormone-based treatment, which degrades the Estrogen receptor. If that receptor is mutating, it may be a more effective treatment, with the added bonus that there is no need for an injection.

Oncology Consultant, Dr Martin Hogg, and his team at the Rosemere Cancer Centre at Royal Preston Hospital, managed to enrol the first UK patient after six months of screening since the trials began, with Haiyan's hard work paying off. Read more, including Martin's comments, on the Trust website.

8. Awards, achievements and other news

i. Rosemere Cancer Centre to showcase achievements at the SGRT Annual Conference in London

Colleagues from Rosemere Cancer Centre have been asked to be part of a specialist panel at the 2023 Annual Meeting of the Surface Guided Radiotherapy Treatment (SGRT) Community at the start of December at County Hall, London.

Speaking at the two-day conference, 'SGRT Europe: A new view of SGRT', will be Lisa Laws, Principal Radiographer, and Lisa Telford, Team Leader, on 'Successful implementation of SGRT: patient benefits and staff satisfaction from a radiographer's perspective.'

The invitation to appear on the special panel comes almost a year after the revolutionary Surface Guided Radiotherapy treatment was installed at Rosemere, funded by the Rosemere Cancer Foundation's 25th Anniversary Guiding Light Appeal, at a cost of £1.3 million.

SGRT's arrival made Rosemere only the second cancer centre in the Northwest, following The Christie in Manchester, to provide the treatment, and only the 15th of the UK's total 65 specialist cancer centres. Read more on the Trust website.

ii. Blended Learning and Medical photography teams win multiple awards at annual conference

Our Blended Learning and medical photography teams won 12 awards at their annual conference, The Institute of Medical Illustrators, in Cardiff in November.

The Institute of Medical Illustrators is Europe's leading professional body, promoting the role of medical illustrators in healthcare teams and providing clinical illustration and communication services for patients and clients. The Institute awards excellence in clinical photography, healthcare design, and clinical video, including Gold, Silver, Bronze, Platinum, and special awards, distributed annually to members.

The award winners have worked with teams across the organisation and want to share their success with everyone involved.

Our Team Lead in Photography, Lucy Tinniswood, collected 3 bronze awards for clinical and ophthalmic photography; Senior Medical Artist, Kelly Cassidy, collected 3 bronze and 2 silver awards; our VR content developer, Xinlin Chen, collected 2 silver awards in her first ever entry to the awards; Multimedia Developer, Deirdre Justusson, collected 3 bronze and 2 silver awards; Wayne Troake, Blended Learning Manager, was awarded 2 silver; Adrian Hawtin, Senior Multimedia Developer, was awarded 1 bronze and 1 silver; and Cat Lamoon, Senior Clinical Photographer, collected 4 bronze and 2 silver awards.

iii. Sylvia Turner retires

After a lifetime in the NHS, Trust Volunteer Services Manager Sylvia Turner retired at the end of October.

A well-known face at both Royal Preston and Chorley and South Ribble Hospitals, Sylvia has spent the last 23 years in her current position, and almost half a century in total within the health service.

As Volunteer Services Manager, she is responsible for nearly 400 volunteers, and two therapy dogs, who give their time generously and go above and beyond to support the Trust in a diverse range of activities and work across many areas.

Sylvia admits she will miss the role and the people, but the time is right, especially with two young grandchildren to look after! Good luck in your retirement, Sylvia.

iv. Happy couple tie the knot on Ward 20 at Royal Preston Hospital

Wedding bells rang out on the Enhanced High Care Unit (EHCU) at Royal Preston Hospital in early October, after a patient was tested for suspected cancer following a fall at home.

The happy couple, Paul and Deirdre Holt, who have known each other for 36 years and been together for five, decided to tie the knot in hospital when Paul's condition deteriorated after being admitted onto the ward.

Paul, who is 66 and lives in Warton, had complained of a bad back before suffering a fall and has since been tested for suspected cancer along with further issues affecting his kidneys, lungs and heart.

After getting permission from Trust Lead Chaplain, Reverand Martin McDonald, the couple quickly got the paperwork signed, and staff on the ward decorated the family room to make the occasion as special as possible for the couple. Read the full story on the Trust website.

v. Trust midwife Deborah awarded NHS Safeguarding Star

A midwife at Lancashire Teaching Hospitals NHS Trust has been awarded an NHS Safeguarding Star Award for her work to promote safer sleep for babies.

Deborah Gibbons, Lead Midwife for Safeguarding at the Trust, was awarded the prestigious accolade for her work around Sudden Unexplained Death in Childhood (SUDC), which is the sudden and unexplained death of a child aged 1-18, as well as her work to embed safer sleep assessments across the Trust.

An emotional Deborah – unaware of her nomination - was surprised with the award at the SUDC group by Catherine Randall from NHS England (National Associate Director of Safeguarding), with Elizabeth Radcliffe (Deputy Director of Quality, Regional Safeguarding & Investigations Lead, (NHS England North West Clinical Directorate) and Jane Jones (Deputy Director for Safeguarding, NHS Lancashire and South Cumbria Integrated Care Board) also present. Well done, Doborah.

9. Recommendations

i. It is recommended that the Board receive the report and note its contents for information.

Lancashire and South Cumbria Provider Collaborative

NHS

Appendix I

Provider Collaborative Board – 16 November 2023

The Provider Collaborative Board (PCB) met on 16 November 2023. It received updates on the following standing items: system pressures and performance updates within Urgent/Emergency Care and Elective Care; Mental Health and Learning Disabilities, and Finances.

Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on several key programmes of work as agreed with Trust Boards. Updates on the One LSC leadership team, the Clinical Programme Board and the Pathology Network Board were discussed under Joint Committee Working items.

System pressures – acute

September saw an increase in overall attendances across Lancashire and South Cumbria (LSC) Emergency Departments despite all the public messaging around industrial action. The trend continued into the first part of October, however towards the end of the month overall attendances started to fall and overall, there were -2% fewer throughout October than the month before. Ambulance handover delays rose by nearly 85% in October and averaged 50 per day.

Patients being seen in urgent care within LSC had high levels of acuity which impacted on length of stay and admissions and this alongside a lack of flow and high number of patients not meeting the criteria to reside (NMC2R) had added to pressures and impacted on performance. There is an issue with data reporting and collection within some Trusts which needs to be addressed as this is impacting on the integrity of comparisons of some metrics.

Although LSC are performing well against both North West and national peers, we do have various points of pressure in the system which require mutual aid and diverts. The ICB and Chief Operating Officers had a planned workshop to discuss winter plans and tactical and operational approach to managing pressure through the coming months.

In recent months there has been a steady reduction in the number of patients waiting over 78 weeks at the end of the month, however the number of 65-week waits is continuing to grow and is above plan. 52 week waits are also continuing to increase across LSC, however the rate of growth has reduced in the last month.

There is still a required focus on longest waits to reduce the Cancer backlog – those waiting over 104 days. Skin, lower and upper GI and Urology continue to be challenged across all providers.

As with all Trusts the system needed to find the right balance between reductions in waiting times and elective recovery and the requirement to deliver savings. Board members had a development workshop following the PCB meeting and as part of this were going to discuss how to set aside time on a regular basis to discuss some of these issues in detail.

System pressures – mental health and learning disabilities

The total bed request rate remains within normal range, with no indications of the extraordinary demand of January - April 2023. A&E bed requests also show more stability. A&E 12-hour breaches are trending downwards from the May 2023 peak and overall bed demand has been in the established range for the last three months.

Actions for the Mental Health Learning Disability and Autism (MHLDA) performance include: admissions management to review all informal patients awaiting admission each day to identify community support or alternatives; a review of all community waits to ensure risks are escalated; Health Based Place of Safety (HBPoS) meetings to take place to review learning from A&R and HBPoS breaches; Clinically Ready for Discharge meetings taking place daily with a 'Perfect Week' event planned for the first week in December, and there is planned to be a future focus on reducing the number of patients in Spot Purchased (inappropriate) Out of Area Placements (OAPs).The Woodview site is due to open in November to provide 32 more inpatient beds to support the local bed base and reduction of OAPs.

The proposal for Blackburn with Darwen transfer of physical health and mental health services would be going to the Integrated Care Board (ICB) board in January. A positive alliance was being formed with Lancashire and South Cumbria NHS Foundation Trust (LCSFT), Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) and Primary Care.

The tender for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) had now been awarded. This is only for assessment, not for treatment and a fully funded pathway would be required from April.

The longest waits within Mental Health are in Childrens' services, and a Quality Impact Assessment was being completed. This issue was a matter of concern for the Trust and for stakeholders, particularly Members of Parliament.

The lead Chief Executive Officer for the PCB is meeting the ICB to ensure that Mental Health strategy was given as much scrutiny and support as the acute.

Blackpool Teaching Hospitals NHS Foundation Trust (BTH) passed on their thanks for the support of all partners after they declared a critical incident level 2 the previous week. There had been a whole system response and leadership quality shone through.

Financial Update

LSC was required to submit an updated and more ambitious financial plan. The Senior Responsible Officer for Finance thanked all organisations for their support on pulling this together and acknowledged that the benefits of collaboration across the system which were becoming increasingly obvious.

There had been a significant improvement in the exit run rate in the last 10 days. Whilst the 5.5% CIP target had not yet been made, plans were in place for over 5% which is significant and demonstrates the scale of the stretch that organisations were making. The £149.49m deficit had been confirmed and Directors of Finance have identified a range of opportunities to manage the risks associated with this.

Financial sustainability plans and metrics need to continue to be undertaken as part of a coordinated system response and it was important that services, outcomes, and safety needs to also be incorporated into the messaging to internal and external stakeholders.

It was vital to ensure we have plans for 2024/2025 in place at an early stage and that Trusts don't lose sight of this as they focus on delivering the year end position. External intervention was still a strong possibility.

LSC didn't fare well under the most recent financial allocation. The ICB had a number of ideas about how things could be done more creatively, however there needed to be a sustained focus on the whole issue of recruitment as some organisations had significantly increased their workforce during the pandemic. A lot of work had been done on the collaborative bank and job and role designs could be an important way of reducing costs in future years.

One LSC leadership team – approval to hire initial roles

Approval was sought to recruit the initial leadership roles for One LSC. These roles were approved by PCB Joint Committee in June 2023 as part of the agreement to next steps for the programme. Now we have the host trust in place, the recruitment to these key roles is a critical next step in moving to our One LSC model.

The roles included for initial appointment are as follows:

1. One LSC Managing Director
2. Director of Procurement (who will be our One LSC Chief Procurement Officer)
3. Director of IM&T (Who will be our One LSC CIO)
4. Director of E&F (Who will be out One LSC Chief Estates & Facilities Officer)

The other programmes are at a less advanced stage, so those appointments would be made at a later time. It is not possible to determine the final impact because we cannot determine who will be appointed to each role. Were it to be an appointment from a role encompassing the current SRO, it may not require backfill as we are moving into a new way of working with this structure in situ. It will also depend on start date that can be agreed. This has been exemplified in terms of several scenarios to show the likely cost. A budget provision had been set aside for this financial year only, specifically to fund the part year cost. For next year we will need to recover the cost of the leadership of One LSC as overhead against savings to be made.

The PCB JC approved the above roles and agreed that they should be recruited to via open internal advert (for colleagues currently working within LSC) as soon as possible.

Clinical Programme Board Update

At the last Provider Collaborative Board meeting, a shortfall of funding was highlighted within the clinical programme. A process is being led through the System Recovery and Transformation Board (SRT) around allocating resource. This process should ensure that the clinical programme receives the correct amount of additional funding, however this process is unlikely to be complete until the SRT board in December. As a result of this, on 1st November, project support provided by the NHS Transformation Unit to the following programmes was suspended: Urology, Musculoskeletal Trauma

and Orthopaedics, Haematology, Ophthalmology, Integrated Mental and Physical Health, and Stroke networks.

Working with other system programme areas we have tried to retain the administrative support to the networks so they can continue meeting, however the ability to progress programme plans has been severely restricted until the resourcing process has been completed. As anticipated, this news has caused some consternation within the networks and has the potential to reduce morale and engagement.

A lot of positive engagement had taken place to get to agreed clinical models in the priority areas and a further clinical workshop was due to take place on 17th November which would cover fragile services, reconfiguration specialities, and the PCB Clinical Service Configuration Plan.

The urology case for change was also presented at the last clinical programme board, with comments from the ICB around us being clearer on the aim of moving to a single urology cancer surgery service for the system.

Pathology Network Board

Updates included the new Laboratory Information Management System (LIMS), the Capital Business Case, and the Pathology Network Board Terms of Reference.

Deployment of the Magentus system at BTH is currently underway, with several critical issues relating to the configuration of the system being addressed with support from an ICB senior digital leader who is reviewing the project and the potential solutions. The timeline remains a challenge with an intended go live date for February 2024 – the contract with the current supplier has been extended to March 2024 using additional funding from NHS, however the availability of staff to undertake the current and future testing phases remains a future problem.

As reported to the last meeting, a programme plan has been developed that aligns with the need to draw down the national capital money of £31.2m by March 2025. Key issues that have emerged in the development of the case were identified, including that the current funding would only support a hub of 2600sqm which would not be sufficient to accommodate more than microbiology, virology, and immunology. There were also significant concerns about the clinical viability of such a facility. PCB Board members and the ICB agreed that we needed a larger viable facility and were committed to finding ways of resourcing the gap, particularly as the new facility would achieve significant annual savings.

Given tight timeframes for the business case, a site needs to have been identified and planning consent obtained by the end of June 2024. In the intervening period, the design team are progressing with the design based on a potential site with a final decision expected by December.

The Terms of Reference for the Pathology Network Board are currently being reviewed and updated to reflect what was discussed at the last PCB meeting, specifically that the Pathology Board would review and make recommendations on any Pathology capital business case to the PCB. In addition, a further request has been made to consider the membership of the Pathology Network Board.

Appendix II

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	8 November 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
Author	Hannah Brooks, Communications and Engagement Manager and Executive Team contributions
Agenda item	5
Confidential	No

Executive summary

This report sets out the current challenges that the ICB is facing in relation to delivering an ambitious recovery and transformation plan, and focuses on what needs to be in place in order for the plan to be achieved.

Major change will require strong commitment and leadership, and the right culture. This will be even more key as more complex programmes of transformation are developed.

There has not been enough progress in relation to the agreed recovery plan and the month six position means that it is now necessary to prepare for intervention from NHS England. Intervention should add value and help to improve the year-end position and future transformation.

Recommendations

The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Which Strategic Objective/s does the report relate to:		Tick
SO1	Improve quality, including safety, clinical outcomes, and patient experience	x
SO2	To equalise opportunities and clinical outcomes across the area	x
SO3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	x
SO4	Meet financial targets and deliver improved productivity	x
SO5	Meet national and locally determined performance standards and targets	x
SO6	To develop and implement ambitious, deliverable strategies	x

Implications

	Yes	No	N/A	Comments
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	

Financial Implications			x	

Where paper has been discussed (list other committees/forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Executive Management Team	31 October	Draft reviewed for agreement.

Conflicts of interest associated with this report
Not applicable.

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data privacy impact assessment completed			x	

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 8 November 2023

Report of the Chief Executive

1. Introduction

1.1 We are acutely aware that we face some major challenges around the Integrated Care Board (ICB). There are even bigger challenges within our system. We are working hard to respond to those challenges, and we have a good plan in place for recovery and transformation, which we covered in detail at the last board meeting in September.

1.2 Since the last formal board meeting, we have held the first two meetings of the System Recovery and Transformation Board, which brings together the leadership of all of our NHS trusts, the ICB and local government.

1.3 We do, however, have some real risks around the speed of implementation of our recovery plan. In the NHS, we are not used to transformational change, and we are encountering some resistance to change. Lancashire and South Cumbria has low turnover and a conservative culture, so major change is a challenge in our system. We need to work closely with our senior and middle managers in the system to build on the positive work that is already taking place and ensure they have what they need to go further, faster and truly embed change.

2. The challenge of execution against our recovery plan

2.1 We have got a good plan, but it is high risk and requires trusts to work closely together, major hospital reconfiguration and a switch to community services. This is nothing short of a revolution. It is not surprising that execution of such an ambitious plan is challenging. It means a major change to how we do things around here and not all the relevant staff have the necessary experience and skills.

2.2 As American novelist Larry McMurtry describes, “what needed to be done was simple, if not easy”. We need to make progress and move forward. To do this, we need to gain momentum. There is a lot that needs to happen and as a system we need to be on the same page.

2.3 The challenge is not going to go away, and as leaders we will need to be decisive in the difficult decisions that we will face over the coming years. It is likely to be a difficult experience if we are going to achieve a real step change across the system.

2.4 It is important that we do not come up short in this respect. One of the things that we can really focus on is getting the culture and leadership right at every

level of our healthcare system, so that we can make big and difficult decisions for the overall benefit of the people of Lancashire and South Cumbria (LSC).

2.5 Our central services programme is one of the more mature and well-developed programmes. The Provider Collaborative joint committee has determined what is in store, set a joint timetable and agreed that East Lancashire Hospitals Trust (ELHT) will be the host organisation.

2.6 However, we are now encountering some slippage which is concerning. This is a perfect example of a programme that has achieved a lot in a short space of time, but now we must ensure that the environment around the programme is right, so that we can continue to meet the challenging and ambitious objectives of the programme. This will require strong commitment and leadership and the right culture. This will be even more key as we move onto more complex programmes of transformation, like clinical service reconfiguration.

2.7 I am keen, therefore, that we get some strong earthed leadership development for the system – for senior leadership and high-potential managers, focused on hard skills around our agenda, such as how to roll out virtual care and zero-based budgeting, soft skills such as collaboration and engagement with clinicians as well as building a community of leaders within our system. In doing so, we will reap the rewards for years to come for people living and working in Lancashire and South Cumbria.

3. Preparing for intervention

3.1 So far, we have been using a range of NHS England (NHSE) financial controls around discretionary spend, consultancy, contract renewals and staff vacancies across the LSC NHS system. We voluntarily adopted these measures in an attempt to improve our financial position.

3.2 Although the three-year recovery plan that we agreed with NHSE is a good one, the execution of the plan has fallen short of what we expected. There is a lot of risk within the plan, due to the underlying deficit.

3.3 Unfortunately, we are not making enough progress and our month six position means that we are now preparing for intervention from NHS England.

3.4 Intervention is not how it should be done. It is much better to get it right first time, rather than intervene after the event.

3.5 We need to make sure that any intervention adds value and helps improve our year-end position and our future transformation.

3.6 We need targeted support from specialists and experts from the national team, who are able to take an objective view of specific areas that would benefit from intervention. We will therefore ask for support in relation to certain areas of commissioning, transformation programmes that are encountering barriers, and the trusts in our system that are most financially off-plan.

4. Organisational development: a way to go

4.1 We are currently in the annual NHS Staff Survey period and in July we ran one of the quarterly NHS Pulse Surveys. This, alongside our monthly wellbeing check-ins with staff has shown that staff satisfaction and morale remains low.

4.2 As chief executive of the organisation, I take responsibility for the results of our surveys and have already begun working with our leadership team to look at how we can improve the experiences of our staff.

4.3 We have a way to go to get some of this right, but we are committed to listening to our staff and are making our organisation a great place to work for everyone.

5. Chief operating officer

5.1 We have updated the job title for Craig Harris to better reflect his portfolio. Although there is no change to Craig's portfolio or responsibilities, his job title is now chief operating officer, or COO. The updated job title is more akin to what is used in other NHS organisations and is intended to help people better understand Craig's role and portfolio.

6. Continuing Healthcare transfer of staff and new model

6.1 On 1 October the All Age Continuing Care (AACC) and Individual Patient Activity (IPA) service provided by Midlands and Lancashire Commissioning Support Unit (MLCSU) transferred into our ICB. This means that the AACC and IPA service has now become a team of circa 250 staff. This also includes existing ICB staff and 75 new starters.

6.2 Four place-based Continuing Healthcare (CHC) teams will operate across the ICB. Discharge to assess, children and young people's continuing care and IPA teams will operate at system level with place-based links.

6.3 A senior leadership team has been established within the ICB led by the director of adult health and care and the associate director of AACH and IPA.

6.4 This has been a significant milestone for the service and many compliments have already been received from external stakeholders and staff who have transferred over about the improved quality and responsiveness.

6.5 It should also be noted that the AACC team has met their NHSE quality premium trajectory and aim to achieve this consistently across all place teams from Q4 as approved by NHSE, which is another milestone achievement.

6.6 The board will be aware that we have got significant financial challenges in the CHC area, with high inflation on packages and increased volumes and some of that is associated with the transfer from MLCSU to us. At the same time, we are confident that that the new model is working really well. Already, we have eliminated the backlog and we are close to hitting our target for the time requirements for assessments. The new model has already received numerous compliments from stakeholders from across the system.

7. National Allied Health Professional Day

7.1 In the week leading up to Allied Health Professionals (AHPs) Day on Saturday 14 October, our AHPs showcased the breadth and depth of their system working innovation through events and social media, with a focus on ‘AHPs in the right place, at the right time, with the right skills’.

7.2 AHPs represent our third largest workforce across the ICB. They are integral to helping us move forward with new multi-professional clinical and care models that will holistically support the needs of our communities both now and in the future.

7.3 It is important to acknowledge the impact that AHPs have in patient care, inspire the future workforce and ensure AHPs play a central role in health and care transformation. Our allied health professions are art therapists, dramatherapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, operating department practitioners, orthoptists, osteopaths, prosthetists and orthotists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, speech and language therapists.

7.4 Katherine Simcock, principal speech and language therapist at Lancashire and South Cumbria NHS Foundation Trust won the ‘AHP leadership for equality, diversity and inclusion award’ the prestigious Chief AHP Officer Awards, announced as part of the national celebrations.

7.5 Katherine's work included a focus on the evidence base for language used to talk about autism. Through co-production with people in Lancashire and South Cumbria, Katherine produced a language guide to help professionals talk to autistic people about their preferences for language whilst continuing to recognise that every person is an individual and language is not ‘one size fits all’. This is a great example of the way in which we are keen to see our teams work across Lancashire and South Cumbria, and rightfully so, has earned national recognition.

8. Our ambition to become a truly anti-racist organisation

8.1 Every October marks Black History Month, which is a time to promote and celebrate Black contributions to British society, including our NHS colleagues across Lancashire and South Cumbria. While this is a time of celebration, it also shines a spotlight on some of differences and issues experienced by Black

people and people from other ethnic backgrounds.

8.2 Nationally, we know that NHS staff from ethnically diverse backgrounds experience disproportionately higher rates of bullying, harassment and discrimination when compared to their white counterparts and are less likely to be represented at senior levels within our workforce. We cannot allow this to be the experience of our people, and therefore we are committed as a senior team to challenge this behaviour and pave the way for equal opportunities for all of our people across the system.

8.3 Through our annual work on the NHS Workforce Race Equality Standard (WRES), we know that our ICB and provider trusts still have a long way to go to ensure that we have a representative workforce and that our people from ethnically diverse backgrounds are able to thrive in a workplace free from discrimination. We have recently completed our WRES System Report for 2023 and will be using this to formulate clear actions to improve the workplace experience of our ethnically diverse staff.

8.4 We are also in the process of engaging with the North West BAME Assembly's Anti-Racist Framework which will help us further in improving workplace experiences and amplifying the voices of our people from ethnically diverse backgrounds.

8.5 As part of our commitment to the Anti-Racist Framework, we will soon be publishing our anti-racism statement which will outline our organisation's stance. Our ambition as an ICB is to become a truly anti-racist organisation and we are fully committed to taking appropriate steps to ensure this happens.

9. Provider Selection Regime

9.1 The Provider Selection Regime (PSR) regulations have been introduced into Parliament by the Department of Health and Social Care (DHSC), and subject to scrutiny by Parliament, the DHSC intends for the new regulations to come into force on 1 January 2024.

9.2 The PSR will be a set of new rules for procuring health care services in England by organisations termed relevant authorities and will replace the existing procurement rules for NHS and local authority funded health care services. Relevant authorities are:

1. NHS England
2. Integrated Care Boards
3. NHS trusts and NHS foundation trusts
4. Local authorities and combined authorities

9.3 The PSR introduces greater flexibility when making decisions about how best to arrange healthcare services, with competitive tendering one of several potential

processes that may be followed.

9.4 To support implementation, NHS England have published draft statutory guidance (subject to parliamentary approval of the regulations) which will be supported by a set of resources including more detailed implementation tools such as process maps and template documents.

9.5 This will require a significant amount of planning for the ICB over the next eight weeks to ensure that we have our internal processes, contract reviews, and decision-making arrangements in place to implement the new regime. We will keep the board informed of any relevant updates in the lead up to anticipated implementation date.

10. Awards and recognition for our staff

10.1 I would like to finish by acknowledging some awards that our ICB staff have recently received.

10.2 Our ICB won an award at the HSJ Patient Safety Awards in the 'Improving Medicines Safety' category for our joint work with Midlands and Lancashire Commissioning Support Unit on enhancing inhaler prescribing practice.

10.3 Louise Hamer was also recently presented with the first ever 'Lads like Us' Ask Why award at the Institute of Health Visiting Evidence-based Practice Conference for showing tremendous trauma informed practice, and exercising professional curiosity.

10.4 Alison Marshall and Jane Shanahan won the Excellence in Pharmacy – Education and Development award at the National Conference for the Association for Pharmacy Technicians, after they collaborated across organisations and professions to share their learning and upskill the workforce in reducing harms and improving quality of life and outcomes for our most vulnerable patients.

10.5 Finally, Dr Andy Knox, associate medical director for population health, received an MBE last week in recognition of his services to primary care and tackling health inequalities across the region, awarded as part of The King's first birthday honours list. Dr Knox has been a leading figure in developing our population health model and the population health equity leadership academy, which launched last year.

10.6 As an ICB, we are keen to recognise and celebrate the hard work and dedication of our staff, and one of the ways that we plan to achieve that is through our new internal awards process.

10.7 In mid-September, we launched our first ever ICB Staff Excellence Awards, which centre around our new 'PROUD' values. During the nomination period we received over 175 nominations for the nine categories, and we will hold an

afternoon celebration event to announce the award winners on 6 December, which board members have been invited to.

Kevin Lavery

1 November 2023

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report							
Report to:	Board of Directors			**Date:**	7th December 2023		
Report of:	Associate Director of Risk and Assurance			**Prepared by:**	K Clay		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of its high level strategic objectives.

The purpose of this paper is to provide the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

Strategic Risks

A copy of the Trust's BAF can be found in Appendix 1, whilst Appendix 2 provides the Strategic Risks with full details of the controls, assurances, any gaps and actions that are being undertaken to mitigate the strategic risks. Due to scheduling of committees, the strategic risks that are detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust.

There has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8.

There has been a decrease in score for the Strategic Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research, from 20 to 16 following discussion at Education, Training and Research Committee in November 2023. Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template.

Operational High Risks for Escalation to Board

There are three operational high risks that continue to be escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.
- Risk ID 1182 (scoring 20) Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

National Infection Prevention and Control Board Assurance Framework (IPC BAF) NHS Improvement (NHSI) version 1.0

The new National IPC BAF document produced by NHS England/Improvement reflects a broader approach to IPC moving away from being solely Covid-19 focused. The document is contained within appendix 3 and shows that the majority of area are compliant, with six areas partially compliant. Any gaps have identified actions that are tracked through the Infection Prevention and Control committee.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks
Appendix 3 – IPC BAF

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Committees of the Board in line with cycles of business

1. Background

1.1 The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives.

1.2 This paper provides the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

2. Discussion

2.1 Board Assurance Framework (BAF)

2.1.1 The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust.

2.2 Strategic Risk Register

2.2.1 There has been no change in score for:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8.

2.2.2 There has been a decrease in score for the Strategic Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research, from 20 to 16 following discussion at Education, Training and Research Committee in November 2023.

2.2.3 Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template in Appendix 2.

2.2.4 It should be noted due to scheduling of committees, the strategic risks detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

2.3 Operational Risk Register

2.3.1 There are three operational high risks that continue to remain escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.

- Risk ID 1182 (scoring 20), Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

2.3.2 Further details on the operational high risks escalated to Board can be found in the BAF in Appendix 1.

2.4 National Infection Prevention and Control Board Assurance Framework (IPC BAF) NHS Improvement (NHSI) version 1.0

2.4.1 The new National IPC BAF document produced by NHS England/Improvement reflects a broader approach to IPC moving away from being solely Covid-19 focused and a copy is contained within appendix 3.

2.4.2 The majority of areas measured (48) are considered fully compliant with 6 areas partially compliant. The main areas partially compliant relate to the limitations of the environment, the re-introduction of the Patient-Led Assessment of the Care Environment (PLACE) assessments (re-started September 2023 and will be on an annual programme in 2024) and adherence to national cleaning standards across all areas. The gaps identified are tracked through the Infection Prevention and Control committee.

3. Financial implications

3.1 Any financial implications are captured within the Risk Register records and managed accordingly.

4 Legal implications

4.1 Any legal implications are captured within the Risk Register records and managed accordingly.

5. Risks

5.1 The paper identifies Strategic and Operational Risks that may compromise the achievement of the Trust's high level strategic objectives and therefore, the entirety of the paper is risk focused.

6. Impact on stakeholders

6.1 A robust and well managed BAF reduces the negative impact on patients and staff and the reputation of the organisation and its purpose is to mitigate and reduce, as far as is reasonably practical, the level of risk to that identified in the trust risk appetite statement.

6.2 All risk records impact upon patient experience, staff experience, Integrated Care System and cross divisional work. This is captured within individual risk register entries on Datix.

7. Recommendations

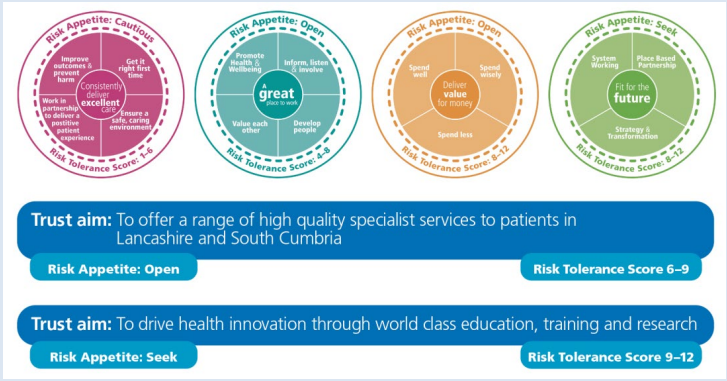
7.1 **It is recommended that Board of Directors:**

i. Note and approve the updates to the BAF.

Appendix 1 - Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions



Current principal risks on the Strategic Risk Register – December 2023

Following a review of the Board Assurance Framework, the following Strategic Risks were identified in June 2020. These are detailed below:

Strategic Risks		Risk ID	Initial Score	Risk Appetite	Risk Tolerance	Oct 2022 Score	Dec 2022 Score	Feb 2023 Score	Apr 2023 Score	June 2023 Score	Aug 2023 Score	Oct 2023 Score	Dec 2023 Score	Change
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		859	8	Open	6-9	8	8	8	8	8	8	8	8	→
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		860	6	Seek	9-12	12	12	20	20	20	20	20	16	↓
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &…	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	855	20	Cautious	1-6	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: A Great Place to Work	856	20	Open	4-8	12	12	12	12	16	16	16	16	→
	Risk to delivery of Strategic Ambition: Deliver Value for Money	857	20	Open	8-12	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: Fit for the Future	858	20	Seek	8-12	15	15	15	15	15	15	15	15	→

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

Risk		Risk ID	Risk Summary
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.		860	There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.
Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service		859	There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	**Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care**	855	There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to: a) Availability of staff b) High Occupancy levels c) Fluctuating ability to consistently meet the constitutional and specialty standards d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services. e) Health inequalities across the system.
	Risk to delivery of Strategic Ambitions.. Great Place to Work	856	There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development. This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.
	Risk to delivery of Strategic Ambitions.. Deliver Value for Money	857	There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection.
	Risk to delivery of Strategic Ambitions.. Fit For the Future	858	There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

See next slide for key operational risks that are for escalation to Board.

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Key Operational Risk Summary for Escalation to the Boards

This details those operational risks that pose a significant threat to achieving organisational objectives

- **Impact of Emergency Department Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The data measured through the ED Dashboard continues to demonstrate a department under significant pressure with sustained attendances and high numbers of patients waiting over 12 hours to be admitted to a ward or mental health facility. In July 2022, a 24 bedded medical ward opened on the CDH site, whilst this has increased the number of beds on the CDH site, analysis demonstrates that at the same time there was an increase in attends through the ED at CDH site, resulting in the additional beds preventing a further escalation of risk rather than reducing the risk overall. Further actions to address the risk include:
  - Converting the former ED COVID Majors space into a new 20 bedded Acute Assessment Unit – in place.
  - 64 beds now open in the Community Health Care Hub to reduce the number of patients in acute beds who no longer meet the criteria to reside in hospital.
  - Virtual Wards in place to reduce length of stay and avoid admission - open to step down and step up referrals, with an action plan to increase utilisation.
  - Strengthened site management arrangements with 8a Tactical Operational Officers now in place 7.30am – 10.00pm 7 days a week.
  - Working with LSCFT to improve the mental health emergency care pathways.
  - Urgent and Emergency Care Transformation Board established with Executive level leadership which will focus on delivering:
    - Newly developed Urgent Emergency Care strategy
    - Therapy admission avoidance 7/7 team ED and MAU/SAU
    - 40% reduction in ambulance conveyances to the ED and implementation of a community based single point of access, to include admission avoidance
    - 10% reduction in length of stay for inpatients through implementation of Pride and Joy
    - 5% reduction in the patients not meeting the criteria to reside in hospital.

  The programme of work continues to be delivered, and unfunded G&A escalation beds are reducing as planned. ED continues to remain under pressure and therefore this risk remains escalated to the Board.

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) - Patients continue to wait for a significant amount of time to receive non-urgent surgery. The plan to eliminate 104+ week waits has been achieved. The plan to eliminate 78 week waits by March 2023 has not been achieved due to the displacement of activity during industrial action, however the Trust is now working towards elimination of 78 week waits (with the exception of orthodontics, which is being managed across Lancashire & South Cumbria due to capacity issues, and patients who choose to wait longer) by the end of December 2023 (extended from July 2023 due to industrial action). Good progress has been made in November 2023 with no industrial action taking place and is continuing to reduce the number of patients waiting over 78 weeks. Achievement of the plan and performance against the trajectory is reviewed weekly. All specialties have target plans to work to and are being supported through divisional meetings and the wider Performance Recovery Group. In addition to this there is an Elective Care Transformation Board established with Executive level leadership which is focusing on delivering:
  - Repatriation of services
  - Diagnostic efficiency
  - Sustainable workforce models
  - Theatre productivity
  - Streamlining elective pathways

- **Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award (Risk ID 1182 – Initial score 16, Current Score 20) -** Strikes have taken place for nursing, ambulance, physiotherapists and junior doctors. In May 2023, a National Pay deal was signed off at a meeting between the government and 14 health unions representing all NHS staff apart from doctors and dentists. In June 2023 the Royal College of Nursing did not meet the required number of votes to implement further strike action, however the British Medical Association (BMA) continues to ballot and schedule strike action for junior doctors and consultants. The Unite Union (on behalf of hospital porters) are also currently undertaking strike ballots. The risks associated with this are being managed in partnership with staff side, workforce, and clinical leaders at the Strike Action Emergency Planning Group. The risk score was reduced in March 2023 from 20 to 16 based on multiple strikes having taken place and these having been managed effectively due to the significant planning undertaken in preparation. In June 2023, however, the score was increased back to 20 in reflection of the ongoing industrial action amongst junior doctors which is having an impact on the hospital's activity, and planned Consultant strikes. Further strike action by junior doctors took place 11th – 15th August 2023, 20th – 23rd September 2023 and 3rd – 4th October 2023. Further strike action has taken place for Consultants 19th – 21st September and 2nd – 5th October 2023. Radiographer strike action took place 3rd – 4th October 2023. The risk is further compounded by the future inability to use agency staff during strike action.

Risk Title: Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care

Risk ID: 855
Risk owner: Chief Nursing Officer
Date last reviewed: 13th November 2023

Risk

There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to:
a) Availability of staff
b) High Occupancy levels
c) Fluctuating ability to consistently meet the constitutional and specialty standards
d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services.
e) Health inequalities across the system

This may, result in adverse patient outcomes and experiences.

Risk Appetite:

Cautious to Risk – Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.

Risk Tolerance

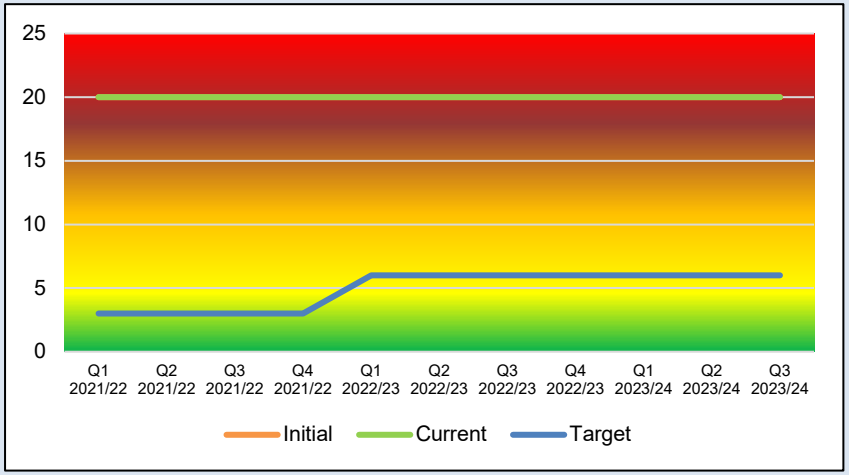
1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 5.5% and an overall Financial Improvement Plan of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Excess waiting times in elective services remain evident for patients.
- Occupancy levels are in excess of 95%.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- There is national acknowledgement that health inequalities exist in all heath and care systems and contribute to poorer outcomes of citizens.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased C. Difficile Infection)
- Recognised health inequalities in the communities we serve
- The annual safe staffing recommendations are delayed in implementation due to financial constraints.

Risk Rating Tracker * (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 1-6



*Initial score also 20 throughout but covered by current score line on above graph

Future Risks

- Risk of New Hospital Programme not progressing.
- Risk that the backlog maintenance of the estate may reach a point where closures of departments is required due to unsatisfactory estate conditions.
- Failure to improve existing operational flow arrangements.
- Failure to address system health inequalities.
- Failure to progress with transformation at scale to live within resources available to us.
- Risk of further financial constraints presenting increased risk to delivery of safe and effective care.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of vulnerable services.
- New Hospital Programme delivery.
- Reduction in vacancy and sickness levels will present an increase likelihood of improved outcomes and experiences for patients and staff.
- Closer working relationship across the health and care system in partnership with public health presents opportunities to level up access to services and design out system inequalities.
- Mobilisation of transformation at scale across the system.

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies and plans in place ○ Always Safety First ○ Clinical Strategy ○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU. • Health Inequalities delivery plan - Core20PLUS5 adults and children. • Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection. ***(Ref CDEC 008)*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 012 and CDEC 019)*** • The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)*** • The implementation of the national cleaning standards is not yet complete. ***(CDEC 018)*** • The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)***	**Internal** • STAR Assurance Framework • Always Safety First Group • Safety and Learning Group • Divisional Governance Structures and arrangements • Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Nurse, Midwifery and AHP safe staffing review annual review and recommendations • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Quality Impact Assessment (EQIA) procedure and reporting in place. • Transformation programme Board • Strengthened IPC BAF **External** • National Surveys • Clinical Negligence Schemes for Trust • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints. ***(CDEC 016 and CDEC 017)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 002	Create a Long term Urgent and Emergency Care Strategy	Chief Nurse/Director of Continuous Improvement	30 June 2023	10 June 2023	Completed	Control	• Integration of services and pathways and effective Place and system-based working
CDEC 007	Create a local plan to respond to the national Core20PLUS5 approach to equitable healthcare for adults and children.	Chief Nursing Officer	31 July 2023	31 July 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristic or those living in deprived areas.
CDEC 008	Progress to the next stage of the New Hospitals Programme.	Chief Medical Officer/Chief Financial Officer	30 June 2023	31 May 2023	Completed	Control	• The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
CDEC 009	Increase oversight of medical device replacement programme and process through Finance and Performance Committee.	Chief Financial Officer	31 August 2023	11 August 2023	Completed	Control	• The demand for medical device replacement exceeds available capital. • Lack of available capital funds to support all medical device requirements
CDEC 010	Review of EQIA policy to extend to wider change and transformation programmes.	Chief Nursing Officer	31 May 2023	31 May 2023	Completed	Assurance	• EQIA policy requires extending to wider programmes of change and not exclusively Cost Improvement programmes.
CDEC 011	Development of a capital investment case to right size the medical and surgical assessment unit.	Director of Strategy	30 June 2023	30 June 2023	Completed	Control	• The current environment within medical and surgical assessment units does not meet demand.
~~CDEC 012~~	~~Development of an ED capital investment case to improve the environment until NHP is delivered.~~	~~Chief Operating Officer~~	~~31 December 2023~~		~~Ongoing~~	~~Control~~	~~• The current environment within the ED requires upgrading to reduce the risk of environmental decontamination.~~
CDEC 012	New Hospital Programme assessment of capital requirements until the New Hospital is built.	Divisional Director of Estates	31 December 2023	31 October 2023	Completed	Control	• The current environment within the ED requires upgrading to reduce the risk of environmental decontamination.
CDEC 013	Weekly executive oversight of progress against updated IPC BAF v 1.11.	Chief Nursing Officer	30 September 2023	30 September 2023	Completed	Assurance	• Gaps identified within the revised IPC BAF version 1.11.
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	31 July 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 015	The Board should extend its knowledge in relation to addressing health inequalities through specific Board development activity in this area.	Chief Nursing Officer	5 September 2023	5 September 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.

CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	31 March 2024		Ongoing	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 017	Determine mechanism to fund safe staffing recommendations for 2023 Adult safe staffing assessment.	Chief Financial Officer	31 March 2024		Ongoing	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	1 March 2024		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete.
CDEC 019	The capital planning group will continue to assess the risks relating to backlog maintenance and determine the priorities from within the capital funding envelope provided.	Chief Financial Officer	ongoing		Ongoing	Control	• The capital required to address backlog maintenance is not sufficient.

Summary of review – November 2023

- Rationale for Current Score and Future Risks narratives updated with concern around financial constraints which impacts on the ability to Consistently Deliver Excellent Care.
- Action CDEC 012 - action changed in response to capital survey undertaken as part of the New Hospital Programme.
- Action CDEC 013 noted to be completed, which leads to the identification of an additional assurance regarding the strengthened IPC BAF.
- The strategic risk has been updated to reflect safe staffing assurances in place and Actions CDEC 016 and CDEC 017 have been identified to address the gap in approving the Chief Nursing Officer safe staffing recommendations due to funding constraints and identifies the requirement to find a solution to this.
- Additional action CDEC 018 identified – The implementation of the national cleaning standards is underway and Priority 1 delivery will be completed by 1st March 2024.
- Additional action CDEC 019 identified – The risk has been updated to reflect the risks associated with the backlog maintenance position.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 13th November 2023

Risk

There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

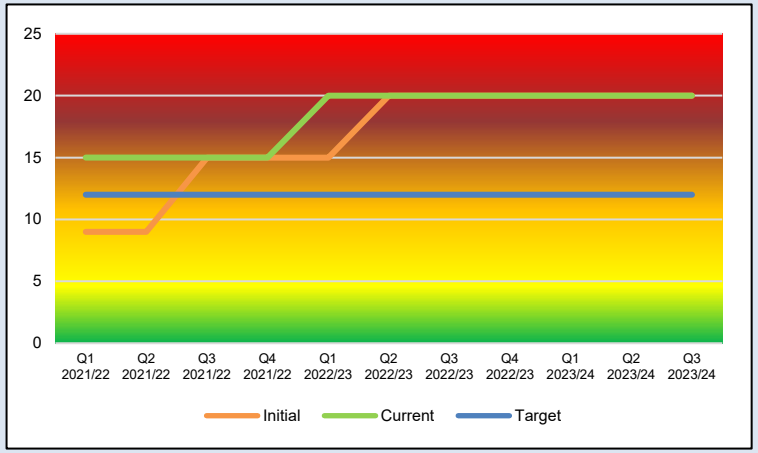
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the System Oversight Framework (SOF). Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Care Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. The Trust must deliver a challenging costing improvement target of 5.5% in 2023-24. In addition, unless a solution can be found to offset the cost of excess unfunded capacity (c3% of operational expenditure), the Trust will fail to meet its financial plan. The Trust has enforcement undertakings relating to its financial position. This may result in a move to SOF four.
- **Excess urgent care demand** – Excess flow related demand on the non-elective pathways have resulted in additional unfunded beds being opened. Despite this additional capacity, the Trust's performance standards are being impacted negatively due mainly to the excess patient demand for hospital beds.
- **Industrial relations** – Increased industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trusts ability to mitigate the impact of these tensions is limited, without some further consequence.
- **Financial recovery (Trust)** – The Trust is unable to deliver a balanced plan for 2023-24 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for 2023-24 and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In setting plans for 2023-24 all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will inevitably lead to changes in the commissioning and provision of services. Some of these changes will inevitably impact on arrangements with partners which may impact further on delivering value for money.
- **Productivity** – Trust productivity when compared to 2019-20 has decreased. Input costs have essentially risen faster than the measured outputs. This has directly impacted upon value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 8-12



The score of 20 reflects the underlying financial position of the Trust.

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust. • **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability. • **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole. • **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money. • **Cost control –** There is a risk that input costs rise faster than activity output further eroding VFM	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There remains an opportunity to increase margins through non-NHS activities. • There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services. • There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale. • There remains an opportunity to commission more effective services to mitigate hospital attendances. • There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes. • To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability. • Better understand why relative productivity has decreased and seek to mitigate where possible.

Controls	**Gaps in Control**	**Assurances** **Internal**	**Gaps in Assurance**
• Workstream related strategies in place ○ Workforce and OD Strategy, ○ Continuous Improvement Strategy ○ Clinical Strategy ○ Financial Strategy ○ IM&T Strategy, ○ Estates Strategy, ○ Our Big Plan, Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first • Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • CCG funding for additional plans in Stroke and Palliative care	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action) escalated to Board) • Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy)	• Specialty Performance meetings • Divisional Improvement Forums • Integrated Performance reporting at Finance and Performance Committee and Board • Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system • Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the System Oversight Framework (SOF)). • Use of Resources assessments now reported through Finance & Performance Committee. • Regular embedded cycle of sharing information relating to the wider programme of change in place • Report on elective productivity and plans for improvement completed to	• The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding. (***DVFM 010)*** • The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better. ***(DVFM 014, DVFM 015, DVFM 016, DVFM 017 and DVFM 018)*** • To support the drive for improved delivery the governance arrangements require some amendment. ***(DVFM 019 and DVFM 020)*** • The trust has an opportunity to improve the rigour and robustness of its decision-making processes. ***(DVFM 021)*** • There is an opportunity to better describe how partnering/collaborative arrangements, e.g. through the Provider Collaborative Board, can help to improve value for money ***(DVFM 022)*** • Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary

• Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • Planning guidance now reflective of current operational pressures secondary to Covid-19 with revised Big Plan and annual business plans in place • Stocktake of senior leadership engagement in place or system decision making processes • Clear and regular updates to/discussions at Board Subcommittees and Board meetings to ensure robust assumptions underpin our planning returns/templates • Vacancy freeze for non-essential posts now in place • Virement policy revised and in place. • Role of the vacancy control process extended to put greater challenge into replacement posts. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts. • A system wide non pay control group has been established with the aim of prohibiting discretionary spend and improving value for money.	• The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety. ***(DVFM 010)*** • The provision of system benefits reports needs to be driven and provided by the joint ICS financial and recovery processes. The associated architecture is being created by the ICB.	better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement. • Action plans relating to overspending costs centres are overseen through DIF processes and are reported to FPC. • A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme • Quarterly monitoring and action plans associated with Use of Resources. Routine reporting have been reintroduced. **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB • Contract monitoring report to provide stronger assurances on the underlying trading position and associated activity now reintroduced. • Considering the deteriorating financial position faced by NHS providers, NHS England have issued a series of checklist with an updated protocol for a deterioration in financial forecast. Now complete and submitted.	control. These will be reviewed and reported back to FPC in quarter three 23/24. ***(DVFM 023)*** • Whilst the Trust and ICB have introduced workforce and non pay controls, these need to be shared with the Committee for assurance. These will be reported for information to FPC from October 2023 ***(DVFM 024)*** • In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits ***(DVFM 026)*** • To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital ***(DVFM 027)*** • No dedicated PMO function to oversee programmes /improve pace and delivery (***DVFM 028***)

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	Develop a medium-term plan with a supporting financial model to outline the route to recovery	Chief Financial Officer and Director of Strategy and Planning	~~30.09.23~~ 18.12.23		Ongoing	Assurance	The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding.
						Control	The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety.
DVFM 014	Clinical strategy (urgent care)	Director of Transformation & Chief Nursing Officer	30.11.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 015	Clinical strategy (scheduled care)	~~Chief Medical Officer~~ Director of Strategy and Planning	~~30.09.23~~ 06.12.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 016	Clinical strategy (provision)	Director of Strategy and Planning	~~30.09.23~~ 06.12.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 017	Income strategy	Chief Financial Officer	~~30.09.23~~ 30.11.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 018	Digital strategy	Chief Information Officer	~~30.09.23~~ 30.11.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 019	Strengthen executive oversight of transformation and subsequent reporting to Committee	Director of Transformation	31.05.23	31.05.23	Complete	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 020	Evolve performance accountability framework	Director of Strategy and Planning	30.09.23	30.09.23	Complete	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 021	Develop a set of strategic decision-making criteria	Director of Strategy and Planning	31.05.23	31.05.23	Complete (STA)	Assurance	The trust has an opportunity to improve the rigour and robustness of its decision-making processes
DVFM 022	Develop a 'value add' reporting for collaborative arrangements	ICS Transformation and Recovery Board (updates to be obtained through Chief Finance Officer)	~~30.09.23~~ 30.11.23		Ongoing	Assurance	There is an opportunity to better describe how partnering/ collaborative arrangements e.g. through the Provider Collaborative Board can help to improve value for money
DVFM 023	Review of effectiveness of internal controls (e.g. budget constraint) relating to temporary workforce	Chief People Officer	~~31.10.23~~ 31.12.23		Ongoing	Assurance	Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary control. These will be reviewed and reported back to FPC in quarter three 23/24.
DVFM 024	New workforce and non pay controls Assurance	Chief Finance Officer	31.10.23	31.10.23	Complete	Assurance	Whilst the Trust and ICB have introduced workforce and non pay controls, these need to be shared with the Committee for

							assurance. These will be reported for information to FPC from October 2023.
DVFM 025	Use of Resources report to be presented to F&P Committee	Director of Strategy and Planning	31.10.23	30.09.23	Complete	Assurance	The Trust stopped the routine monitoring and action plans associated with Use of Resources. Routine reporting needs to be reintroduced in quarter three
DVFM 026	Refine approach to benefits realisation and embedding in arrangements for programme assurance	Director of Improvement and Transformation	~~31.10.23~~ 31.01.24		Ongoing	Assurance	In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits
DVFM 027	Increase the scope of the Transformation Programmes to include workforce and digital	Director of Improvement and Transformation	30.03.24		Ongoing	Assurance	To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital
DVFM 028	Reintroduction of Programme Management Office (PMO)	Chief Operating Officer	~~31.10.23~~ 30.11.23		Ongoing	Assurance	No dedicated PMO function to oversee programmes/improve pace and delivery

Summary of updates to risk – October and November 2023

- Narrative regarding Rationale for Current Score, Future and Escalating Risks and Future Opportunities updated.
- Additional Gap in Control and Assurance identified.
- Updates to Gaps in Controls to recognise the recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety – leading to the update of action alignment for Action DVFM 010.
- Updates to Gaps in Assurances to recognise the need for PMO to improve pace and delivery – leading to the identification of Action DVFM 028.
- Action DVFM 010 deadline extended in line with agreement at September's Finance & Performance Committee. Draft plan shared at Finance & Performance Committee in September 2023 and will be presented to Board in October 2023 before being finalised.
- Action DVFM 015 and DVFM 016 deadlines extended to 6th December 2023, Strategy will be fully drafted by the end of October 2023 and will be presented to Board 6th December 2023. The Clinical Strategies are being updated by the Director of Strategy and Planning, so the action owner for DVFM 015 has been updated.
- Action DVFM 017 deadline extended as Income Strategy will be presented at Finance & Performance Committee in October. Due date extended to allow for any amends following that presentation.
- Action DVFM 018 deadline extended as awaiting update on progress and completion of the Digital Strategy from the Chief Information Officer
- Action DVFM 020 marked as completed.
- Action DVFM 022 deadline extended as awaiting confirmation that steps in place from ICS Recovery and Transformation Board through the Chief Financial Officer. Action responsibility updated.
- Action DVFM 023 deadline extended to December 2023 in line with gap in assurance narrative that adequacy of controls to be reviewed and reported back to FPC in Q3 2023/24
- Action DVFM 024 noted to have been completed in October 2023.
- Action DVFM 025 marked as completed.
- Action DVFM 026 due date extended as update from Associate Director for Transformation the work remains ongoing and further time is required to gain assurances. Work ongoing to identify dedicated support from finance team for transformation programmes to work together to balance skill sets to complement the approach to working up and realising benefits.
- Action DVFM 028 due date extended by one month as resources in the process of being released and put into place.

Risk Title: Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work

Risk ID: 856
Risk owner: Interim Chief People Officer
Date last reviewed: 31st October 2023

Risk

There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development.

This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

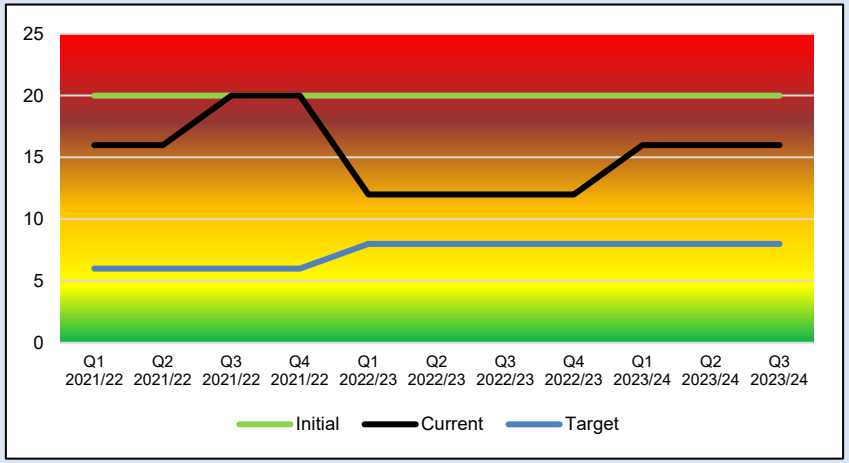
4-8

Rationale for Current Score

- Workforce shortages in some key professional groups, which creates vacancies and creates pressure on existing staff in particular registered nurses and some medical specialties.
- High turnover of less than 12 months in some staff groups particularly support workers and ability to recruit from local labour market.
- Staff engagement score is currently at the national average and has reduced in year.
- Staff advocacy scores currently below the national average and have deteriorated over the last four quarters.
- Physical environment, colleague facilities (catering) and car parking cited as a concern by departments and teams for having an impact on morale, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries and lack of capacity in health and wellbeing service to respond to needs in a timely way.
- Increased pressure from restoration leading to staff burn out post COVID and ability to participate in wider engagement and development activities.
- Gap between the desired and the current culture indicates improvements are needed.
- Staff not feeling valued due to inconsistency in employment offers internally and across the region.
- Impact of cost of living pressures on staff which are further compounded in some grades by implications from pension scheme as a result of levels of contribution and tax implications.
- The impact of uncertainty and clear direction from PCB plans is leading to higher levels of turnover, inability to recruit to vacancies, reduced engagement and morale levels in teams potentially affected by the changes, making it difficult to deliver on strategic plans described in Our People Plan.
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace and respond to changing directions from the PCB.
- Vacancy freeze for all non-clinical roles along with a competitive recruitment market will mean vacant posts will be unable to be filled, leading to non-delivery of core objectives and business as usual.
- 3% reduction in establishment is likely to create additional pressures on existing staff impacting on sickness, well being and morale

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x4 = 16 Target: 4-8



	• Local onboarding processes do not consistently provide new recruits with a positive employment experience. • National unrest regarding cost of living and national pay deals leading to strike action taking place in most professional groups. • National pay and reward contract negotiations outcomes not seen as favourable by Unions leading to continuing strike action taking place. • The junior doctor strike action will have an impact on the delivery of planned activity due to consultants required to act down to provide strike cover. • The British Medical Association (BMA) rate card challenge will have a significant impact on the overall pay bill if implemented. If not implemented this could create a significant resourcing challenges and inability to deliver on planned activity and restoration plans as it is likely Consultants will withdraw from supporting waiting list initiatives. • Due to the BMA rate card challenge we are seeing an increased appetite for the establishment of Limited Liability Partnership (LLPs) by our Consultant workforce, at present there is limited governance in place to ensure adequate controls and regulation.	
	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of training and support for international new recruits on current staff and the retention of the new recruits. • Inability to source additional temporary workforce to support restoration and recovery plans • Further reduction in staff morale given focus on need to deliver financial turnaround • Non-delivery of New Hospital Programme impacting on ability to utilise available workforce effectively. • ICS transformations on corporate services benchmarking identified significant opportunity for saving in HR/OD workforce which is in direct contrast to the significant service pressures on the teams and ability to deliver transformational culture and OD programmes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction • Central services collaboration may de-stabilise some of the Trust's processes.	**Future Opportunities** • There are opportunities to work across the ICS to support workforce supply, i.e., international recruitment, creation of new roles. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Opportunity to adequately resource an OD programme to increase staff engagement and cultural transformation at pace. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience. • Central services collaboration may provide efficiencies and resilience to some services once in place and embedded.

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workforce and OD strategy related strategies and plans in place
  ○ Trust Values
  ○ Workforce Plan
	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking	**Internal**
		• Divisional Governance Structure and Arrangements
			[None]

○ Targeted recruitment & plans (international and healthcare support workers) ○ Workforce policies with EIA embedded ○ Health and Wellbeing strategy ○ Just culture ○ Regular temperature checks in place for staff satisfaction, culture, with action plans e.g., Staff Survey, NQPS, HWB, TED, Cultural survey ○ Leadership and Management Programmes ○ Appraisal and mentoring process ○ Workforce business partner model and advice line in place ○ Staff representatives in place, including union representatives, staff governors ○ Vacancy control panel in place and meeting weekly ○ Strike Action Emergency Planning Group weekly meeting • Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan	and action plans to reduce unwanted variation in existing strategies. ***(GPTW001/DVFM002)*** • Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. ***(GPTW002)*** • Ability to influence the direction of the Provider Collaborative Board with regards to programmes of work, desired impact measures and methods for achieving aims. • Sufficient staffing within workforce and OD to support work required to deliver transformation and deliver of the Trust's People Plan	• Divisional Improvement Forums (including Part II process to address cultural concerns) • Raising Concerns Group • Workforce Committee • Education Training and Research Committee • Safety and Quality Committee • Audit Committee assurance processes. • Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy **<u>External</u>** • National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) • Internal audit and external reviews e.g. • External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent) • rostering review by NHSI indicating excellence in rostering practice	

• Communications strategy • Accountability Framework • Safety Forums • New Hospitals Programme • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision included within the revised People Plan launched in April 2023 • Chief People Officer and Deputy/Associate Directors are present at all People and Transformation Meetings at the Provider Collaborative Board			

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW001	Review strategies considering financial pressures and delivering value for money as part of committee cycles of business.	Executive Leads	31st March 2023	1st April 2023	Complete	Control	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies. • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision.
GPTW002	Incorporate transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Director of Strategy and Planning	31st May 2024		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – October and November 2023

- Narrative regarding future risks and future opportunities enhanced with detail around the introduction of central services collaboration.
- Additional control identified regarding the Trust's representation at People and Transformation Meetings at the Provider Collaborate Board.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Fit for the Future

Risk ID: 858
Risk owner: Director of Strategy and Planning/Chief Medical Officer
Date last reviewed: 28th November 2023

Risk

There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

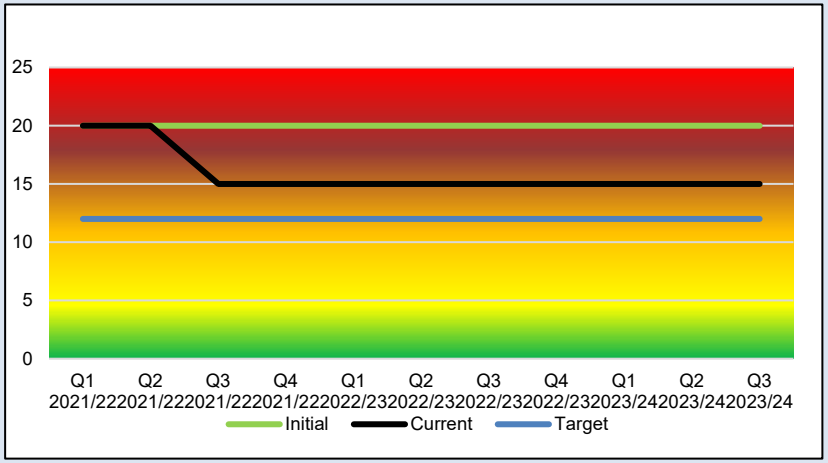
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance
8-12

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans and within this context LTH has reputational/performance challenges that are challenges to our ability to work effectively at both levels. System working has progressed to a clearer position though there is still a need for greater clarity particularly in relation to driving benefit across the quadruple aim. Place Based working is still being fully established. Whilst governance processes and operational oversight are being fully established as a Board we are placing significant reliance for our assurance/decision making on our CEO & Chair.
- The Clinical Programme Board (CPB) is established, meeting regularly to oversee the PCB clinical transformation programme with a range of Programme plans, Trackers and Toolkits in place. The Benefit Tracker for the CPB is shared with the Trust's Finance & Performance Committee – progress is being made but there remains work to be done to show clear contribution against all the quadruple aims.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge in terms of resources, organisational change and system working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet delivery of the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- Delivering the above will be a major challenge which will require the highest levels of staff engagement and communication, areas where the Trust scores relatively well compared to our peers but we will need significant improvement in future to deliver our ambitions

Risk Rating Tracker (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 3x5 = 15 Target: 8-12



Future Risks

- Demographic pressures
- Population health and Health inequalities challenges
- Estates challenges/backlog maintenance
- Workforce gaps/challenges

Future Opportunities

- System and Place working
- Service transformation/integration
- Digital
- New Hospitals Programme

	• Delivering the above will require the Trust to develop its capacity, capability and governance to robustly deliver major change programmes	

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established, where LTHTR continue to link own strategies with Place and System plans. A Central Lancashire Executive Oversight Group has been set up and discussions are underway regarding the options for the Lancashire Place Partnership. The ICB have established a a new Recovery Board, with a focus on system wide recovery and transformation
• LTHTR executive leads with Place/ICS responsibilities.
• Director of Communications & Engagement and Head of Communications in roles of SRO and Chairs of professional networks and providing significant contribution to the Provider Collaborative
• Clinical Programme Board (CPB) in place meeting monthly overseeing the PCB clinical transformation programme
• ICB has published 5 Year Joint Forward Plan
• Transformation Programmes developed and being led by Executive Team
• LTH Transformation & Recovery Board in place chaired by CEO, strengthening oversight of delivery of transformation programmes against agreed trajectories and addressing barriers for progress.
• Digital Northern Star working groups in place to deliver the Digital Northern Star programme
• Organisations within Digital Northern Star are sharing information regarding infrastructure digital contracts for a collaborative approach to networking and data centres.
• Improved communications Trustwide and External – HeaLTH matters, In Case You Missed It and Exec Q&A session all put in place to enhance staff engagement and External newsletter reinstated for key stakeholders across our communities.
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
		<u>Internal</u>
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		<u>External</u>
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***
			• Gaps in Clinical Programme Board Benefit Tracker to show clear contribution against all the quadruple aims ***(FFTF 001)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024		Ongoing	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 006	Deliver New Hospitals Programme	Chief Finance Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Director of Strategy & Planning,	31st March 2024		Ongoing	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.

Updates – November 2023

- No change to risk content or action plan.
- Detail of operational high risks linked to Fit For The Future now included for consistency between Strategic Risk documents.
- Action plan updates:

FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies - senior leaders for the Provider Collaborative and the ICB met on Friday 17 November to consider how our system will work effectively on issues relating to the sustainability, recovery and redesign of clinical services over the next few years. The group considered how we unblock some of the challenges we've encountered in reaching agreement about major strategic service reconfigurations. The meeting agreed to commit to a focused three to six month process to articulate a joint L&SC vision and roadmap for clinical configuration and estates utilisation strategy. This will substantially mitigate our risk in relation to linking LTHTR strategies with Place, Provider Collaborative and ICS Strategies. A refreshed LTH Clinical Services Strategy is on the Part 1 Board agenda.

FFTF 004 - Develop and deliver Digital Northern Star strategy - a new Digital Transformation Group has been initiated reporting into the LTH Transformation and Recovery board. A blueprint for generating Target operating models for each of the digital components of the central services has been created and is being piloted with Information Governance. Technical groups are aligning to define common architecture across L&SC for digital to ensure best value infrastructure across multiple programmes. Funding has been approved for the secure data environment, recruitment is underway, a cloud based environment has been developed and procurement is underway for design and build of an ICS wide data lake. The Electronic Patient Record Group are defining an approach to create cross organisational pathways.

FFTF 005 - Work continues with the local regional and national media including various items on how we are managing current pressures, and extensive filming with our breast care unit and chemotherapy departments. ITV Granada has been following the journey of one of our breast cancer patients and this has gained national attention. Series two of Cause of Death has how begun to air on Channel 5 and we are working closely with partners to maximise media activity for the show. Plans are being explored for further documentaries. We continue to engage with staff through our internal bulletins, keeping them abreast of the latest news and developments. Following publication of our CQC Inspection report, updates were sent to stakeholders, staff and governors and a number of briefings with the local press. We continue to lead on and make a significant contribution to communications for the Provider Collaborative. Our online presence has continued to increase over the last two months and we have a continuing upwards trend of engagement with more of our local population. We also recently reviewed our website to ensure it is accessible to all users, including those with disabilities, having implemented changes to the website in line with guidance from the Cabinet Office. Our goal is to provide an inclusive online experience for all visitors.

FFTF 007 - deliver our Social Value Strategy - a paper is on the Part 1 Board agenda.

FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change - a plan has been developed to establish a PMO (within existing resources) to track the current programmes of work. A senior member of the Continuous Improvement team will head up this work, supported by the two members of the transformation team who currently track the transformation programmes. The team will be supported by colleagues from across corporate teams to ensure that the programmes of work are tracked to enable the Board to have visibility of the entirety of the programmes and projects underway that are within the scope of the PMO. The PMO will sit under the Chief Operating Officer and will oversee the design, delivery and tracking of the progress and benefits of the transformation programmes.

Risk Title: Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services

Risk ID: 859
Risk owner: Chief Medical Officer
Date last reviewed: 23rd November 2023

Risk Description:
There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.

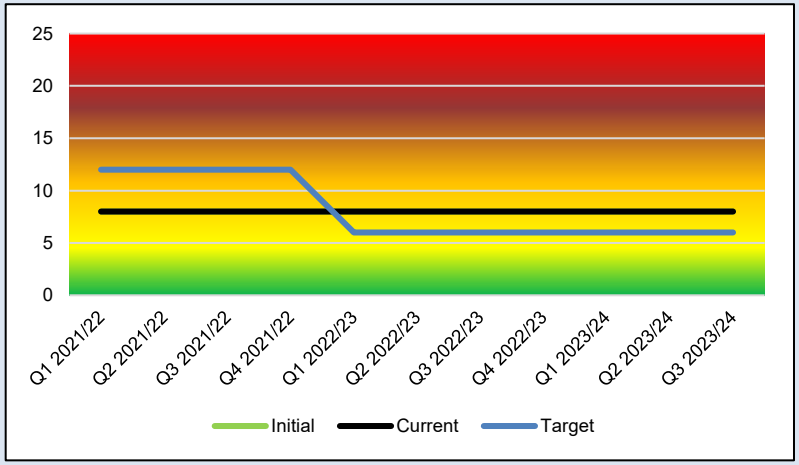
Risk Appetite: Open to Risk - prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

Risk Tolerance
6-9

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to deliver the services our patients and partners rightly expect, and our staff will be focused on immediate operational challenges rather than service and pathway integration.
- The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- ICS and LTH Clinical Strategy developed.
- Provider Collaborative Board Clinical Strategy approved.
- Limited availability of NHS capital prevents further rationalisation of the estate to more effectively provide specialist services (i.e. Neurosciences, Trauma Services, Stroke Services, and Vascular Services).
- Aging estate with significant backlog of maintenance will produce ongoing limitations with implementing options for service developments in the interim before the new hospitals programme.
- Geography and mutually dependent infrastructure.
- With the transition to the new year the financial rules which apply resource allocation within the NHS in England have transitioned. These rules give some clarity in the allocations awarded to Integrated Care Systems but not to how allocations will be distributed across those systems. The Trust will need to monitor funding allocations and patient access as the changes begin to take shape. Any changes in the commissioning arrangements may cause challenges in developing a future state operating model.

Risk Rating Tracker * (Likelihood x consequence)
Initial: 2x4 = 8 Current: 2x4 = 8 Target 6-9



*Initial score also 8 throughout but covered by current score line on above graph

	Future Risks	Future Opportunities
	• Risk of New Hospital Programme not progressing. • Commissioning risks to lower volume/low priority services. • Potential risks associated with changes in specialised commissioning arrangements.	• ICS networks and collaboration leading to reconfiguration of services. • New Hospitals Programme investment leading to establishment of Lancashire Specialist Hospital which may include additional specialist services. • Increasing research and innovation profile of specialist services. • Harnessing innovative ways of working using technology

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies in place - LTHTR Clinical Strategy - ICS Clinical Strategy - PCB Clinical Strategy - Estates Strategy - Finance Strategy and Plans • New Hospitals Programme • LTHTR Executive leads with Place/ICS responsibilities e.g. Chief Medical Officer located on a number of network bodies e.g. Chair of Cancer Alliance, Chair of Clinical Oversight Group for New Hospitals Programme, Lead Medical Director for the PCB • Quality and safety controls support the retention of specialist services. *Full details of controls associated with quality and safety of specialist services will be noted in the Strategic Risk associated with the Strategic Ambition to Consistently Deliver Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment. • Specialist services included within the planning framework. • PCB/ICB Clinical Strategy Configuration Events held in August and November 2023 with further work planned in 2024	• *Services being compliant with the service specification* ***(SPEC 002)***	**Internal** • Speciality Boards • Divisional Governance Structures and Arrangements • Divisional Improvement Forums • Safety and Quality Committee • Finance and Performance Committee • Strengthened updates to Board and Audit Committee regarding Specialised Services risk **External** • Scheduled contractual reviews with Specialised Commissioners including Executive Management Team forums to progress and resolve issues. • New Hospitals Programme Oversight Group • ICS and ICB system delivery Boards	• None documented.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
SPEC 001	Link LTHTR and ICB Clinical strategies with PCB Clinical Strategy	Chief Medical Officer	30th September 2023	25th September 2023	Complete	Control	• Integration of services and pathway and effective Place and system-based working • PCB clinical strategy still in development
SPEC 002	Agree interim and longer term plan for reconfiguration of specialised services across Lancashire and South Cumbria, aligned to the New Hospitals Programme.	Chief Medical Officer	31st March 2024		Ongoing	Control	• Services being compliant with the service specification

Updates to risk – October and November 2023

- Risk reviewed and additional control identified regarding PCB/ICB Clinical Strategy Configuration Events held and further plans for 2024.
- There are no Operational High risks linked to this Strategic Risk at this time.

Risk Title: Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research

Risk ID: 860
Risk owner: Chief People Officer (updated by Deputy Director of Education and Deputy Director of Research & Innovation)
Date last reviewed: 25th September 2023

Risk

There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.

Risk Appetite:

Seek – Eager to be innovative and to choose options offering higher rewards despite inherent business risks.

Risk Tolerance

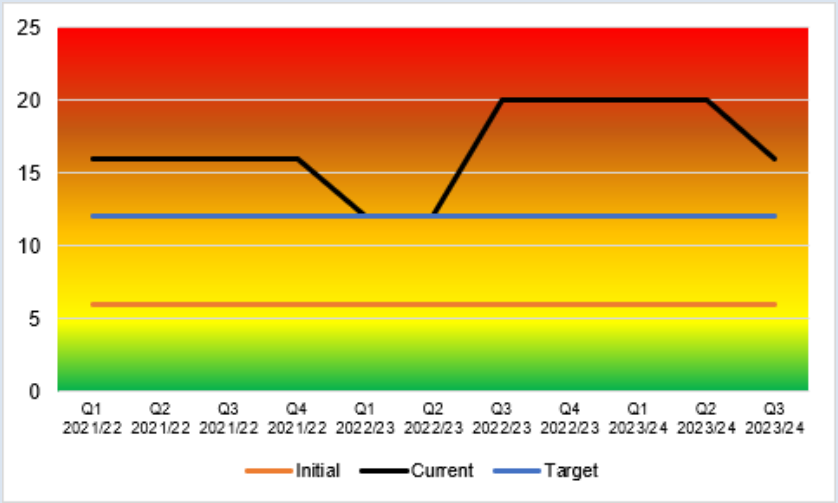
9-12

Rationale for Current Score

- Inability to invest educational income in capital development programmes to expand our education infrastructure.
- NHS Education Contract Tariff changes effective from September 2022 resulting in a review and removal of roles previously funded through education income.
- Ongoing capacity challenges to support education and R&I activity.
- Workforce shortages impacting on capacity and educational quality.
- Increasing evidence of health and wellbeing concerns in student and learner community.
- Ongoing challenges to achieve optimum faculty for specialist teaching requirements.
- Impact of economic climate/loss of work due to diagnostic/aseptic backlogs on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- While being managed by NIHR, ongoing backlog in research study start-up due to 2-year Covid disruption (Covid studies vs re-start vs new) and significant impact on commercial research portfolio, investigator time to dedicate and set-up. Therefore, NIHR guidance changes to re-prioritise studies and rectify necessitates revision of the portfolio. As a result of these R&I running at reducing loss, year on year. The O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist ongoing mitigation.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work. Presentation of present work has commenced in the PCB.
- Inability to influence essential release of staff for education activity due to service pressures.
- Audit requirements for management of educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation

Risk Rating Tracker (Likelihood x Consequence)

Initial: 2x3= 6 Current: 4x4 = 16* Target: 9-12



*Current score decreased to 16 at Education, Training and Research Committee in November 2023

Future Risks

- Capacity for effective marketing and communications.
- Impact of the New Hospitals Programme on Education estate
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.
- Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income.

Future Opportunities

- Continued participation and development of funded COVID/respiratory/UKCRF Network sourced related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital/AI solutions to provide education and research programmes.
- Launch of Trust innovation hub and external funding opportunity.
- Development of hi-tech education programmes including robotics and simulation learning.
- Development of joint appointments with HEIs.

	• UK becoming less competitive/losing commercial research trials • Impact of UGME capacity scoping exercise being undertaken by HEE • Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in CPD/Workforce Development funding and/or potential bid income	• Re-focus of research activity on key national clinical priorities. • Opportunity to bid for capital to update Health Academies to provide hi tech simulation and education. • Opportunity for LTH to become apprentice provider for ICS • Opportunity to manage income generation via Edovation • Potential to expand student placement offer to HEIs within and outside region. • Provision of a range of educational services to primary care • Potential to lead a range of education activity as part of ICS shared service development

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**
• Workstream related strategies in place: ○ Education & Training Strategy ○ Apprenticeship Strategy ○ Digital Education Strategy ○ Research Strategy ○ Our Big Plan, Annual Business Plan Planning framework ○ Workforce & OD Strategy • Ring-fencing of education and research funding. • Divisional education contracts. • NHS Education Contract with HEE. • Policies in place with review cycle. • Business continuity plans in place. • Head of R&I now part of New Hospitals Programme and ICB programme working parties. • Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes • Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis • Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team	• Lack of research leads embedded in divisions ***(ETR 007)*** • No mechanism to utilise educational income to support capital developments ***(ETR 004)***.	**Internal** • Sub-committees for education, training and research incorporating risk reviews. • Quality assurance and performance management of education activity. • Learner improvement forum. • Monthly training compliance reports. • Divisional performance reviews • Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO • Monthly finance reviews. • Education, Training & Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system. • Board. **External** • Full OFSTED inspection completed August 2022 with 'Good' rating achieved. • ESFA audits • HEE self-assessment return. • Matrix accreditation. • Annual performance reviews with Manchester Medical School • National Student Surveys. • National Education Trainee Surveys. • STAR accreditation for Clinical Research Facility. • Engagement in range of external forums and committees. • Quarterly strategy meetings with local HEIs • Trust Involvement/leadership in ICS discussions re education and R&I	• None currently identified.

Action Plan

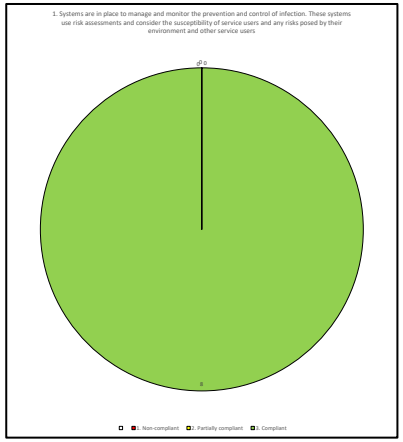
Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 001	Reset research provision to develop an affordable portfolio and refer to this in the refreshed Research and Innovation Strategy.	Head of Research & Innovation	30.04.23	30.04.23	Complete	Control	• Ongoing losses in research income which necessitate a recovery plan.
ETR 004	Include development of international education programmes post-Covid in Education and Training Strategy.	Deputy Director of Education	31.12.23		Ongoing	Control	• No mechanism to utilise educational income to support capital developments
ETR 005	Identify solutions to facilitate and support creation and delivery of a capital programme for education.	Chief Finance Officer, Associate Director of Education	30.07.23	25.07.23	Complete	Control	• No mechanism to utilise educational income to support capital developments • Ability to income generate in current economic climate
ETR 006	Identify a plan to mitigate identified risks associated with change in deferred income	Chief People Officer/Chief Finance Officer	30.04.23	30.04.23	Complete	Control	• Control of in-year adjustments relating to income deferral
ETR 007	Have Research roles in place within 2 Divisions	Head of Research & Innovation	~~31.08.23~~ 31.03.24		Ongoing	Control	• Lack of research leads embedded in divisions.

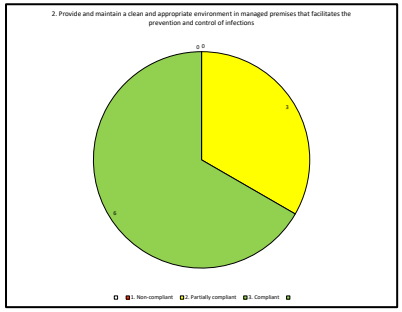
Summary of Updates – September 2023

- From an education perspective, no updates this month and risk score remains at 20 until full time Chief People Officer in post.
- From a research perspective, some updates made to rationale for current score, gaps in controls and assurances
- Action ETR 007 due date extended as work continues to ensure Research roles in place. A paper has been drafted and is awaiting Chief Medical Officer approval for an agreed approach to R&I and Divisional working.

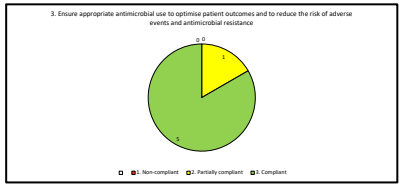
Infection Prevention and Control board assurance framework v0.1

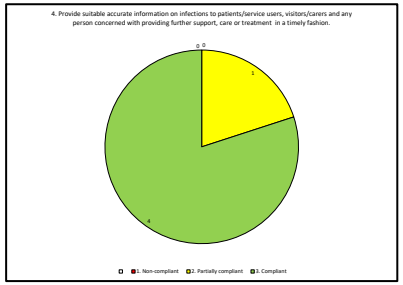
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	There is a governance reporting structure from Clinical Divisions through to IPC Committee which reports in to the Safety and Quality Committee via monthly Chair's report. An annual report and plan is presented to Safety and Quality Committee and Trust Board. There is a DIPC in post and Matron for IPC who both have clear defined roles and lines of accountability. There are weekly and fortnightly communication mechanisms directly from the DIPC to NMAHP and Medical leaders. **Appendix 1. IPC Governance structure and IPC Team Structure.** **Appendix 46. IPC Roles and Responsibilities**	None			3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	The mandatory reported HCAIs are collated and reported daily with nursing advice onto the electronic patient record (EPR) (flex), records are also kept on IPC owned spreadsheets, on the Trust database, and the UKHSA HCAI Data Caputre System. All HCAI's are reported and monitored via the Trust incident management system (Datix) with Multi Disciplinary Team (MDT) Post Infection Reviews carried out where necessary, being uploaded with tracked actions for completion. Any patterns or periods of increased incidents are monitored by the IPC Data Analyst and escalated appropriately. The mandatory data is reported and shared within the IPC Teams report to IPC Committee and divisional IPC reports presented at IPCC. **Appendix 2. IPCC Cycle of Business 2023-2024** **Appendix 3. IPC Annual Plan 2023-2024** **Appendix 4. Sample IPC Team report** **Appendix 5. IPCC Terms of Reference 2023-2024**	None			3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	The Trust has a patient safety strategy (Always Safety First (ASF) 2021-2024) which includes the promotion of a safety culture, learning from incidents and safety ti learning from what goes well. Infection prevention and control has been identified as one of the top 5 safety themes of focus. This is overseen monthly at ASF Committee. In addition, there is an ASF section every week at the Clinical leaders meeting and the promotion of an open culture of reporting and learning from incidents. There is also a Trustwide Safety and Learning Group that meets weekly and reviews every datix submitted that week. A summary of the months reported incidents via datix are discussed at IPCC. Reporting incidents is actively encouraged in order to identify any themes and trends to chart improvements. **Appendix 6. Datix report sample** **Appendix 47. Always Safety First Strategy**	None			3. Compliant
1.4	They implement, monitor, and report adherence to theNational Infection Prevention Control Manual (NIPCM.)	The NIPCM has been adapted for use within the Trust within the IPC Annual plan to support and guide actions to demonstrate compliance with the ten criteria of the 'Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance. The IPC Annual Plan is monitored and reviewed monthly at IPCC and reported to the Safety and Quality Committee Annually. **Appendix 3. IPC Annual Plan 2023-2024** **Appendix 4. Sample IPC Teams report** **Appendix 7. IPC Policy Tracker 2023-2024**	None			3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	The mandatory reported HCAIs are collated and reported daily with nursing advise on EPR flex, on IPC owned spreadsheets, on the Trust database, and the UKHSA HCAI Data Caputre System. All HCAI's are reported and monitored via Datix with Post Infection Reviews where necessary, being uploaded with tracked actions for completion. Any patterns or periods of increased incidents are monitored by the IPC Data Analyst and escalated appropriately. The mandatory data is reported and shared within the IPC Teams report and divisional IPC reports presented at IPCC. The reduction of mandatory infections is part of the IPC Annual Plan and monitored through the IPC committee through to Board. **Appendix 8. IPC Annual report 2022/23** **Appendix 3. IPC Annual Plan 2023-2024** **Appendix 9. Sample CDI PIR Meeting** **Appendix 10. Sample Norovirus Outbreak meeting**	None			3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	The IPC Team, Estates and Facilities, and Divisions host monthly IPC meetings with the Chair's report being fed through to IPCC. These reports include audit results, areas for escalation, and levels of infections. The system AMAT is used to input and monitor audit compliance with appropriate actions. Any incidents are reported via Datix which are monitored by the Governance teams. **Appendix 4. Sample IPC Teams report** **Appendix 11. Sample E&F Patnership Board report** **Appendix 12. Sample DCS Chairs report** **Appendix 13. Sample Medicine Chairs report** **Appendix 14. Sample Surgery Chairs report** **Appendix 15. Sample W&C Chairs report** **Appendix 16. Sample IPCC Agenda**	None			3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Training compliance and audit results are reviewed within the monthly IPC Teams report. Compliance on Asceptic Non Touch technique (ANTT) training and Antimicrobial Resistance (AMR) are reviewed bi-monthly at Antimicrobial Management Group (AMG). **Appendix 4. Sample IPC Teams report** **Appendix 17. Sample AMG Minutes**	None			3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	The IPC team attend the operational capacity meetings to support clincial areas with decision making about patient placement to reduce risk of transmission. The IPC team support clinical areas with daily decision making and dynamic risk assessments for individual and cohorting needs. The risk register is updated on Datix with a report being embedded within the IPC teams report which is reviewed monthly at IPCC. Estates and Facilities risks are raised and discussed each month at the E&F partnership board meeting. A Chairs report is shared and discussed at IPCC. **Appendix 11. Sample E&F Patnership Board report.** **Appendix 18. IPC Risk Register 2023-2024**	None			3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	A Standard Operating Procedure is in place to highlight the roles and resonsibilities of the nursing team regarding daily, weekly, and discharge cleaning of the environment and patient equipment. There is an executive oversight group in place to review the implementation of the National Cleaning Standards in ward areas. Currently around 25% of areas fully compliant with national cleaning standards. There is a plan to progress this and a date for completeion is being worked through at this time with estates division. At present, the resource is not yet in place to fully implement across all areas. **Appendix 19. SOP for Nurse Cleaning**	The gap in compliance in national cleaning standard presents a risk. Circa 25% of wards are now fully compliant. The plan to achive compliance will be completed by 20 December 2023. It is expected there will be a resource implication to fully implement this.	Weekly Executive oversight meetings are in place to facilitate different ways of working to meet the standards required. Priority areas have been identified. A comprehensive review of cleaning systems including completion of fogging, bed transfers, domestic and nursing cleaning has been undertaken with detailed oversight from the matrons to ensure work done is as planned. The STAR quality assurance programme, monthly and accreditation and cleaning audits are in place and reported to ensure standards of cleanliness remain high whilst not fully compliant with all componants of the standards.		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	The PLACE review in September 2022 did not go ahead due to COVID-19 restrictions. PLACE visits have recommenced in 2023. Facilities completed an informal PLACE audit, with rectifications picked up last year in a more informal basis. **Appendix 20. PLACE 2022 audit report**	PLACE visit recommenced in September 2023. Gap due to COVID-19 pandemic.	Planned visit cycle recommenced in September 2023 and annual cycle planned for 2024.		2. Partially compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	A Standard Operating Procedure is in place to specify the roles and resonsibilities of the team members regarding daily, weekly, and discharge cleaning of the environment and patient equipment. Each ward has a specific domestic checklist for daily cleaning. Compliance is assessed and monitored via STAR and divisional nursing leads. **Appendix 19. SOP for Nurse Cleaning** **Appendix 21. CrCU Domestic Cleaning schedule** **Appendix 22. W24 Domestic Cleaning schedule**	None			3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Saftey group meetings are held quartely with a Chairs report reported to IPCC and Health and Safety Committee. A ventilation group has been convened in quarter 3 2023 and is now meeting quarterly feeding in to IPCC. The Ventilation policy has been reviewed and air purification systems were ordered and placed in areas with poor ventillation. Following any outbreaks a review of the ventilation is completed and air purification systems are utilised. **Appendix 23. Ventilation Policy** **Appendix 24. Water Safety Group Sample report**	None			3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09.	The monthly Estates and Facilities partnership board reviews capital workstreams. There is also monthly meetings between Estates and IPC to review any estate issues. **Appendix 11.** **Sample E&F Patnership Board report**	Due to the age of the estate and limited capital funds, there is a backlog of maintainance that is managed in accordance with risk.	In the short to medium term, any areas that are not able to completed are added into the risk register. The divisional improvement process and capital planning forums are forums in which to escalate risks that may increase and require reprioritisation. The longer term action is the delivery of the New Hospitals programme.		2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Domestic and STAR audits monitor compliance of the policy. **Appendix 25. Management of Linen & Laundry Policy**	None			3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07-01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Domestic and STAR audits monitor compliance of the policy. **Appendix 26. Waste Management Policy**	None			3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	The Trust adheres to the HTM 01-01 standards in Sterile Services Department, with external audits ensuring compliance. The Quality Assurance is certified under ISO 13485:2016 QMS for Medical devices. The 2022-year audit confirmed that we are maintaining the quality assurance 100% and no major or minor noncompliance. The ^{6}Endoscopy decontamination follows HTM 01-06 and meets regulatory standards set by JAG for flexible endoscope decontamination. The Trust Endoscopy Department maintain the JAG accreditation based on inspection and maintain the HTM 01-06 standards. Please note that HTM 01-05 for dentistry is not relevant in our context.	None			3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food hygiene training is represented within the training needs analysis and monitored via education committee. Domestic and STAR audits test compliance with regulations.	None			3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						

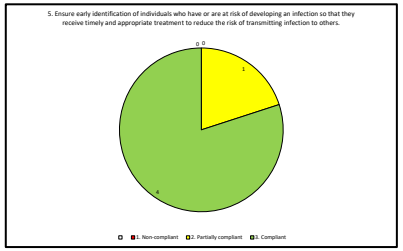


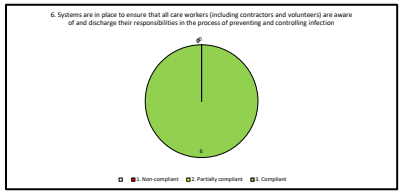


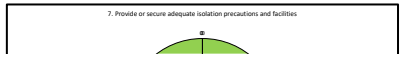
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Antimicrobial Management Group (AMG) in place which reports to Medicines Governance Comitee (MGC). Consultant Microbiologist appointed as Antimicrobial Lead who works closely with Lead AMS Pharmacist and Antimicrobial Technician to support AMS at the Trust. **Appendix 8. IPC Annual Report 2022-23**	None			3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Report included in the IPC Annual Report. **Appendix 8. IPC Annual Report 2022-23**	None			3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The Chief Medical Officer is responsible for antimicrobial stewardship. **Appendix 8. IPC Annual Report 2022-23**	None			3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •To optimise patient outcomes. •To minimise inappropriate prescribing. •To ensure the principles of Start Smart- Then Focus are followed.	**Appendix 27. NICE NG15 Baseline assessment tool**	None			3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •Total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	Antimicrobial consumption, regional data, CQUIN performance and quarterly Point Prevavalence Audit (PPA) results are reported at AMG, AMG minutes then shared with Medicines Governance committee. Medicines governance committee reports into safety and quality committee. There is a 6 monthly report received by safety and quality committee regarding the provision of pharmacy services. **Appendix 59 - bi annual pharmacy report**	Increased rigour required to increase assurance on appropriate length of antimicrobial treatment.	Antimicrobial prescriptions including duration are highlighted in a Pharmacy Prioritisation whiteboard for ward pharmacists. Audit and antimicrobial leadership actions continue to raise awareness of best practice.		2. Partially compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Trust antimicrobial guidelines available in PDF format as well as mobile APP. Eectronic antimicorbial prescribing order-sets in place to support prescribing. Antimcrobial review manadated as part of ward Round proforma. Point Prevalence Audits conducted each quarter with results shared trustwide. Teaching provided to staff of different grades. AMS E-learning in place. Regular antimicrobial MDTs and ward rounds for various care areas. Robust Microbiology referral system.	None			3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	The Patient Information Group, which has been established 4 years, has currently 26 members from the following areas, clinical governance, pharmacy, library services, PALS, blended learning, psychology, and our Unison branch secretary. Membership also includes 2 Governors, an employee from Healthwatch, the chair from the V.I (visual impairment) Forum and patients and carers from different backgrounds, some of which are physically disabled and someone with a special interest in LGBTQ+. These people have been instrumental in taking this work forward, without them the process of ratifying our information would not take place with a consistent and fair approach, they ensure that our leaflets are read from a patient/carer perspective and are easy to understand and to the point. The patient experience strategy was launched in 2022. **Appendix 60 - Patient Expereince strategy**	None			3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Tracker in place to monitor patient information. Patient Information Leaflets are not permitted to be photocopied or printed using our own equipment and are only available through S F Taylors to ensure quality is maintained and available in the required diverse fromats. The Big Word facility is in place. **Appendix 28. Hand Hygiene Patient Information Leaflet** **Appendix 29. MRSA Patient Information Leaflet** **Appendix 30. CPE Patient Information Leaflet** **Appendix 31. CDI Patient Information Leaflet**	None			3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Leaflets are available and reflect evidence based practice and receomndations. **Appendix 32. Adult Antimcrobial Policy** **Appendix 7. IPC Policy Tracker**	None			3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	The Trust provide patient information leaflets and NHS choices for infections. The ICB and LCC update the Trust monthly at IPCC. The IPC Team will visit patients and discuss any concerns to answer any questions. **Appendix 28. Hand Hygiene Patient Information Leaflet** **Appendix 29. MRSA Patient Infomration Leaflet** **Appendix 30. CPE Patient Infomration Leaflet** **Appendix 31. CDI Patient Information Leaflet**	None			3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	The infection status of patients is available on the red triangle on Flex. The IPC team complete a clinical entry for any infections and any review of patients. The new Nursing Kardex was introduced to identify and prompt a response for patients with diarrhoea regarding reason for diarrhoea and actions. There is a diarrhoea dashboard and wards specific whiteboard to highlight any patients that have had diarrhoea within the last 2 days to be reviewed daily. The IPC team form part of the daily flow management arrangements. **Appendix 34. Minutes from the Continence and Bowel Care meeting**	The Implementation of Continence and Bowel Care - Catheter passports is not yet completed.	A Working Group meets monthly to lead all aspects of continence and bowel care including documentation and education. The assessment and care planning processes include all activities of daily living.		2. Partially compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM.						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	The infection status of patients is available on the red triangle on Flex. The IPC team complete a clinical entry for any infections and on daily review of infectious patients. The new Nursing Kardex was introduced to identify and prompt a response for patients with diarrhoea regarding reason for diarrhoea and actions. There is a diarrhoea dashboard and wards specific whiteboard to highlight any patients that have had diarrhoea within the last 2 days to be reviewed daily. The isolation audit can be taken from Flex to confirm appropriate use.	None			3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	The infection status of patients is available on the red triangle on Flex. The IPC team complete a clinical entry for any infections and on daily review of infectious patients. The new Nursing Kardex was introduced to identify and prompt a response for patients with diarrhoea regarding reason for diarrhoea and actions. There is a diarrhoea dashboard and wards specific whiteboard to highlight any patients that have had diarrhoea within the last 2 days to be reviewed daily. The isolation audit can be taken from Flex to confirm appropriate use. The patient flow arrangements include IPC teams and patients who require isolation are identified and monitored to ensure action is taken as swiftly as possible.	None			3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	The infection status of patients is available on the red triangle on Flex. The IPC team complete a clinical entry for any infections and on daily review of infectious patients. The new Nursing Kardex was introduced to identify and prompt a response for patients with diarrhoea regarding reason for diarrhoea and actions. There is a diarrhoea dashboard and wards specific whiteboard to highlight any patients that have had diarrhoea within the last 2 days to be reviewed daily. The isolation audit can be taken from Flex to confirm appropriate use. Rapid GI tests are available in admission areas and can be requested with review from IPC for patients with diarrhoea and/or vomitting. Handover policy and procedures are in place to set out expected standards regarding handover.	The SBAR process is not standardised across the Trust.	Handover policy in place.		2. Partially compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	The Trust responds to any infections as per UKHSA, LCC, and ICB guidance. Comms are circulated with any high prevalence infections. **Appendix 35. Influenza Poster** **Appendix 36. C. difficile Poster**	None			3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	The process to follow on the identification of an outbreak is included in the Outbreak Management policy and the C. difficile policy. An email is sent to the Ward Manager, Matron, DND, and Domestic services on confirmation of an outbreak and regular meetings follow. Any outbreaks are also reported within the IPC Teams report presented at IPCC monthly. **Appendix 37. C. difficile Policy** **Appendix 38. Outbreak Procedure**	None			3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	The mandatory IPC elearning programme for all Trust staff (clinical/non-clinical) is updated and reviewed annually with compliance recorded in the IPC team report shared monthly at IPCC. **Appendix 4.** **Samole IPC Teams report**	None			3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	The mandatory IPC elearning programme for all Trust staff (clinical/non-clinical) is updated and reviewed annually with compliance recorded in the IPC team report shared monthly at IPCC. **Appendix 4.** **Samole IPC Teams report**	None			3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Compliance is monitored within the divisions and is reviewed and discussed at IPCC each month. If compliance is below 90%, this is negatively escalated through Chairs reports with approiate actions. The Education Training Research committee reviews educational compliance as part of its cycle of business. **Appendix 55 - ETR training reoprts**	None			3. Compliant
6.4	Monitoring compliance and update IPC training programs as required.	Content included in IPC E-Learning package. **Appendix 56- Elearning content**	None			3. Compliant
6.5	Monitoring compliance and update IPC training programs as required.	Clinical patient facing staff members are contacted as part of the mandatroy training regarding fit-mask testing. Records are kept on the status of staff members fit-testing on Health roster. **Appendix -57 Fit mask testing training reports**	None			3. Compliant
6.6	Monitoring compliance and update IPC training programs as required.	The IPC team monitor compliance in training as part of IPCC, this is included in the ETR reports and the review of the quality and content of the IPC training materials is undertaken on a cycle of business. **Appendix 55- ETR training reports** **Appendix 58- IPC Elearning training package**	None			3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	The infection status of patients is available on the red triangle on Flex. The IPC team complete a clinical entry for any infections and on daily review of infectious patients using the 5 criterion approach. The new Nursing Kardex was introduced to identify and prompt a response for patients with diarrhoea regarding reason for diarrhoea and actions. There is a diarrhoea dashboard and wards specific whiteboard to highlight any patients that have had diarrhoea within the last 2 days to be reviewed daily. The isolation audit can betaken from Flex to confirm appropriate use. Rapid GI tests are available in admission areas and can be requested with review from IPC for patients with diarrhoea and/or vomitting.	None			3. Compliant



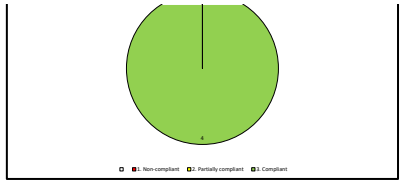


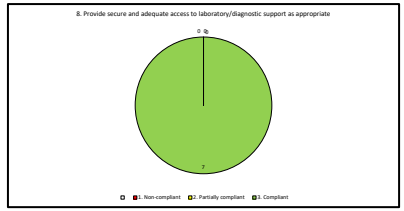


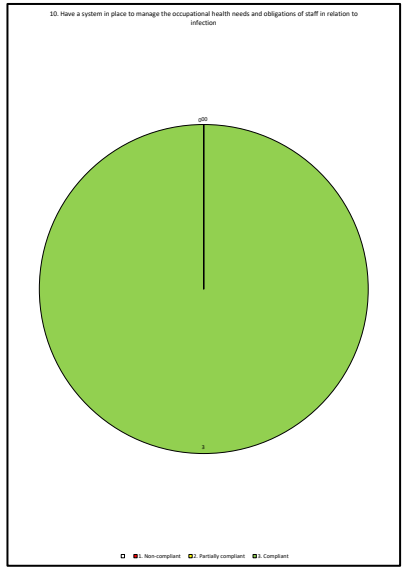




7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	The Trust have numerous policies theat include isolation advise including the Isolation room procedure, Procedure for the management of Influenza , and Norovirus Policy. Winter preparedness meetings are arranged annual as part of the IPC Annual Plan and Bed meetings take place three times daily to prioritise side rooms. **Appendix 39. Isolation Procedure** **Appendix 40. Management of Norovirus** **Appendix 41. Outbreak Procedure** **Appendix 42. Procedure for the Management of Influenza**	None			3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	This is included in the Isolation policy, outbreak policy, Covid policy, ebola policy etc. Signage is placed on the doors of infected side rooms or in outbreak situations. **Appendix 39. Isolation Procedure** **Appendix 41. Outbreak Procedure** **Appendix 43. Ebola Policy** **Appendix 44. Policy for COVID19** **Appendix 45. Stop, Do Not Enter Signage**	None			3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	The infectious status of patients in included in the Red triangle ond additional clinical entries on Flex. The infectious status of patients is also listed on the SBAR document and available of the ward specific Whiteboards, and isolation room audit. Any incidents of inappropriate transfers are reported on Datix and reviewed monthly in IPCC. Any issues regarding isolation are discussed daily in the Bed meetings, escalated and reviewed by the IPC Team and the Clinical Business and Emergency Planning Manager.	None			3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	LTHTR has a UKAS accredited microbiology service - all staff have appropriate qualifications, competency assessment and in the case of Biomedical Scientist staff are state registered.	None			3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	As part of UKAS accreditation test selection is regularly reviewed. Methods align with national standard methods and are carried out in adherence to internal Standard Operation Procedures.A combination of rule based algorithms within the laboratory information system and business intelligence (BI) searches direct significant results to medical staff validation lists, Infection control and national reporting systems	None			3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	The Pathology User Guide documentation outlines user information and stated turnaround times for all specimen types. Were testing is performed on behalf of users external to the Trust service level agreements are sought with appropriate review intervals	None			3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Testing procedures are available within Trust policies that are created and amended following National Guidance. **Appendix 37. *C. difficile* policy** **Appendix 44. Policy for COVID19** **Appendix 53. CPE Policy** **Appendix 54. MRSA Policy**	None			3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Testing procedures are available within Trust policies that are created and amended following National Guidance. **Appendix 37. C. difficile Policy** **Appendix 44. Policy for COVID19** **Appendix 53. CPE Policy** **Appendix 54. MRSA Policy**	None			3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high -risk pathogens.	Laboratory support during an outbreak investigation is clinically led in response to the nature of the incident. Identification of samples relating to a particular outbreak/incident can be managed within the laboratory using the incident monitoring procedure (internal document LA008) Management of significant pathogens is also clinically led with established protocols in place for suspected pathogens.	None			3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Transport of samples to the laboratory is made via porters or known couriers which is risk assessed and monitored by audit. Referral of specimens from the laboratory is made via established documented protocols. Audit of specimen transportation is a component of the laboratory quality management system.	None			3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A-to-Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Processes are planned in policies for the management of specific infectious agents is followed. **Appendix 9. Sample CDI PII Meeting** **Appendix 10. Sample Norovirus Outbreak meeting** **Appendix 37. C.difficile Policy Appendix 38. Outbreak Procedure**	None			3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Policies are in place to mitigate risks to pregnant, immunocompromised, any othe staff members who may be at high risk in clinical areas. Individual risk assessments are completed by line managers and Occupational Health referals are completed to support this. **Appendix 48. Policy for Controlling the Risks of Chickenpox Infection in the Trust**	None			3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	There are Occupational Health policies and procedures in place that provide advice for needle stick injuries/occupational ecposure. All staff adhere to IPC policy and Procedures to promote best and safe practice. **Appendix 49. Needlestick Or Body Fluid Contamination Incidents**	None			3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Occupational health complete pre-placement assessments ensuring that staff members have the appropriate immunisations before starting a role/new job. **Appendix 50. Occupational Health Leaflet** **Appendix 51. Occupational Health Policy Statement** **Appendix 52. Occupational Health Staff Support**	None			3. Compliant







Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

2023/24 Annual Plan Update			
Report to:	Trust Board	**Date:**	7th December 2023
Report of:	Director of Strategy & Planning	**Prepared by:**	I. Ward
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance on the Trust's progress against the 31 national NHS ambitions outlined in the 2023/24 priorities and operational guidance published on 23rd December 2022. The final Plan was signed off by the Board at the June 2023 meeting, where a request was made for a progress update at the December meeting. The Trust Board and its sub-committees receive regular updates with regards to performance against national targets and ambitions – as requested by the Board this paper seeks to bring those updates together in a brief summary to provide assurance around compliance and achievement against both our current position and forecast achievement for the year against the metrics.

A forecast of the Trust's compliance, or achievement of the national ambitions by area is outlined below:

Urgent & Emergency Care:	Achieve
Elective:	Achieve
Cancer:	Achieve
Diagnostics:	Partially Achieve
Maternity:	Achieve
Use of Resources:	Not Achieve
Workforce:	Achieve
Health Inequalities:	Achieve

It is recommended that:

I. The Trust Board receives this report as assurance regarding delivery of our 2023/24 Annual Plan

Appendix 1 – National NHS Ambitions.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒

To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			

1. **Introduction**

The 2023/24 priorities and operational planning guidance published on the 23rd of December 2022, outlined 31 national NHS objectives across a range of domains for recovering core services and improving productivity. A complete list of the objectives can be found in Appendix 1 – "National NHS Ambitions". Of the 31 national objectives, 13 were directly applicable to the Trust and are outlined below:

- Improve A&E waiting times.
- Reduce bed occupancy.
- Eliminate long waiters.
- Deliver the system specific activity target [Elective Recovery Fund (ERF].
- Reduce the number of cancer patients waiting >62days.
- Meet the cancer faster diagnosis standard (FDS) by March 24.
- Increase the proportion of patients receiving diagnostic test within 6 weeks.
- Deliver increased diagnostic activity to support elective and cancer backlogs.
- Make progress towards the national safety ambition to reduce stillbirth, neonatal and maternal mortality.
- Increase fill rates against establishment for maternity staff.
- Delivery a balance net system financial position for 2023/24.
- Improve retention and staff attendance through focus on the NHS people promise.
- Continue to address health inequalities and delivery of the Core20PLUS5 approach

Systems [Integrated Care Boards (ICBs) and Trusts] were required to submit a comprehensive, detailed suite of Operational Planning returns laying out their delivery plans for:

- Activity & Performance
- Finance
- Workforce

The Board had extensive discussions to develop the 2023/24 Plan and engaged the Council of Governors in those discussions as well as working with system partners across Lancashire and South Cumbria to reflect common assumptions and principles in our plans. The Trust Board receives updates at every meeting with regards to performance against a wide range of national targets and ambitions. This regular assurance is enhanced through additional meetings, for example the Special Board of Directors meeting held on the 22nd of November 2023. All of our annual plan commitments receive detailed scrutiny through our Board Subcommittees which provide assurance and the opportunity to escalate positive and negative assurance to the Board. This paper seeks to provide a high level summary as to our current position and forecast achievement for year against our key annual plan metrics.

2. **Discussion**

The following sections illustrate the Trust's current position alongside a predicted year end position for each of the applicable NHS national objectives, detailing where necessary the additional / mitigating steps being taken to improve the position where applicable, or explaining in further detail where compliance is not expected.

Urgent & Emergency Care (UEC)

Ambition:	Current Position	Forecast Position
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.	67.5%	76%
Reduce adult general and acute (G&A) bed occupancy to 92% or below	96.4%	95%

The national ambition to achieve 76% of patients waiting less than 4 hours is forecast to be achieved, however the ambition to reduce bed occupancy to 92% will not be met, particularly during the winter period given the additional pressure we will face. We expect some improvement on our current bed occupancy position as a result of a range of transformation and operational actions we are taking forward within the Trust and working with partners including:

- Reducing Ambulance conveyances to ED by 40%
- Improve flow through the hospital, reducing LOS by 10% (Pride & Joy impact on pilot wards 4, 21 and RWB, roll out extended to 10 wards).
- Reducing not meeting criteria to reside (NMC2R) to 5%.
- Increased utilisation of Virtual Ward capacity.
- Creation of Care ConneXion Hub to support demand management incorporating Virtual Ward, 2 Hour Urgent Crisis Response, NWAS and SDEC, with phase 2 including IDS, LCC and Age UK.
- Inflow programme targeting efficiency from arrival to admission to ward
- Flow programme targeting efficiency from admission to discharge.
- Continued utilisation of the Healthcare Hub at Finney House.

Elective

Ambition:	Current Position	Forecast Position
Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	1024	0
Deliver the system- specific activity target (agreed through the operational planning process)	On track	Achieve

Our clinical teams have worked exceptionally hard to maintain performance in this area, despite the challenges of industrial action. At month 7 our performance is ahead of our planned trajectories for both 65-week & 52-week waiters, and assuming no further industrial action we forecast compliance with the target, though we do face significant pressures in one specialty (orthodontics) where we are working with our system partners to progress solutions.

Our performance against our elective activity trajectories are ahead of plan for the year to date , and we expect this to continue allowing us to achieve the national requirement.

We have a comprehensive Elective transformation programme which has several workstreams to support delivery of Elective, Cancer & Diagnostics which include:

- Cancer
- Clinical Pathway Transformation
- Diagnostics
- High Volume Low Complexity
- Market share management
- Right Procedure Right Place

Our elective plans seek to maximise the opportunity afforded to us by our nationally accredited surgical hub at Chorley hospital. For example, we have successfully developed Paediatric surgery at the Chorley elective hub, which has been nationally recognised and has resulted in an additional 36 children being treated per month with no additional resource, supporting the reduction in long waiting times and providing a much-improved patient experience for the children and their carers.

Cancer

Ambition:	Current Position	Forecast Position
Continue to reduce the number of patients waiting over 62 days.	222	180
Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	71.7%	75%

The target to reduce both targets; patients waiting >62 days for 2023/24 to 180 and the 75% faster diagnosis standard are achievable with support from the Cancer Alliance. There are agreed tumour group specific trajectories for both measures, with performance and risks reviewed by the Performance Recovery Group. Tumour site specific actions plans are monitored weekly at tumour specific PTL meetings, with additional input from the Cancer Transformation Director supporting faster recovery. We have seen positive impacts through the implementation of our “Day Zero PTL” approach, which we are rolling out across tumour groups.

Diagnostics

Ambition:	Current Position	Forecast Position
Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	54%	64%
Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Below Plan	Partially achieve

The Trust plans to achieve an improvement in 6 week waiting times in year, the most significant gains are expected in 2024/25 once Community Diagnostic Centres (CDCs) are fully mobilised and new endoscopy suites have been built. The Trust is working to maximise the opportunity presented by the development of Community Diagnostics Centre programme and have commissioned additional capacity in key modalities such as endoscopy units, however the impact of these has not been delivered as quickly as we had anticipated. Mitigations have been put in place to bridge some of the shortfall and delays through utilising space within the

Cuerden unit at Chorley Hospital to facilitate CDC activity, and a mix of temporary mobile units and outsourcing to increase endoscopy capacity.

As demonstrated within the elective and cancer section of this report we have been able to deliver the diagnostic activity levels required to support plans to address those backlogs.

Maternity

Ambition:	Current Position	Forecast Position
Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	On track	Achieve
Increase fill rates against funded establishment for maternity staff	On track	Achieve

The Trust continues to commit to the delivery of the Clinical Negligence Scheme for Trusts (CNST) 10 safety actions to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury and has achieved each of the CNST schemes for the previous 4 years. Year 5 is in progress and whilst there are risks identified within the plan we are on track to deliver. The Board receives bi-monthly updates and there are regular "deep dives" within the Safety and Quality Committee.

The funded 2023/24 establishment was compliant with the Birthrate plus assessment at that time and forms the baseline measure for this target. The service is on track to demonstrate an improved fill rate position in line with plan by year end. The most recent birthrate plus assessment indicates additional resource is required which is currently under discussion with commissioners.

Use of Resources

Ambition:	Current Position	Forecast Position
Deliver a balanced net system financial position for 2023/24	-£15m	-£50.6m

In September the Trust's risk adjusted forecast deficit for FY23/24 was (£55.3m). This has improved by £4.7m to (£50.6m) due to:

- Increased CIP delivery (non-recurrent), offsetting £3m system stretch assumption.
- Income increase related to lowering of the ERF threshold by 2%.
- Increased balance sheet scrutiny and Grip and Control measures forecast to improve expenditure run rates across the trust.

LTH, along with the rest of the Lancashire and South Cumbria system, set itself a very ambitious and challenging financial plan for 2023/24. Though significant efficiency improvements have been achieved (of the core cost improvement we are currently forecasting delivery of £38.7m against the target of £48.5m) we have not been able to deliver the range of operational actions and transformational changes we had planned. Our financial target will not be delivered and the Trust is not expecting to achieve the system stretch target. We are working with the ICB to agree revised financial trajectories.

Workforce

Ambition:	Current Position	Forecast Position
Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	On track	Achieve

Our People Plan (2023-26) has a number of strategic aims including 'To Engage, Retain, Reward and Recognise' and 'To be inclusive and supportive' and a detailed progress report was provided to the November 2023 Workforce Committee. Staff turnover has been consistent with the same period last year and the level of absences due to ill health have reduced. In the last 12 months some of the highlights of our progress against include:

- Reporting for the first time that Lancashire Teaching Hospitals were above national average in all areas of the NHS People Promise as measured by the NHS Staff Survey with an overall improvement across colleague morale.
- Introducing eight new Lightning Sessions to support team leaders on key topics such as Induction, Recognition, Wellbeing, Recruitment, Team Engagement, Culture, Banter and Coaching.
- 173 teams completed a TED (team, engagement and development) tool within 2022-23, exceeding the Trust target by 18%

The TED approach (Team Engagement and Development) is an evidence-based diagnostic tool designed and structured around the key features of highly engaged and high performing teams. TED also contains a team development toolkit linked to the areas measured by the diagnostic to provide specific guidance and development tools.

We have several high-level impact measures specified to support the measurement and impact of actions taken which demonstrates an improving position in almost all areas. The progress against individual measure can be seen in 'Appendix 2 – Workforce high impact measures'.

The Our People Awards brings together colleagues from across the Trust to celebrate our colleagues and team achievements and recognises exemplar behaviours linked to our shared purpose and organisational goals. In the last 12 months our award categories were re-developed to ensure they were inclusive for all colleagues and new categories were introduced to support Trust priorities, we received 150 nominations which is the most received to date.

Over the past 5 years LTHTR has significantly developed the Advanced Practice workforce and enhanced the training and support available across the ICS. Since 2019 LTHTR has led a monthly Advanced Practice forum across the ICB to enable the sharing of knowledge, skills and experience.

Prevention & Health Inequalities

Ambition:	Current Position	Forecast Position
Continue to address health inequalities and deliver on the Core20PLUS5 approach	On track	Achieve

The LTH health inequalities delivery plan is structured around the ICB health inequalities programme and will evolve to link closely with the Preston and Chorley health and well being partnership Boards, of which LTH is a member. There are a number of projects underway to target specific groups of the population to reduce health

inequalities. A health inequalities group has been established and it is suggested this will report into the transformation boards and safety and quality committee.

There are both strategic and operational actions required to integrate this agenda fully into the organisation alongside a number of related strategies that will support the delivery of this plan. These include; Always Safety First, Patient Experience and Involvement, Mental Health, Learning Disability, Autism, Green Plan and the social value strategy that speaks to the ongoing work fulfilling our role as an anchor institution. Several local projects are underway with the aim of reducing health inequalities. These include;

- Institute for Health Improvement (IHI) Accelerator Collaborative (NHS England) early cancer diagnosis
- Outpatient Did Not Attend (DNA)/Was Not Brought (WNB) Children and Young People
- Muslim Girls School Health awareness and education programme.
- Long wait harm review – Severe mental Illness and learning disability
- Peer Support workers in the Emergency Department
- Continuity of Carer – maternity services
- CURE smoking and alcohol screening and brief interventions
- Special care dentistry- Learning Disability and autism
- Audiology- Learning Disability and autism
- Annual Our Health Day – Learning Disability and autism
- Childrens mental health
- Prisoner access to healthcare services

Six members of staff are taking part on the health equity programme in partnership with Lancaster University and the Board of Directors have commenced a series of health inequalities training.

Next Steps

- Focus on the specific actions required to deliver our year end forecasts and where possible deliver further improvements
- Build our forecast year end position into our planning process for next years annual plan and our 5 year plan

3. Financial implications

No direct implications.

4. Legal implications

No direct implications.

5. Risks

A range of risks are present in relation to the forecast achievement of our year end targets. These will be managed, mitigated and reported to the Board using our established processes and governance systems.

6. Impact on stakeholders

No direct impact.

7. Recommendations

It is recommended that:

I. The Trust Board receives this report as assurance regarding delivery of our 2023/24 Annual Plan

Appendix 1 – National NHS Ambitions.

Objectives not directly related to the Trust are greyed out, however have been included for completness.

Area	Objective
UEC	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
UEC	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
UEC	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community Health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
Community Health services	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary Care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
Primary Care	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
Primary Care	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
Primary Care	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
Elective	Deliver the system- specific activity target (agreed through the operational planning process) Ask for ERF (System) is to deliver 109% average rising to 113% by end of year.
Cancer	Continue to reduce the number of patients waiting over 62 days
Cancer	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Diagnostics	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
Maternity	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental Health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)

Area	Objective
Mental Health	Increase the number of adults and older adults accessing IAPT treatment
Mental Health	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
Mental Health	Work towards eliminating inappropriate adult acute out of area placements
Mental Health	Recover the dementia diagnosis rate to 66.7%
Mental Health	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
People with a learning disability and autistic people	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention & Health Inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
Prevention & Health Inequalities	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
Prevention & Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Clinical Services Strategy Refresh			
Report to:	Trust Board	**Date:**	7th December 2023
Report of:	Gary Doherty	**Prepared by:**	Gary Doherty
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to ask the Board to note our refreshed Clinical Services Strategy and agree to bring forward to early 2024 the work to develop a new Strategy. The Clinical Services Strategy was approved by in April 2022 and runs until the end of 2024. The period from 2022 until now has seen the context facing the Trust materially change in a number of key areas such as the impact of Covid, the financial context and the level of collaborative/system working. Reflecting this, our Strategic Risk Action Pan for Delivering Value for Money incudes the requirement to refresh the Clinical Services Strategy. As such the Strategy has been updated, particularly in relation to:

- The national planning context including the financial context
- The latest Trust elective and urgent care strategies
- System and collaborative working
- Health inequalities

During early 2024 a new Clinical Services Strategy will be developed with full engagement with key stakeholders.

It is recommended that:

I. The Board notes the refreshed Clinical Services Strategy and agrees that the work to develop a new Strategy is brought forward to early 2024

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

1. **Background**

Significant work was undertaken during 2022 to develop the Trust Clinical Services Strategy. The Strategy was co-designed with our clinical leaders, frontline staff and operational leaders. The period from 2022 until now has seen the context facing the Trust materially change in a number of key areas such as the impact of Covid, the financial context and the level of collaborative/system working. Reflecting this, our Strategic Risk Action Pan for Delivering Value for Money incudes the requirement to refresh the Clinical Services Strategy.

2. Discussion

The Clinical Services Strategy covers all services (acute and community) and specialist services provided by LTH. The strategy outlines the following priorities:

- ***The national planning context, our Trust Strategic Objectives and Our Big Plan:*** the Trust's Clinical Services Strategy responds to the national planning context as laid out in the NHS Long Term Plan and our Integrated Care Board and Provider Collaborative strategies and priorities, including a move to increased upstream interventions, whereby instead of treating patients in hospitals once their condition has significantly progressed, we focus on earlier stage treatment in ambulatory and community settings. This "left shift" requires identifying disease at an earlier stage, enabling earlier interventions.
- ***Our Strategic Clinical Priorities*** to provide outstanding and sustainable healthcare to our local communities. This includes improving the efficiency and productivity of our planned care services to reduce our waiting lists and transforming Urgent and Emergency Care services to reduce waiting times in our Emergency Department and "right size" our urgent care capacity
- ***Delivery of our specialised services to patients in Lancashire and South Cumbria:*** the strategy outlines the Trust's priorities for the improved provision of high quality tertiary services over the course of the clinical services strategy
- ***Driving health innovation through world class education, teaching and research:*** the strategy outlines how our Education and Research Strategies will support the delivery of the Clinical Strategy.
- ***System working in the new NHS landscape,*** implementing national and regional schemes and transformation programmes currently taking place at three levels across our system; ICS level, Place and organisational level. The strategy outlines our plans to make a leading contribution to these priorities as the major specialist centre for Lancashire and South Cumbria
- **Reducing Health Inequalities:** our commitment to reducing health inequalities is outlined in this Clinical Services Strategy
- **New Hospital Programme:** we have a once-in-a-generation opportunity to transform our region's hospitals. By creating a network of brand new and refurbished facilities, we will help local people live longer, healthier lives.

The period from developing our previous Clinical Services Strategy in 2022 until now has seen the context facing the Trust materially change in a number of key areas such as the impact of Covid, the financial context and the level of collaborative/system working. As such the attached Strategy has been refreshed to update the contents in all areas particularly in relation to:

- The national planning context including the financial context
- The latest Trust elective and urgent care strategies
- System and collaborative working
- Health inequalities

During early 2024 a new Clinical Services Strategy will be developed with full engagement with key stakeholders.

3. Financial implications

The agreement of this refreshed Clinical Services Strategy does not in itself involve any additional financial commitment over and above agreed budgets. As laid out in the Strategy, our current finical challenge is a major driver for the need to transform services through our agreed programmes of work both within LTH and also working with system partners.

4. Legal implications

None

5. Risks

The risks arising from delivering the refreshed Clinical Services Strategy are addressed through our Risk Management system and Board Assurance Framework.

6. Impact on stakeholders

The refreshed Clinical Services Strategy reflects our agreed work programmes/plans as discussed with partners. During 2024 we will develop our new Clinical Strategy, with full engagement with key stakeholders.

7. Recommendations

It is recommended that:

I. The Board notes the refreshed Clinical Services Strategy and agrees that the work to develop a new Strategy is brought forward to early 2024

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Summary of Clinical Services Strategy 2023–2024

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Contents

Foreword

We are delighted to present this refresh of our Trust Clinical Services Strategy 2023 – 2024. Our 2021–2024 Clinical Services Strategy was co-designed with our clinical leaders, frontline staff and operational leaders. This refresh allows us to reflect some of the key developments since we drafted that document; in particular it allows us to incorporate significant developments in our system working such as the recently agreed Lancashire and South Cumbria Integrated Care Board 5 year Forward Plan and our developing strategies to respond to key challenges such as meeting demand within the resources available to us and responding to the challenges posed by health inequalities within our population.

There is a rising demand for health services due to an ageing population with increasingly complex healthcare needs. People are living longer and, as they age, their healthcare needs change. The number of people living with long-term conditions is set to increase, with more individuals managing multiple conditions, requiring the NHS and its partners to develop integrated, joined up pathways. Workforce supply has been a major challenge as demand has risen – the NHS now has its first comprehensive workforce plan but it will take time to put staffing on a sustainable footing. The COVID-19 pandemic has caused life expectancy to fall, and has further increased inequalities in mortality and the number of years lived in good health across the population. The resources available to public services are constrained and under pressure. As such the NHS is seeking to deliver a number of challenging short and longer priorities to allow us to recover our core services and productivity and make progress in delivering the key ambitions in the NHS Long Term Plan.

The key message within this refreshed Clinical Services Strategy is the need to transform our services and pathways to deliver our Big Plan Aims and Ambitions. In so doing we will ensure that we are able to deliver sustainable services for the communities we serve and are able to take the once in a lifetime opportunity afforded to us by the New Hospitals Programme. We are designing and implementing new models of care and treatment pathways which are fit for the future. In designing our new models of care, we will focus on targeted population health management and reducing inequalities, co-designing clinical models and services with our patients as partners, to improve their health and life expectancy. We will continue to work collaboratively with local partners to drive improvements and provide integrated care to meet the needs of our communities. Our commitment to delivering this strategy and measuring its success is fundamental to the delivery of high-quality clinical services

This clinical strategy covers all services (acute and community) and specialist services provided by Lancashire Teaching Hospitals (LTH).

Our thanks to all of our clinicians and operational leaders who are leading the work to develop and deliver our new models of care. This strategy will be fully aligned to our annual 'Our Big Plan' and the implementation of the strategy will be through the divisional teams and overseen by the Trust Board.

Dr Gerry Skailes

Chief Medical Officer

Sarah Cullen

Chief Nursing Officer

Faith Button

Interim Chief Executive

Our Trust Strategic Objectives and Our Big Plan

To provide outstanding and sustainable healthcare to our local communities

To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

To drive health innovation through world class education, training and research

Delivery of the Trust's Clinical Strategy will be supported by a range of other detailed plans such as our Workforce and Organisational Development Strategy, Digital Strategy, Continuous Improvement Strategy, Knowing the Business Financial Strategy and Communication and Engagement Strategy.

National and Local Context

The NHS Long Term Plan identifies that population demand will continue to outstrip supply unless we do something differently. There are key changes the NHS must make if it is to provide high quality, sustainable services that improve the health and wealth of the UK - the NHS must increasingly be:

- **More joined-up and coordinated in its care**. More than 25% of the adult population in England now lives with two or more long-term conditions, increasing the likelihood of admission to hospital. In 2019, 33% of people over 18 were estimated to be living with complex multimorbidity, having doubled from 15% in 2004". The NHS must break down traditional barriers between care institutions and move away from competition to integration whereby teams and funding streams come together to support the growth in long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care.
- **More proactive in the services it provides**. The majority of initial medical contacts with the NHS occur when a patient calls NHS 111 or 999, or visits their pharmacist, GP practice or A&E but we need to move to 'population health management' approach, using predictive prevention (linked to new opportunities for tailored screening, case finding and early diagnosis) to better support people to stay healthy and avoid illness complications.
- **More differentiated in its support offer to individuals**. This is necessary if the NHS is to make further progress on prevention, on inequalities reduction, and on responsiveness to the diverse people who use and fund our health service. More fundamentally, with the right support, people of all ages can and want to take more control of how they manage their physical and mental wellbeing.

Building on the Long Term Plan, the Lancashire and South Cumbria Integrated Care Board Joint Five Year Forward Plan identifies the following key strategic priorities:

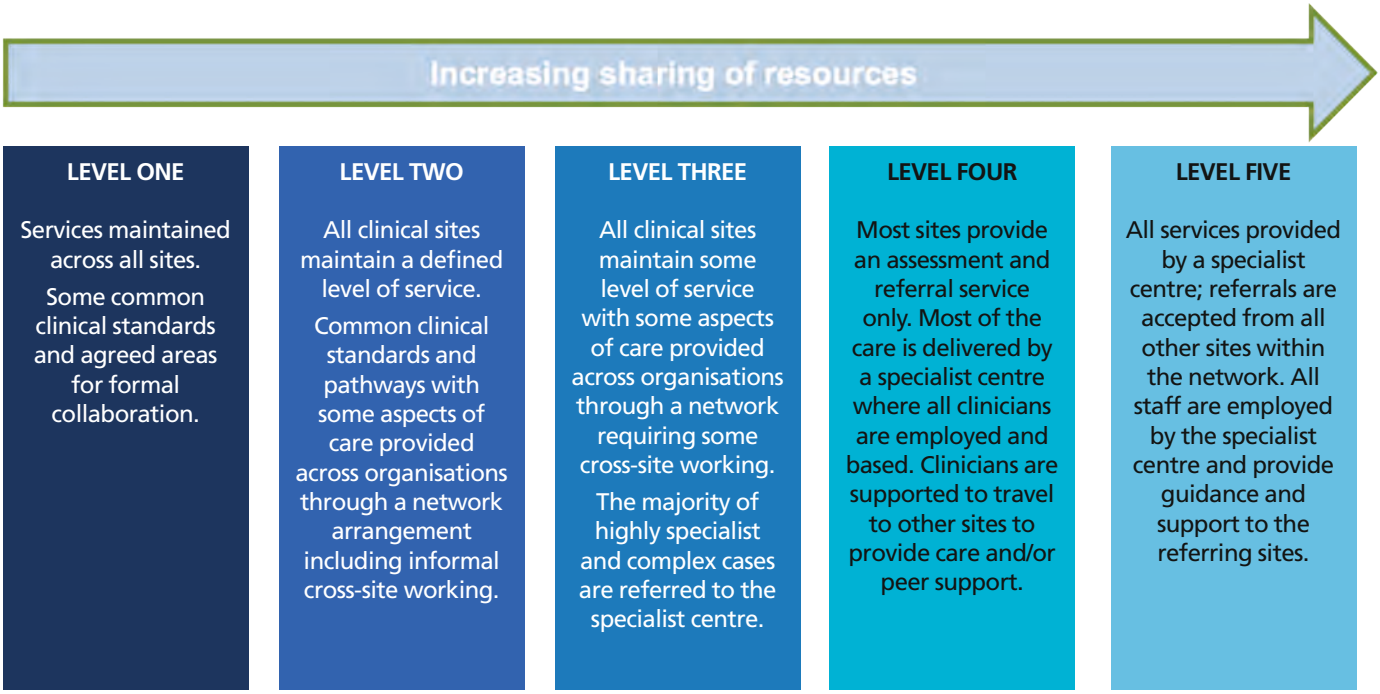
1. We must strengthen our foundations by changing how organisations work together and how the NHS provides services to improve our financial situation.
2. We must take urgent action to reduce the level of long-term disease, working with partners to prevent illness and reduce inequalities.
3. We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care services.
4. We must make sure there is more consistent and high-quality care. We will standardise, network, and improve our pathways of care.
5. We must take targeted action to deliver world-class care for priority diseases and conditions, population groups and communities.

Taking forward the above priorities will require the introduction of new models of care to allow us to achieve what is described as a "Left Shift" in healthcare – a move to increased upstream interventions, whereby instead of treating patients in hospitals once their condition has significantly progressed, we focus on earlier stage treatment in ambulatory and community settings. This left shift requires identifying disease at an earlier stage, enabling earlier interventions. The result would almost certainly be better clinical outcomes, better patient satisfaction and a reduced burden on health systems. The financial challenge within Lancashire and South Cumbria is particularly significant. Prior to the COVID-19 pandemic, the Lancashire and South Cumbria health and care system was consuming more financial resources than it was allocated - our distance from target is the highest in the UK at more than seven percent which means we are deemed to be over-resourced. This is in addition to the requirement to make savings to cover pressures brought about by inflation. Lancashire Teaching Hospital has a forecast deficit of £50.6m for 2023/24 and is likely to start 2024/25 with a significant underlying deficit.

The Lancashire and South Cumbria Provider Collaborative have developed a Clinical Vision to respond to the NHS Long Term Plan and the ICB key strategic priorities and also to help frame individual Trust strategies. The Clinical Vision sets out a compelling case for change, which is summarised below:

- All of our Trusts are both individually and collectively challenged to different degrees across a range of performance indicators in quality, operations, workforce, and finance - our population is aging faster than the national average and faces significant health inequalities and socioeconomic challenges
- Issues vary in magnitude across individual providers, but the collective position is unsustainable and the system is increasingly reliant on non-recurrent external support
- As a system we are significantly financially challenged. We also have significant workforce supply issues which are exacerbated by the current configuration of clinical services, and by our proximity to other tertiary centres which can be attractive to potential staff. Our future collaborative work and our service model must link to sustainable workforce solutions based on future predictive workforce supply

The Lancashire and South Cumbria Provider Collaborative Clinical Vision describes how a networked service delivery model is needed to enable providers to work more effectively together in the planning and delivery of clinical services. Operating at scale across Lancashire and South Cumbria, the network will be underpinned by consistent clinical policies and protocols, and harmonised support services. It will also give the opportunity to develop more specialist expertise associated with centres of excellence while allowing Trusts to continue with the local delivery of services. This network of provision will operate on a spectrum; there will not be a single model that is right for each service. The following diagram gives a high-level overview of some potential methods of delivery:



More detail on the Provider Collaborative clinical work programme is given in Section 2 of this document.

Our Strategic Clinical Priorities

1) To provide outstanding and sustainable healthcare to our local communities

Maximising treatments and reducing waiting lists

The COVID-19 pandemic led to significant increases in waiting lists and waiting times, but we faced challenges even before the pandemic because the demand for outpatient appointments, diagnostic tests and operations was higher than we were able to meet with supply. Covid 19 led to a reduction in the efficiency and effectiveness with which we were able to use our operating theatres and other facilities as it required us to socially distance and introduce new processes to avoid spreading the infection to patients a and staff. At the same time the pandemic accelerated the use of new technologies and innovative ways to treat patients. We are committed to reducing waiting lists and waiting times for our patients as quickly as possible in the most efficient and effective way we can.

Our key strategic priorities for our planned care services are to:

Improve the efficiency and productivity of our services – delivering improvements in theatre utilisation, cases per operating/diagnostic list, daycase rates, lengths of stay and readmission rates.

Maximise the benefits from our Chorley Site and nationally recognised Surgical Hub – our ambition is to separate elective and non-elective services across the Trust to reduce patient cancellations due to a lack of an available bed due to emergency admissions and protect patients from infection. The Chorley site is one of only 8 nationally recognised Surgical Hubs and over the life of this strategy we have opened our new state of the art Ophthalmology Unit as well as expanding our theatre capacity on the site. We have expanded the range of specialties that operate from the site and we will seek further opportunities to allow more patients to receive a first class service that is not as exposed to emergency pressures as our Preston site. Routine day case activity for children is now provided from the Chorley Surgical Hub. Neurosurgery, Plastic Surgery, and potentially Gynaecology will develop their elective service by using the CDH elective site.

Reducing the number of patients that receive treatment from other providers – maximising our efficiency and effectiveness will allow us to increase our capacity, allowing us to reduce the number of Central Lancashire residents that are treated by other providers. Repatriating this activity will allow us to improve our financial position through increased income and will also help us to ensure we can provide a broad range of training, experience and education to help us give the best possible experience for our staff.

Transform our Cancer pathways – we have introduced new pathways in our cancer services that radically reduce the time taken to assess our patients, making sure those that do need treatment get vital care as soon as possible. We will seek to expand this approach as well as looking to invest in the facilities at our Chorley site to allow us to provide more specialist cancer services from there in future.

Transform our outpatient services – we are committed to delivering the nationally mandated 25% reduction in follow up appointments to allow us to reinvest this resource in seeing more new patients and other key clinical activities. Our plan focuses on a range of actions and improvement with four key transformational projects as follows: Referral Optimisation & Demand Management commencing in cardiology & ENT, Personalised Outpatient Care (including Patient Initiated Follow up) and Outpatient Digitisation (including the development of a Patient Engagement Portal).

Maximising community treatments – we will work collaboratively with partners across the ICS and to review pathways and maximise the level of service available ion the community. Community Diagnostic Centres will allow us to promote early diagnosis and equitable access, with plans in place to increase the range of services available and the number of tests carried out. We will explore other opportunities to review and change pathways – for example within Ophthalmology we are working to integrate pathways to ensure only those patients that would benefit from hospital care have to travel to hospital and to develop a great range of expertise and capacity within Primary Care through the development of GPs with a Specialist Interest.

System working – we will continue to work with other Trusts across Lancashire and South Cumbria and beyond to work together through mutual aid to ensure that wherever possible patients receive equitable waiting, and where one Trust is able to offer quicker, appropriate treatment we will ensure that patients are given the choice to move to that provider if they wish to do so.

Population health – maximising the health and wellbeing of our population will help to reduce the increase in the demand for all hospital services. For example, every pound of body weight places four to six pounds of pressure on each knee joint and individuals with obesity are 20 times more likely to need a knee replacement than those who are not overweight. Please see the section on health inequalities for more information on how we will work with partners to maximise population health.

Transforming Urgent and Emergency Care

Since we published our first Clinical Services Strategy we have developed our 2023–2025 Urgent and Emergency Care Strategy. Transforming Urgent and Emergency Care services is critical if we are to provide high quality, sustainable services to patients and a high quality working experience to our staff. Our population has a higher proportion of older people and more of our patients have multiple long term conditions leading to significant increases in the demand for urgent care. The NHS Long Term Plan highlights the need to boost out-of-hospital care and to redesign emergency hospital services. Our Urgent and Emergency Care strategy commits us to:

Right size capacity – dedicated funding of £12 million has been invested in the Development of Finney House, Acute Frailty Assessment Unit and Virtual Wards and an additional £15 million capital funding has been secured for the right-sizing of our Surgical and Medical Assessment Unit. Work is ongoing to develop a Mental Health Urgent Assessment Centre (MHUAC) collocated with the ED at RPH. We will expand our 'same day' emergency care services in partnership with the North West Ambulance Service and the Lancashire and South Cumbria LSCFT UEC 2 hour response team. This reduces the time patients are required to stay in hospital and provides care closer to home. Our strategic intention is to move from a 12-hour to a 24-hour emergency department at Chorley General Hospital, when it is possible to safely staff the emergency department. These developments, alongside the actions below, will help us better support our population with alternatives to coming to hospital, and will also allow us to reduce the length of time patients spend in hospital which will allow us to go back to our agreed, funded levels of beds and staff while making sure patients still get the care they need when they need it.

Right size our workforce – we recognise our workforce skill mix, knowledge and skills are essential in meeting the needs of our patients and wider population. As we develop so will the skills and design of our workforce to ensure we meet the needs of the people using our services. This part of the strategy will be addressed through Our People Plan 2023–2026 and is not duplicated in this strategy.

Speed up discharge from hospitals – an 'Integrated Community Referral Hub' has been established in our community ahead of winter 2023/24 which will mean faster discharge to the right setting, so that people do not stay in hospital longer than necessary. New approaches to step-down care are being implemented so, for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.

New services in the community – with fully integrated working across Central Lancashire up to 20% of emergency admissions can be avoided. We will offer more joined-up care for older people living with frailty, including scaling up our urgent community response, frailty and falls services and increase our clinical in-reach into care homes – meaning the right people get the care they need, without needing an admission to hospital if it's not necessary. Greater use of 'virtual wards' will allow people to be safely monitored from the comfort of their own home, allowing staff to care for up to 500 patients a month this way over the longer term.

Help people access the right care first time – 111 should be the first port of call and will help us to reduce the need for people to go to ED. By April 2024, urgent mental health support through NHS 111 will be universally available. The Immediate Response Service will continue to be supported as this is an exemplar one single access point, reducing the demand for the Emergency Department. The establishment of the integrated community referral hub will support an increase in people accessing alternative services to avoid unnecessary attendance and admission to hospital.

Working at both a system and local level, we are utilising an approach known as Engineering Better Care (EBC) to transform our urgent care pathways. Engineering Better Care (EBC) is a framework for improvement designed by the Department of Engineering at the University of Cambridge. It is based on a set of questions addressing people, systems, design, risk and management perspectives. The programme enables leaders within healthcare systems to deliver improvements in focused areas, tackling wicked problems that result in unsatisfactory outcomes or performance. Skilling teams up with improvement science methodology and practical tools, the programme provides a holistic immersive experience into the discipline of system level improvement using the following stages:

Understand – a description of the current system, a common understanding of the problem, a consensus view of the future and a clearly articulated case for changing the system.

Co-Design – a clear description of the future system and a plan for its delivery.

Deliver – successful deployment of the new system.

Sustain – continued operational success of the new system along with consideration of further improvement potential or wider deployment.

The focus for the first phase of the programme was to support those living with frailty:

> "We aim to create a seamless journey to support people to age well across Lancashire & South Cumbria, leading to better outcomes and improved experience for our population living with frailty (over 65s)"

As a system, there are a number of cross cutting workstreams which have been identified and developed as part of the EBC approach:

Identification & Assessment of Frailty – working as a coordinated system to enable early identification of mild to moderate frailty and provide an anticipatory approach to aging well. A standard definition has been agreed, as has the widespread use of the Clinical Frailty Scale. Next steps include scale and spread with Primary Care Networks across Lancashire and South Cumbria.

Proactive Care Planning – aims to improve the quality of care and outcomes for frail individuals whilst promoting the efficient use of healthcare resources by standardising Proactive Care Planning across Lancashire and South Cumbria.

Co-Production – the focus for this work is on Co-developing the Pulmonary Rehabilitation Programme.

Frailty Measurement System – this group are working on the creation of a frailty dashboard for use across Lancashire and South Cumbria.

In addition to these cross cutting workstreams, work is also ongoing at place level to make improvements using the EBC methodology. For example within Central Lancashire, a team conducted a test of change within care homes. The aim was to provide comprehensive geriatric assessments (CGA) for residents, looking specifically at frailty indicators and subsequent interventions to reduce potential ED attendance. Current data tells us that a large proportion of ED attendances are from care home residents. The learning from this test of change enabled the team to consider another test that would support a larger cohort of the population, working across a Primary Care Network (PCN). The function of the proposed Enhanced Frailty Service is to assess and address patients' needs rapidly within a multidisciplinary structure. This is an integrated model working with our acute and community frailty colleagues and in collaboration with Primary Care colleagues to ensure that appropriate care provision is in place. This will allow a patient to remain in their preferred place of residence without the need for additional hospital referral or subsequent hospital admission.

Working with partners to address Health Inequalities

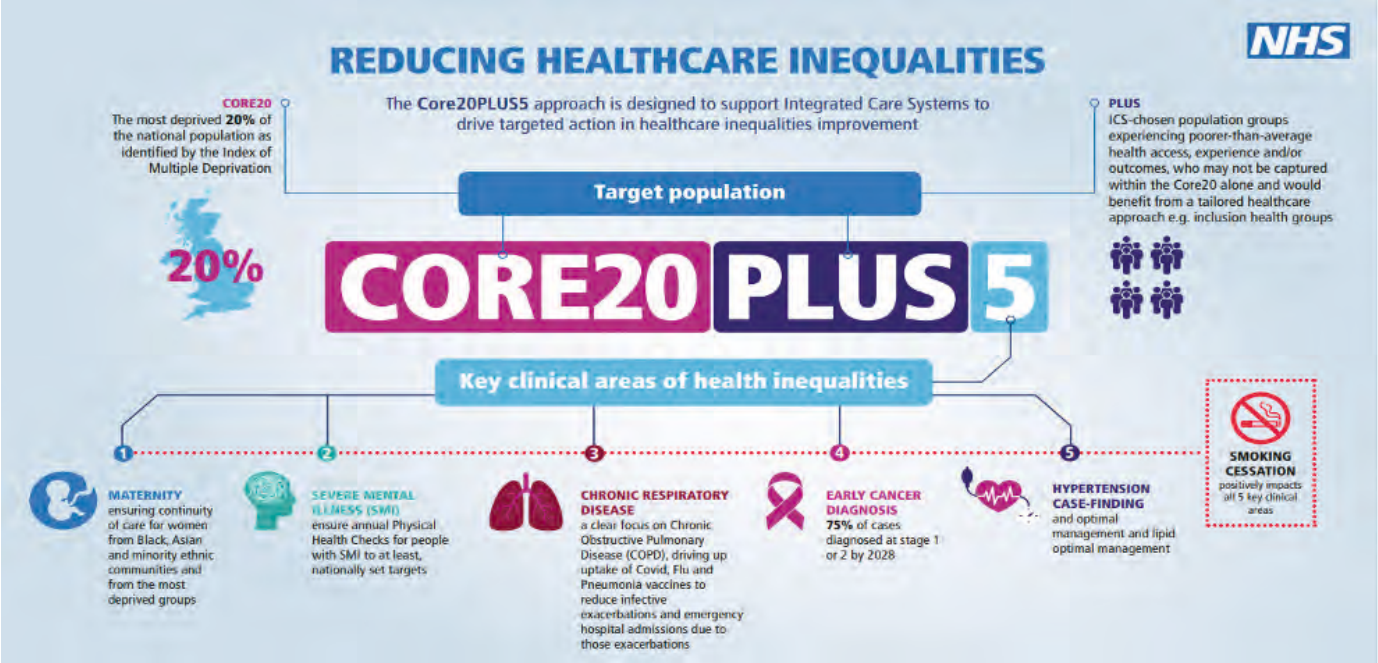
Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. The NHSE Core20PLUS5 framework is a national approach to inform action to reduce healthcare inequalities at both national and system level which is based on the theory of social determinants of health. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement, shown in the image overleaf.

The 'Core20' – the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

The 'PLUS' – plus population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups such as coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

The '5' – there are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

The Trust will use the NHSE Core20PLUS5 framework for adults, and children and young people as the scope and direction of work to focus on tackling health inequalities.



There are several LTH workstreams already underway with a specific focus on tackling health inequalities including, but not limited to:

Institute for Health Improvement (IHI) Accelerator Collaborative (NHS England) – Focus on early cancer diagnosis for one population in Preston. 'Inch wide, mile deep' methodology to deep dive root cause for one small population, focused engagement with patients and co create interventions around access and awareness.

Outpatient Did Not Attend (DNA)/Was Not Brought (WNB) Review (NHS England) – review of DNAs through health inequality lens. Targeted review of patients from high areas of deprivation and in the top 5 clinical domains to find root cause of DNA and ways the Trust can support patients to attend their appointments. Initial focus on paediatrics.

Muslim Girls School health awareness and education programme – Utilising existing and developing relationships with Imams and Alimas to create awareness of cervical cancer, HPV vaccine, breast health and maternal health.

Long wait harm review – Utilising waiting list data focused on Severe Mental Illness (SMI) and Learning Disability (LD), a harm review process has been designed to enable specialties to understand which patients on the waiting list have a SMI or LD leading to a proactive review of these patients. The progress with this is measured through the elective care Board and will be monitored through the governance dashboards.

Peer support in Emergency Department – Recognising the adverse experiences that may occur when a patient who uses drug and alcohol regularly, the ED team are working with Red Rose recovery to pilot a peer support worker in the ED that will specifically focus on providing peer support, establishing when health checks were last undertaken and signposting to health and social care services.

Continuity of Carer – The Continuity of Care teams currently provide care to all women who have diabetes, mental health, learning disability, declared domestic abuse, dug and alcohol and teenage pregnancy. The next stage of this work will be to expand this to focus on Black Asian and Minority Ethnic groups.

CURE smoking and alcohol screening and brief interventions – As part of the big plan, smoking and alcohol screening and interventions are monitored, ensuring teachable moments are acted upon during a hospital inpatient episode.

Special care dentistry – the service has developed generic resources (films and easy read information) and bespoke welcome meetings with patients who have a learning disability or autism to improve access to services. These continue to be well received by patients and families and lead to successful dental extractions alleviating patients of the pain they experience.

Audiology – the audiology team have developed easy read and access pathways for patients with learning disabilities to reduce the fear and anxiety associated with using the audiology services. The pre-appointment calls enable the service to understand if longer appointment times and adjustments are required to ensure patients are able to access the services.

Prisoner access to healthcare services – The Chief Operating Officer has commenced work with the prison service to understand how health inequalities relating to prisoner access can be reduced.

2) To offer a range of high quality specialised services to patients in Lancashire and South Cumbria

The Trust will continue to focus on ensuring the improved provision of high quality tertiary services over the course of the clinical services strategy. We will ensure that this provision is also efficient and patient centred. This includes continuing to provide our existing tertiary services, transforming care delivery within the provider collaborative framework, creation of new collaborations and networked services across our healthcare system. We will continue to provide the following tertiary services;

- Radiotherapy and Specialist Cancer Surgery
- Major Trauma
- Neurosciences
- Plastics & Burns
- Renal
- Specialist Mobility and Rehabilitation Centre
- Vascular
- Neonatal Intensive Care

Plans for a clearly identified and integrated Neurosciences Centre for Lancashire and South Cumbria (similar to those already established in Manchester and Liverpool) will be progressed to help improve recruitment, service co-ordination, pathway re-design and the profile of the Neuroscience specialties.

Significant improvements to Renal Medicine service provision are being implemented by locating provision in areas away from the LTH "hub" to support community provision and improved patient accessibility.

Plastic surgery capacity will be increased, as will the breadth of treatments to enable equitable access for patients in L&SC.

The Specialist Mobility and Rehabilitation Centre (SMRC) will continue to support national rehabilitation priorities and the military veterans programme.

The robotic programme has been sustained, and the specialties will continue to ensure that there is equitable access to these procedures by ensuring the national direction for increased robotic surgery is available locally Consideration will also be given to developments in the field of robotics and AI.

Working with colleagues within the ICB and Provider Collaborative a Clinical Services Collaborative has been established comprising of three main programmes/areas of work:

Reconfiguration – cross system networks working to design and implementing new models of care that are characterised by a single network of provision. These models will typically have teams working across organisational boundaries, with a cross site single leadership team, and are largely focused on meeting national mandated standards/ best practice. As a result they will deliver a more effective and efficient model of care. This is being undertaken in Vascular, Head and Neck cancer and Urology services.

Improvement – cross system specialty networks delivering pathway level improvement and tackling the issues identified as most prescient to them. This includes Stroke, MSK/T&O, Haematology, Dermatology, Ophthalmology and Frailty.

Fragile/unsustainable – providers have undertaken an assessment to highlight their most fragile services. Based on a consistent assessment matrix considering clinical standards/workforce/finance. The assessment has been used to agree which fragile services would benefit from taking a collaborative approach to agree action plans to address the underlying causes to ensure we have sustainable services in these specialties.

Other key collaborative clinical programs include:

Pathology collaboration – collaborative working is underway to drive partnership benefits across a range of areas including Laboratory Information Management systems, Digital Pathology, Workforce Strategy, Equipment Procurement and the development of a business case for a L&SC Pathology Laboratory utilising £31m national capital funding.

Radiotherapy operational delivery networks – we are working in collaboration with the Christie and Clatterbridge Cancer centres to achieve national recommendations as part of the North West Radiotherapy ODN.

Maternal medicine – the creation of a centre for L&SC at RPH and the development of the NW maternal medicine networ.k

Tertiary paediatric services – the provision of further specialist services for children and young people in L&SC to allow access to services more locally will be explored and advanced in conjunction with the well-established tertiary children's services in Manchester and Liverpool.

3) To drive health innovation through world class education, teaching & research

Our Education and Research Strategies support the delivery of the Clinical Strategy by ensuring we provide high quality education for our students and staff and we provide a wide range of accessible research and innovation projects. There is robust evidence that leading healthcare organisations that maximise recruitment of patients to clinical trials and other research studies deliver higher quality care. We will link into the ICB research and innovation forum and harness shared learnings to developing a research culture across clinical services to grow research activity, deliver innovative care pathways and develop our clinical academic workforce. When transforming pathways of care we will review best practice and the evidence base, to ensure that services maximise quality and outcomes.

Education

The primary objectives of our education strategy are:

- to deliver and support education and training for our current and future workforce at Lancashire Teaching Hospitals NHS Foundation Trust.
- to extend our education and training offer to healthcare staff locally, regionally, nationally and internationally.

The model focuses on the three key components to successful careers:

- **Getting in** – creating and inspiring opportunities and access to careers.
- **Getting on** – developing staff skills and competencies through excellent education and training.
- **Going further** – offering career-enhancing education opportunities that enable career progression.

Research & Innovation

Our vision is to be the highest recruiting and most innovative, patient and staff-focused Research & Innovation (R&I) collaborative in Lancashire and South Cumbria. Our research strategy has seven strategic aims which support the delivery of our Clinical Strategy:

Forge better links to our Local/partner Higher Educational Institutions and significantly increase clinical academic appointments at all levels in The Trust.

Continue build the **capability and capacity** within the Trust to lead and deliver high quality research and innovation and offer our patients greater access an enhanced experience and better care through access to research, clinical trials and via the Lancashire Clinical Research facility experimental medicine.

To rebuild a **sustainable and growth-focused** department

To increase our **presence and profile** in and out of The Trust including the ICS, widening public involvement and encouraging EDI.

Enhance the **commercial strategy** for R&I.

Develop an **Innovation and Digital strategy** for R&I that feed into The Trust's plans for commercialisation, that will forge a way for the inventors and entrepreneurs in The Trust to seek out opportunities for commercialisation, and likewise commercial entities such as SMEs to reach-in.

Complement and service the Trust's plans for **Continuous Improvement**.

4) Local Services: Integration, Place Based Care

This strategy recognises the importance of prevention and integrated service provision and will build integrated working at place and neighbourhood level within pathway developments. We will work together with partners to identify opportunities to transform clinical services and rethink how they are delivered across the system. By doing this we can make significant improvements and efficiencies in the way services are delivered over the next three years to benefit our communities. The ICB recognises that there are varied models, funding levels and providers across the ICB area and one of the key areas of transformation over the next three to five years will be to transform Primary, Community, and Intermediate Care services taking account of the learning from high performing areas within L&SC such as the integrated model at East Lancashire NHS Trust.

In May 2023, the Lancashire and Cumbria ICB announced its intention to undertake a transformation piece of work for services in Central Lancashire and establish a community services partnership board led by the Place lead but with key input from Lancashire Teaching Hospitals FT and Lancashire and South Cumbria FT to work towards vertically and horizontally integrated community services, by April 2024. Since this announcement, A Central locality Community Health Service Transformation Programme Board has been established to bring health partners together to drive the delivery of a joint Transformation Programme that focuses on supporting people to remain at home, through the provision of care in the community and 'community based, short term and crisis intervention' such as short-term episodic care, community based, integrated same day urgent care and step up and step down support. Central locality health partners recognise the need for a shift in focus from systems and pathways centred around hospitals to systems and pathways that focus on the needs of communities and the community services that can meet these needs. We also recognise that changes to current systems and working cannot be achieved by community health services working in isolation but require general practice, social care, hospital services and others to also work differently. As part of the Central Transformation Programme, LTH and LSCFT have been working closely together and with health and Place partners to take forward 2 key pieces of work to improve our services and change how we work together.

The first of the pieces of work has been the agreement of key transformation priorities to improve pathways and how we deliver services in a more integrated way. It is our aim to have delivered these priorities by the end of March 2024. Areas under focus include developing an Integrated Single Point of Access & Urgent Response Team, improving how our therapy teams work together to ensure we're delivering a joined-up service that makes the best use of our clinical teams and avoids duplication and improving access to phlebotomy services. The second of these pieces of work is looking at how our organisations develop an integrated operating model to provide community health services in a more joined up way, through a Provider Alliance. This work will support our pathway and service transformation through more formal partnership arrangements between LTH and LSCFT initially. As part of this work, we are looking to develop a joint Provider Board to oversee the community health services delivered by both LTH and LSCFT initially although we expect that this work could develop overtime to involve other health partners. It is our aim for the Provider Board and Provider Alliance to be in place by April 2024.

The Trust is also working to strengthen and develop relationships with Primary Care working with our partners in Primary Care Networks and with the Local Medical Committee and the Voice of Central Lancashire. A number of workstreams are underway including the following agreed in response to the NHS/DHSC document 'Delivery Plan for Recovering Access to Primary Care' (May 2023):

- Referral processes.
- Fit notes.
- Discharge summaries.
- Call and recall.
- Points of contact.

Other areas where joint work is underway with Primary Care where we will look to further develop in future include:

- Improved use of shared digital information, making the whole system simpler and easier to navigate for staff, patients, their families, and carers.
- Improved End of Life Care to reduce avoidable hospital admissions and ensuring excellent liaison across the acute, community and wider system teams.
- Closer work with voluntary sector organisations building on work already underway for example with Parkinson UK.
- Updating the Trusts clinical Directory of Services to help staff and potential users navigate the care system and more easily find the support they need.

- Shared pathway improvements building on for example the work underway in shared dementia care to deliver innovative, community-based, personalised care.
- Working together with community teams and GP practices to deliver the Fuller Report recommendations, which promote improved collaboration to maximise the capacity of local integrated neighbourhood teams.
- Considering the potential to expand the range of elective care services which can be delivered closer to people's homes in local GP practice's.

5) New Hospitals Programme

Lancashire & South Cumbria
New Hospitals
Programme

July 2021	Publication of our Case for Change
Sept 2021	Publication of the longlist of proposals
March 2022	Completion of analysis and engagement on longlist of proposals – publication of shortlist
Sept 2022	Publication of preferred options (new builds) and alternative options (partial rebuilds)
Oct 2022	Preferred options (new builds) and alternative options (partial rebuilds) submitted as part of national programme business case
Dec / Jan 2023	Business case reviewed by Government
May 2023	Secretary of State announcement – two new hospitals on new sites to replace Royal Lancaster Infirmary and Royal Preston Hospital

We have a once-in-a-generation opportunity to transform our region's hospitals through the New Hospitals Programme. By creating a network of brand new and refurbished facilities, we'll help local people live longer, healthier lives and we will also make Lancashire and South Cumbria a world-leading centre of excellence for hospital care. Our journey to date is summarised below:

Our new build will give us:

- State-of-the-art new build on a new site, providing major trauma and specialist services to the population of Lancashire and South Cumbria and acute hospital services to Central Lancashire.
- Increased capacity for specialist services (providing greater patient choice).
- Fully addresses the Case for Change, improves care for patients and the work environment for staff.
- Designed and built to the national Hospital 2.0 (centralised design and standardised approach, configurable to site and hospital needs).
- 70 to 100% single en-suite rooms, Net Zero Carbon, digitally-enabled.
- Significant system wide benefits.
- Maximises the wider socio-economic potential.
- Clinical, operational and cost efficiency benefits.
- Education, training, and research will be embedded as part of a networked Lancashire and South Cumbria model, maximising the campus style approach.

Further detailed work is underway to assess the viability of potential locations for our new hospital build and to develop the required business cases.

Implementing our Clinical Services Strategy

A robust implementation plan is in place for the delivery of our strategy.

Links to Other Strategies

The Trust is a clinical organisation and as such this Clinical Services Strategy is our key strategy and the foundation for our Big Plan. A range of other supporting or enabling strategies have been developed in the Trust, as shown in the summary below:

Planning

- **Benchmarking and learning from best practice**: The use of getting it right first time (GIRFT) visits and recommendations informs the strategy and vision of our Clinical Services Strategy and our specialty strategies. Systematic analysis of the model hospital opportunities allows further benchmarking and provides services with examples of organisations that are excelling in their delivery of highly efficient and good quality clinical care. Our strategy is to improve any services identified as outliers to the median and to ensure all services move towards best practice
- **Engagement on our proposed service changes**: The speciality level clinical strategies contain various service changes that are at a formative stage. These will require further development involving our patients, staff and wider stakeholders to co-design future services
- **Business case development**: A number of the proposals outlined in our Clinical Service Strategies will require a robust business case before proceeding to implementation and therefore in the event that the priorities cannot be funded, delivery will remain a risk
- **Delivery plan development**: The Trust Planning Framework and the Clinical Service Strategies outline the key actions and timelines required to deliver this strategy. Detailed specialty level strategies and delivery plans are in place , which are aligned to and inform the annual planning process.

Communications and engagement

A consistent and engaging narrative for our organisation: We have ensured that the clinical services strategy forms an integral part of the Communication and Engagement strategy. This will be the key enabler in promoting and engaging staff, patients, stakeholders and our local population with our clinical priorities.

Measuring Success

Successful delivery of our strategy, its successors and the system clinical strategies in the long-term will be measured against six key outcomes:

1 Improved health and wellbeing of our local population: measured by health outcomes such as life expectancy, mortality and morbidity and health inequalities between regions

2 Reduction in Health Inequalities

3 Improved outcomes for our patients: measured by clinical outcomes, safety and patient experience

4 Improved patient experience: measured by patient satisfaction and patient reported outcomes

5 A great place to work: measured by staff and trainee satisfaction, and our ability to recruit and retain our talented workforce

6 A financially sustainable system: measured by efficiency and productivity and the sustainability of Lancashire Teaching Hospitals NHS Foundation Trust and our partners in Central Lancashire and the ICB

Board of Directors Report

Social Value Strategy Update							
Report to:	Board of Directors			**Date:**	7th December 2023		
Report of:	Deputy Chief Executive			**Prepared by:**	T. Calvey		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☒		

Executive Summary:

The purpose of this report is to provide an update on the Trust's social value strategy, summarising progress to date with the social value accreditation quality mark and laying out our intended future actions.

Social Value accreditation is a key Trust aim and our commitment towards this as an Anchor Institution is outlined within Our Big Plan.

To gain accreditation as a Trust, we committed ourselves to carry out value-based actions and activities to help tackle health and socio-economic inequalities, making lives fairer with improved quality and inclusivity for our communities, businesses, patients, and workforce.

The Level One accreditation is valid until March 2024 and as part of the accreditation process a road map was developed, setting out how the Social Value Pledges (SVPs) and Key Value Indicators (KVIs) would be monitored and reported (Appendix 1).

The progress and performance of the SVPs and KVIs have been captured in a performance monitoring framework (PMF) (Appendix 2), which is updated subsequently following the quarterly monitoring meetings in preparation for the submission of the silver award (Formally Level 2) accreditation to the Social Value Quality Mark in April 2024.

The Silver award will be valid for a period of 24 -months, with the Trust having the options of progressing to Gold and ultimately Platinum awards which both are valid for 24 months respectively (Appendix 3).

The following recommendations are made:

- To note the progress to date

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions

To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

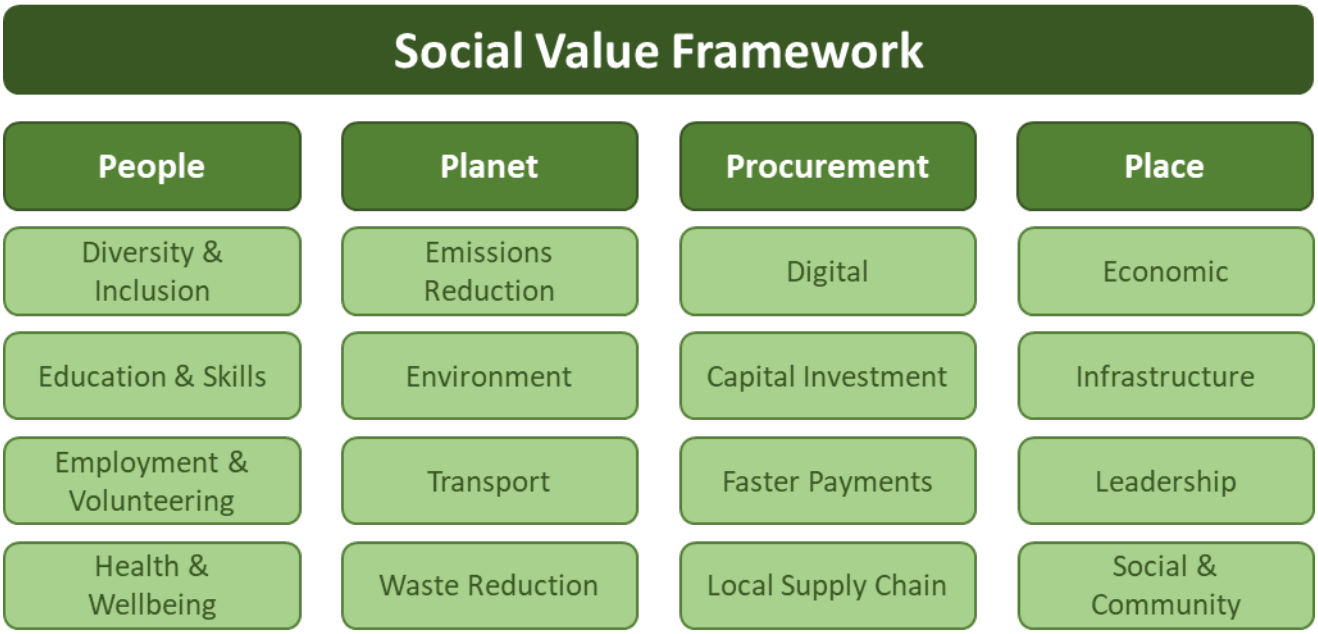
Previous consideration

Board Committee, 5th August 2021, approval of social value framework and approach
Board Committee, 6th October 2022, social value strategy update report

Background

1. The Trust's social value strategy outlined a framework with a focus on four lenses: People, Planet, Procurement and Place as demonstrated in figure one. This framework maps onto the social value themes defined in our level 1 social value accreditation. The mapping from our four lenses to the accreditation supports the Trust to describe the positive contributions that it makes within the local community and monitor progress towards delivering the levels of social value accreditation and implementation of the Trust's social value strategy.

Figure 1 - Social Value Framework



2. In March 2023 we were successful in being awarded the level 1 social value accreditation quality mark by the Social Value Quality Mark social enterprise. The work undertaken to achieve this status included the development of co-produced social value pledges (SVPs) and key value indicators (KVIs) across seven thematic domains which provide a collaborative and co-ordinated approach to social value action across the organisation.

3. We have made an organisational commitment to achieving social value silver accreditation status in April 2024. This accreditation is based upon building on the commitment made in level one and evidencing how the SVPs have been achieved through the selected KVIs. The following timeline outlines this commitment.

4. Over the course of this year, we have continually evaluated the KVIs to ensure these remain applicable in collating sufficient evidence for the purpose of advancing to the next level of accreditation.

5. A social value performance management framework has been developed to manage performance and develop social value action within the organisation (Appendix 2).

6. Since April 2023 quarterly social value monitoring meetings have been in place to provide oversight and assurance to the Anchor Institute Meeting (Steering Group).

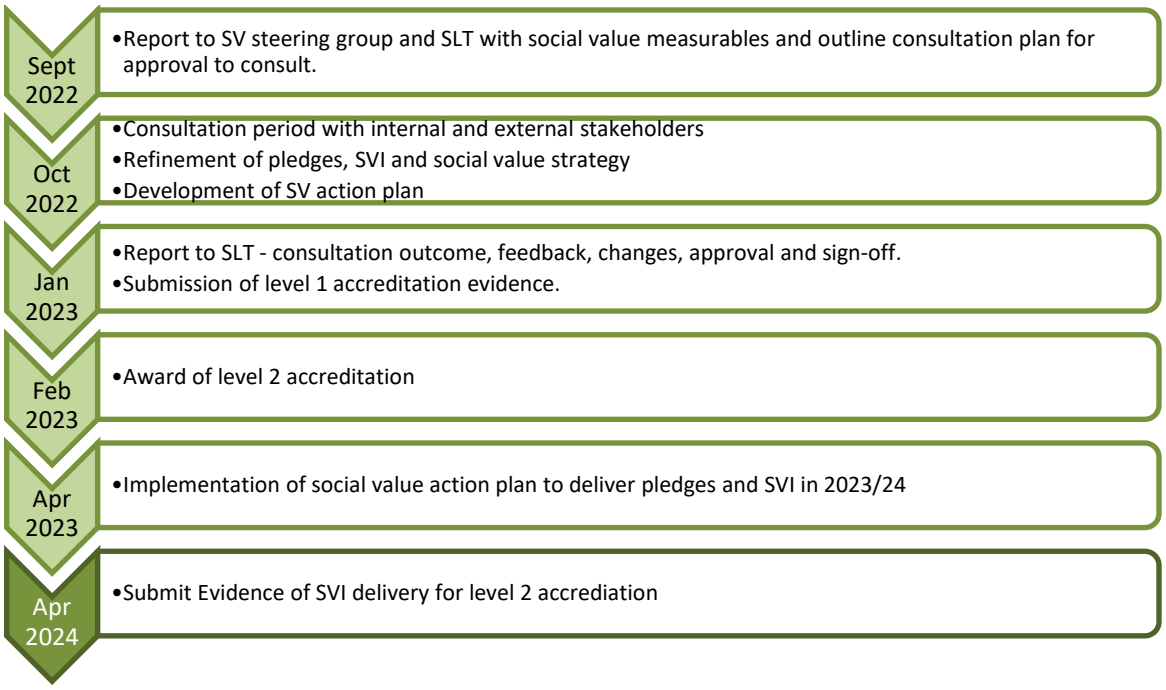
Discussion

7. Strong collaborative multi-agency relationships have been established across Lancashire to support more joined up thinking and progressive change that will be embedded and sustained within organisational practices and place-based approaches. A social value network is in development and each anchor institution has outlined a key set of pledges, with common themes of employment, local supply chains, volunteering, and waste reduction.

8. The Trusts social value strategy will continue to evolve and will be updated to reflect social value developments across Lancashire.

9. To continue momentum with this agenda and benefit the communities that we serve. The following timeline have been committed to.

Figure 2 - Accreditation Timeline



PEOPLE

Education and Skills

10. Good progress and lots of meaningful social value work is being carried out in this area. One annual target had been attained by Q1 and the remainder are all on track for end of year achievement.

Employment and Volunteering

11. Lots of exciting developments are underway to constantly improve recruitment approaches and programmes. The team are working with local partner organisations to raise the possibility of our vacancies and improve the accessibility of employment and volunteering. All KVIs were achieved by the end of Q1.

Health and Wellbeing

12. All KVIs are progressing to plan. Health and wellbeing campaigns and promotions are well underway. Two targets were achieved by the end of Q1, with the remaining being achieved by Q2.

PLANET

Environmental

13. Good progress is being made overall. The completion of the migration to one drive will conclude a further KVI.

PROCUREMENT

Economic and Procurement

14. Procurement systems and processes are in place to support social value requirements and work is underway to identify opportunities for local businesses.

PLACE

Leadership

15. Social value is now recognised and embedded as a strategic priority and has also been integrated within leadership frameworks to drive social value action throughout the organisation. Work is ongoing to blend social value within the organisational culture so that it becomes a reality and integral part of business activities.

Social and Community

16. Community and charity continue to develop and make good progress with their KVIs.

Financial implications

17. None, social value reform will be developed and embedded within current system resourcing.

Legal implications

18. None

Risks

19. None

Impact on stakeholders

20. Improved social value change and outcomes for internal and external stakeholders.

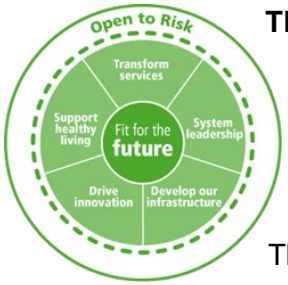
Recommendations

21. The following recommendations are made:

- To note the progress date.

Appendix 1 – Social Value Level 1 Accreditation Road Map

Mission Statement: Lancashire Teaching Hospitals will carry out value-based actions and activities to help tackle health and socio-economic inequalities, making lives fairer with improved quality and inclusivity for our communities, businesses, patients, and workforce.



Theme Selection: The pledge themes selected were identified to align with our strategic ambitions, especially those within the "Fit for the Future". This ambition encompasses the supporting healthy living agenda and social value. The themes selected compliments current service provision in delivering excellent care with compassion to our patients and supporting the workforce as a conscientious employer.

Themes selected for Social Value Pledges and Key Value Indicators development were:

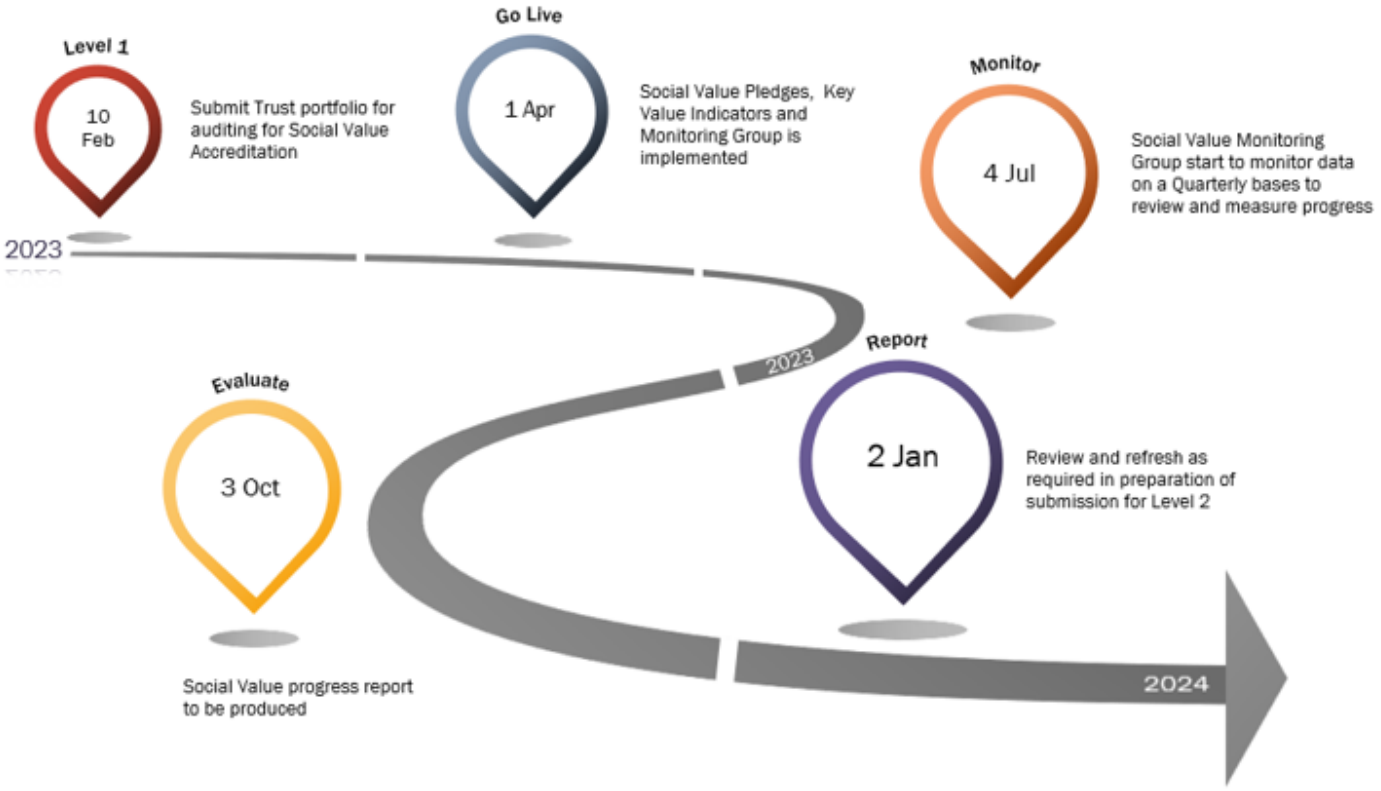
1. Economic and Procurement
2. Education and Skills
3. Employment and Volunteering
4. Environmental
5. Health and Wellbeing
6. Leadership
7. Social and Community

Pledge and Indicator Development: Each theme has a designated lead who is responsible in overseeing the delivery of their pledge. Each pledge has been developed using SMART principles consulting with internal and external stakeholders. Feedback from the consultation has influenced our final social value pledges and key value indicators, as we have listened to our local communities and stakeholders.

Monitoring: The Trust will monitor and demonstrate our commitment to delivering social value through embedding tools for monitoring, measuring, and reporting on social value outcomes through the social value monitoring group, as part of our organisational processes.

Reporting: The Trust will communicate our social value outcomes internally and externally, ensuring meaningful engagement with our local communities and stakeholders. A bi-annual social value board report will be produced to underpin our social value commitments and verification of further social value accreditation.

Level 2 Road Map



Task	Responsible	Accountable	Consulted	Informed
Implementation of SVPs and KVIs across the Trust	Pledge Leads	Social Value Working Group	Monitoring Group	Social Value Anchor Group
Monitoring of SVPs and KVIs - Quarterly meetings	Social Value Lead	Monitoring Group	Social Value Anchor Group	
Updating of SVPs and KVIs progress data collection	Monitoring Group / Planning officer	Social Value Lead	Social Value Anchor Group	
Bi-annual Social Value Board report	Social Value Lead	Social Value Anchor Group	Senior Leadership Team	Senior Leadership Team
Evaluate impact and relevance of SVPs and KVIs going forward for the next 12 months	Monitoring Group	Social Value Lead	Social Value Anchor Group	
SVPs and KVIs report preparation for Level 2 accreditation	Social Value Lead	Monitoring Group	Social Value Anchor Group	Senior Leadership Team
Final Social Value Report April 2023 – March 2024	Social Value Lead	Monitoring Group	Social Value Anchor Group	Senior Leadership Team
Submit for Social Value Level 2 – accreditation.	Social Value Lead	Social Value Anchor Group		

Task	Responsible	Accountable	Consulted	Informed
Feedback from Level 2 accreditation audit from SVQM	Social Value Lead	Monitoring Group	Social Value Anchor Group	
Continuation of monitoring and review of SVPs & KVIs as set out above for Level 3 – Evaluate accreditation 2026	Monitoring Group	Social Vale Lead	Social Value Anchor Group	Senior Leadership Team

Appendix 2: Social Value Pledges and Key Value Indicators- performance monitoring framework (PMF)

Pledge	Lead	Key Value Indicator (1 April 2023 - 31 March 2024)	2023/24 Target/RAG	Quarterly target	YTD actual	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Comments / Evidence
Economic & Procurement	**Kevin Fletcher**									
We will deliver value for money by working with local communities for maximising economic opportunities to buy locally to procure good and services.		1. Deliver at least 4 Net Zero carbon NHS Green Plan supporting projects at the Trust per annum.	4	1	0	0	Data still being collated			Working with NHS Supply Chain and Clinicians on Value Based Procurement projects and other initiatives
		2, Increase expenditure with local suppliers by 5% per annum each year from FY 2020/21 baseline.	Put £ figure (TBC)	tbc	tbc	tbc	Data still being collated			Rationale for local suppliers to be confirmed and incorporated in Q2
		3.Increase the number of business/tender opportunities at the Trust for local, SME and VCFSE by 5% each year. These opportunities may be direct (Trust's own procurement) or indirect (sub-contract opportunities via the Trust's contractors).	>12	3.25	0	0	Data still being collated			Advertising Dynamic Purchasing System to support tender opportunities/give visibility to local, SME, VCFSE companies. Planned to be advertised Q2

		4. Increase the number of procurements incorporating Net Zero and Social Value evaluation criteria each year.	>12	3.25	3	3	Data still being collated			EPR/Laundry/Beds tendered in the first quarter with inclusion of social value. New Zero
		5. Report each year the social value benefits delivered through Trust contracts.	Annual qualitative report	n/a	n/a		Data still being collated			Captured through the Award reports and via the Sustainability Impact Assessment section.
		6. Attend at least 3 Meet the Buyer or similar supplier forums each year.	3	0.75	0	0	Data still being collated			Working regionally from on a horizontal and vertical approach to support Meet the Buyer events. Last financial year attended 4 events.
		7. Deliver at least 4 Net Zero & Social Value training sessions for Procurement staff and key Trust	4	1	0	0	Data still being collated			Program to be developed

		stakeholders each year.								
Education & Skills	**Lauren O'Brien & Jacqueline Higham**									
Working in collaboration with local stakeholders, we offer excellence in education, training, development, and support into employment for our staff and local communities, enabling a workforce that is fit for the future.		1. Invest in 60 local people to develop employability skills to support them into employment.	60	15	35	35 delivered	15 planned	15 planned	15 planned	17 candidates who were almost employment ready but lacked qualifications have been supported with numeracy and literacy skills - now in job roles 11 candidates have successfully completed an 8 week pre employment programme delivered by LTH - now in job roles 7 candidates joined our restart programme delivered in partnership with the Growth

										company over 4 weeks - now in job roles
		2. Deliver 10 careers activities/events targeted towards local communities to promote the range of careers in healthcare.	10	2.5	7	7 careers events/activities delivered externally at schools/colleges	4 further invites received and booked to attend			7 events have been attended by WP team at schools, colleges and other organisations. Activities have included promoting NHS careers, delivering curriculum support sessions in the classroom, interview skills, pathway choices advice sessions etc
		3. Offer 100 work experience opportunities to people who aspire to a career within the NHS.	100	25	44	91 applications received in Q1 44 of which have placements so far	Next application window opens in Sept		Application window opens in Jan 24	Work experience application windows open in Jan, May, Sept and Nov each year. Applications are

										submitted via a central ICB platform. LTH received the highest number of WE applications of all NHS trusts within our ICB.
		4. Deliver 4 programmes that provide learners who have additional learning needs and/or disabilities with 'world of work' knowledge.	4	1	0		Sept - 2 programmes due to start, 1 at each site		Jan- 2 programmes due to start, 1 at each site	2 x 6 week programmes are delivered at each site starting in September and January totalling 4 programmes. Between 10 and 16 students attend each programme.
		5. Offer 4 Year 12 career events per annum.	4	1	1	1 x yr. 12 targeted event with Runshaw college	Data still being collated	2 x yr. 12 targeted events planned	2 x yr. 12 targeted events planned	
		6. Offer a minimum of 10 additional places on apprenticeship programmes delivered by LTH for internal staff.	>/ 10	2.5	20	Additional cohort of 20 places added to senior healthcare apprenticeship	Data still being collated			

		7.Increase our true apprenticeship offer for external candidates by 10%	2	0.5		Last year 16 new apprentices on an apprentices salary were recruited into LTH. This Q1 5 have been approved for advertising so far	Data still being collated			
Employment & Volunteering	**Stefanie Johnson**									
We will work with local partner organisations to raise the visibility of our vacancies and improve the accessibility for hard-to-reach groups into employment, volunteering, or work experience opportunities.		1.Identify, engage, and work with at least three more partner organisations in addition to continued, established partners. Creating the space to share ideas, resources, improve accessibility and receive candidate feedback.	3	0.75	1	1	2			Partners meeting booked for 19.10.23 with great commitment to attend from all local Job Centres, local Councils, third sector partner organisations. New partners have been invited to attend and participate.
		2. Support 10 people to overcome barriers to work.	10	2.5	11	11	11			We continue to have very much an outward looking community

										engagement approach to recruitment for entry level roles. We have recently purchased promotional merchandise from some external; funding we received which has enabled us to present a much more professional image. This was used for the first time w/c 25.9.23 when we attended two external recruitment fairs.
		3. Support 10 people into volunteering or work experience at the Trust.	10	2.5	0	0	5			New Volunteers intranet page live and communicated to all recruiting managers in the organisation on several occasions - outlines new role profiles and sets out the

										approach to recruiting more volunteers. Hospital Guides voluntary role being widely advertised and seeks to recruit a good number of new volunteers. Volunteers to Careers paper drafted which sets out a new approach to recruiting volunteers and how we will guarantee interviews etc. Not yet launched but being discussed and finalised. Currently recruiting new Volunteer Manager with a focus on community engagement and inclusivity as key parts of the role.

		4. Create and deliver two pre-employment programmes in addition to the ones already planned.	2	1	0	0				Ongoing discussions with colleagues in Widening Participation to look at local supply and demand. Escalated issues to Associate Director of Workforce around lack of manager engagement with the approaches we are co-designing. Asked to establish a Recruitment Strategy group where these types of approaches can be formally signed off and communicated.
Environmental	**Stephen Dobson & Cliff Howle**									

We will improve environmental sustainability, focusing on reducing carbon emissions and improving health outcomes for our local communities.		1. We will reduce carbon emissions by embedding and increasing agile working practices.	Maintain 700 remote workers everyday	700	700	700	Data still being collated			
		2. We will reduce carbon emissions by increasing virtual/tele consultations to 25% of all outpatient clinics.	25%	6.25%	25%	25%	Data still being collated			
		3. We will reduce carbon emissions by maintaining high levels of MS teams meetings.	>/ 1000hours per day of meetings on MS teams	1000hours per day	Maintain ed	Maintaine d	Data still being collated			
		4. We will reduce paper usage by 5%	5.00%	1.25%	5%	5%	Data still being collated			
		5. Increase the usage of one drive	Increase usage of one drive and SharePoint 0.5 million files to 100 million files	25 million files	0.5 million files	0.5 million files	Data still being collated			
Health & Wellbeing	**Rachael O'Brien & Lindsay Wharrie**									

We will engage with local partners and organisations to address health, social and lifestyle issues and support our workforce to improve their physical and mental health.		1. Deliver a range of health and wellbeing campaigns (at least 2) aimed at addressing health inequalities within the workforce.	>/ 2	0.5	1	1	Data still being collated			Created 'supporting wellbeing during Ramadan' information, shared via health and wellbeing newsletter, created an intranet page, with 180 visits from March-May 2023. Arranged for promotion of psychological wellbeing service on prayer room screens during Ramadan.
		2. Offer 10 Mental Health training course places per year to local people, e.g., community groups, patient experience groups.	10	2.5	10	10	9			Health and Wellbeing Lead has completed instructor training to enable local delivery of NHS national wellbeing conversation training and RPSH Making Every Contact Count training. Offered three free of charge

										courses to Wellfest members throughout 2023, including Making Every Contact Count, Menopause Awareness and Introduction to CBT Skills. Also offered a small number of unfilled places for Sage & Thyme Communication Skills course. 9 Wellfest member delegates attended free menopause awareness training delivered by LTH.
		3. Engage and work with at least 2 external/partner organisations to offer improved access to support for health and wellbeing issue.	>/ 2	0.5	2	2	1			Joined Wellfest network, led by LCC, attended two network meetings and committed to supporting task and finish group for world mental health day

										community event. Connected with Let's Grow Preston, site visit completed and a range of potential collaborative activities identified, will pursue via sustainability plan. Promoted Sahara in Preston community voluntary organisation, promoted SafeNet external organisation offering support to those affected by domestic abuse, met with HSBC explored possible financial wellbeing support and advice services for colleagues and on-site pop up advice stands offering

										free, no obligation household bills assessments. Attended Wellfest event for World Mental Health Day, engaged with 100 people from local community areas. Engaged with FIT FANS local commissioned weight management service, offered free weight management programme at Chorley Hospital
		4. Launch a policy enabling colleagues to access paid time to perform volunteer roles.	Policy in place	n/a			Data still being collated			Meeting arranged with Sam Kenny (OD Programmes) to explore.
Leadership	**Jonathan Wood & Louisa Graham**									
Developing an organisational culture that is consciously inclusive through		1. To develop and agree the Lancashire Teaching Hospitals Social Value Strategy	Social value strategy approved	n/a	n/a	Draft produced to be approved	Data still being collated			

compassionate, engaging leadership and effective, fair management practices.										
		2. Increased representation of ethnic minority colleagues and colleagues who have a disability/long term condition in senior roles as benchmarked against the 2022 WRES and WDES submission.	>baseline figure	annual metric	Achieved and exceeding model trajectories	Achieved and exceeding model trajectories	Data still being collated			
		3. To ensure there is no adverse impact for ethnic minority or disabled candidates in the recruitment process (likelihood of appointment from shortlisting) by achieving a disparity ratio of between 0.8 – 1.2 as measured through WRES and WDES submission.	Disparity ratio of between 0.8 – 1.2	annual metric	1.34	Red WRES 1.34	Data still being collated			
			Disparity ratio of between 0.8 – 1.2	annual metric	1.13	Green WDES 1.13	Data still being collated			
		4. To see a reduction in the percentage of ethnic minority and disabled colleagues experiencing bullying	Disparity ratio of between 0.8 – 1.2.	annual metric	0.81	Green for WRES no adverse impact 0.81	Data still being collated			

		and harassment of abuse from the public as measured in the WRES and WDES submission by achieving a disparity ratio of between 0.8 – 1.2.	Disparity ratio of between 0.8 – 1.2.	annual metric	1.46	Improved since 22, however still adverse impact for WDES 1.46	Data still being collated			
		5. To see a reduction in the percentage of ethnic minority and disabled colleagues experiencing bullying and harassment of abuse from colleagues as measured in the WRES and WDES submission by achieving a disparity ratio of between 0.8 – 1.2.	Disparity ratio of between 0.8 – 1.2.	annual metric	1.08	Green for WRES no adverse impact 1.08	Data still being collated			
			Disparity ratio of between 0.8 – 1.2.	annual metric	1.57	Improved since 22, however still adverse impact for WDES 1.57	Data still being collated			
		6. To see a reduction in the percentage of ethnic minority and disabled colleagues experiencing bullying and harassment of abuse from managers as measured in the WRES and WDES submission by achieving a disparity	Disparity ratio of between 0.8 – 1.2.	annual metric	1.98	This isn't measured in WRES it is discrimination from managers, which shows adverse impact 1.98	Data still being collated			

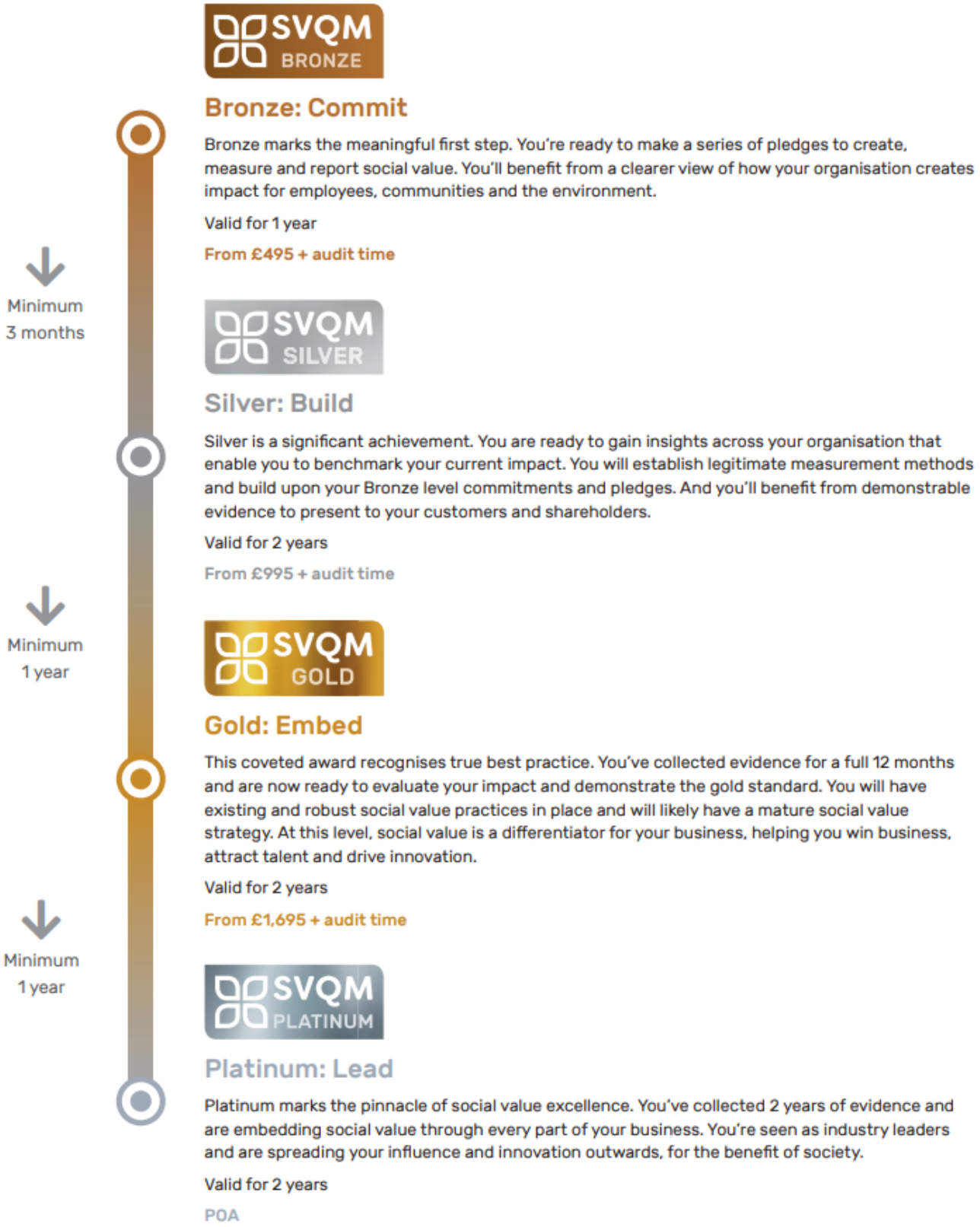
		ratio of between 0.8 – 1.2.	Disparity ratio of between 0.8 – 1.2.	annual metric	1.91	Improved since 22, however still adverse impact for WDES 1.91	Data still being collated			
		7. In the annual cultural values assessment to see an increase in the proportion of values which colleagues use to describe the current culture reflective of the aims of the social value strategy (i.e., values such as compassion, inclusive, equality, involvement, inclusiveness, integrity, making a difference	Increase from 2022/23 figure - put figure here	annual metric	n/a	Current top 5 values are cost reduction, hierarchy, bureaucracy, continuous improvement and confusion	People desire a culture which has the following 5 values - continuous improvement, accountability, compassion, home/work balance and teamwork			
Social & Community	**Daniel Hill**									

We will add value to patient care through working in partnership with local organisations, communities, and the public we serve.		1. We will work with 3 non profit organisations to enhance patient care and outcomes	3	0.75	3	Through NHSCT stage 2 funding agreement working with 3 local non profit organisation to enhance patient care and outcomes	Ongoing			Ongoing partnership with 3 external Not for Profit organisations. St Catherines Hospice, EFL Trust & Spring North
		2. We will fund 2 research projects to support Lancashire Teaching Hospitals ambition to be fit for the future through funding clinical excellence	2	n/a	0	2 research applications under consideration for funding via RCF & BB at LTHTR	2 projects approved for funding. 3 awaiting consideration			2 research based projects have been agreed at LTHTR (1 in partnership with Lancaster University). Potentially 3 more to be agreed over coming months
		3. We will fund 5 innovation projects to support Lancashire Teaching Hospitals ambition to be fit for the future through funding clinical excellence	5	1.25	ongoing	Ongoing	Ongoing			4 innovative projects either completed or had funding agreed in Q1/Q2. (Lung Vision, Complementary Therapy treatments for

										Oncology patients, SPYPHI Extracorporeal Imager & Vectra H2 3D Camera)
		4. We will reduce social isolation through offering charity volunteering opportunities		n/a	ongoing	Ongoing drive to recruit new volunteers whilst supporting existing ones via BB Ltd & RCF Coffee Shop	Ongoing			Ongoing volunteer recruitment for charity services including RCF Coffee Shop and BB Shop
		5. We will develop community engagement opportunities through working with local groups and organisations.		n/a	ongoing	Ongoing work with local community groups and organisations via LTHC, RCF & BB	Ongoing			Ongoing work with community groups and organisations via Charity Events, Third Party fundraising activities and charity engagement opportunities
		6. We will seek patient feedback on the difference we make through the projects we fund.	Impact reporting on funding	n/a	ongoing	Ongoing	Ongoing			Patient feedback/case studies constantly sought to support positive

										impact stories on charity funding

Appendix 3: Duration and costing of Social Value Accreditations



Taken from https://socialvaluequalitymark.com/wp-content/uploads/2023/07/SVQM-Accreditation-pack.pdf

November 2023

Chair's Report

Committee:	Safety and Quality Committee
Chairperson and role:	Kate Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	29 September 2023 and 27 October 2023
Purpose of report:	To update the Board on the business discussed by the Safety and Quality Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

29 September 2023

Following the meeting held on the 29 September 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department); maternity; and neonatal and children and young people services.
- CQC Update Report.
- National Picker Adult and Urgent & Emergency Care Survey 2022.
- Patient Safety Investigation Response Framework Implementation Plan.
- The Quarterly Equality Impact Assessment Report.

27 October 2023

Following the meeting held on the 27 October 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department and Finney House) maternity; and neonatal and children and young people services.
- Bi-annual Safe Staffing Adult and Maternity Report.
- Always Safety First Strategy 2021-24.
- Central Alert System Assurance Report.
- Changes to Fire Safety Legislation.

Items for the Board's attention	
The Committee were provided with an update on the implementation of the Patient Safety Incident Response Framework (PSIRF). It was explained that the Patient Safety Incident Response Framework (PSIRF) was a key component of the new National Patient Safety Strategy and would replace the NHS Serious Incident Framework. The Committee confirmed its assurance in respect of the actions taken to commence the transition from the Serious Incident Framework to PSIRF from 6 November 2023 and resolved to monitor the implementation of PSIRF, through the receipt of regular update reports. The National Picker Adult and Urgent and Emergency Care Survey 2022 provided an update of the results of patients attending the Royal Preston Hospital (Adult inpatient and Emergency Department|) and Chorley District General Hospital (Adult inpatient). The Urgent and Emergency Care Survey is undertaken every 2 years and the previous survey had been undertaken in 2020. The report demonstrated comparisons between the data from 2020 and 2022 and outlined the focus of the subsequent action plan to respond to the survey results. The purpose of the survey was to understand what patients thought of the care they had received within a Type 1 department. The results demonstrated an improved position for the Emergency Department compared to the last National Picker survey in 2022. The Trust was ranked 18th out of 62 trusts nationally compared to the 2020 survey, when the Trust was ranked 34th out of 66 Trusts surveyed.	The findings of the Lancashire Teaching Hospitals bi-annual maternity staffing review were presented to the Committee. The report triangulated workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels. The funding of this is yet to be identified. A biannual update was presented for the progress made against the Always Safety First strategy (2021-2024) deliverables, at the end of year 2. The Committee confirmed its assurance in respect of the strategy action plan, the monthly Always Safety First Committee escalation report and to receive an annual update in 12 months' time.
Positive escalation	
29 September 2023	**27 October 2023**
- The Committee recognised the high audit compliance in cleaning standards and was informed that learnings from peers had led to a change in the routine use of sporicidal products that aimed to reduce the sporicidal burden on the environment. - Maternity services received positive feedback from the National and Regional Maternity NHSE visit on the 13 September 2023. - National Picker Survey results demonstrated an improved position for the Emergency Department compared to the last National Picker survey in	- The annual update of the Always Safety First Strategy was presented to the Committee. The scale of work undertaken in the strategy that was demonstrated in the improvements for the Trust was recognised. The 3-year plan was launched in September 2021 and actions that had not been a priority throughout year 2 would move forwards in year 3. The Always Safety First Committee would continue to oversee the progress of the strategy throughout year 3. - The overall adult inpatient ward staffing fill rate was 99%. The Chief Nursing Officers safe staffing

2022. The Trust was ranked 18th out of 62 trusts nationally compared to the 2020 survey, when the Trust was ranked 34th out of 66 Trusts surveyed. - The overall staffing fill rate for adult inpatient wards in August was exceeded 98%.	recommendations were not yet reflected in the target levels as not funded and this presents an ongoing risk. - Staff had made progress with focus on listening to patients with additional needs. There had been positive progress in increased awareness and training for managing reasonable adjustments for patients with protected characteristics.
Negative escalation	
29 September 2023	**27 October 2023**
- The Clostridium Difficile Infection rates continued to exceed the trajectory and continued to fluctuate. There was weekly Executive oversight of the action plans, sharing best practice learning from peers and working collaboratively with the estates team reviewing cleaning standards and new products were being tested. - The Pressure ulcers rate per 1000 bed days. The Trust agreed overarching pressure ulcer action plan was in place with agreement from all divisions and governance teams. There had been some areas that were demonstrating improvements, seen for a small number of clinical areas. These improvements were being monitored for sustainability.	- The Clostridium Difficile Infection rates continued to exceed the trajectory. There was weekly Executive oversight of the action plans, sharing best practice learning from peers and working collaboratively with the multidisciplinary team. The areas of focus include ethe roll out of the national cleaning standards, change in sporicidal cleaning agent, reduction in patient movement around the hospital, bed and mattress cleaning and integrity. The IPC BAF will be presented to Board in December as part of the BAF. - The Emergency Department at Royal Preston Hospital had high occupancy levels leading to longer waiting times for patients and delays in receiving patients from ambulances. The number of patients waiting longer than 12 hours was highlighted as an area that was not showing the required improvement. The committee had requested a more detailed review of the impact of this on patients. The Urgent and Emergency care strategy outlined the actions being taken to address increasing occupancy levels. - During September there had been an increase in additional patients on wards outside of allocated bed spaces. The data is now being monitored and reported through to the Strategic Operations Group and will feature on both the safety and quality and finance and performance dashboards in future to ensure oversight.
Committee to Committee referral	
29 September 2023	**27 October 2023**
A referral to the Workforce Committee to bring divisional leadership teams closer to the Board in meeting the aims and objectives of the organisation, particularly with regard to VFM and delivery of CIP.	No referrals.

Items recommended to the Board for approval	
29 September 2023	**27 October 2023**
Patient Safety Investigation Response Framework (PSIRF): Implementation Plan and Policy.	None
Committee Chairs reports received	
29 September 2023	**27 October 2023**
(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement	(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Safety and Learning Group (e) Medicines Governance Committee (f) Patient Experience and Involvement (g) Mortality and End of Life (h) Health and Safety Governance (i) Health inequalities group
Items where assurance was provided and/or for information	
29 September 2023	**27 October 2023**
The Committee was provided with an update on the risks aligned to the Committee following the development and refinement of the strategic risk register that informed the Board Assurance Framework. There remained three escalated risks to Board, these were the impact of exit block on patient safety, elective restoration and probability of ongoing strike action. The Committee was assured of the mitigating actions that were in place. The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for improvement. The Neonatal and Children and Young People report provided a monthly overview of the services staffing and assurance that safe staffing was being deployed. Assurance was provided that any risks were being appropriately mitigated. An update was provided on the progress against the 2023 Quality Improvement Plan (QIP). The plan combined the recommendations from the 2022 CQC inspection of Urgent and Emergency Services and Medical Care at Royal Preston Hospital. It included three recommendations from the 2018/2019 inspection that were carried forward from the previous QIP as per the recommendation to Safety and Quality	The Central Alert System Assurance report was presented and provided the Committee with assurance in respect of the actions being taken to address gaps in the timely management of the safety alerts. The Neonatal and Children and Young People report provided a monthly overview of the services staffing and assurance that safe staffing was being deployed. Assurance was provided that any risks were being appropriately mitigated. Following the recent changes to fire safety legislation, the Committee confirmed its assurance in respect of the Trust being fully compliant with the updated Fire Safety Regulations. The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for improvement.

Committee in March 2023. Also included was an update on the improvement plan for Finney House following an inspection by the CQC on 14 June 2022 whilst the service was under L&M Healthcare and an update on associated regulatory matters. The Committee confirmed its assurance in respect of progress of the QIP, Finney House Improvement Plan and the governance arrangements to respond to regulatory matters.	
Progress against the Committee's cycle of business	
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 24 November 2023 using Microsoft Teams.	

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Safety and Quality Committee agenda (29 September 2023)

Appendix 2 – Safety and Quality Committee agenda (27 October 2023)

Safety and Quality Committee

29 Sept 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 25 August 2023	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Safe Staffing Report	12.50pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.00pm	✓	Assurance	E Ashton
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	CQC Update Report	1.20pm	✓	Assurance	H Ugradar
7.5	National Picker Adult and Urgent & Emergency Care Survey 2022	1.40pm	✓	Assurance	J Howles
8.	GOVERNANCE AND COMPLIANCE				
8.1	Patient Safety Investigation Response Framework Implementation Plan	1.50pm	✓	Decision	S Cullen
8.2	Strategic risk register review	2.10pm	✓	Decision	K Smyth
8.3	Items for referral to the Board or to/from other Committees	2.15pm	Verbal	Information	K Smyth
8.4	Reflections on the meeting and adherence to the Board Compact	2.20pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	Equality Impact Assessment Report		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) Always Safety First Committee d) Medicines Governance Committee e) Safety and Learning Group f) Patient Experience and Involvement g) Health Inequalities Group – stood down		✓		
9.4	Date, time and venue of next meeting: *27 October 2023, 12.30pm, Microsoft Teams*	2.30pm	Verbal	Information	K Smyth

Safety and Quality Committee

27 October 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 29 September 2023	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Safe Staffing Report	12.50pm	✓	Assurance	C Gregory
7.2	Bi-annual Maternity Safe Staffing Report	1.00pm	✓	Decision	S Cullen
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	Always Safety First Strategy 2021-24	1.20pm	✓	Assurance	C Gregory
8.	GOVERNANCE AND COMPLIANCE				
8.1	Central Alert System Assurance Report	1.30pm	✓	Assurance	S Regan
8.2	Changes to Fire Safety Legislation	1.40pm	✓	Assurance	C Howell
8.3	Strategic risk register review	1.50pm	✓	Decision	K Smyth
8.4	Items for referral to the Board or to/from other Committees	2.00pm	Verbal	Information	K Smyth
8.5	Reflections on the meeting and adherence to the Board Compact	2.10pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) Always Safety First Committee d) Medicines Governance Committee e) Safety and Learning Group f) Patient Experience and Involvement g) Health Inequalities Group h) Mortality and End of Life Care Committee i) Health and Safety Governance		✓		
9.3	Date, time and venue of next meeting: *24 November 2023, 12.30pm, Microsoft Teams*	2.20pm	Verbal	Information	K Smyth

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Update					
Report to:	Board of Directors	**Date:**	7th December 2023		
Report of:	Chief Nursing Officer Divisional Midwifery and Nursing Director	**Prepared by:**	Jo Lambert		
Part I	✓	**Part II**			
Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Board of Directors with assurance on the safety and quality programmes of work within the maternity and neonatal services up until and including the 15th November 2023. NHS Resolution is operating in year 5 of the Maternity Incentive Scheme (MIS) and this report details progress against work relating to the ten safety actions of the Clinical Negligence Scheme for Trusts (CNST) and other high level service updates.

The service has remained on track with all the requirements set out in the year 4 incentive scheme MIS and continues to make progress against the additional actions required to ensure that the service is able to declare compliance with the Year 5 MIS. The service is currently 90% (9/10) compliant with the year 5 CNST safety actions with Standard 6 (SBLV3) currently at risk due to the additional safety actions needed to achieve these standards and is reliant on approval of funding for essential equipment which has been requested from the previous year's 2023 CNST rebate. However, if this is not agreed the service will be unable to declare compliance with SBLV3 and consequently with all ten CNST safety actions. This is currently being considered by the Chief Financial Officer.

The Board should note the Maternity and Neonatal Voices Partnership (MNVP) workplan has been jointly approved and is included in Appendix 6 for information and approval prior to being shared with the Integrated Care Board (ICB).

The Maternity Incentive Scheme (MIS) Collaborative Advisory Group (CAG) met on 11 October 2023 to discuss and consider the feedback from Trusts in relation to the current pressures being experienced because of ongoing industrial action, and the impact this is having on Trusts' ability to meet the MIS safety action 8. In recognition of industrial action, a lower target of 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) has been applied.

The service has previously identified the impact of industrial action on training performance for PROMPT. However, the service reports that performance has been recovered, with additional training and teaching

sessions and as a result all staff groups have achieved at least 90%. Gap and Grow remains and area of focus and is the only training parameter below 90% (current position 85% overall).
To demonstrate that there are robust processes in place and to mitigate against the current staffing position, the perinatal quality surveillance dashboard (Table 5) includes nationally mandated specified minimum data set requirements and additional local level indicators. The dashboard triangulates workforce information with safety, patient experience, and clinical effectiveness indicators.

Since September 2023 to date (15/11/2023), the maternity service has referred five incidents to Maternity and Newborn Safety Investigations Programme (MNSI formally HSIB) for consideration of external investigation in accordance with the MNSI referral criteria. In response to the cluster of MNSI reportable incidents, a round table meeting was convened and a decision to undertake a thematic review, supported by an external consultant obstetrician taken. The committee will be updated of the outcome in due course.

The perinatal quality surveillance dashboard indicates a relatively stable service. However, risks are evident relating to antenatal booking performance (this is affected by the current level of sickness in community midwifery service), continuing inability to accept all intrauterine transfers (impacted by the number of Midwives available to provide 1:1 care) and high levels of reg flag reporting (affected by the near miss experiences midwifes and obstetricians are reporting due to staffing pressures within the service).

Both midwifery and neonatal services continue to experience significant staffing challenges and whilst considerable effort is made to mitigate against this, it is impacting on the overall service provision. The Birthrate plus safe staffing assessment will address each of the risks identified here and to date whilst the resolution to fund this remains outstanding, the Chief Financial Officer is progressing commissioning discussions with the aim of resolving this. The finance and performance committee have received a report outlining the requirements of the service in the next 12 months to remain compliant with national requirements in relation to maternity and newborn services.

Recommendations

The Board of Directors are asked to:

i. Approve the CNST update report and acknowledge the risk to delivery.
ii. Approve the associated action plans for information oversight and assurance.

Appendix Catalogue

1. Action Plan Progress Tracker
2. PMRT Cases
3. Overarching PMRT Action Plan
4. Obstetric Medical Action Plan
5. Neonatal Medical Workforce Action Plan
6. Workforce Action Plan
7. Maternity Voice Partnership Work Plan 2023/24
8. Core Competency Framework Action Plan
9. HSIB Case overview
10. Red Flags

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒
Previous consideration			
Safety and Quality Committee November 2023.			

1. INTRODUCTION

The purpose of this report is to provide assurance to the Board of Directors of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts maternity incentive scheme (CNST MIS). The Report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators.

2. MATERNITY INCENTIVE SCHEME

A summary of progress to date regarding the attainment of all ten safety actions is detailed in the progress tracker below. (Table 1)

The service is currently 90% (9/10) compliant with CNST MIS safety standards. Safety action 6 is on track to deliver by December 2023 but requires additional evidence and funding approval for essential equipment to achieve full compliance.

Table 1: Progress Tracker

Safety Action	Progress Update	RAG Rating	Areas of concern/Update
Safety Action 1 - PMRT	On track		Compliant with requirements. Expected to deliver.
Safety Action 2 - MSDS	On track		Compliant with requirements. Expected to deliver.
Safety Action 3 - ATAIN	On track		Compliant with requirements. Expected to deliver.
Safety Action 4 – Clinical Workforce planning	On track		Compliant with requirements. Expected to deliver.
Safety Action 5 – Midwifery workforce staffing	On track		BirthRate Plus additional staffing requirements shared with ICB. Action plan in place which enables compliance to be declared.
Safety Action 6 – SBLV2	At Risk		Awaiting outcome of funding request for essential equipment. If funding approved, expected to deliver by December 2023.
Safety Action 7 – Maternity Neonatal Voices Partnership (MNVP)	On track		Compliant with the requirements. Expected to deliver.
Safety Action 8 - Training	On track		Compliant with requirements. Expected to deliver.
Safety Action 9 – Board Assurance	On track		Compliant with requirements. Expected to deliver
Safety Action 10 – NHS Resolution	On track		Compliant with requirements. Expected to deliver

The relevant action plans for CNST MIS are included in appendices 2- 7. Appendix 1 provides an overview of progress made against each action plan.

3. SAFETY ACTIONS UPDATE

SAFETY ACTION 1: ARE YOU USING THE NATIONAL PERINATAL MORTALITY REVIEW TOOL (PMRT) TO REVIEW PERINATAL DEATHS TO THE REQUIRED STANDARD? *(• All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth).*

To meet the requirements of standard 1, Trust Executive Boards must receive a report each quarter from 30 May 2023 that includes details of all deaths reviewed. Any themes identified and the consequent action plans should be included in Board reporting for oversight. The report should also evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) (Table 2) have been met.

As of the 15th of November 2023, there were twelve eligible cases (Appendix 2). All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to meet the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed to the draft report stage within four months of the death and published within six months. Table 2 details the current position for all perinatal mortality reviews.

Table 2: Perinatal Mortality Tool progress tracker

Safety Action 1 (Standard A) *	**Compliance score**		**RAG**
i. All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**Notification**	**14/14**	
	Surveillance	**12/12**	
Safety Action 1 (Standard B) *			
i. For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**On track**	**12/12**	
Safety Action 1 (Standard C) *			
i. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months	**On track**	**Commenced with 2 months. 10/10**	
		Completed within 4 months: 10/10	
		Completed within 6 months: 10/10	

Safety Action 1 (Standard D) *		
i. Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023 onwards that include details of all deaths reviewed, thematic learning and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**April 2023**	
	July 2023	
	September 2023	
	November 2023	
Neonatal Deaths		
I. The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death	**5/5 on track**	
II. Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information.	**5/5 on track**	

***Exclusions:** If the surveillance form needs to the assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

Appendix 2 details the progress against each review and the outstanding overarching action plan is included for oversight in Appendix 3. All deaths are reviewed individually, and any themes identified shared locally and regionally. During October there were two cases of neonatal death of term infants, both cases have been StEIS reported and referred to the Maternity and Newborn Safety Investigation (MNSI) for consideration of external investigation.

SAFETY ACTION 2: ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?

Trust Boards are advised to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. (Published in October 2023).

The service continues to be on track with 11 out of 11 CQIMs and the National Maternity Dashboard data for July 2023 has now been published and confirms that the standard has been passed. The data integration will continue to be undertaken and monitored for assurance.

SAFETY ACTION 3: CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL (ATAIN) UNITS PROGRAMME?

Pathways of care into transitional care and ATAIN continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams. In addition, the ATAIN and Transitional Care (TC) dashboards and

associated action plans continue to be reviewed and approved by the Safety Champions QUAD meetings for assurance.

The division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. The transitional Care and ATAIN quarter 1 and 2 reports as well as the dashboards and joint action plan have been shared with the Trust Board, LMNS and ICB Quality Assurance Panel for oversight.

Lancashire Teaching Hospitals continues to have the lowest term admission rates of all 4 providers in the LMNS. The Working Better Together Group (WBT) convenes on a fortnightly basis to undertake multi-professional audit of all admission to the neonatal unit from 37 week+0 days gestation.

SAFETY ACTION 4: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF CLINICAL WORKFORCE PLANNING TO THE REQUIRED STANDARD?

a) Obstetric medical workforce

Within the CNST reporting period a local review of the obstetric medical workforce has been undertaken between 30 May 2023 – 7 December 2023. The review identified that to meet the 98-hour Consultant standard on the delivery suite, safe care of women on the maternity wards and assessment suite and outlying areas along with the increased demand in antenatal clinic reviews and Caesarean sections, Investment equating to 2.7 WTE Consultant Obstetricians is required. The associated action plan is included in appendix 4.

In order to demonstrate that safe processes are in place for short and long term obstetric locum employment, the service is required to confirm that; doctors either currently work in their tier 2 or 3 rota, have worked in their unit in the last 5 years as a post graduate doctor in training, remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

In addition, Trusts/organisations are required to implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board.

The service utilises the monitoring/effectiveness tool contained within the ‘RCOG guidance on the engagement of short and long-term locums in maternity’ to track and review compliance with the recommendations for locum doctors. The standard operating procedure and associated audit is also used to ensure that compliance to this requirement continues to be met and which is overseen by the Clinical Director for Obstetrics.

To provide additional assurance and oversight, the acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) is monitored monthly and reported on the Perinatal Surveillance dashboard. The data reflects the actual medical staffing compliance for the acute obstetric service, in relation to the planned staffing levels. In October 2023 100% of the rota was covered.

Finally, the service is required to demonstrate engagement with the Royal College of Obstetricians and Gynaecologists (RCOG) ‘Roles and responsibilities of the consultant providing acute care in obstetrics

and gynaecology' document and action plans to review any non-attendance to the clinical situations listed in the document are detailed in the monthly audits. In October 2023 100% compliance was achieved.

b) Anaesthetic medical workforce

To comply with the anaesthetic medical workforce requirements associated with CNST year 5, a copy of the anaesthetic rota for all months during the reporting period is held as evidence for monitoring purposes by the service, detailing that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. To date the service is 100% compliant with this standard.

c) Neonatal medical workforce

Within the CNST reporting period a review of the neonatal medical workforce should be undertaken of any 6-month period between 30 May 2023 – 7 December 2023. In addition, and following this review, the Trust is required to formally record in Trust Board minutes whether it meets the relevant British Association of Perinatal Medicine (BAPM) recommendations for the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A local workforce review of the neonatal medical staffing requirement to achieve BAPM standards has been undertaken by the Divisional Director and the Clinical Director for Neonatology. The review identified the Trust is not yet complaint with BAPM standards for neonatal medical workforce and identified a gap of 1.7 WTE Consultant and 1 WTE Non-medical Consultant.

A position paper detailing the additional financial investment required has been collated and will be discussed with commissioners as part of commissioning discussion. At this time, funding to support an uplift in establishment has not been secured and the action plan required to meet the BAPM neonatal medical work force is contained within appendix 5.

d) Neonatal nursing workforce

The Trust is required to formally record in the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report and for the 2022/23 reporting period, compliance to the BAPM standard was achieved based on the average activity for the previous 3 years. This provides assurance that the current establishment meets the requirement for BAPM nurse staffing, and no further action is required.

SAFETY ACTION 5: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?

Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The detailed breakdown of the BirthRate + requirements has

been presented to Board regularly throughout the reporting period as part of previous maternity and neonatal update papers and has been included in the October 2023 bi-annual safe staffing report. It should be noted that whilst funding requirements have been agreed in principle, the Trust Board has referred the funding of this to the ICB for consideration.

Currently, the service continues to actively recruit to vacancies within the current establishment. It is acknowledged that the current vacancy and required uplift in the establishment to reflect BirthRate Plus is having an impact on service delivery. Whilst it is recognised that there is a national shortage of midwives, the uplift in establishment which includes several speciality posts and support worker post would improve the service's ability to provide safer services, whilst funding approval and subsequent recruitment is achieved.

The overarching workforce action plan (appendix 6) details the work streams to support ongoing recruitment and retention. The Birthrate plus assessment has been considered by Board and will be discussed with commissioners as part of the 2024 commissioning discussions. Whilst the gap in funding continues there are risk identified that the service continues to experience notably, continued deflection of intrauterine transfers, delays in induction of labour, risk of 1:1 care in labour not being delivered and less optimum experience for women and families.

SAFETY ACTION 6: CAN YOU DEMONSTRATE COMPLIANCE WITH ALL SIX ELEMENTS OF THE SAVING BABIES' LIVES CARE BUNDLE VERSION THREE?

The Saving Babies' Lives Care Bundle' version 3 (SBLCB V3) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

The implementation tool is now being utilised by the service to track and evidence improvement and compliance with the requirements set out in Version 3. The requirement to achieve the standard is significant for providers and there are 86 separate interventions consisting of 29 guideline-based indicators, 34 data requirements and 23 audit actions.

To evidence adequate progress against this deliverable by the submission deadline on the 1st February 2024, table 3 provides a breakdown for each of the elements. To meet the standard, the service must demonstrate implementation of 70% of safety interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. This work stream is on track and has achieved the 50% target in each element and is almost at the 70% target for achievement of 70% of interventions met overall. It is anticipated that the additional action ongoing be achieved by December 2023.

To achieve compliance with SBLV3, funding from the previous CNST rebate has been requested by the service for essential equipment to meet the requirements for management of reduced fetal movement, management of fetal growth restriction, adequate fetal heart monitoring and personalised care and informed choice. A decision is awaited regarding this funding. However, if this is not agreed the service will be unable to declare compliance with SBLV3 and as a consequence with all ten CNST safety actions.

Table 3 Project Action Tracker for Implementation of SBLV3 2023-24

Project Progress Report Tracker				
Project Name	Saving Babies Lives Care Bundle v3			
Report Date	9/11/23			
Intervention Element	**Description**	**% interventions on track to achieve**	**Number of interventions with good potential to achieve in given timeframe**	**Number of interventions which are difficult to achieve in given timeframe**
Element 1	Smoking in Pregnancy	60% (6/10)	0/10	4/10
Element 2	Fetal Growth Restriction	60% (12/20)	7/20	1/20
Element 3	Reduced Fetal Movements	100% (2/2)	N/A	N/A
Element 4	Fetal Monitoring in Labour	60% (3/5)	0/5	2/5
Element 5	Preterm Birth	70% (19/27)	5/27	3/27
Element 6	Diabetes	67% (4/6)	1/6	1/6
Total		**66% (46/70)**	**13/70**	**11/70**

The SBLV3 project has an identified lead overseen by the Quality Improvement (QI) team and Deputy Divisional Midwifery and Nursing Director and quarterly quality improvement visits are scheduled and undertaken with the Integrated Care Board. Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element, and reviewing the overarching improvement action plan, is undertaken at each assurance visit. The committee will continue to receive regular updates on the trajectory for full implementation.

SAFETY ACTION 7: CAN YOU DEMONSTRATE THAT YOU HAVE A MECHANISM FOR GATHERING SERVICE USER FEEDBACK, AND THAT YOU WORK WITH SERVICE USERS THROUGH YOUR MATERNITY AND NEONATAL VOICES PARTNERSHIP (MNVP) TO COPRODUCE LOCAL MATERNITY SERVICES. SPECIFICALLY, THAT THE SERVICE LISTENS TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND CO-PRODUCE SERVICES WITH USERS

In line with the single delivery plan and MNVP guidance the service must commission a funded and renumerated user-led Maternity and Neonatal Voices Partnership (MNVP). The MNVP lead and maternity and neonatal service should also develop an agreed workplan based on the Care Quality Commission (CQC) maternity survey, service user feedback and local and national agenda. Actions agreed should include response to feedback received in the free text of the survey report, prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation. Progress should be monitored regularly by safety champions and the LMNS Board.

The service confirms that a funded lead for the MNVP service has been agreed and Health Watch Lancashire has been commissioned by the ICB to oversee the programme of work. The service confirms

that the provisional work plan has been reviewed and updated jointly to confirm the key priorities for 2023-2024**.** Several actions to prioritise hearing the voice of service users that are "seldom heard" and Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation are ongoing. The MNVP work plan is included in appendix 7 for oversight.

SAFETY ACTION 8: CAN YOU EVIDENCE THAT A LOCAL TRAINING PLAN IS IN PLACE TO ENSURE THAT ALL SIX CORE MODULES OF THE CORE COMPETENCY FRAMEWORK WILL BE INCLUDED IN YOUR UNIT TRAINING PROGRAMME OVER THE NEXT 3 YEARS, STARTING FROM THE LAUNCH OF MIS YEAR 4?

In collaboration with the national maternity and neonatal partner organisations, the Maternity Transformation Programme published an updated Core Competency Framework (CCFv2) in June 2023. This publication replaces the first version and sets clear expectations for both the minimum standard and the stretch target for excellence.

The service confirms that the full Training Needs Analysis (TNA) standards have been aligned with version 2 of the CCF (appendix 7) and the programme of training has been approved by both Divisional Safety Champions QUAD and the MNVP lead. It should be noted that the additional training requirements will increase the training burden on the service, and this has been included in the BirthRate Plus staffing paper with a requested uplift from 23% to 25%.

The Maternity Incentive Scheme (MIS) Collaborative Advisory Group (CAG) met on 11 October 2023 to discuss and consider the feedback from Trusts in relation to the current pressures being experienced because of ongoing industrial action, and the impact this is having on Trusts' ability to meet the MIS safety action 8. In recognition of industrial action, a lower target of 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) has been applied. Positive progress to recover the reduced performance seen in August and September 2023 is illustrated in table 4 where all staff groups have achieved the required 90% compliance.

Table 4 PROMPT Compliance by Staff Group

	MIDWIVES	CONSULTANT	DOCTORS (JCF, SCF, ST1-7, FY)	ANAESTHETISTS	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**96%** 169 out of 175	**100%** 13 out of 13	**91%** 20 out of 22	**90%** 18 out of 20	**93%** 40 out of 43	**95%**

SAFETY ACTION 9: CAN YOU DEMONSTRATE THAT THERE ARE ROBUST PROCESSES IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL SAFETY AND QUALITY ISSUES?

The expectation from the service and Board is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; complaints triangulation: minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly.

The Perinatal Quality Surveillance dashboard (Table 5) provides performance data in relation to key indicators of safety and quality to ensure that clinical quality is reviewed regularly and that the board-level perinatal safety champion and wider Board retains oversight of perinatal safety.

Reviewing trends and themes from complaints and claims provides the maternity service with the opportunity to learn and improve care and systems. Assurance is provided that actions have already been implemented by the maternity service to learn from the triangulated themes/trends identified within the new referrals to NHS resolution, the new letters of claim/ claims being considered, the claim score card, patient complaints and the concluded StEIS investigation reports. All StEIS investigations (including Maternity and Newborn Safety Investigations Programme formally HSIB investigated incidents) are subject to detailed actions plans and compliance with associated actions monitored through the maternity safety and quality committee.

The Trust's claims score card continues to be reviewed quarterly alongside incident, complaint and patient experience data and a divisional report has outlined the detailed findings and targeted intervention for improvement.

Trust level safety intelligence and learning from excellence and incidents continues to be shared via the Lancashire & South Cumbria Local Maternity and Neonatal System Serious Incident Review group. The Serious Incident (SI) meetings provide a system level approach to sharing high level themes, learning from incidents, and provide a forum for peer and system support and review.

The Maternity and Neonatal Board Safety Champions meeting and walk arounds continue to be undertaken monthly to ensure floor to Board triangulation of safety intelligence. In response to staff feedback the format of the meetings have been updated to include alternate virtual and face to face sessions to enable a wider reach for teams to be able to access the executive safety champions.

The service confirms that it is has partially implemented the Patient Safety Incident Response Framework (PSIRF) on the 6th November 2023 in line with the wider Trust and a staggered arrangement for full roll out is ongoing.

SAFETY ACTION 10: HAVE YOU 100% OF QUALIFYING CASES TO HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB/CQC/MNSI) AND TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME FROM 30 MAY 2023 TO 7 DECEMBER 2023?

In line with national reporting recommendations, details of all HSIB referrals are included in this report to enable the committee to triangulate incidents with safety outcome data and for oversight. Appendix 9 details the HSIB investigations referred by the Trust since the 6th of December 2022. The service confirms that it has reported all qualifying cases to HSIB reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC).

4. THE PERINATAL QUALITY SURVIELLENCE DASHBOARD

To meet the requirements of the perinatal quality surveillance model, the service must inform the Board regarding safety intelligence, including the number of incidents reported as serious harm, themes identified serious issues, complaints and proactively gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Table 5 details the performance over time from November 2022- October 2023.

Table 5: Perinatal Quality Surveillance Model Safety Outcomes Table

Metric	Red flag		Green flag		Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23
CNST 10 Key safety actions (Year 5 scheme updated in 31st May 2023)					**80%**	**80%**	**100%**	**100%**	**100%**	**100%**	**100%**	**40%**	**40%**	**60%**	**60%**	**80%**
Births					354	318	350	304	376	298	339	371	362	369	352	344
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	2.9	6.3	5.7	0.0	5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9
Stillbirth rate excluding termination for fetal abnormality					****	3.1	2.9	0.0	5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9
Examination of the newborn completed within 72 hours	<	95%	≥	95%	95.9%	96.5%	95.1%	95.7%	94.7%	95.6%	96.2%	95.7%	96.7%	96.5%	92.6%	95.1%
Breastfeeding initiation	<	70%	≥	70%	76.0%	75.9%	73.9%	76.3%	82.9%	79.8%	76.3%	77.6%	79.8%	77.9%	76.1%	78.4%
Booked by 9+6	<	50%	≥	50%	51.0%	45.8%	32.6%	38.7%	47.3%	42.2%	51.5%	51.3%+	47.4%	48%	30.3%	NA
Booked by 12+6	<	90%	≥	90%	93.1%	90.7%	88.0%	90.8%	88.9%	83.3%	92.7%	90.3%	48%	85.5%	81.5%	NA
Women giving birth in a midwife-led setting	<	25%	≥	30%	20.0%	18.0%	17.5%	16.6%	15.1%	16.6%	14.2%	15.8%	15.2%	14.2%	12.5%	14.8%
Home birth	<	1.7 %	≥	2.0%	2.0%	1.9%	2.3%	3.3%	2.1%	3.7%	3.2%	2.4%	2.5%	3.3%	2.3%	2.9%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	1.6%	4.2%	2.4%	2.1%	2.8%	2.3%	1.5%	2.7%	2.6%	1.8%	2.9%	3.0%
One-to-one care in labour in Delivery Suite.	<	100 %	=	100%	98.9%	97.7%	99.6%	98.4%	99.7%$	99.2%	97.6%	100%	100%	100%	99.5%	100%
One-to-one care in labour in Preston Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95%	=	100%	100%	92.9%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HDU trained per shift.	<	89%	=	90%							99.57%	99.57%	100%	100%	98%	98%
Supernumerary status of DS coordinator	<	95%	=	100%	100%	100%	100%	100% **	100%	100%	100%	100%	100%	100%	100%	100%
CTG update training	<	90%	≥	90%	95%	94%	92%	93%	94%	96%	99%	98%	99%	97%	97%	95%
Annual competency (K2 Training Package)	<	90%	≥	90%	99%	98%	99%	99%	99%	97%	97%	96%	95%	94%	95%	96%
GAP/GROW (Growth Assessment Protocol Training)	<	90%	≥	90%	87%	87%	82%	82%	87%	83%	80%	82%	83%	80%	80%	90%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90%	≥	90%	97%	98%	93%	93%	94%	93%	96%	94%	94%	86%	83%	95%
Incidents of moderate harm and above	--		--		4	3	1	2	2	0	0	3	0	3	2	3
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened.	--		--		0	2	0	2	1	0	0	0	0	0	2	2
Complaints	--		--		1	2	2	3	2	2	2	2	1	2	2	3
Prevention of future deaths regulation 28	--		--		0	0	0	0	0	0	0	0	0	0	0	0
CQC Enquiries	--		--		0	0	0	0	0	0	0	0	0	0	0	2

Maternal Death	> 1	<1	0	0	0	0	0	0	2	0	0	0	0	0
Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5% hrs	76.6% hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance	--	--	100%	100%	93%	95%	94%	100%	100%	100%	91%	100%	100%	100%
24-hour acute obstetric medical staffing fill rate	<95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28	≤26	24	21	23	22	25	21	23	24	26	25	24	23
Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<95%	100%									90%	98%	65%	69%
Staff sickness rate	4%	4%	7.6%	11.5%	8.7%	8.6%	8.6%	7.9%	8.47%	8.6%	8.7%	8.8%	8.6%	9%
Fill rate RM Day	<85%	>85%	78%	73%	82%	81%	81%	82%	NA	93%	95%	91%	74%	79%
Fill rate MSW Day	<85%	>85%	77%	67%	77%	72%	71%	73%	NA	93%	90%	86%	76%	74%
Fill rate RM Night	<85%	>85%	88%	89%	95%	94%	90%	97%	92%	90%	84%	82%	82%	81%
Fill rate MSW Night	<85%	>85%	95%	89%	95%	94%	95%	100%	94%	89%	91%	100%	94%	98%
Registered Midwife shifts sent to agency per month.	--	--			122	143	152	107	110	110	127	127	146	146
Registered Midwife Agency hour fill rate percentage.	--	--			58%	51%	51%	51%	46%	45%	39%	49%	42%	42%
Maternity Diverts	> 1	<1	0	0	0	0	0	0	0	0	1	0	2	0
Red flags reported.			12	2	5	12	126	44	71	218	187	105	205	103
In- utero transfers declined to accept from other units (maternity)	--	--	0	4	1	2^	2	0	2	5	4	5	5	5
In- utero transfers declined to accept from other units (NICU)	--	--	0	0	0	4	0	2	1	1	2	0	4	10
In- utero transfers from LTHTR to another Trust (Antenatal)	--	--	0	0	0	0	0	0	10	0	0	1**	1**	0
NICU Closure	--	--	0	0	0	3	2	5	13	1	1	0	1	2
Maternity Triage BSOT standard (15min)	--	--			90%	89%	86%	94%	90%	91%	93%	89%	91%	92.4%
Maternity Triage NICE standard (30 min)	90%	90%			97%	97%	94%	99%	98%	98%	98%	98%	97%	97%

* Amended rate following further case review from 92% to 94% after data validation. ** Data amended following publication of new guidance which clarified definition of supernumerary status (based upon deep dive results) *** Recording methodology changed and now reported as overall compliance following roll out of full day training. $ Adjusted 1:1 care rate following review of cases. ^ Rates adjusted in months where previously both maternity and neonatal declined IUT were recorded cumulatively. + Adjusted figure for month end extraction**One mother transferred to ELTH following the regional gold call, due to ongoing delays with induction of labour within the maternity service.

4.1 GAP AND GROW

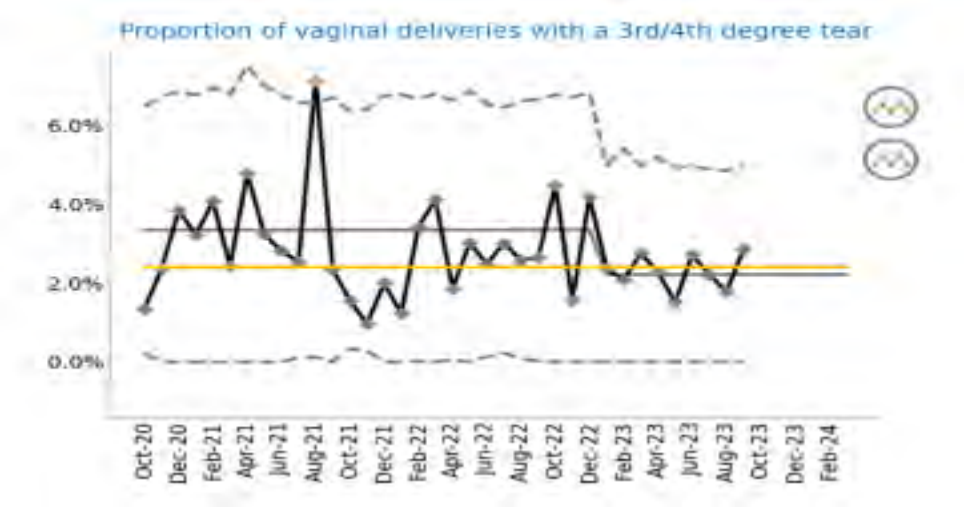
As anticipated and reported to Trust Board in October 2023, an improvement in training compliance for Gap and Grow has been observed from 80% to 90% due to focused, additional training sessions being delivered. In addition, an improvement plan is in place to maintain the 90% stretch target by December 2023. The CCFV2 training programme for saving babies lives 2024 includes the introduction of face-to-face training session for fetal growth surveillance which will replace the current e-learning (Gap and Grow) and it is anticipated that this change in delivery will stabilise performance capturing all groups consistently.

4.2 THIRD- AND FOURTH-DEGREE TEARS

The service continues to monitor the incidence of third- and fourth-degree perineal tears monthly and notes that in October the rate was reported as 3%. Following CQC feedback, these are now routinely reported as patient safety incidents. Statistical process control (SPC) analysis of the data has been undertaken which demonstrates common cause variation within the expected range. In September 2023 a statistically

significant improvement in performance was noted and the SPC target was rebased to reflect a positive improvement in performance since February 2023. Table 6 displays the SPC performance. Work within the service to improve these outcomes for women includes the delivery of the OASI care bundle as part of the PROMPT training and a number of staff have received training in antenatal preventative pelvic floor exercises and localisation (APPEAL) training to support best practice for perineal care.

Table 6



4.3 SICKNESS ABSENCE MANAGEMENT

Each speciality within the division of Women's and Children's is meeting with workforce partners to better understand the reasons for the high sickness rates and support the managers more effectively manage absence and timely return to work. The service work force plan supports this work, as does the recently developed divisional people plan and birthrate plus assessment which is likely to be contributing to colleagues' confidence to return to work.

4.4 SAFE STAFFING

The service has a current registered midwifery vacancy rate as of the 31st October 2023 was 15.22 WTE The midwifery establishment tracker indicates an improving position over the next few months. It is anticipated that the staffing establishment gap as of the 31st March 2024 will have reduced to 9.22 WTE Recruitment to maternity leave vacancy continues and all vacant shifts are sent to bank and agency. The Chief Financial Officer is progressing discussions relating to the funding required for the 2023 Birth rate plus safe staffing recommendation.

4.5 FILL RATES

The fill rates for Registered Midwives (RM) and Maternity Support Workers (MSW) demonstrates a sustained, lower than planned fill rate particularly for Registered Midwives (RM) day and night shifts overall, year to date. In November 2023, the noted decline in fill rates for daytime shifts across midwifery and MSW staffing continues to reflect the establishment gaps associated with maternity leave and ongoing sickness absence.

The deep dive review of the maternity rosters related to roster build, long shift templating, supernumerary tiles and roster cleansing has resulted in more accurate calculation of unfilled shifts. The service continues to monitor fill rates with oversight from the Division and Trust Safety and Quality Committee's. All shifts are initially offered as bank and are then converted to agency after 2 weeks of not being filled.

This demonstrates the commitment of the service to fill all vacant shifts. Consistently the service fills between 40-50% of all unfilled agency shifts.

4.6 NEONATAL (NICU) NURSE BAPM FILL RATES

In September (65%) and October (69%) 2023, a reduction in BAPM compliance was noted and attributed to a 16% sickness absence rate alongside higher intensive care activity. As previously discussed, there is ongoing deep dive review of sickness absence throughout the Women's and Children's division and review meetings have been scheduled with NICU to consider any further actions taken to improve the position. All vacant shifts are sent to bank and agency to mitigate the shortfall and the service reports a 0% nurse vacancy.

4.7 INTERUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

Higher acuity and increased sickness absence in both maternity and neonatal services also triangulates with the number of IUT's declined in October 2023. NICU (10) Maternity (5). These indicate that both services are under pressure. Actions are taken to undertake risk assessments at the time of transfer request and decision making takes into account the safety of the units at that time. The services work as a network, discussing service need and contributing towards solving transfer requests collectively.

4.8 UNIT CLOSURES OR DIVERTS

The NICU closed to new admissions on 2 occasions in October 2023 again demonstrating the pressure on the service resulting from sickness absence and a higher requirement for an intensive care cots. Staffing establishment vacancy did not result in any maternity diverts in October 2023

4.9 RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. The breakdown of red flags by category is detailed in Appendix 10. There was a reduction in red flag reporting observed in October 2023 overall, with a significant reduction in reporting observed in the category of deferred and rearranged planned consultations within midwifery led services. No incidents of harm have been associated with any maternity red flag incident and all reports are linked to the active risks on the risk register for ongoing oversight by the division.

4.10 REFERRALS TO MNSI (FORMALLY HSIB)

Since September 2023 up until the 15th November 2023, the maternity service has referred five incidents to MNSI for consideration of external investigation in accordance with the MNSI referral criteria. Of these incidents, there has been two instances of neonatal death of a term infant and three case of therapeutic cooling of a term infant. Both cases of neonatal death occurred following decisions to compassionately reorientate care. The deaths of both babies were discussed with His Majesty's coroner and in one case, following joint agency review (JAR), a decision was made by His Majesty's coroner for home office postmortem.

In response to the observed cluster of MNSI reportable incidents, a round table multiple- professional meeting was convened by the division. The unanimous decision was that a thematic review, supported by an external consultant obstetrician, should be undertaken. The findings of the thematic review will be shared once completed.

4.11 CONTINUITY OF CARER (MCOC)

The Trust is required to confirm that Board level discussions related to the ability of the maternity workforce to maintain current and future rollout of MCoC have taken place. The service confirms that the current level of MCoC is reviewed regularly and can continue to be delivered safely without impacting on the safety of the service. However, until staffing has stabilised, there will be no further expansion of MCoC. The service continues to seek innovative ways to expand the provision of MCoC so that priority can be given to those most likely to experience poorer outcomes first, including women from Black, Asian and mixed ethnicity backgrounds and those living in the lowest decile of deprivation.

In addition, the service has submitted an expression of interest to support our attainment of 75% MCoC in the most deprived groups in line with the CORE20PLUS5 ambition. The NHS Race and Heath Observatory has partnered with the Institute for Healthcare Improvement (HI) and the Health Foundation (HF) to deliver a Learning in Action Network which aims to tackle and close the gap seen in maternal mortality and morbidity between women from different ethnic backgrounds. If successful, this bid would provide opportunity to review and consider pathways into continuity for women in the lowest deciles and ethnic groups.

5. CONCLUSION

This purpose of the report is to provide assurance to the safety and quality committee on the programmes of work within the maternity and neonatal services. The report confirms progress against the ten new workstreams set out by the CNST NHS Resolution for year 5 of the maternity incentive scheme with 90% compliance to date.

The service is on track to deliver against all ten CNST MIS safety standards by the end of December 2023 but is reliant on approval of funding for essential equipment which has been requested from the previous years 2023 CNST rebate. However, if this is not agreed the service will be unable to declare compliance with SBLV3 and as a consequence with all ten CNST safety actions.

The service has seen an increase in Maternity and Newborn Safety Investigations Special Health Authority (MSNI) (previously HSIB) referrals this month, as a result of this a round table multiple-professional meeting was convened and a decision to undertake a thematic review, supported by an external consultant obstetrician, should be undertaken. The findings of the thematic review will be shared once completed.

The perinatal quality surveillance dashboard indicates a relatively stable service with actions being taken to manage the risks. However, concerns remain related to antenatal booking performance, continuing inability to accept intrauterine transfers and reg flag reporting. Both midwifery and neonatal services continue to experience significant staffing challenges and whilst considerable effort is made to mitigate against this, it does impact on the overall service provision. The Chief Financial Officer is progressing discussions with the commissioners on the funding source for the 2023 Birthrate plus assessment.

6. RECOMMENDATIONS

The Board of Directors are asked to:

ii. Approve the CNST update report and acknowledge the risk to delivery.

iii. Approve the associated action plans for information oversight and assurance.

APPENDIX 1 ACTION PLAN PROGRESS TRACKER

Action Plan Progress Tracker					
Action Plan	**Total number of actions**	**Deadline Extended not closed**	**On track to be delivered** (including those where action deadlines have been extended)	**Completed awaiting evidence**	**Fully complete**
PMRT Overarching Action Plan **(18.09.2023)**	38	2	7	1/38	31/38
Obstetric Medical Workforce Action Plan	6	0	2	0	4/6
Neonatal Medical Workforce Action Plan **(12.09.23)**	13	2	6	1/13	7/13
Workforce Action Plan **(05.03.23)**	64	14	29	9/64	35/64
MNVP Maternity Voice Partnership Work Plan 2023/24 **(2.11.2023)**	23	0	17	2/23	6/23
Core Competency Framework Action Plan **(11.09.2023)**	47	0	4	3/47	43/47
Total	185	18	63	16	122

Appendix 2 – PMRT cases

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 4 months	Actions ongoing
125023	33+1	Neonatal death	IUT from BVH. Antenatally diagnosed fetal anomaly.	Yes	88023	Yes	Yes	PMRT has been completed, care graded as B, B, C. Ongoing work with the LMNS advocate to develop a SOP for when PMRT review is shared between organisations.
125969	24+5	Neonatal death	Multiple pregnancy – Significant antenatal haemorrhage, emergency caesarean section performed.	Yes	88146	Yes	Yes	Second twin survived.
127505	33+1	Antepartum stillbirth	Multiple pregnancy – fetal heart seen to slow during routine USS. Transferred for emergency caesarean section from scan but unsuccessful resuscitation.	Yes	88277	Yes	Yes	Second twin survived.
130650	26+6	Antepartum stillbirth	Multiple pregnancy – twin one	Yes	88804	Yes	Yes	Emergency caesarean section performed for the health of the second twin.
131848	26+6	Neonatal death	Multiple pregnancy – twin two	Yes	88804	Yes	Yes	
133056	24+1	Antepartum stillbirth	Early onset fetal growth restriction. Antenatally Trisomy 18 suspected.	Yes	89093	Yes	Yes	
135345	28+4	Antepartum stillbirth	Early onset fetal growth restriction -declined delivery at earlier gestation.	Yes	89276	Yes	Yes	
138212	37+4	Neonatal death	Suspected vasa praevia. Baby born in poor condition. Therapeutic cooling commenced but decision made to stop cooling and compassionately reorientate care to palliative.	Yes	98958	Yes	Yes	Referred to HSIB in accordance with referral criteria. StEIS reported. Formal DOC provided to the family. Referred to Child Death Overview Panel.
138783	38+1	Neonatal death	SROM, declined IOL. Absconded from the unit following commencement of IOL process. When returned to the unit terminal CTG pattern. Initially declined emergency caesarean section (CS). CS later accepted. Baby born in poor condition. Resuscitated and transferred to NICU however, decision made for compassionate reorientation of care to palliative.	Yes	89944	Yes	Yes	Referred to HSIB in accordance with referral criteria. StEIS reported. Formal DOC provided to the family. Referred to CDOP. Referred to SUDCI. JAR meeting held; home office postmortem requested from JAR.
140588	33+6	Antepartum stillbirth	Type one diabetic, uncontrolled blood sugars in pregnancy. Admitted unwell in DKA and stillbirth diagnosed on admission.	Yes	90218	Yes	Yes	Rapid incident review to convened.

Appendix 3 PMRT overarching action plan.

Action Plan – PMRT overarching action plan.

Version	Date
V1	18.09.2023
V2	14.11.2023

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
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Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
TF 106111 StEIS 2023/365 PMRT 85133						
1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Debrief meeting to be organised to feedback the investigation findings to the family.	Matron for safety and quality	30.06.2023	Specialist midwife for bereavement to organise family meeting once investigation is finalised. 16.05.2023 ACTION COMPLETED.	
		PMRT review to be completed and provided to the family.	Matron for safety and quality	30.05.2023	16.05.2023 – PMRT review held for the case, care graded as D and C. Family feedback meeting held on 23.05.2023 and PMRT report provided.	
2	Ockenden safety action – incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in	To share the case at the next stillbirth special interest group for wider system level learning	Divisional midwifery clinical governance and risk management midwife	30.05.2023	16.05.2023 Presented at May 2023 regional stillbirth special interest group.	
		Regional meeting to be organised regarding the NWAS current position regarding the presentation of	Matron for safety and quality	30.01.2023	Meeting held on 20.01.23. Action completed.	

	practice in a timely manner.	neonates to the emergency department in resuscitation situation.				
		To present the case for discussion at the LMNS quality assurance panel for wider system level learning	Divisional midwifery clinical governance and risk management midwife	30.06.2023	Action completed presented at LMNS serious incident overview panel.	
		Learning template to be generated and shared with all staff relating to threatened preterm labour, template to include discharge advise.	Matron for safety and quality	30.06.2023	Learning template generated and action completed.	
3	Clinical guidelines should be up to date and evidence based.	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the triage algorithms which are in use.	Matron for safety and quality	30.06.2023	30.05.23 Guideline has been reviewed and is currently in the ratification process. Action completed.	
		Task and finish group to be established to review the Trust SOP for babies born in the emergency department.	Deputy divisional midwifery and nursing director	30.04.2023	Guideline reviewed, ratified and published March 2023. Action completed.	
4	Point of care testing for assessment of preterm labour risk should be available.	Until a reliable supply of fFN can be assured, MAS should continue to stock Actim Partus as an alternative to fFN.	Maternity assessment suite manager	30.05.2023	30.05.2023 Stock of Hologic fFN received May 2023 however, only 75 units can be guaranteed therefore MAS will continue to stock Actim partus as an alternative. ACTION COMPLETED.	
5	Ockenden safety action – bereavement care. Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Bereavement support to be provided to the family for as long as required.	Specialist midwife for bereavement.	30.05.2023	30.05.2023 the specialist midwife for bereavement continues to support the family. Action completed.	
		Referral to the reproductive trauma service to be offered to the family.	Matron for safety and quality	30.06.2023	30.5.2023 – updated from the bereavement midwife – the mother is already being supported by RTS.	
RD 101722 StEIS 2022/24747 PMRT 84476						

1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Arrange family meeting to feedback the investigation findings to the family.	Divisional Midwifery Clinical Governance and Risk Manager	30/05/2023	Action completed; family meeting organised by the specialist midwife for bereavement.	
2	Ockenden safety action – incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Review and update the pre-eclampsia and hypertension in pregnancy guidelines to include a plan for increased pre-eclampsia surveillance for mothers with uterine artery notching.	Consultant obstetric lead for Delivery Suite	30/11/2023	18.09.2023 EH – action ongoing. 13.11.2023 FGR guideline under review	
		Share learning with the midwifery team regarding the significance of uterine artery doppler notching.	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	Learning template generated and shared. Action completed.	
		NWAS consultant midwife to review the prehospital care.	NWAS Consultant Midwife	31/12/2022	NWAS consultant midwife contributed to the investigation process. NWAS records obtained for the investigation. Action completed.	
		Use the mother's atypical presentation in pre-eclampsia/ eclampsia skills drills taught on the multi-disciplinary PROMPT study day.	Midwifery practice educator	30/08/2023	18.09.2023 EH – case included in the TNA for PROMPT 2024. Eclampsia to be included in the drills on PROMPT in 2024. Atypical presentation to be used as part of the drill.	
3	Ockenden safety action – complex antenatal care. Trusts must follow national guidance for managing women with hypertension in pregnancy.	Clinical guideline EGB00176 Nausea and vomiting in pregnancy and hyperemesis gravidarum should be reviewed to include a section relating to management of onset of vomiting in the second and third trimesters of pregnancy.	MAS lead midwife	30/10/2023	18.09.2023 EH – action ongoing.	
		Establish a failsafe process to ensure that attendance in antenatal clinic, for ultrasound scan review, can be monitored and non-attendance identified and actioned.	Matron for Complex Midwifery Care	30/12/2023	18.09.2023 EH – a working party has been convened and development of a SOP is ongoing. 13.11.2023 BadgerNet referral created to alert ANC when unplanned scan review is required. Awaiting evidence	

		Make a CleverMed change request for the Aspirin compliance question to be added to the midwifery led antenatal appointment templates and the obstetric specialist review antenatal appointment templates on the BadgerNet system.	Digital lead midwife	~~31/10/2023~~ 31/12/2023	18.09.2023 Change request to be made to Clevermed. 14.11.2023 EH – update requested from HR digital lead midwife. Deadline extended.	
		Review the current arrangement of offering universal uterine artery doppler scanning at the anomaly ultrasound scan and advise if this practice, outside RCOG (2014) recommendations, should continue.	Fetal medicine consultant obstetrician	31/12/2023	31.07.2023 Awaiting specialist consultant to commence in post with the Trust. Recruitment has been successfully completed. 18.09.2023 EH – consultant now in post. Process to be reviewed. 13.11.2023 FGR policy being review and to apply for TOMMY's trial to support recommendations	
		Until the universal offer for uterine artery doppler scanning has been reviewed, all women that have uterine artery doppler notching identified at the anomaly ultrasound scan, should have their blood pressure measured and recorded at 20 weeks gestation (at the scan review) and an additional antenatal appointment for measurement of blood pressure and urinalysis at 25 weeks gestation. Update schedule of antenatal appointments guideline.	Matron for safety and quality	~~30/11/2023~~ 31.12.2023	31.10.2023 EH – action is ongoing.	
4	Ockenden safety action – bereavement care. Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Bereavement support to be provided to the family.	Specialist Midwife for Bereavement	20/11/2022	20.11.2022 The specialist midwife for bereavement continues to support the family. Action completed.	
		PMRT investigation	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	02.08.2023 PMRT review held, and report provided to the family along with the StEIS investigation report. Action completed.	

5	HSIB national learning investigation report – Telephone triage services should support 24-hour access to a systematic structured risk assessment of pregnant people's needs. Telephone triage services should be operated by appropriately trained and competent clinicians who are skilled in the specific needs required for effective telephone triage.	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the telephone triage algorithms which are in use.	Safety and quality maternity matron	30/04/2023	11.04.2023 Guideline updated and ratified action completed.	
		The MAS phone should be relocated to an area away from the MAS environment. The investigation team recommends that the completion of this action be prioritised to remove the risk of unconscious bias affecting decision making when performing telephone triage assessments.	Deputy Divisional Midwifery and Nursing Director (DMND)	30/01/2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.13.11.2023 Action ongoing.	
		The investigation team recommends that the maternity service works towards full implementation of the BSOTS system in accordance with the actions detailed on the risk register.	MAS lead midwife/ matron for complex midwifery care.	30/01/2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.13.11.2023 Action ongoing.	
HF 105125 HSIB MI-019756 StEIS 2022/27283 PMRT 85135						
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to HSIB	Clinical governance and risk management midwife	31.12.2022	HSIB investigation completed, and final report received. Action completed.	
		StEIS report	Clinical governance and risk management midwife	15.12.2022	StEIS number obtained when 72-hour report submitted. Action completed.	
		Formal duty of candour	Clinical governance and risk management midwife	15.12.2022	Verbal and formal DOC provided to the parents prior to discharge from hospital. Action completed.	

		Perinatal Mortality Review Tool (PMRT) review	Clinical governance and risk management midwife	13.04.2022	PMRT reported on 23/12/2022 review completed on 27.07.23 following receipt of final HSIB report. Graded as C and B. HSIB involved in the PMRT review and agree with the grading. Action completed.	
2	**HSIB safety recommendation:** The Trust to ensure that staff are supported to complete a comprehensive risk assessment for each mother at the beginning of, and at least hourly throughout her labour to ensure place of birth is in line with national guidance.		Deputy divisional nursing and midwifery director	Action completed	Hourly holistic reviews and hourly CTG peer reviews implemented into practice. Action completed.	
3	**HSIB safety recommendation:** The trust to ensure all members of the clinical team undergo training in Human Factors, including the risks of normalisation and expectation.	Implementation of Human Factors within the mandatory PROMPT and Fetal Monitoring Training.	Practice Education Midwife/Fetal Monitoring Lead Midwife	Action Completed	Human Factors training included in PROMPT and Fetal Monitoring training. Action completed.	
4	**Trust Action:** Transferring Midwife to reflect on the documentation of the neonatal resuscitation with the matron for midwifery led services		Matron for Midwifery led services	30.01.2023	Action has been completed.	
HH 117009 PMRT 86858						
1	**Ockenden safety action –** incident investigations must be meaningful for	Ability for the mother to add communication notes to the Badger	Digital lead midwife	30.11.2023	18.09.2023 EH – action ongoing by the maternity digital team.	

	families and staff, and lessons must be learned and implemented in practice in a timely manner	record to be removed as this is an unmonitored function.			14.11.2023 EH – action has been reviewed by the division and has been stood down as unable to deactivate the function locally. Communication has been shared with all staff regarding the functionality of the feature and the advice to be given to women about the feature.	
MC125023 PMRT 88023						
1	**Ockenden safety action – bereavement care.** Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	To work with the LMNS advocate and BVH to agree the roles and responsibilities of each Trust when PMRT investigations are shared across organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – working party was convened and process agreed with BVH for the management of joint cases between the two organisations. Action completed.	
		Review the PMRT card for LTHTR to align with the recently published tools on the MBRRACE website.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – letter updated and approved by the Trust patient experience lead. Action completed.	
		Review the PMRT letter for neonatal deaths to include information on the CDOP process.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – letter updated and approved by the Trust patient experience lead. Action completed.	
		Develop a PMRT letter for use when care is shared between two organisations. The letter should give information regarding the named family liaison person for the family at both organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – working party was convened and process agreed with BVH for the management of joint cases between the two organisations. Letter drafted and content agreed jointly by the two organisations. Letter approved by the Trust patient experience lead. Example of the good practice/ joint working shared at	

					the October 2023 LMNS quality assurance panel. Action completed.	

Action Plan – Obstetric Medical Workforce Review Action Plan

Version	*Date*
V1	16/11/2023

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Anna Bewlay
Position:	Clinical Director Obstetrics
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Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**RCOG requirement to meet the 98-hour Consultant standard on the delivery suite.**	Identify, in hours, the current consultant obstetric cover for the delivery suite	Associate medical director for obstetrics	30.11.2023	20.11.2023 – action completed. Workforce review undertaken Kendall Bluck Currently 76 hours of consultant obstetric cover provided.	
		Add risk to the risk register regarding non-compliance with the 98-hour consultant standard cover for the delivery suite.	Associate medical director for obstetrics	30.09.2023	20.11.2023 – action completed. Active risk on the risk register – risk 1013 current risk score of 15.	
		Undertake an obstetric medical workforce review 2023 reporting period.	Associate medical director for obstetrics	30.11.2023	20.11.2023 – action completed. Obstetric workforce review has been completed. Investment of £394,200 required equating to 2.7 WTE Consultant Obstetricians.	
		Present the findings of the workforce review to the finance and workforce committee.	Associate medical director for obstetrics	31.12.2023	20.11.2023 – paper presented to finance and performance committee outlining the staffing requirement and financial ask.	
		Business case to be written to source funding for the 2.7 WTE consultant	Divisional director for the division of	30.01.2024	20.11.2023 – development of the action plan ongoing with Divisional Director and Obstetric CD	

		obstetricians identified as being required.	women and children			
		Recruit to 2.7 WTE equivalent consultant obstetricians identified as being required.	Associate medical director for obstetrics	30.03.2024	20.11.2023 – awaiting approval of the business case.	

Appendix 5 Medical Staffing Neonatal Workforce 2023

1	*12.09.2023*

Action Plan – Medical Staffing Neonatal Workforce 2023

Organisation:	Lancashire Teaching Hospitals NHS Foundation Trust
Lead Officer:	Dr Aubrey Makhalira
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Address:	NICU, Royal Preston Hospital

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	Neonatal Medical workforce review	Local review of neonatal medical workforce to benchmark current establishment against BAPM standard.	Clinical Director for Neonatal/ Divisional Director	30/10/2023	07/09/2023 Workforce review of WTE medical neonatal workforce per tier groups undertaken to identify further funded establishment required to meet 1:8 ratios for safe neonatal staffing based on BAPM recommendations	
				30/11/23	12/09/2023 Staffing review to be presented to Medical Director for approval at DIF in November 2023.	
2	Tier 1 (ST1-3) does not currently meet BAPM standards of 1 in 8 rota requirements. Currently achieving 1:7	2 ANNP's in training. Planned to integrate into tier 1 rota by July 2023	Clinical Director for Neonatal services	~~05/02/2023~~ 05/02/2024	**Action carried over from year 4.** 8/09/23: ANNP completed training and now integrated into the Tier 1 rota. There are plans to review current staffing to transition to 1 in 8 rota.	
					13.11.2023 Outcome of the DIF paper awaited to be presented in November 2023.	
3	Funding: Tier 2 (ST4-8) does not currently meet BAPM standards, 1 in 8 rota requirements. Currently achieving 1:7	ANNP's to be integrated into medical rota to support Tier 2 rota as non-medical Consultants	Clinical Director for Neonatal services	~~05/2/2023~~ 01/12/2023	15/11/22 Paper planned for Divisional Board in December 22 to move ANNP's with appropriate competencies onto middle grade rota. – completed.	
					08/09/23 ANNP transitioned to Tier 2 rota on 3rd April 2023. Currently rota does not meet BAPM compliance until further	

					recruitment of 2 posts to Tier 2. 1 post out to recruitment Via ORDER program. 13.11.2023 Recruited to post awaiting start date.	
4	Recruitment Maternity leave back fill	To recruit 2 senior clinical fellows to replace specialty doctors (on maternity leave)	Clinical Director for Neonatal services	01/09/2022	23/2/22 Recruited 1 senior clinical fellows and 1 Medical Training Initiative MTI to replace specialty doctors who are on maternity leave. Action complete.	
5	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU) Currently achieving 1:7	To present the BAPM medical staff gap to prepare business case for 2 additional consultants to support Tier 2 and Tier 3 rota and enable expansion of Tier 2 and Tier 3 cover to achieve (1 in 7 rota)	Clinical Director for Neonatal services	June 2020	Business case for 2 additional resident consultants approved July 2020. Action complete.	
		Recruited to 2 WTE consultant posts as above following approval of business case	Clinical Director for Neonatal services	01/09/2024	1/5/22 All post now recruited. (This facilitated a move from 1 in 6 to 1 in 7)	
6	Expansion of workforce Consultant's rota does not currently meet BAPM standards 1 in 8 requirements (Based on the birth-rate and admission to NICU)	To present 2023 medical staffing review to specialist commissioning to seek funding to achieve BAPM compliance.	Clinical Director Neonatal services/ Divisional Director	31/12/2024	September 2023 - Speciality staffing review completed.	
					November 2023 – present to medical Director at DIF	
					December 2023 – Present approved gap analysis to specialist commissioning.	

Appendix 6 Workforce action plan

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 To commence week beginning 15.05.2023. 15.05.2023 First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up. 18.09.2023 Action ongoing. 13.11.2023 Action continues to be explored and monthly finance and workforce meetings continue.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open. 18.09.2023 Action completed.	
		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 Draft template to be updated by MR 03.07.2023 Template trialled and to be revised. 18.09.2023 Action ongoing. 13.11.2023 Action stood down as not longer applicable.	

		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff. Considered and excluded	
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023. 18.09.2023 Options reviewed and agency booked when possible. Agency fill rates included in the perinatal Surveillance table. Action Closed	
		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with “Safe practice principles for adult nurses working as part of multidisciplinary teams (MDT) in Maternity Services” published by NHS England on 25th May 2023. Options for other nurse roles within maternity services to be explored. 18/09/2023 continuous review of alternative bookings via nursing and critical care. Action closed	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment. 18/09/2023 Action completed	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place. 18/09/2023 Action completed	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	

2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a "floating midwife". 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	
		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ ~~31.07.23.~~ 1.11.2023	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options. 18/09/2023 Action ongoing. 13.11.2023 Options continue to be reviewed by LMNS. No further options at present stood down	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	

		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife. 15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	
		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ ~~01.08.2023~~ ~~1.12.2023~~ 5/01/2024	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23. 18/09/2023 Action ongoing.13.11.2023 Action deadline extended to reflect ongoing action.	
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review. 15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023	

					26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Trust Board to share findings of BR+ assessment with ICB	Chief Nursing Officer	~~1.12.2023~~ 1.02.2024	18.09.2023 Br+ Paper approved for sharing and consideration with the ICB and LMNS. 13.11.2023 Action ongoing deadline extended.	
		PWR data review to be undertaken to ensure accurate midwifery staffing establishment reported to NHSE.	Divisional midwifery and nursing director	1.11.2023	25.08.2023 PWR Data review meeting arranged and discrepancies noted with national data published. Escalated to national team via Regional Associate lead Midwife. Awaiting update. 13.11.2023 Action Completed	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed. Action completed.	

		Meet with team leaders/ ward managers regarding summer annual leave planning. Reiteration that maximum allowance is 17%.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	~~31.07.23~~ 1.12.2023	15.05.2023 Finance BP to create new cost centre. Update awaited. 18/09/2023 Action ongoing. 13.11.2023 Cost Centre created. Action completed	
		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	
		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing.	

					18.09.2023 Local recruitment for international recruitment in house commenced. 13.11.2023 Paper collated to consider continued funding for international recruitment	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies. 30.06.2023 Item to be added to workforce committee in July 2023. Workforce action tracker in place. Action closed.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	
		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently. Action closed	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	

		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out. Action closed	
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ ~~31.07.2023~~ 1.12.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new starters required. 01.07.23 – ongoing next recruitment event to be confirmed.18.09.2023 events ongoing.	
		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit. 18.09.2023 funding awaited Awaiting outcome of funding overall. 13.11.2023 Notification of funding confirmed by LMNS awaited	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~ 31.1.20234	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023. 18.9.2023 Additional band 3 recruitment undertaken for MAS. Funded 4.6 WTE Action closed	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	01.01.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean	

					section list, induction of labour and maternity triage. 18.9.2023 action ongoing.13.11.2023 Paper taken to F&P to seek funding	
6	**Retention** **Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings. Action completed	
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	~~31.09.2023~~ 31.01.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams. 18.09.2023 Awaiting confirmation that all areas have signed up to TED. 13.11.2023 Part of the W&C people plan deadline extended	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	
		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes. 18.9.2023 Staff identified to complete flow coaching. Action ongoing. 13.11.2023 Leaders identified to attend coaching programme. Action Closed	
		Opportunities for development and career progression available via CPD funding work streams	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal monitoring speciality training, maternal medicine. ANNB ARC. Action complete	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	

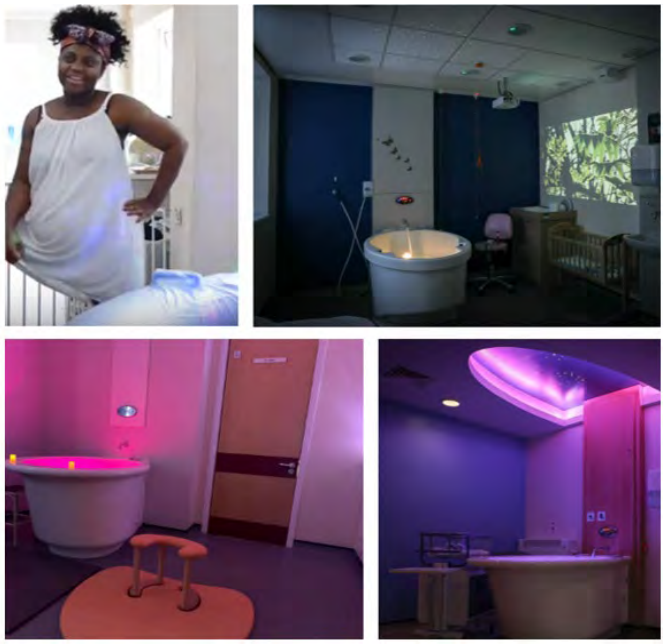
10	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ 01.01.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing. 18.09.2023 Actions continue. 13.11.2023 Meeting arranged with LMNS workforce committee and UCLAN 16.11.2023	
		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding. 03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
11	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	
		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ 1.01.2023	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service. 1.09.2023 Additional £11,00 funding agreed via a bid for backfill for establishing PMA's 13.11.2023 Action ongoing.	

		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed. 15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ ~~31.08.2023~~ 1.12.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.18.09.2023 13.11.2023 Action ongoing	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	~~01.09.2023~~ 1.12.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed. 18.09.2023 Draft action plan in place and awaiting confirmation. Action ongoing13.11.2023 Divisional People Plan developed. Action closed	
12	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service user feedback, governance systems.	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	
13	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	~~30.09.23~~ 1.1.2023	Chief Nurse leading.18.09.2023 awaiting update of plan.13.11.2023 Action ongoing	

		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	~~1.11.2023~~ ~~3~~1.12.2023	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division. 18.09.23 Action ongoing. 13.11.2023 Actions ongoing with divisional people plan	
		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support, consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	OD and Divisional Board to commit & enable attendance	~~31.10.2023~~ 31.03.2024	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post. 18.09.2023 Action ongoing. 13.11.2023 Deadline extended	
		Based on the findings of the training needs analysis consider the delivery of a series of bespoke leadership 'away days.	OD and Divisional Board to commit & enable attendance	~~30.09.2023~~ 31.03.2024	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team. 18.09.2023 Action ongoing.13.11.2023 Deadline extended	
		To improve the quality of appraisal conversations/paperwork, objective and development planning in appraisal. This will be achieved by all appraisers attending the Appraisal Masterclass.	OD and Divisional Board to commit & enable attendance	31.03.2024	30.06.2023 Improved appraisal quality audit rating. • Increased use of 360 feedback in appraisal. • Increased number of appraisals with objectives and personal development plan completed. • Increased scores benchmarked against the 2022 National Staff Survey for questions relating to having a quality appraisal. 18.09.2023 Action ongoing.	

					13.11.2023 People Plan developed by OD. Therefore action closed.	
		Increased capacity within senior midwifery team through creation of: - Deputy Divisional midwifery and Nursing Director - Creation of Safety and Quality matrons - Creation of the Specialist Midwife for maternal medicine - Creation of the Planned work, capacity, and flow co-ordinator - Enhanced antenatal and newborn screening leadership capacity	Chief Nursing Officer	~~31.04.23~~ 01.09.23	03.07.23 – All posts recruited.	

Maternity and Neonatal Annual Work Plan 2023/24



Lancashire Teaching Hospitals

Executive Summary

Evidence tells us that providing personal, safe, and high-quality care for women* and babies and families throughout pregnancy, during birth and following birth has a positive impact on the health and life chances as well as on the healthy development of children throughout their life. This can help to reduce the impact of inequalities which can have longer-term health consequences for families, securing the best possible outcomes for families and communities. (*The use of women is used throughout the document and inclusive to all pregnant people)

Lancashire Teaching Hospitals maternity and neonatal voice strategy is aligned to Trust, Regional and National directives for safer maternity care and aims to deliver clinical excellence and evidence-based care based on the ambitions set out in Better Births, The NHS National Maternity Transformation Programme, NHS Long Term Plan and most recently the Three-year Single Delivery Plan.

The Three-year Delivery Plan for maternity and neonatal services and the Clinical Negligence Standards for Trusts set's the ambition that Maternity & Neonatal Voices Partnerships will:

- have the infrastructure they need to be successful to include workplans are funded. MNVP leads are appropriately remunerated and receive appropriate training, administrative and IT support. (ICB/Healthwatch)
- listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- have strategic influence and are embedded in decision-making utilising the executive Safety Champions to drive quality equity and safe maternity and neonatal services.
- service user involvement in developing and delivering of training.

Service Overview

The maternity service provides consultant led and midwife-led service across two sites (Royal Preston Hospital Sharoe Green and Chorley General Hospital) delivering a 24/7 service. We offer four choices of place of birth: home, alongside birth centre, free standing birth centre and consultant-led obstetric unit.

To support the safe delivery of care the service is complimented by care provision delivered using a continuity of carer model and the provision of a Tier 3 Neonatal Unit for Lancashire and South Cumbria located on the Royal Preston Hospital site in addition to neonatal outreach services provided within the community setting.

Our multi-professional maternity and neonatal team and local community have an essential role in the pregnancy continuum ensuring that safe, effective, and personalised care are provided. To ensure women's long-term wellbeing and that our population have the best start in life, we need to develop sustainable services that are responsive to their social, emotional, and physical health needs.

Maternity and Neonatal Voices Partnership (MNVP)

An MNVP is a partnership that works to review and contribute to the development of maternity and neonatal services within a local area. It brings together the staff who pay for (commission) and provide maternity services with the women, birthing people and families who use those services. The MNVP is coordinated by a service user chair or leadership team, who are independent lay people. All members of the partnership take responsibility for the development and delivery of an agreed workplan.

Voices of all women including those from diverse backgrounds must be heard, and services should work closely with all service users to collaboratively plan, design, and improve care. "A Maternity Voices Partnership (MVP) is an NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care".

The Team

The membership includes but is not exclusive to:

Midwives, health visitors, doctors and managers, women, birthing people and families from a diverse range of backgrounds, members of the wider community such as birth workers and charities specialising in mental health, supporting refugees, etc. The members work together as equals, recognising that each person brings a different set of experiences, skills and resources that will contribute to the strength of the partnership. It is intended that everyone who uses or works in NHS maternity services in England can choose to get involved in a local Maternity Voices Partnership.

Meet The Team

Work Plan 2023-24

The Lancashire Teaching Hospitals Maternity and Neonatal Voice Partnership (MNVP) work plan is based on the principles included in the 3-year single delivery plan and the MNVP Guidance (awaited) and includes overarching principles from recent external reviews, safety bundles and public Health policy. (Ockenden, Kirkup reports and Clinical Negligence Scheme for Trust).

Its aim is the co-produce and design a safer caring and personalised maternity service that is equitable to all service users, which is modern and reflective of the local population. The actions included in the plan are written in response to national external recommendations, national maternity survey results, neonatal network and BAPM requirements and local datasets related to compliments, complaints, and patient experience feedback. The plan is co-designed and produced in response to the local population demographics and ethnicity to ensure that voices are representative of all service users, including the seldom heard voices within Preston and South Ribble for both maternity and neonatal services. It is acknowledged that this work plan is fluid and will change in response to new publications, statutory regulation and any local priorities or other system change which requires a response.

Goal 1: Align Workplan to National MNVP Guidance (Awaiting publication)					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CNST MIS Year 5.	Align Workplan to National MNVP Guidance	NMVP Lead	Guidance awaited	1.11.2023 Guidance from National MNVP awaited. Action on hold	
Goal 2: Confirm Agreed Renumeration Arrangements.					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CNST Year 5. Single Delivery Plan	Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan	ICB/Health Watch	31.10.2023	31.10.2023 Provider meeting with ICB and Health Watch. Funding arrangement confirmed Health Watch has been commissioned to host.	
Goal 3: Agree Schedule of Essential Provider Engagement					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CNST Year 5 3-year Single Delivery Plan	Schedule of Provider Meetings to be agreed and shared: • Maternity/Neonatal Safety and Quality Committee.	Matron for Safety and Quality/MNVP Lead	1.12.2023	3.11.2023 Safety and Quality Matron issued meeting schedule on MS Teams to MNVP lead.	

	• Safety Champions and ad hoc Safety walk rounds. • Birth Forum • Quarterly engagement Meetings				
	Trusts must be able to evidence service user involvement in developing and delivering training.	Matron for Safety and Quality/MNVP Lead	3.11.2023	3.11.2023 Formal sign off 2023-24 programme at provider sign off committee on 3.11.2023. Awaiting formal sign off agreement	
	Strategic Engagement and Collaboration for all external facing communication	Divisional Midwifery and Nursing Director	31.03.2023	3.11.2023 Ongoing live action responsive to national or local priorities.	
Goal 4: Service User Experience and Feedback					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CNST Year 5 3-year Single Delivery Plan	Present findings of 2023 engagement events: • 15 steps April 23 • National Bereavement Pathway Peer Review. • Gynaecology Improvement Plan 2023 • Ockenden insight MNVP walk round May 23 • Leyland Festival Community Engagement Event	MNVP Lead/ MNVP East Lancs	31.10.2023	31.10.2023 Presentation update provided on 3.11.2023. Presentation shared with MNVP and Health watch.	
	Review the CQC Maternity Survey findings annually and develop.	Matron for Safety and	31.3.202	3.11.2023 Last report (Feb 2022 data) reviewed, and a	

		Quality/MNVP Lead		paper and action plan collated Matron for Safety and Quality	
				3.11.2023 Awaiting latest February 2023 report. MNVP and Safety and Quality Lead to review	
	Learn from concerns and complaints and review complaints quarterly to ensure that thematic concerns are identified and used to co-design services.	Matron for Safety and Quality/MNVP Lead	31.3.2024	3.11.2023 Matron for Safety and Quality to share and update complaints triangulation report to co-produce any changes.	
	Commission a fresh eyes 15 steps repeat baseline walk round with new MNVP Lead	Divisional Midwifery and Nursing Director/ MNVP Lead	31.3.2024	3.11.2023 Open conversations about undertaking 15 steps as an early action for 2024.	
	Using a variety of platforms to engage with local communities to seek feedback and to hear the voice of families using maternity services.	MNVP Lead	31.03.2024	3.11.2023 Develop and agree wider feedback forums and service user engagement discussed at work plan meeting. Project agreed to work with Leyland House. See action below	
	Arrange quarterly engagement events chaired by the MNVP lead which are both virtual and in community locations.	MNVP Lead	31.03.2024	3.11.2023- Quarterly Meetings to be confirmed by Health Watch and MNVP.	
	Meet with the neonatal team to consider neonatal voices partnership requirements and PAG.	MNVP Lead/Clinical Director	30.06.2024	3.11.2023- New action	

CNST Year 5 3-year Single Delivery Plan NHS Digital	Refresh and review Gap analysis for LTHTR Web pages in collaboration with MNVP to reflect changes required to improve information, equity, and accessibility.	Deputy Divisional Midwifery and Nursing Director/ MNVP Lead	31.03.2024	3.11.2023 New Chair in post and schedule for completion to be agreed.	
Goal 5: National maternity and Neonatal Strategy					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CNST Year 5 3-year Single Delivery Plan NHS Ockenden	Ensuring pregnant women and new mothers have access to the right pelvic health services.	ICB/LMNS	30.6.2024	3.11.2023 Pelvic Health Midwife appointed. To agree schedule of work to co-produce new service as required either jointly with LMNS or locally driven.	
	Choice and Personalisation - Enhance the antenatal experiences and choices of mothers and their families	ICB/LMNS	30.06.2023	3.11.2023. Continue LMNS system work around choice and personalisation.	

	Plan bereavement services that are responsive to women's needs and in response to feedback, surveys and national recommendation	Bereavement Lead Midwife/MNVP	30.6.2024	20.7.2023 National Bereavement Pathway Peer review undertaken at LTHTR. Share response paper	
	Support early pregnancy improvement plan	Bereavement Lead Nurse/MNVP	30.6.2024	3.11.2023 Continue to support the experience and co-production plan	
Hearing the Voice of the seldom Heard and Minority groups Equality and Diversity					
National Agenda	Key Actions	Lead Officer	Deadline for action	Progress update	Current Status 1 2 3 4
CORE 20+5 CNST Year 5 3-year Single Delivery Plan NHS Ockenden	Services listen to and work with women from all backgrounds to reduce inequality and improve access, plan, and deliver personalised care.	Divisional Midwifery and Nursing Director	30.6.2024	1.7.2023 Chief Nursing Officer to linked with local Muslim girls' school and arranged a visit to seek views of young women who are future service users.	
				3.11.2023 Consider a listening event in collaboration with residents of the Leyland Hotel are a hard to reach and seldom heard population.	
	Promote cultural diversity and ethnicity engagement in maternity care.	ICB/MNVP	30.6.2024	3.11.2023. Consider system level actions in line with the LMNS equity and diversity plan	
	Review provision of enhanced continuity of care in 2024.	Divisional Midwifery and Nursing Director/MNVP	30.06.2024	12.11.2023 Meeting with National maternity team planned.	
				03.11.2023 Await outcome of the NHS Race & Health Observatory has partnered with the Institute for	

				Healthcare Improvement (IHI) and the Health Foundation (HF) to deliver a Learning Action Network which aims to tackle and close the gap seen in maternal mortality and morbidity between women from different ethnic backgrounds.	

Appendix 8 Core Competency Framework

Organisation:	Lancashire Teaching Hospitals Womens and Children's Division
Lead Officer:	Emma Holden
Position:	Divisional Midwifery and Nursing Director

Version	Date
1.0	11/09/2023
1.1	13/11/2023

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
Core competency module one – saving babies lives care bundle.						
1	Saving babies lives care bundle eLfH e-learning module.	Staff to complete eLfH module every three years with 90% compliance achieved.	Midwifery practice educator	01.01.2024	20.10.23 EH – liaise with the training analytics team to develop a bespoke training report for maternity mandatory e-learning. 13.11.23 EH – action completed.	
1a	Smoking in pregnancy: Very brief advice	Mandate e-learning on blended learning for midwives	Maternity matron for safety and quality	31.09.2023	20.10.23 EH – Training has been mandated. To liaise with the training analytics team to develop a bespoke training report for	

					maternity mandatory e-learning. 13.11.23 EH – action completed.	
2	Smoking in pregnancy: NCSCT e-learning	Mandate e-learning on blended learning for midwives	Maternity matron for safety and quality	31.09.2023	20.10.23 EH – Training has been mandated. To liaise with the training analytics team to develop a bespoke training report for maternity mandatory e-learning. 13.11.23 EH – action completed.	
3	Fetal growth restriction: Teach local referral pathways	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024	
4	Fetal growth restriction: Identification of risk factors and actions to be taken	Add to saving babies lives study day from January 2024	Midwifery practice educator	30.10.2023	20.10.2023 – teaching delivered 19.10.2023	
5	Fetal growth restriction: Evidence of learning from local trust detection rates and actions implemented	Add to saving babies lives study day from January 2024	Midwifery practice educator	30.10.2023	20.10.2023 – October training delivered. Date planned for November 2023 13.11.23 EH – action completed.	
6	Fetal growth restriction: Measuring symphysis fundal height practical training and assessment	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	

7	Fetal growth restriction: Case reviews from examples of missed cases locally.	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
8	Reduced fetal movements: Teach local referral pathways	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
9	Reduced fetal movements: Advice given to women and actions to be taken.	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
10	Reduced fetal movements: Evidence of learning from case history, service user feedback, complaints, and local audit.	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
11	Preterm birth: Identification of risk factors	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to	

					PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
12	Preterm birth: teach local referral pathways and MDT collaborative approach to care.	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to PROMPT study day from January 2024 20.10.2023 – training material prepared, and training added to the agenda for 2024.	
13	Preterm birth: All elements in alignment with the BAPM/ Mat Neo SIP optimisation and stabilisation of the preterm infant pathway of care	Add to saving babies lives study day from January 2024	Service development midwife	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to saving babies lives study day from January 2024. 20.10.2023 added to the public health programme 2024.	
14	Preterm birth: Risk assessment and management in multiple pregnancy	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to saving babies lives study day from January 2024. 20.10.2023 added to the public health programme 2024.	
15	Diabetes in pregnancy: Identification of risk factors and actions to be taken	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	11.09.2023 – taught on public health study day 2022. Add to saving babies lives study day from January 2024. 20.10.2023 added to the public health programme 2024.	

16	Diabetes in pregnancy: Referral pathways	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	20.10.2023 added to the public health programme 2024.	
17	Diabetes in pregnancy: Glucose management including continuous glucose monitoring	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	20.10.2023 added to the public health programme 2024.	
18	Diabetes in pregnancy: care of the diabetic woman in labour.	Add to saving babies lives study day from January 2024	Midwifery practice educator	01.01.2024	20.10.2023 added to the public health programme 2024.	
Core competency module two – fetal monitoring and surveillance, antepartum and intrapartum.						
19	Fetal monitoring lead trainers must attend annual specialist training updates outside the unit.	LM to provide certificates for assurance of attendance.	Fetal monitoring lead midwife	01.01.2024	20.10.2023 added to the public health programme 2024.	
20	Service user feedback to be included in teaching.	Add patient story from complaint – Dawes Redman criteria complaint.	Fetal monitoring lead midwife	01.01.2024	20.10.2023 – patient story taken from letter of complaint incorporated into the 2024 fetal monitoring study day teaching materials. Content to be approved by LMNS chair. 13.11.2023 EH action completed.	
21	Human factors training as agreed with the LMNS	Seek agreement from the LMNS regarding approved human factors training	Deputy divisional midwifery and nursing director	31.10.2023	20.10.2023 training materials prepared, to be approved by the LMNS during the November 2023 assurance visit.	
Core competency module three – maternity emergencies and multi-professional training.						

22	Training must: Include identification of deteriorating mother using MOEWS chart.	Add Maternal observations and care following post operative interventions to PROMPT agenda 2024.	Midwifery practice educator	31.10.2023	11.09.2023 EH – A-E assessment taught on PROMPT 2023, to continue bring taught in 2024 as part of care following post operative interventions update.	
23	Training must: Include identification of deteriorating baby including use of the NOTTS chart.	Add to the saving babies lives study day programme 2024.	Midwifery practice educator	01.01.2024	20.10.2023 – included on the saving baby's lives study day.	
24	Lessons from clinical incidents should be included in the drills.	SL HSIB investigation (shoulder dystocia) to be included in PROMPT 2024.	Midwifery practice educator	01.01.2024	11.09.2023 EH – maternal death sepsis included in 2022 and 2023. To include learning from SL severe shoulder dystocia HSIB investigation in 2024 teaching (incident occurred 2023). Learning from local incidents and audit slide included in all teaching presentations.	
25	Be tailored for specific groups (home birth teams/ MSW's)	A range of scenarios to be developed to encompass emergency situations in different environments.	Midwifery practice educator	01.01.2024	20.10.2023 range of scenarios to be developed for use during PROMPT.	
26	One of the emergency scenarios should be conducted in the clinical area.	Neonatal resus to be performed in the clinical areas from 2024 not skills lab.	Midwifery practice educator	01.01.2024	20.10.2023 – neonatal resuscitation practical session taught on the delivery suite as part of the PROMPT study day.	

Core competency module four: Equality, equity and personalised care						
27	Ongoing antenatal and intrapartum risk assessment.	Added to the public health study day programme 2024.	Consultant midwife	01.01.2024	20.10.2023 - Added to the public health study day programme 2024.	
28	Risk communication	Added to the public health study day programme 2024.	Consultant midwife	01.01.2024	20.10.2023 - Added to the public health study day programme 2024.	
29	Personalised care and support planning.	Added to the public health study day programme 2024.	Consultant midwife	01.01.2024	11.09.2023 EH – delivered on public health study day 2022. To deliver teaching again on 2024 programme.	
30	Informed decision making, enabling choice, consent and human rights.	To be included in ESMT 2024 update on the public health study day.	Maternity matron for safeguarding	01.01.2025	20.10.2023 - Added to the public health study day programme 2024.	
Core competency module five: Care during labour and immediate postnatal period						
31	Management of labour including latent phase	Formal teaching in care during labour and immediate postnatal period added to the public health study day 2024.	Midwifery practice educator	01.01.2024	11.09.2023 EH – Covered on fetal monitoring study day 2022 however, added to the public health study day 2024.	
32	Group B Streptococcus in labour.	Added to the public health study day 2024.	Midwifery practice educator	01.01.2024	11.09.2023 EH – Covered on fetal monitoring study day 2022 however, added to the PROMPT study day 2024.	
33	Management of epidural analgesia	Currently on blended learning – e-learning needs to be mandated	Maternity matron for safety and quality	31.09.2023	20.10.2023 given learning from recent incidents to be added to face-to-face training as part of labour	

					teaching on the public health study day.	
34	Recovery care after general anaesthetic.	Added to the PROMPT study day programme 2023.	Midwifery practice educator	01.01.2024	20.10.2023 – added to the 2024 PROMPT study day. Training materials have been prepared.	
35	Operative vaginal birth	Added to the PROMPT study day programme 2023.	Midwifery practice educator	01.01.2024	20.10.2023 – added to the 2024 PROMPT study day. Training materials have been prepared.	
36	Multiple pregnancy	Added to the saving babies lives study day programme 2024.	Midwifery practice educator	01.01.2024	20.10.2023 - to be added to face-to-face training as part of labour teaching on the public health study day.	
37	ATAIN	Added to the saving babies lives study day programme 2024.	Service development midwife	01.01.2024	20.10.2023 - Added to the saving babies lives study day programme 2024.	
Core competency module six: Neonatal life support.						
38	Include recognition of the deterioration of black and brown babies.	Added to the saving babies lives study day programme 2024.	Midwifery practice educator	01.01.2024	20.10.2023 - Added to the saving babies lives study day programme 2024. Content of presentation to be approved by the neonatal team.	
39	Include recognition of deteriorating newborn, actions to be taken and local escalation procedures.	Added to the saving babies lives study day programme 2024.	Midwifery practice educator	01.01.2024	20.10.2023 - Added to the saving babies lives study day programme 2024. Content of presentation to be approved by the neonatal team.	

40	Use of SBAR for handover.	Currently taught on PROMPT, however, need to formalise the content taught by adding a slide to the teaching presentation.	Midwifery practice educator	01.01.2024	20.10.2023 – neonatal resuscitation presentation updated for 2024 and use of formal handover communication tool, to the neonatal team, added to the presentation.	
41	Include human factors	Currently taught on PROMPT, however, need to formalise the content taught by adding a slide to the teaching presentation.	Midwifery practice educator	01.01.2024	20.10.2023 – neonatal resuscitation presentation updated for 2024. Human factors added to the presentation.	
42	Psychological safety and civility	Currently taught on PROMPT, however, need to formalise the content taught by adding a slide to the teaching presentation.	Midwifery practice educator	01.01.2024	20.10.2023 – neonatal resuscitation presentation updated for 2024. Psychological safety and civility added to the presentation.	
43	Tailored for specific groups and where they work (home birth and MSW's)	Scenarios are tailored for the staff groups but no formal documentation to support. Scenarios to be written for different staff groups and different clinical scenarios.	Midwifery practice educator	01.01.2024	20.10.2023 range of scenarios to be developed for use during neonatal resuscitation training delivered on the PROMPT study day. 13.11.2023 EH – action completed.	
44	Cover scenarios in different environments.	Scenarios are tailored for the staff groups but no formal documentation to support. Scenarios to be written for different staff groups and different clinical scenarios.	Midwifery practice educator	01.01.2024	20.10.2023 - range of scenarios to be developed for use during neonatal resuscitation training delivered on the PROMPT study day. Some scenarios to use the resuscitaire	

					equipment and some to use bag valve mask/ community midwifery resuscitation equipment. To deliver practical training on the delivery suite, the alongside birth centre and in a simulated home birth setting. 13.11.2023 EH – action completed.	
55	Include training on the use of equipment available in the different areas.	Currently taught on PROMPT, however, need to formalise the content taught by adding a slide to the teaching presentation.	Midwifery practice educator	01.01.2024	20.10.2023 – neonatal resuscitation presentation updated for 2024. Equipment available in the different areas added to the presentation.	
56	Neonatal resuscitation should be taught by a UK resuscitation council certified NLS instructor.	Timetable to be agreed by those with the appropriate qualifications, to commit to teach specific dates for the 12-month period.	Midwifery practice educator	01.01.2024	20.10.2023 – teaching schedule to be agreed across the maternity and neonatal services. NLS instructors to be asked to support one PROMPT study day each. 13.11.2023 EH – action completed.	

Appendix 9 Summary of HSIB cases

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of HSIB investigation	Final HSIB report sent to legal team.	Duty of Candour
019756	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed severe HIE. Decision made for compassionate withdrawal of care.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
020352	Induction of labour. Transferred to delivery suite once labour established. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. At 24 hours cooling stopped by the neonatal team as baby clinically very well. MRI performed and did not show evidence of HIE.	Not applicable – confirmed by legal department. Cooling not completed, no HIE on MRI and HSIB declined to investigate.	Not applicable – confirmed by the Trust legal department.	HSIB declined to investigate as referral criteria not met – based on MRI and the parents had no concerns with care.	Not applicable	Yes
021966	Severe shoulder dystocia (22 minutes) following instrumental birth. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
022696	Induction of labour. Fetal bradycardia on the antenatal ward. Category one caesarean section. Therapeutic cooling treatment initiated. Post cooling MRI showed severe HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
024639	Induction of labour. Abnormal fetal heart rate auscultated; Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
032957	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed moderate to severe HIE	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

34308	Spontaneous onset of labour at term. Admitted to birth centre and transferred to delivery suite following a delay in the second stage of labour. Following transfer to delivery suite decision made for assisted birth. Sequential instrument used on repeat occasions. Assisted birth abandoned and transferred to theatre, baby born by emergency caesarean section in poor condition, significant subgalea haemorrhage identified at birth. Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
35266	Seen in maternity assessment suite at term with vaginal bleeding and irregular uterine activity. Following spontaneous rupture of membranes, significant antepartum haemorrhage occurred. Transferred to theatre for emergency caesarean section. Baby born in poor condition, resuscitated and transferred to NICU. Cooling commenced; however, decision made to stop cooling and reorientate care to palliative. Baby died shortly after the reorientation of care.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
35563	SROM at term, declined IOL. Absconded from the unit following commencement of IOL process. When returned to the unit terminal CTG pattern. Initially declined emergency caesarean section (CS). CS later accepted. Baby born in poor condition. Resuscitated and transferred to NICU however, decision made for compassionate reorientation of care to palliative.	Not applicable neonatal death incident.	Not applicable neonatal death incident.	MNSI attempting to contact mother to confirm consent to proceed with investigation.	MNSI attempting to contact mother to confirm consent to proceed with investigation.	Yes
Awaiting confirmation of MI number	Induction of labour at term for reduced growth velocity and raised blood pressure. Delay in the progress of the first stage of labour, decision made for category two caesarean section. Constriction ring identified at caesarean section, deeply impacted fetal head. Thirteen-minute period between knife to uterus and delivery of baby. Baby born in poor condition. Resuscitated and transferred to NICU. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

Appendix 10 – Maternity red flag data

*7 incidents reported on Datix however, when reviewed as part of the monthly assurance process, it was assessed that one-to-one care in established labour was provided on all occasions.

Red flag Reporting Metrics	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr-23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Delay in time critical activity	11	16	2	1	2	13	54	22	17	17	50	43	34	38
Missed or delayed care> 60 mins in washing or suturing	0	2	0	0	0	0	1	0	0	1	2	0	0	0
Failure for women to receive the medication required.	2	3	2	0	0	0	1	0	0	0	0	0	0	0
>30-minute wait for pain relief.	2	1	0	0	0	0	1	0	0	0	3	2	3	0
Lack of full examination when woman presents in labour.	0	1	0	0	0	0	1	0	0	0	0	1	1	1
>2-hour delay in induction?	15	19	3	1	1	0	10	1	6	4	30	10	16	10
Delay in recognition of and action of abnormal signs.	1	1	0	0	0	0	2	2	0	0	0	2	0	0
Inability to provide one to one care in labour?	4	5	0	0	0	0	2	0	0	0	7*	0	1	2
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS	1													
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)												5	21	18
>30-minute wait for obstetric triage.	2	1	1	0	1	1	40	15	15	15	29	29	25	11
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)		1	0	0	0	0	0	0	0	0	1	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)		13	3	0	1	0	7	3	5	3	24	5	15	8
Was there a delay in transfer once labour was established? (New parameter Oct 22)		3	0	0	0	0	1	0	0	1	3	1	1	1
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)		1	0	0	0	0	0	0	0	0	0	1	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)		1	1	0	0	0	0	0	1	0	0	1	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)		9	0	0	0	0	2	0	1	0	7	1	3	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)		1	0	0	0	1	4	1	27	177	31	4	85	14
Total numbers of red flags	**38**	**78**	**12**	**2**	**5**	**15**	**126**	**44**	**72**	**218**	**187**	**105**	**205**	**103**

Chair's Report

Committee:	Education, Training and Research Committee
Chairperson and role:	Professor Paul O'Neill, Non-Executive Director
Date(s) of Committee meeting(s):	8 November 2023
Purpose of report:	To update the Board on the business discussed by the Education, Training and Research Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and for escalation to the Board

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda, approved the minutes of the June meeting and noted the status of the action log.

The Committee scrutinised the core skills training report, which provided a summary of compliance status at Trust and Divisional level. Key points to note included appraisal compliance was 88.6% (target 90%), medical device compliance was 86.19% (target 90%), 6 mandatory training metrics were currently below compliance target and 1 new training module had been added to the mandatory group in September 2023.

The Committee reviewed the education quality surveillance report, which provided an update on information presented to the Committee in August 2023 in relation to the NHS England (NHSE) (NW) quality intervention visit on 5 and 7 July 2023. It also provided an update on progress made against the 2023 GMC National Training Survey. The Committee noted concerns that the survey had identified several specialities with poor results.

The Committee considered and endorsed the HEE self-assessment report, which presented the annual NHS England Self-Assessment for Placement Providers which was submitted on 31 October 2023.

The Committee was presented with the Research and innovation annual report strategy update (interim review), which updated on the progress within the R&I department and of the strategy 2022-2025 which began in October 2022. It highlighted the direction taken as the department had been managing financial turnaround and some of the barriers and hurdles both departmental, Trust and system-wide, university interactions and limitations regarding the innovation agenda.

The Committee received the education annual showcase for 2022-23, which was supplementary to the Education & Training strategy annual report 2022-23 that was presented to ETR Committee in June 2023. It focussed on some of the key successes and achievements. The showcase also highlighted some of the challenges in the current climate which had been presented to the Committee throughout the previous 12-15 months. The showcase also detailed upcoming developments alongside the intended full refresh of the Education & Training strategy.

The Committee scrutinised and endorsed in principle the PACCAR draft business case regarding the proposed Technology Enhanced Learning Centre (TELC) development in Education Centre 3 on the Chorley site.

The Committee reviewed the Finance update, which presented the education & training annual income and expenditure accounts year to date for 2023- 24 and outlined the full year forecast for 2023-24.

The Committee considered and agreed the strategic risk rating should be reduced to 16.

The Committee noted positive and negative escalations from the ETR feeder groups - Apprenticeships Strategy & Assurance Committee, Training Compliance and Assurance Sub-committee and Research and Innovation Sub-committee.

Items for the Board's attention

Positive escalation

None.

Negative escalation

Education quality surveillance report - the Intensive Support Framework (ISF) rating for Neurology had increased to a Level 2 (Significant concern) from a Level 1 (Minor Concern) meaning there were a significant number of areas where the Trust was not meeting NHSE standards and / or plans in place were not delivering sustainable improvement at the pace required. The GMC survey had identified several other specialities with extremely poor results. Those areas currently under internal scrutiny included Gastro, Oncology, general surgery F1/F2 programme, Urology, Paediatrics, Plastics and Acute Internal Medicine.

Committee to Committee escalation

None.

Items recommended to the Board for approval

None.

Committee Chairs reports received

a) Training Compliance and Assurance Sub-committee
b) Education Quality & Performance Sub-committee
c) Research and Innovation Sub-committee

Items where assurance was provided and/or for information

a) Core skills training report
b) Education Quality Surveillance report
c) Education annual showcase
d) Finance update

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its cycle of business.
The next meeting of the Committee will take place on 12 December 2023 using Microsoft Teams.

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Education, Training and Research Committee agenda (8 November 2023)

Education, Training and Research Committee

8 November 2023 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.15am	Verbal	Information	P O'Neill
2.	Apologies for absence	11.16am	Verbal	Information	P O'Neill
3.	Declaration of interests	11.17am	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 8 August 2023	11.18am	✓	Decision	P O'Neill
5.	Matters arising and action log	11.19am	✓	Decision	P O'Neill
6	Strategic risk register review	11.25am	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	11.30am	✓	Assurance	S Maxwell
7.2	Education quality surveillance report	11.40am	✓	Assurance	S Maxwell
7.3	HEE self-assessment report	11.50am	✓	Assurance	S Maxwell
8.	STRATEGY AND PLANNING				
8.1	Research and Innovation annual report strategy update (interim review)	12.00pm	✓	Assurance	P Martin-Hirsch
8.2	Education annual showcase	12.15pm	✓	Information	L O'Brien
8.3	PACCAR business case	12.30pm	✓	Decision	L O'Brien
9.	GOVERNANCE AND COMPLIANCE				
9.1	Finance update	12.40pm	✓	Assurance	R Patel
9.2	Strategic risk register review	12.50pm	✓	Decision	S Regan
9.3	Items for referral to the board or items to/from other committees	1.00pm	Verbal	Information	P O'Neill

№	Item	Time	Encl.	Purpose	Presenter
9.4	Reflections on the meeting and adherence to the Board Construct	1.05pm	✓	Assurance	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Feeder group Chair's reports negative/positive escalations: a) Training Compliance and Assurance Sub-committee b) Education Quality & Performance Sub-Committee c) Research and Innovation Sub-committee	1.10pm	✓	Information	L O'Brien / P Brown
10.2	Date, time, and venue of next meeting: 12 December 2023, 1pm via MS Teams	1.15pm	Verbal	Information	P O'Neill

Chair's Report

Committee:	Workforce Committee
Chairperson and role:	Jim Whitaker, Non-Executive Director
Date(s) of Committee meeting(s):	14 November 2023
Purpose of report:	To update the Board on the business discussed by the Workforce Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda and approved the minutes of the meeting on 12 September 2023 and noted the status of the action log.

The Committee scrutinised the Workforce and Organisational Development integrated performance report review, noted the key metrics, improvements made and continued areas of challenge.

The Committee received the Health Roster strategy report, which provided an update in relation to the Trust rostering strategy with a particular focus on nursing/medical rostering and grip/control.

The Committee was presented with an overview of workforce transformation & cost efficiency, which provided assurance on the workforce grip and control which was currently in place, an overview of the current multiple assessments, audits, and Cost Improvement Programme (CIP) checklists that had been completed.

The Committee reviewed the AHP strategy delivery and noted the progress made over the last year.

The Committee was provided with a central services update.

The Committee received the annual medical employee relation cases between November 2022 and October 2023 for senior medical and dental employees.

The Committee scrutinised the leadership and management development strategy report, noted the progress against the Our People Plan Strategic aim 'To be Well Led' and the associated impact measures.

The Committee received the engagement & recognition strategic aim update report, acknowledged the progress against and the associated impact measures.

The Committee reviewed the Guardian of safe working report, which provided assurance that junior doctors had been safely rostered within the Trust and were working hours that were safe and in line with the new safe working rules as set out within the 2016 contract. The Committee reviewed the strategic risk register and agreed the risk rating should remain at 16.
Items for the Board's attention
Positive escalation
AHP Strategy and implementation.
Negative escalation
Increased cases of violence and aggression but the positive work on the Big Room initiative was noted.
Committee to Committee escalation
None.
Items recommended to the Board for approval
None.
Committee Chairs reports received
Temporary staffing group.
Items where assurance was provided and/or for information
Workforce and organisational development integrated performance report review Health roster strategy report Overview of workforce transformation & cost efficiency AHP strategy delivery Update for central services Annual medical employee relation cases Leadership and management development strategy report Engagement & recognition strategic aim update report Guardian of safe working report Exception report from the DIFs
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 9 January 2024 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Workforce Committee agenda (14 November 2023)

Workforce Committee

14 November 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	J Whitaker
2.	Apologies for absence	1.01pm	Verbal	Information	J Whitaker
3.	Declaration of interests	1.02pm	Verbal	Information	J Whitaker
4.	Minutes of the previous meeting held on 12 September 2023	1.03pm	✓	Decision	J Whitaker
5.	Matters arising and action log	1.05pm	✓	Assurance	J Whitaker
6.	Strategic risk register review	1.10pm	Verbal	Assurance	J Whitaker
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Information	K Downey
8. STRATEGY DELIVERY					
8.1	Health roster strategy report	1.25pm	✓	Assurance	K Downey
8.2	Overview of workforce transformation & cost efficiency	1.35pm	✓	Assurance	K Downey
8.3	AHP strategy delivery	1.45pm	✓	Assurance	H Pennington
8.4	Update for central services	1.55pm	Verbal	Assurance	N Latham
9. TO DELIVER A RESPONSE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Annual medical employee relation cases	2.00pm	✓	Assurance	R O'Brien
10. TO BE WELL LED					
10.1	Leadership and management development strategy report	2.10pm	✓	Assurance	L Graham
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Engagement & recognition strategic aim update report	2.20pm	✓	Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					

№	Item	Time	Encl.	Purpose	Presenter
12.1	Guardian of safe working report	2.30pm	✓	Assurance	D Kendall
12.2	Strategic risk register review • Referral from SQC re oversight of equality impact assessments and cost improvement programmes.	2.40pm	✓	Decision	J Whitaker
12.3	Reflections on the meeting and adherence to the Board construct	2.45pm	✓	Information	J Whitaker
12.4	Items for escalation to the Board or items to/from other committees	2.47pm	Verbal	Information	J Whitaker
13. ITEMS FOR INFORMATION					
13.1	Exception report from the DIFs	2.48pm	✓	Information	
13.2	Feeder group Chair's reports: a) Temporary staffing group	2.49pm	✓	Information	
13.3	Date, time, and venue of next meeting: *9 January 2024 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	J Whitaker

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Allied Health Professionals Workforce Strategy – Year 1 Update

Report to:	Board of Directors	**Date:**	7th December 2023
Report of:	Chief Nursing Officer	**Prepared by:**	C. Granato & H. Pennington
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to inform the Board of Directors of progress made against Lancashire Teaching Hospitals (LTH) Allied Health Professional (AHP) Workforce Strategy (2002-2025). Progress made will be reported against each of the 10 themes, advising the status of year 1 metrics and any metrics that span the lifetime of the strategy. Highlights for the theme will be discussed along with an overview of next steps. 24 objectives were expected to be achieved during year 1, 18 have been achieved in full and the remaining 6 have been partially achieved and are actively being worked upon.

In June 2023 NHS England launched the 'NHS Long Term Workforce Plan', it has very similar aims to the LTH AHP workforce strategy. With a focus on sustainable workforce supply to improve patient care, retention and recruitment. There is a specific focus on AHP apprentices in the national strategy which complements local ambitions.

Highlights from the first year include:

- An increase from 9 to 27 AHP degree apprentices and all 27 were recruited from the LTH support workforce.
- Development of AHP specific pathways within the in-house level 3 apprenticeship.
- Introduction of a quality assurance tool for learner placements.
- Development of the first AHP Clinical Academic role in Radiotherapy in conjunction with Lancaster University.
- Establishment of an AHP research steering group and setting of research key performance indicators.
- Multiple award winning AHPs, at internal and external events.
- Delivery of an AHP level 3 coaching cohort in conjunction with the organisational development team.
- Increased numbers of AHPs in advanced and consultant practice roles (total of 23).
- Development of link-grade positions for band 5 to 6, part of the solution to overcome the band 6 supply issues in several professions.
- Opening up of 2 key roles to AHP applicants (Cancer Clinical Nurse Specialist and Pre-operative Practitioner).
- Involvement of 3 AHPs in the Leadership in Lancs programme.
- Supporting 6 AHPs to return to practice.
- International recruitment in Diagnostic Radiography and Occupational Therapy.
- Implementation of a 'newly qualified' Electronic Staff Record (ESR) tag, to track early career attrition, organisation leavers and internal promotions.

The focus for year 2 will be the following areas and objectives:

- Continuing to prioritise widening participation, rolling out new degree apprenticeship programmes as they are approved.
- Rolling out the in-house level 3 AHP pathways to other Trust's in our Integrated Care System (ICS).
- Continued focus on careers promotion, to tackle supply issues at the starting point.
- Complete e-job planning for in-scope AHPs.
- Develop advanced practice opportunities for the AHP groups currently without.
- Complete succession planning for some key at risk senior leadership/clinical positions.
- Focused engagement on equality, diversity, inclusion and belonging to inform next steps.
- Development of an AHP workforce dashboard, to improve access and visibility of the data.

The over-arching aim of the strategy is to influence supply/retention and in turn reduce vacancies. Appendix 1 includes the vacancy data charted by professional group from April 2021 to September 2023. Minimal or no vacancy has been maintained this past year in Orthoptics, Prosthetics & Orthotics, Therapeutic Radiography and for Operating Department Practitioners. The largest improvements are seen in Physiotherapy, Diagnostic Radiography and Speech and Language Therapy. Physiotherapy and Diagnostic Radiography have had a consistently low vacancy rate this past 12 months compared to the previous, mainly owing to over-recruitment of band 5's in August 2022. Speech and Language Therapy have halved their vacancy rate down from 40% to 20% this past year and it is on track to reduce to 10% by this December. Strategies they have used to impact this have included. a strengthened leadership structure, link-grade positions for band 5 to 6 and promotion of the service/team via social media. Occupational Therapy and Dietetics remain professions of concern and will be areas of focus for the next 12 months.

It is recommended that:

I. The Board of Directors receives the year 1 update for the AHP Workforce Strategy and notes the progress made.
II. The Board of Directors receives a further update in 12 months' time.

Appendix 1: AHP Vacancy Run Charts (April 2021 – September 2023)

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☐	Consistently Deliver Excellent Care	☐
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

N/A

1. Background

In October 2022 the Lancashire Teaching Hospitals (LTH) Allied Health Professional (AHP) Workforce Strategy for 2022-2025 was launched.

The strategy aims to address the current and future supply chain issues impacting many of the AHP groups and contained 6 co-designed key commitments, which are:

1. Utilise All Supply Chain Options
2. Raise Profiles
3. Grow Our Own
4. Increase Development Opportunities
5. Give AHPs the Best Start to Their Careers
6. Value Our Workforce

The strategy contains 88 objectives themed into 10 groups:

1. Apprenticeships
2. Support workers
3. Education
4. Research
5. Raising profiles
6. Leadership
7. Clinical workforce
8. Equality, diversity and inclusion
9. Workforce supply
10. Newly registered workforce

During year 1, 24 objectives were expected to be achieved along with progress made on many others. The purpose of this report is to provide an update on delivery of year 1 objectives, highlight areas of outstanding practice and advice on any risks to future delivery.

In June 2023 NHS England launched the 'NHS Long Term Workforce Plan', it has very similar aims to the LTH AHP workforce strategy. With a focus on sustainable workforce supply to improve patient care, retention and recruitment. There is a specific focus on AHP apprentices in the national strategy which complements local ambitions.

2. Discussion

The progress of the strategy will be reported against each of the 10 themes, advising the status of year 1 metrics and any metrics that span the lifetime of the strategy. Highlights for the theme will be discussed along with an overview of next steps. Of the 24 objectives expected to be achieved during year 1, 18 have been achieved in full and the remaining 6 have been partially achieved and are actively being worked upon.

Apprenticeships

Year 1 Objectives	Achieved?	Comments
Standardise level 6 (degree) application route (terms & conditions, job descriptions, contacts)	Yes	Policy produced standardising all elements, annexe 21 agreed for pay progression during the programme.
Standardise bridging course recruitment (terms & conditions, job descriptions, contracts)	Yes	Policy produced standardising all elements.

Implement a financial model utilising workforce underspend to fund apprenticeships in high vacancy areas	Yes	Implemented pre-financial restrictions in Occupational Therapy and Diagnostic Radiography (areas of high vacancy). Unable to consider as an option currently.
2022-2025 Objectives	**On track?**	**Comments**
Commit to widening participation of AHP careers, by increasing access to level 6 (degree) apprenticeships	Yes	Expanded from 1 professional group to 5 over the past 12 months. Plans for a further 3 professions in 2024.
Influence and collaborate with local Universities to develop programmes for Assistant Practitioners/those with relevant degrees	Yes	Success in Dietetics (nutrition degree bridging) and in Therapies (ability to jump to year 2 degree course following AP course completion).
Explore and influence the creation of an AHP module on the in-house level 3 support worker apprenticeship	Yes	Theatre and therapies pathway delivered and imaging pathway in development.

Apprenticeships - Highlights

Apprenticeship standards and providers for level 6 courses have expanded significantly for AHPs, pre-strategy launch LTH only had ODP apprentices and there are now apprentices in Occupational Therapy, Physiotherapy, Diagnostic Radiography and Therapeutic Radiography. In numbers this is an increase from 9 AHP degree apprentices to 27.

The Deputy Chief AHP has worked closely with the education team to expand the in-house level 3 support worker apprenticeship. A therapy specific pathway has been designed and delivered for Core Therapy support workers and a theatre pathway for theatre support workers. In development is an imaging pathway for Radiography. Theatres have mandated the level 3 apprenticeship for all support workers and the other 3 areas are moving towards mandating it, this will ensure the support workers are appropriately skilled and able to progress in their career if aspiring to.

In 5 of the 10 AHP groups there is now the ability to progress from a band 3 to registered band 5 using the apprenticeship route, supporting the widening participation agenda for AHP careers.

Apprenticeships - Next Steps

- Ensure future apprenticeship plans align to the 2023 NHS Long Term Workforce Plan
- Ensure effective use of apprenticeship levy, with decision based on supply data
- Continue to roll out of level 6 degree apprenticeship to more AHPs. Plans underway for Speech & Language Therapy, Dietetics, Prosthetics & Orthotics.
- Support the education team to expand the level 3 therapy pathway offer to other Lancashire and South Cumbria NHS Trusts.

Support Workers

Year 1 Objectives	Achieved?	Comments
All AHP support workers to have access to a support forum to receive information and give feedback	Yes	For areas that have support workers all have access to a forum or a departmental meeting for this purpose.
Roll out an annual internal support worker survey for continued engagement	Partially	Survey drafted and planned to roll out in January 2024 and then repeat annually.

2022-2025 Objectives	On track?	Comments
Develop new Assistant Practitioner roles	Yes	Pre-strategy launch there were 3 roles across all 10 AHP groups. Since the launch 10 new roles have been developed across Core Therapies and Diagnostic Radiography.
Enable support workers to access relevant level 3 apprenticeships to support career progression	Yes	Level 3 apprenticeship open to all AHP support workers and specific pathways for theatres and therapies, imaging pathway in development.

Support Workers – Highlights

Opportunities and career progression for our AHP Support Workers are now readily available, particularly in professions where national supply is a concern (Occupational Therapy and Diagnostic Radiography). The majority of the Support Workers can access a level 3 apprenticeship, those who can't will be able to during 2024 (imaging pathway in development), which then allows further career progression for those interested.

During the past 12 months 10 new Assistant Practitioner roles have been created (4 in Stroke, 4 in Core Therapies for admission avoidance and 2 in Diagnostic Radiography). All 10 positions are trainees on day release for the level 5 apprenticeship.

All the 27 degree apprentices detailed in the previous section of the report have been recruited from existing the LTH Support Workers pool, resulting in a true 'grow our own' model and career progression within the organisation. All 27 are guaranteed a band 5 position upon completion which should support retention.

Support Workers – Next Steps

- Launch the annual support worker survey in January 2024, engage and gain feedback to focus next steps.
- Roll out the NHSE 'Support Workers Competency, Education and Career Development Framework' for use in appraisals and career conversations.

Education

Year 1 Objectives	Achieved?	Comments
Gain oversight of the AHP learner tariff	Yes	Full oversight gained
Ensure AHP representation on the apprenticeship levy decision making panel	Yes	Deputy Chief AHP is a member of this committee.
Standardise learner feedback for all AHP areas	Yes	AHP learner feedback questionnaire designed and launched, supported by the education quality assurance team who pull quarterly reports.
2022-2025 Objectives	**On track?**	**Comments**
Engage and apply for all HEE grants/bids the are offered for AHPs and support workers	Yes	All appropriate bids/grants applied for and utilised: • Critical Care Upskilling (£17.5k) • Elective Recovery Upskilling (£5k) • Apprenticeship implementation fund (£80k) • HEE workforce development programme Radiotherapy (58k)

		• HEE upskilling grant – CT whole body phantom Radiotherapy (£31k) Total of £191.5k external funding for workforce development.
Ensure a sustainable AHP workforce through the provision of quality learning environments	Yes	The quarterly learner feedback indicates high quality learning environments across all AHP areas.

Education – Highlights

Over the past 12 months all AHP departments have worked hard to maintain the learner placement expansion numbers achieved in 2021/22, numbers have been maintained and, in some areas, increased further. Introduction of a standardised learner feedback across all AHP areas means there is assurance that quality has not been impacted, with nearly 100% positive feedback across the board every quarter.

Recent changes to the structure and leadership within the education team has positively impacted AHPs, the multi-professional focus of the team is evident and feels inclusive. This has resulted in the Chief AHP or Deputy Chief AHP being present in key education committees and decision making panels.

Education – Next Steps

- Explore education funded AHP educator post/s for areas without but with large learner numbers, this is being tested in Core Therapies using the NHSE apprenticeship implementation fund.
- Ensure apprenticeship levy funding is used effectively and for areas where supply is challenged.
- Work closely with Universities and AHP leads to ensure placement demand does not exceed capacity, this is vital given the rising number of apprentice learners.

Research

Year 1 Objectives	Achieved?	Comments
Ensure AHP representation on all appropriate research committees	Yes	AHP representatives are in all committees.
Monitor and report on year 1 research KPI's	Partially	KPI's agreed and set, data collection began April 2023, therefore reporting will be in May 2024.
Roll out profession specific lead research champion roles (Year 2 delivered ahead of plan)	Yes	Leads all recruited. Meet quarterly as part of the research steering group and attend relevant external events.
2022-2025 Objectives	**On track?**	**Comments**
Develop AHP Clinical Academic roles by exploring funding options, developing job descriptions, and agreeing priority areas	Partially	1 role developed in Radiotherapy (charity funded) with Lancaster University. Challenges with funding further roles currently.
Increase the number of successful applications to research internship programmes	Yes	Numbers increasing year on year, data collected by research leads and reporting included in KPI's.
Implement and embed the 'AHP Research and Innovation Strategy for England'	Yes	Workshop held with research leads to complete gap analysis.

Research – Highlights

The AHP Research Steering Group (RSG) has been established and is led by a core group of research active AHPs. The group have set research key performance indicators (KPI's), created profession specific lead roles and recruited to them, delivered a robust induction to these leads and recently complete a gap analysis of the national AHP Research Strategy. The AHP RSG meet quarterly and will report on the first year of the KPI's in May 2024.

Another highlight has been the appointment of a Clinical Academic in Radiotherapy. This collaboration with Lancaster University has led to Dr Lisa Ashmore (Therapeutic Radiographer) being seconded 7.5 hours per week to LTH. This was funded for 12 months by the Cancer Alliance and following a 3 month break, Dr Ashmore will be returning in December for another 12 months, this time funded by North West Cancer Research. The focus for the role has been the Cancer pre-habilitation agenda, key achievements during year 1 include:

- Patient and public involvement funding for a Therapeutic Radiographer led project on fatigue in cancer.
- Submission of a funding application to the Royal College of Radiographers for a project on pre-habilitation for breast cancer.
- Stage 1 application on decision making in radiotherapy, LTH as co-investigator.
- Development of a funding application Royal College of Radiographers application on fatigue in cancer.
- Protocol development, sponsorship approval and ethics approval for pre-habilitation in cancer project with a Physiotherapist.
- Supporting conference abstract submissions, all of which were accepted.

The above achievements highlight the positive impact Clinical Academic roles bring to the organisation and patient care, there is the potential for many more and the majority should income generate enough funding to be cost neutral.

Research – Next Steps

- Report on year 1 AHP research KPI's in May 2024.
- Continue Research Steering Group focus on implementing the national AHP research strategy.

Raising profiles

Year 1 Objectives	Achieved?	Comments
Design and implement AHP celebration corridor boards at RPH, CDH and SMRC	Yes	Corridor boards installed at all 3 locations; positive feedback received.
Create and LTH AHPs Twitter account to collaboratively raise the profile and promote vacancies	Yes	Central account not progressed, instead each profession/department has joined Twitter to promote their service/vacancies.
2022-2025 Objectives	**On track?**	**Comments**
Annually celebrate national AHPs day	Yes	National AHP day continues to be celebrated annually.
Promote nomination opportunities for annual national and local award programmes	Yes	Award nomination opportunities cascaded when available. Various awards won this past 12 months, see detail below in 'highlights.
Plan and deliver an AHP support worker media campaign	Partially	Not yet planned but a priority for the next 12 months to support attraction/recruitment.
Collaborate with relevant teams on AHP career promotion	Yes	Career ambassadors in all groups, joined up with the ICB AHP Workforce team and regularly support career events.

		Deputy Chief AHP has supported ICS wide virtual work experience events for 14-16 year olds.

Raising Profiles – Highlights

Creating the LTH AHP branding with the Trust's graphic designer has been a success, uniting the 10 professional groups and raising profiles through multiple routes. The branding commenced with the strategy design and has then been replicated on the corridor celebration boards, posters, PowerPoint templates and social media advertising.

The Radiotherapy department have introduced open days for those interested in a career as a Therapeutic Radiographer, so far there have been 3 events and feedback from those attending is positive. The Deputy Chief AHP has supported these events and used the opportunity to promote all AHP careers.

Over the past 12 months there have been many AHP award nominations/winners and recognition is seen as a priority by all the AHP leaders. Awards have been won in the following schemes/categories:

- Our People Awards – 2 AHP winners and many nominations.
- LTH Education Awards – 3 AHP winners and many highly commended/nominated.
- Practice education and reimagining learning (PEARL) Awards (ICB AHP Workforce team led) – 4 winners.
- Chief AHP Officers Awards (CAHPO) – 1 winner and several nominations
- Radiographer of the Year (Society of Radiographers) awarded to an LTH Therapeutic Radiographer

Raising Profiles – Next Steps

- Design and deliver an AHP celebration event with a specific focus, allowing AHPs to come together and share improvement projects, research and success stories.
- Plan and deliver an AHP support worker media campaign.
- Continue to focus on careers promotion, attend more face-face events at High Schools/Colleges to tackle supply issues by increasing local applications to AHP programmes.

Leadership

Year 1 Objectives	Achieved?	Comments
Launch an LTH AHP Coaching network by training cohorts of AHPs and trialling an online platform to connect coaches with coachees	Yes	Deputy Chief AHP completed ILM 5 in Coaching 10 AHPs currently completing the ILM 3 in Coaching. Online platform not yet available to test, led by OD team.
Introduce regular development 'time out' for the AHP senior leadership team	Yes	Implemented and 2 sessions completed to date.
Complete a mapping exercise of the NHSi 'Developing AHP Leaders' guide to internal/external development opportunities to be utilised at appraisals.	Partially	Mapping exercise completed but not yet written up in a format for sharing/using at appraisals.
Complete full benchmarking of ICS AHP leadership structures to draw comparisons and make future recommendations	Partially	Being completed through the AHP Council, chaired by the ICB Chief AHP.

2022-2025 Objectives	On track?	Comments
Ensure AHP applications and cohort membership on the annual Flow Coaching Academy programme	Yes	AHP membership on all cohorts to date.
Ensure leadership development is a priority from day 1, by utilising leadership placements for learners, encouraging access to OD programmes at every level and promoting leadership at every level	Yes	Leadership placements implement in Core Therapies. AHPs are attending the various OD led internal leadership development programmes.

Leadership – Highlights

The leadership structures with 2 AHP groups have been strengthened over the past year. In Core Therapies this has involved introducing a band 8a operational layer in Acute Medicine, Outpatients and Neurosciences. This not only provides development opportunities and bridges the gap from band 7 to 8b, it also allows transformation work to move at pace, band 7 therapy staff to have access to regular supervision and adequate leadership/support for the business unit that contains 240 people. In Speech and Language Therapy an Associate Head has been introduced, which is a hybrid clinical/leadership position to support running of the inpatient and outpatient services whilst also aiding succession planning for the Head of Speech and Language Therapy role.

In collaboration with the Organisational Development team a level 3 coaching programme has been delivered to a group of 10 AHPs. This is the beginning of growing the coaching culture with AHP departments and there are plans to utilise an online platform to host a coaching network for AHPs to connect.

Development time out for the senior AHP leadership team has been established this past 12 month and has been positively received. 3 half day sessions have been delivered and supported by the OD team, various board members and the Chief/Deputy Chief AHP. The early aim was to unite the group as a team, allow sharing of transferrable good practice and to enable peer support. Later sessions have allowed for collaborative working and a focus on the new national 'AHP Delivers' strategy.

Leadership – Next Steps

- Develop and Introduce specific stretch/development opportunities for future AHP leaders, supported by the Chief and Deputy Chief AHP.
- Complete appraisal support document for AHP leadership development (using internal/external mapping to the NHSi Developing AHP Leaders guide).

Clinical workforce

Year 1 Objectives	Achieved?	Comments
Ensure all AHPs have equitable access to CPD funding and standardised processes are in place to access ring-fenced funding	Yes	AHPs have had access to ring-fenced CPD funding and to the central education fund. No concerns escalated around access.
Increase the number of AHPs in advanced and consultant practice roles	Yes	This figure increases year on year. In March 2022 there was 19 AHPs in advanced roles and in May 2023 this had increased to 23.
Develop link-grade positions in AHP groups with supply/recruitment challenges to allow band 5's to progress into band 6 positions in a specific time frame with a competency framework	Yes	Link-grade positions developed and recruited to in Occupational Therapy, Diagnostic Radiography and Speech & Language Therapy (areas where band 6 recruitment is challenged).

2022-2025 Objectives	On track?	Comments
Develop rotational clinical posts in our larger professional groups, to aid attraction and retention and offer wider clinical development opportunities	Yes	Currently being explored in Radiography and in an integrated approach with community partners in Core Therapies.
Complete job planning for all in-scope AHPs and ensure supporting professional activity (SPA) is clearly outlined	Partially	New system (L2P) procured by Trust. AHP in-scope staff members provided for system build. Awaiting admin support to roll out.
Ensure all job descriptions and person specifications consider inclusion of AHPs	Yes	Ongoing process as new senior leadership vacancies arise. 2 clinical roles have been opened up to AHPs, see 'highlights' for more information.
Increase the number of AHPs successfully appointed into roles outside their direct professional environment	Yes	This figure is slowly rising. In March 2022 there was 9 AHPs in non-traditional roles and in May 2023 this had increased to 10.

Clinical Workforce- Highlights

The number of AHPs in advanced and consultant practice roles continues to rise year on year, offering more opportunities then ever to many professions. During the first year of the strategy the number rose from 19 to 23 and there are new roles currently being planned. LTH have supported advanced practice opportunities for 2 new AHP groups this year, a Paediatric post in Orthoptics and a Stroke post in Speech and Language Therapy.

The innovative roll out of link-grade positions from band 5 to 6 has been a success for Occupational Therapy, Diagnostic Radiography and Speech and Language Therapy. Allowing currently hard to fill positions (due to supply issues at band 6) to be offered to a more junior clinicians with a clear competency framework and development plan, leading pay/band progression in a 12-18 month period.

The Deputy Chief AHP has led 2 key workforce changes, opening up 2 roles to appropriate AHPs that have historically been open to Nursing applicants only. The first is the Pre-operative Practitioner role, the person specification and job description are now inclusive of Nurse's and Operating Department Practitioners (ODPs). The second is the Cancer Clinical Nurse Specialist (CNS) role, the recruitment documents for this role are not inclusive of Nurses and any appropriately experienced/skilled AHP (this will vary depending on the cancer site). If an AHP is appointed the job title Cancer Clinical Specialist will be used.

Clinical Workforce – Next Steps

- Support the development of advanced practice roles for the AHP groups with limited opportunities (Occupational Therapy, Dietetics, Diagnostic Radiography).
- Complete the job planning process for all in scope AHPs using the new L2P system.

Equality, Diversity and Inclusion

Year 1 Objectives	Achieved?	Comments
No year 1 objectives		
2022-2025 Objectives	**On track?**	**Comments**
Increase the diversity of AHP students by supporting local HEI's with careers events and open days and ensure our attendance from the Trust is representative and inclusive	Yes	Collaborative work ongoing within the AHP Workforce Board, where local HEI's are members.

Locally in-reach into schools/colleges who have a higher proportion of students with protected characteristics to promote AHP career pathways	Yes	Career events attended at various local schools/colleges.
Ensure AHP representation on the Trusts EDI forum	Yes	2 AHP representatives at the EDI forum.
Encourage the AHP workforce to self-report their protected characteristics to enable more accurate understanding of the AHP workforce minority group characteristics	Yes	Being captured for all new starters unless they opt out. Plan to circulate a link/instructions for existing staff to input/update as some long-service staff have never self-reported.
Develop an AHP talent pool for individuals from underrepresented groups who are rising stars, taking positive action to support their development through stretch opportunities and participation in Inclusive Leadership at Lancs Programme	Yes	3 AHPs have completed the Leadership in Lancs Programme.

Equality, Diversity and Inclusion – Highlights

A focus recently has been on marketing AHP careers at various education/career events where the local diverse population is in attendance. Along with these events, attracting diverse applicants to our local universities has also been a focus within the ICB Workforce Board and data is being utilised here to inform programmes of work.

3 AHPs have completed the LTH Leadership in Lancs programme, a leadership development programme for current/aspiring leaders from an ethnic minority group. There is further work to do here, the Chief AHP plans to have a follow up meeting with the 3 individuals and seek feedback to inform the next steps.

NHS England have delivered an AHP Allyship Programme, 5 AHP leads from LTH have took part in this. A local (Lancashire and South Cumbria) follow up workshop is planned for December to allow participants to reflect on the programme and collectively set inclusive objectives to deliver outputs and learning from the programme locally.

Equality, Diversity and Inclusion – Next Steps

- Conduct specific engagement with AHPs who have protected characteristics to listen and learn and inform next steps.

Workforce Supply

Year 1 Objectives	Achieved?	Comments
Standardise the AHP return to practice process by having a specific lead/contact, SOP and HR process	Yes	Completed and being utilised.
2022-2025 Objectives	**On track?**	**Comments**
Utilise HEE funding and Northwest collaborative approaches for international recruitment	Yes	Initially LTH signed up to the Northwest collaborative to internationally recruit Occupational Therapists, £25k funding received, however the Trust is now recruiting independently.
Actively promote and support return to practice	Yes	Posters produced and distributed, and social media advertisements shared regularly.

		5 AHPs have been supported to return to practice over the past 12 months.
Explore and scope further integration of AHP services with our partners and progress where appropriate	Yes	Ongoing integration projects within Core Therapies. Chief AHP is a member of the ICB Central Community Integration Board.
Ensure AHP vacancies are marketed appropriately through various networks, social media and included in Trust wide careers and recruitment events	Yes	Good collaboration with the recruitment team to ensure vacancies are marketed appropriately and AHPs are linked into any events.

Workforce Supply – Highlights

The return to practice focus has resulted in 5 AHPs being supported to return at LTH, 2 Therapeutic Radiographers, 2 Physiotherapists and 1 Occupational Therapist. The process surrounding this have been streamlined and a policy written. Marketing posters have been produced and the opportunity is regularly advertised on social media channels.

International recruitment for Diagnostic Radiographers and Occupational Therapists has been completed and scoping is underway for other professions. To date 2 Radiographers are in post and 2 Occupational Therapist are in post and 2 further offers made. Competition is high across the United Kingdom, and we are often finding candidates have multiple offers and prefer to choose the larger cities.

Over-recruitment strategies have been implemented in Radiography, Physiotherapy and Occupational Therapy to good effect for the band 5 groups. Particularly in Physiotherapy this has meant a relatively low vacancy rate for the past 12 months (see appendix 1) due to constant supply of band 5's and internal promotions. It is vital that these strategies are repeated year on year, as there is no risk to budget overspend.

Workforce Supply – Next Steps

- Continue to scope and explore international recruitment options for at risk professions.
- Undertake succession planning for highly specialist roles.
- Review exit interview process and support improvements to the process and data available.

Newly Registered Workforce

Year 1 Objectives	Achieved?	Comments
Establish newly registered AHP focus groups to gain feedback on a regular basis and maintain engagement	Partially	Not yet established, annual newly registered survey in design. For role out March to capture September and January graduates.
Ensure all newly registered and new starters cover freedom to speak up at induction to ensure concerns can always be raised	Yes	Covered in Trust induction and reinforced within departments.
Establish new graduate forums in each profession to further support the induction and preceptorship process	Partially	Present for 7 of the 10 AHP groups.
2022-2025 Objectives	**On track?**	**Comments**
All new graduates employed from August 2022 to have ESR newly qualified code applied, to ensure they can be identified and retention monitored	Yes	Code is being applied by the workforce team.

Newly Registered Workforce – Highlights

The Employee Service Record (ESR) code for newly qualified AHPs has been implemented and from September 2023 all new graduates will have this applied. This means going forwards new graduate retention can be specifically measured, areas where there appears to be high attrition can be looked into further and actions put in place.

Newly Registered Workforce – Next Steps

- Gain assurance on the quality of AHP preceptorship programmes and that the programme is meeting the individual needs of that professional group.
- Explore setting up an AHP graduate forum to connect those from the smaller groups.

Overarching Strategy Impact on Supply and Vacancies

The over-arching aim of the strategy is to influence supply/retention and in turn reduce vacancies. Appendix 1 includes the vacancy data charted by professional group from April 2021 to September 2023. To analyse the impact of the strategy the last 12 months of data has been considered.

Minimal or no vacancy has been maintained in Orthoptics, Prosthetics & Orthotics, Therapeutic Radiography and for Operating Department Practitioners. Supply remains healthy and retention is not an issue in these areas.

The position remains challenged for Occupational Therapy, this group are on the national shortage list and locally we are struggling to recruit at band 6, particularly in Acute Medicine. Dietetics is also of concern, the vacancy rate here has gradually been increasing and is now averaging 14%, this professional group are also on the Integrated Care Boards (ICB) vital and vulnerable list. A specific focus on these 2 professional groups is required for the year ahead.

Successes to highlight for the past 12 months are in Physiotherapy, Speech and Language Therapy and Diagnostic Radiography. Physiotherapy and Diagnostic Radiography have consistently maintained a low vacancy rate and this is significantly better that the 12 months previous. The over-recruitment strategy for band 5's in summer 2022 was successful and has contributed to this for both professional groups. Speech and Language Therapy's vacancy rate peaked at 40% in September 2022 and the team have worked hard to reduce this by strengthening their leadership structure, creating link-grade positions, and promoting their service and team over social media. The predicted vacancy rate for this group for December 2023 is 10%.

This data will continue to be monitored across the life span of the strategy and there are plans to develop an AHP workforce dashboard to allow this data to be updated monthly and visible.

3. Financial implications

There are no direct financial implications currently, however, long-term funding for apprenticeships (salary, not training costs) remains a concern and will require a solution to enable them to continue in areas without consistent vacancy.

4. Legal implications

None

5. Risks

The most significant risks to the delivery of the Strategy remain the same as 12 months ago and are:

- Workforce – the current supply, recruitment and retention challenges
- Finance and investment – sustainable financial solutions are required for initiatives such as apprenticeships and international recruitment

6. Impact on stakeholders

The objectives outlined in the Strategy continue to have implications for stakeholders, mainly local universities, and our partner organisations. Continued collaboration is required with stakeholders to engage them and jointly plan full delivery of the strategy.

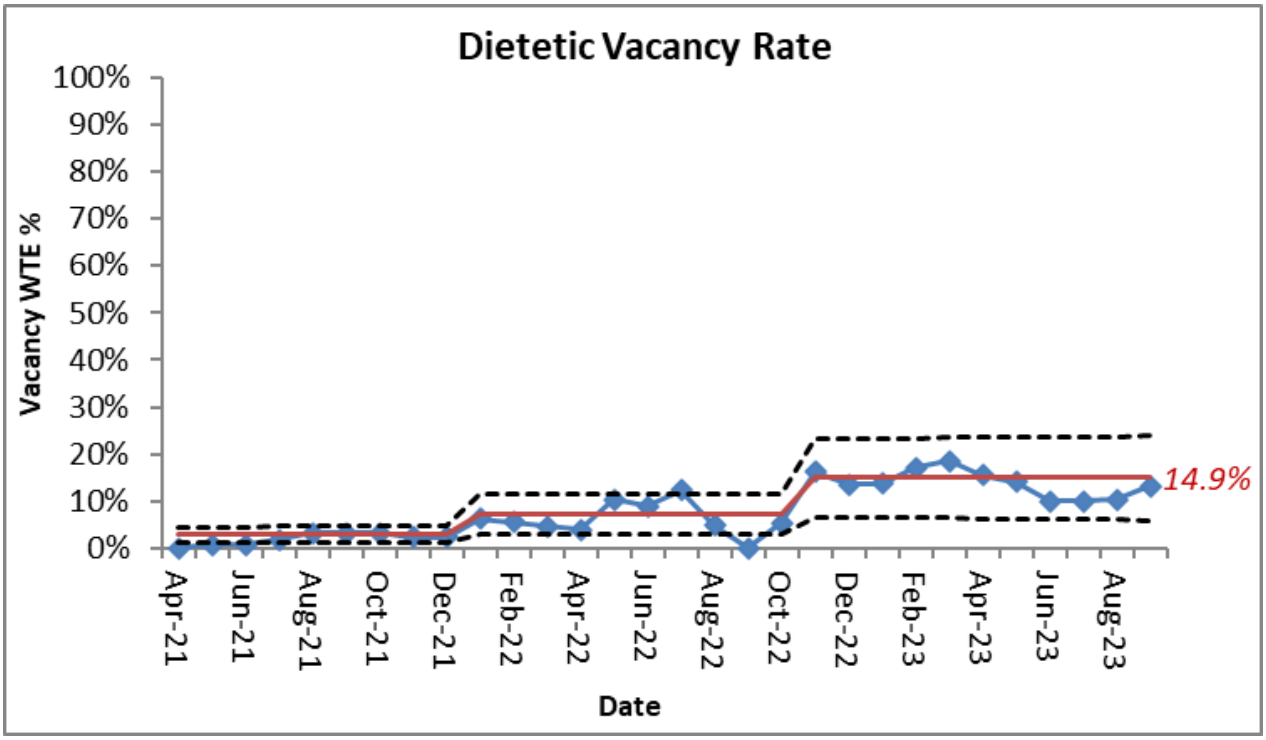
7. Recommendations

It is recommended that:

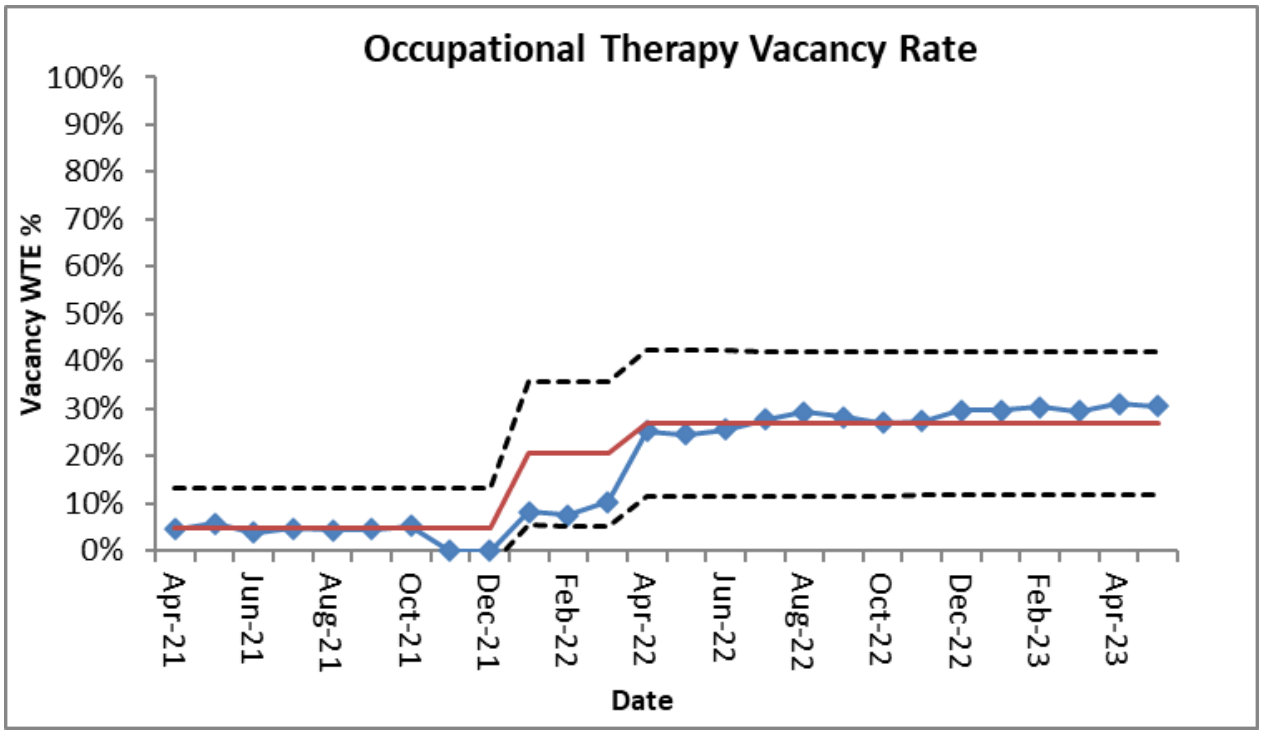
I. The Board of Directors receives the year 1 update for the AHP Workforce Strategy and notes the progress made.
II. The Board of Directors receives a further update in 12 months' time.

Appendix 1: AHP Vacancy Run Charts (April 2021 – September 2023)

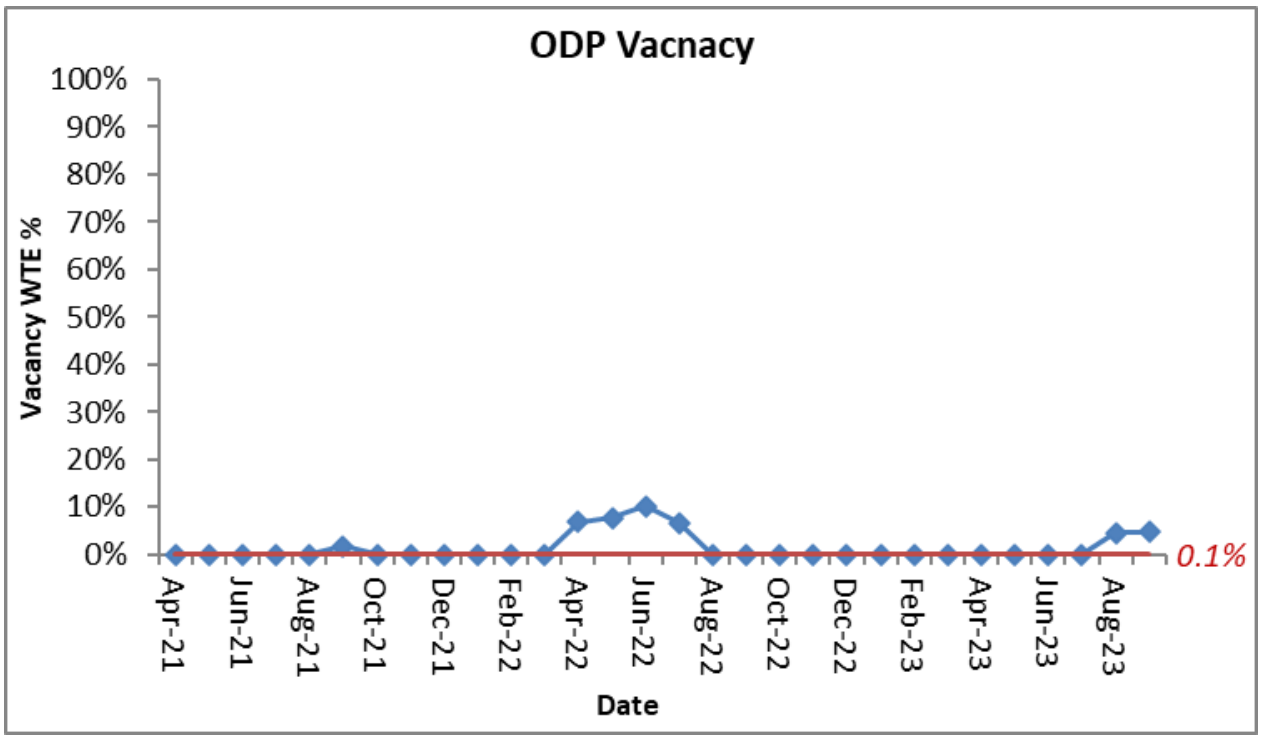
Dietetics



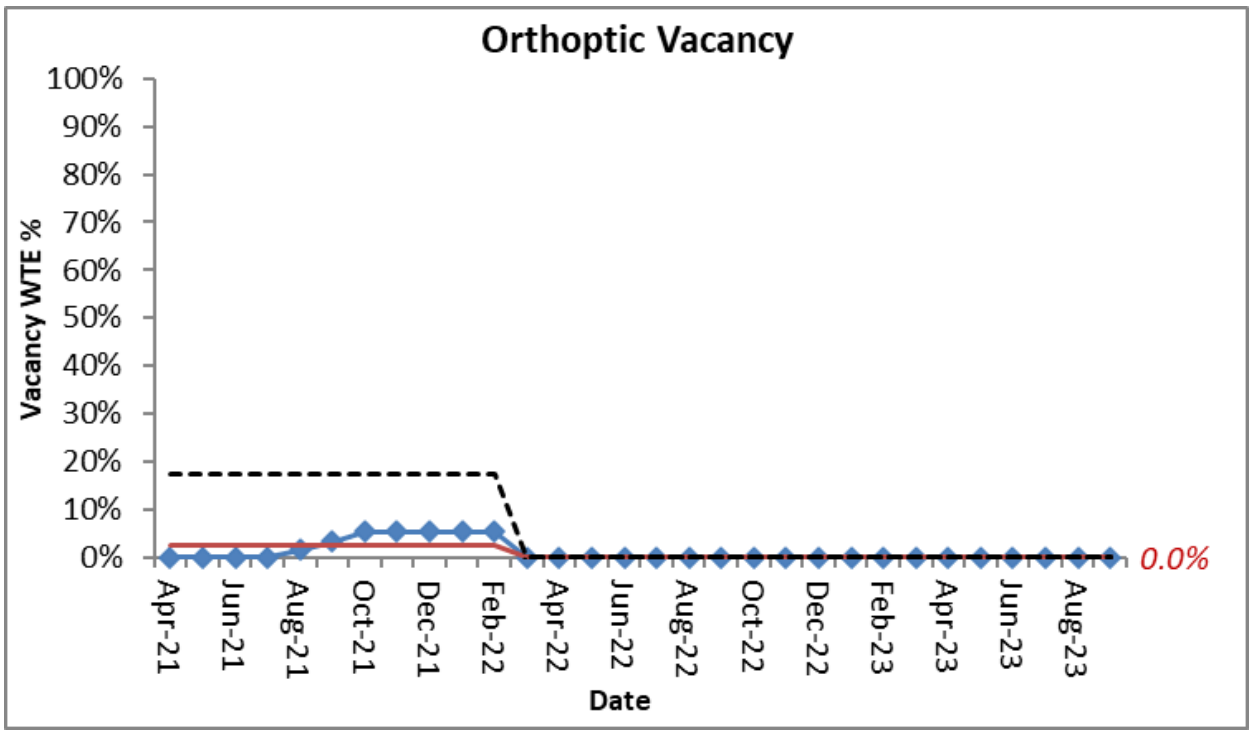
Occupational Therapy



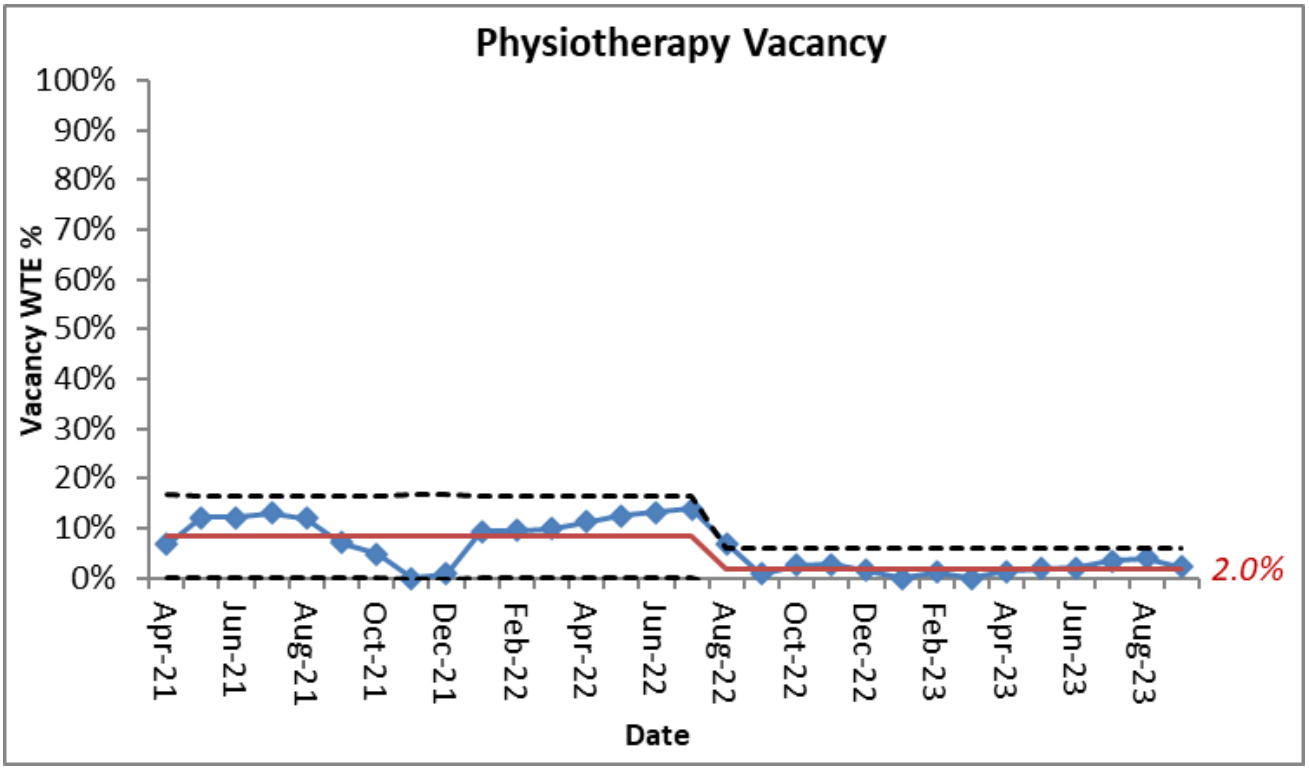
Operating Department Practitioners (ODPs)



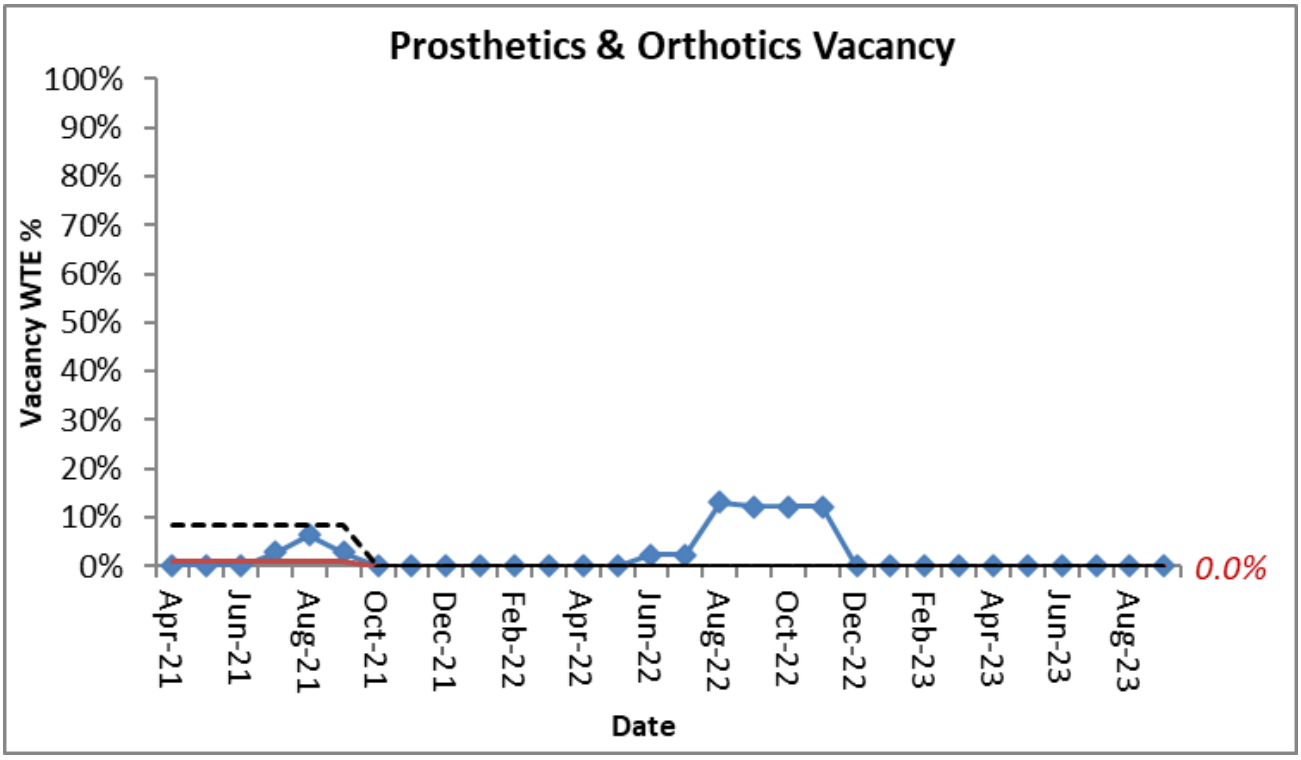
Orthoptics



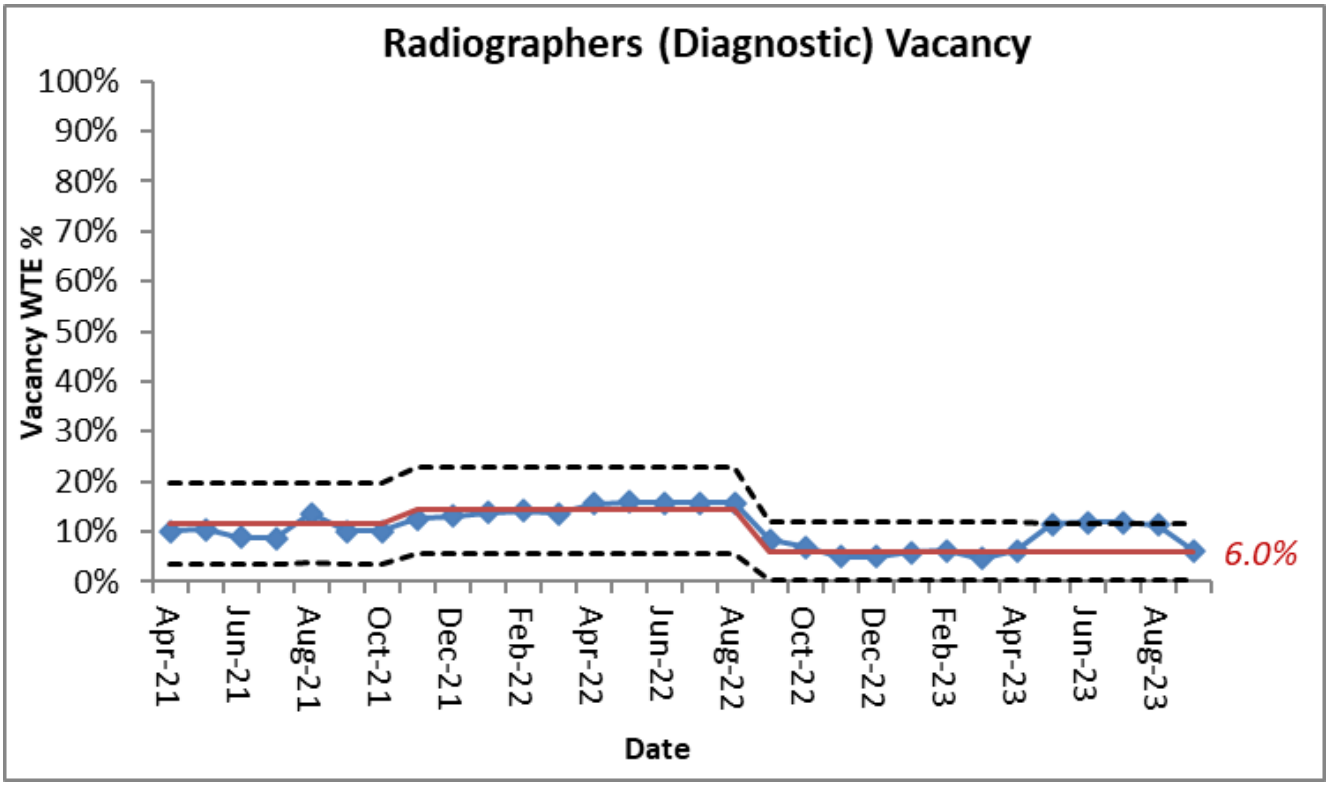
Physiotherapy



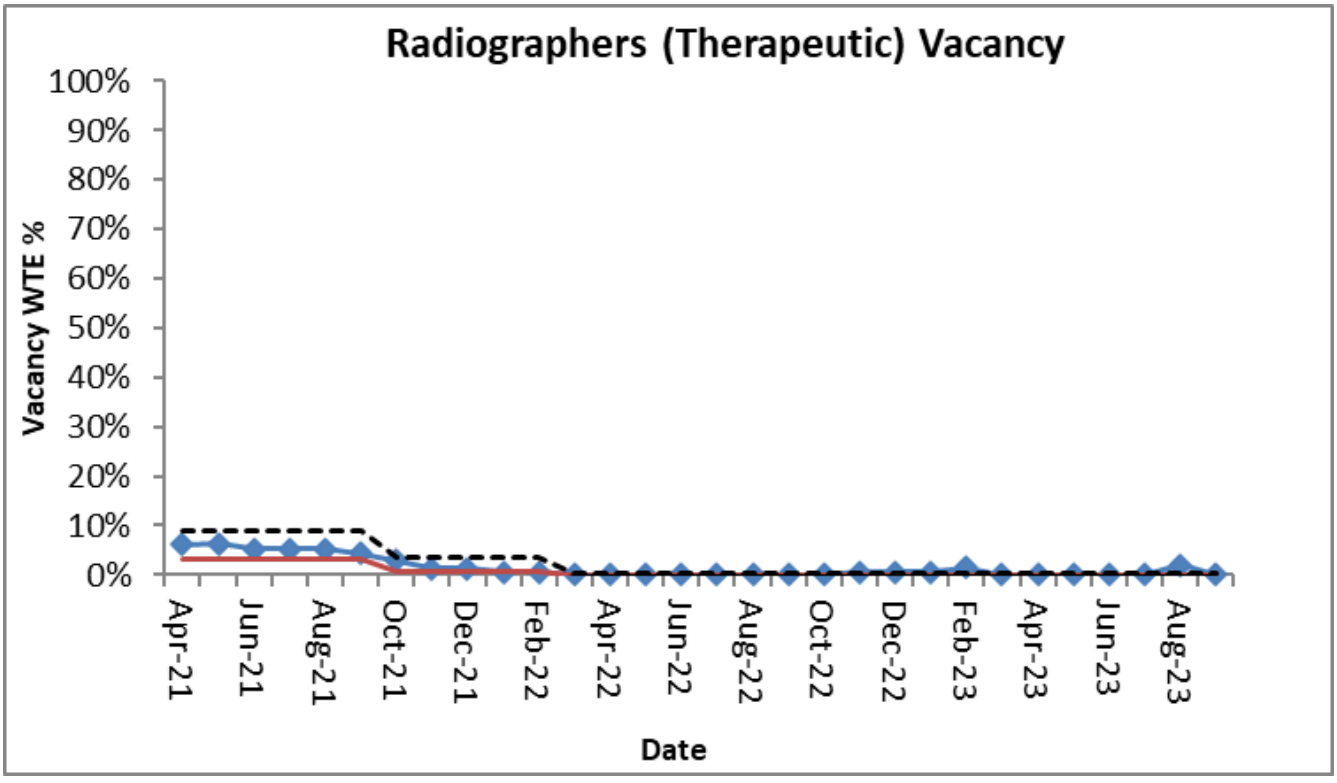
Prosthetics and Orthotics



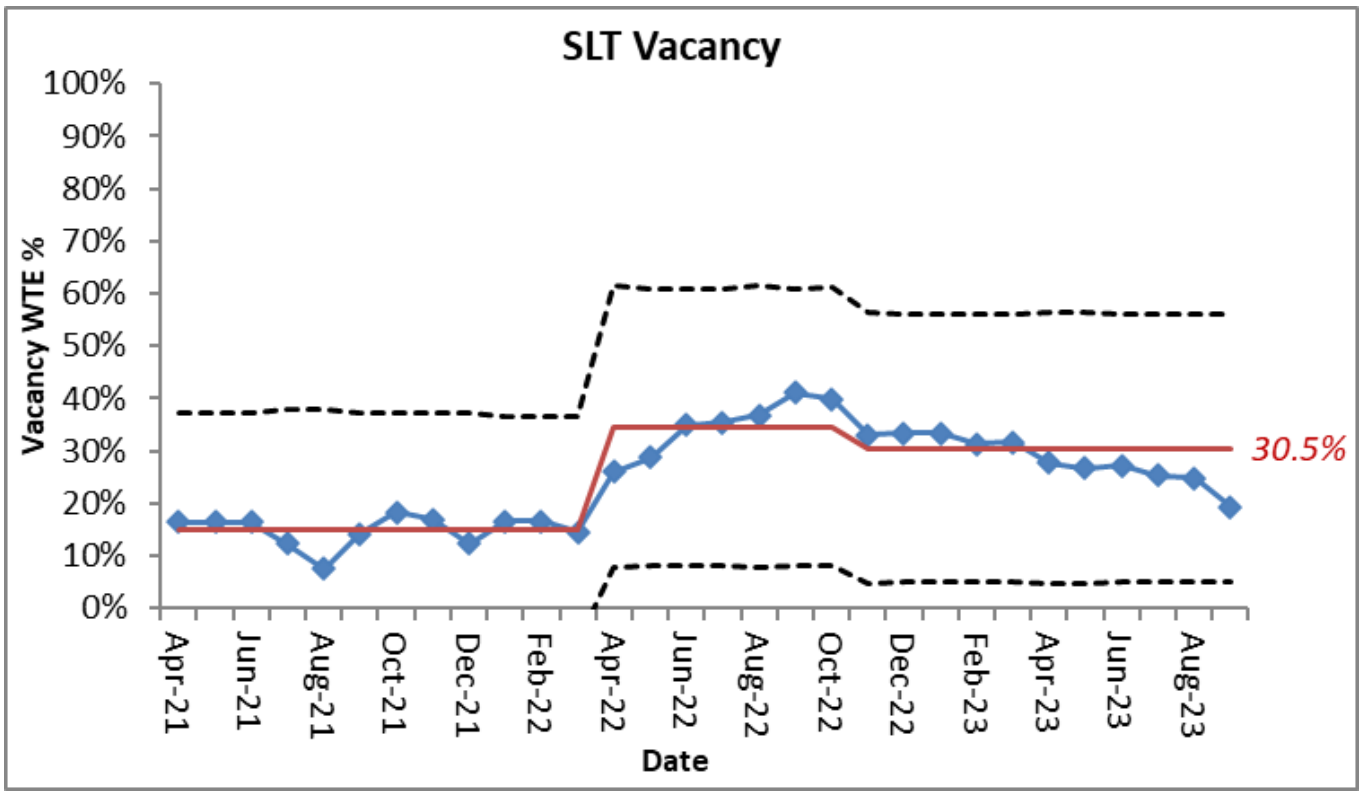
Radiographers (Diagnostic)



Radiographers (Therapeutic)



Speech and Language Therapists (SLTs)



Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Guardian of Safe Working Quarterly Report			
Report to:	Board of Directors	**Date:**	7 December 2023
Report of:	Chief People Officer	**Prepared by:**	D Kendall and L Eccles

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance to the Board of Directors that junior doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within 2016 contract.

This is a report for the period from 1 July to 30 September 2023 and outlines the following:

- Number of exception reports submitted with reasons – there were 96 exception reports raised in the time period above and this is significantly lower than the previous quarter (171),
- There was one immediate safety concern (ISC) from an FY1 in Chorley Cardiology,
- Assurance is provided in relation to the actions undertaken by the Guardian of Safe Working (GOSW) in response to these exception reports and ISCs,
- There are likely to be some guardian fines during the reporting period in Plastic Surgery (tbc),
- The vacancy position is highlighted, this shows the recruitment challenges and work being done to fill hard to fill posts.
- Bank and agency usage is detailed,
- A junior doctor forum was held in September 2023.

The Trust Board is asked to:

- Note the contents of the report
- Confirm they are assured that the issues identified are being addressed by the relevant specialities/departments, through escalation of the concerns to the appropriate teams by the work of the Guardian
- Escalate discussions regarding the report to the Board of Directors as appropriate.

Appendix 1. Minutes of JDF September 2023

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			
Workforce Committee on 14 November 2023			

1.0 INTRODUCTION

The purpose of this report is to provide assurance to the Board of Directors that junior doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within 2016 contract.

This report covers a 3-month period and covers 1st July to 30th September 2023 and outlines the following:

- Number of exception reports submitted in the quarter with reasons,
- Actions undertaken by the Guardian of Safe Working (GOSW) in response to exception reports and ISCs (work schedule reviews instigated),
- Fines applied,
- Trust vacancy position,
- Bank and Agency Usage.

2.0 EXCEPTION REPORTS

Exception reporting is the mechanism used by doctors engaged through the 2016 contract to report variances from their agreed work schedule. Reasons for exception reporting include variance to hours/rest, difference in pattern of hour's worked, educational opportunities and support provided. From Feb 2020 all doctors who are engaged on a national training program are employed through the new 2016 junior doctor contract.

From August 2021 a new mirrored 2016 T&Cs were introduced for all trust doctors (junior and senior clinical fellows) and as such they are entitled to exception report as well and any exception reports raised are included within this report

There were 96 exception reports raised in the time period being reported. This is significantly less than was reported in the last quarterly report (171). This may however be due to the time of year (summer) and changeover of doctors.

Most of the exceptions are for extra hours worked across a number of specialties, although there have been a number of missed teaching and service support issues raised.

The largest proportion of exception reports were submitted by doctors working on the following rotas:

- Surgical Specialties RPH (FY1 and FY2) – 28 reports related to extra hours worked,
- Oncology (FY1) – 9 reports relating to working extra hours,

- Trauma and Orthopaedics (FY1 and FY2) – 9 reports due to working extra hours and 3 related to missed breaks.

The exceptions in plastic surgery (ST3 non-resident on call rota) may be subject to guardian fines due to breaches in 48 hours and 5 hours continuous rest overnight (tbc).

All exception reports are sent to both the clinical and educational supervisor and a resolution is sought where possible within 7 working days. However we are continue to experience difficulties gaining responses within this timeframe due to leave etc. In response to additional hours worked, the trust offers time off in lieu or payment: if the trainee is unable to take this TOIL by 3 months or the end of the rotation (whichever is first) then payment is made.

The exception reporting policy is available on the trust intranet http://lthtr-documents/current/P2169.pdf.

Table 1: Exception reports between 1 July 23 to 30 Sept 23

Row Labels	Missed Teaching	Natural Breaks	Overtime	Pattern	Service Support	Grand Total
Emergency Medicine (FY1)			2			2
Emergency Medicine (FY2) | Rota A			1			1
Emergency Medicine (ST1-2) | Rota A			1			1
GP (FY2) | Broadway Surgery			2			2
MAU CDH (FY2)			1			1
Medicine CDH (FY1)		2			1	3
Medicine CDH (ST1 - ST2)					1	1
Medicine RPH (FY1)			1		3	4
Medicine RPH (FY2) | Rota A	1	1	4			6
Medicine RPH (FY2) | Rota B			3			3
Medicine RPH (IMT3)			3			3
Microbiology (ST3 - ST5)		1	1			2
Neonates (FY2)	2					2
Obs & Gynae (FY1)			1			1
Oncology (FY1)			9			9
Paediatrics (FY1)			1			1
Plastic Surgery (ST3 - ST5)			2	1		3
Renal Medicine (FY1)			2			2
Renal Medicine (ST3 - ST5)			2			2
Surgical Specialties (FY1)	4		20		2	26
Surgical Specialties (FY2)			2			2
Trauma & Orthopaedics (FY1)			1			1
Trauma & Orthopaedics (FY2)		3	5			8
Urology (Junior Clinical Fellow)		1				1
Vascular Surgery (Junior Clinical Fellow)			1			1
Urology (LTFT)	1		2			3

Intensive Care (LTFT)					1	1
Medicine RPH (LTFT)			4			4
Grand Total	**8**	**8**	**71**	**1**	**8**	**96**

2.1 Immediate Safety Concerns

There was one exception reports which stated immediate safety concerns (ISC) in this period and this was related to service support as follows:

Specialty	ISC
Medicine CDH (FY1)	1
Grand Total	**1**

The doctor had made the following comments within the report:

"This afternoon, I was the only doctor on CCU Chorley. There was no senior support. There were several very sick patients on the ward, including one for full escalation. This patient deteriorated but I had no senior cardiology doctor to come review the patient"

This was escalated to the CDH Medicine and Cardiology clinical directors and the doctor was encouraged to submit a datix. Cross-cover arrangements to cover gaps were highlighted as an issue and there has been a proposal made after the Deanery visit to have an additional 2-3 floating junior doctors and 1-2 middle grades to help support the gaps on the wards. At present there is little flex in the Rota / staffing to cover any sickness or last minute gaps.

2.2 Work Schedule Reviews

Exception reporting, feedback from the junior doctor forum and queries/concerns raised by doctors directly to the Guardian of Safe working may result in a work schedule review. A work schedule review is to ensure rotas remain compliant to safe working rules and are fit for purpose and trainees are paid correctly for the work they do.

<u>RPH Surgical Specialties</u>

A work schedule review has been requested for the RPH surgical specialties on 13th June with reference to the high numbers of exception reports, the overnight staffing levels, senior support in the OOH period and the way the SOTW rota is staffed.

The Associate Divisional Medical Director Surgery has responded that the problem of inadequate junior staffing on the surgical wards is on the risk register. It has also been discussed and reviewed several times in the Divisional Workforce and Wellbeing Committee meetings. A combination of inadequate number of juniors compounded by sickness, patient acuity, and increased number of referrals to the surgical departments are the driving force for the issues. The division struggles to even employ locums or use the Hospital bank to provide cover when needed. It is busy and people are not very keen to do the extra work even if you offer them good rates. The Division has done an optional appraisal of the best way to provide adequate and safe cover for the wards and SAU, and a business case to improve staffing has been developed (progress TBC).

2.3 Guardian Fines

The exceptions in plastic surgery (ST3 non-resident on call rota) may be subject to guardian fines due to breaches in 48 hours and 5 hours continuous rest overnight (tbc).

3.0 VACANCIES

Trainee vacancy rates are monitored monthly manually through the medical workforce team by using a spreadsheet, this is because lead employer doctors (ST1-8) are not currently reported on our ESR therefore need to be reported manually.

We have recently changed our reporting of trust doctor vacancies and now use the ledger to report on such vacancies, we are aware of some issues relating to the ledger, for example, 1) the ledger double counts when doctors leave and a new doctor starts within the same month and 2) is based on the establishment within a budget being correct.

We are working with our finance and business manager colleagues to ensure the finance ledger is accurate in line with our medical establishment and at ways we can report in a different way to ensure the vacancy % is as accurate as it can be.

For this report trainee vacancies have been reported by medical workforce and the trust vacancies are taken from the ledger however we are conscious the trust vacancies may not be fully accurate at this point.

Table 3 - Vacancy rates at the end of quarter reported:

Grade	Nov-22			Mar-23			Jun 23			Sept 23		
	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant
FY1	3.5%	56	2	1.8%	57	1	1.8%	57	1	4.55%	66	3
FY2	1.9%	54	1	3.6%	56	2	1.9%	53	1	0%	54	0
ST1-2	6.0%	109	6	2.6%	116	3	9.7%	114	11	3.42%	117	3
ST3+	11.8%	143	16	7.2%	155	11	7.8%	154	12	3.25%	154	5
JCF	27.4%	61	23	29.5%	85	25	31.5%	89	28	20%	77	15
SCF	30.1%	86	37	26.5%	125	33	28.1%	128	36	20.1%	110	23
SAS	19.4%	75	18	16.4%	98	16	15.3%	98	15	1%	82	1

There has been a lot of recruitment activity with trust recruitment and between the 1st July and 30 September 2023 we have had 28 doctors start in post in the following specialties (Fellows/SAS Drs)

Table 4: Recruitment Activity

Grade/Specialty	Number of Drs started
Junior Clinical Fellow in Acute Medicine	4
Junior Clinical Fellow in Anaesthesia	1
Microsurgery and Hypospadias Fellow	1
Junior Trust Dentist in Oral and Maxillofacial Surgery	4
Senior Clinical Fellow in Neurosurgery	2
International Junior Training Fellow in Neurosurgery	1
ST3+ International Training Fellow (MCh) ENT	1
Senior Clinical Fellow in Diabetes	1
Junior Clinical Fellow in ENT	1
Junior Clinical Fellow in Neurosurgery	1
Junior Clinical Fellow in Elderly Medicine	1
Senior Clinical Fellow in Geriatrics	1
Senior Clinical Fellow Simulation for Obstetrics and Gynaecology	1
Senior Clinical Fellow in Simulation and Emergency Medicine	1
Senior Clinical Fellow in Paediatrics	1
Junior Education Clinical Fellow in Emergency Medicine	2
Junior Clinical Fellow Diabetes	1
Senior Clinical Fellow in Diabetes	1
Senior Clinical Fellow in Respiratory	1
Specialist in Plastic Surgery	1

At the point of writing this report we have a further 39 offers (all grades including consultant) in the pipeline, this includes 15 doctors who have been recruited into Senior Clinical Fellow posts through the new ORDER program who will be starting before Jan 24..

Our Workforce Business Partners are working closely with departmental management teams to develop recruitment strategies to fill hard to fill posts and we continue to work closely with a number of specialties to review and refresh job descriptions and have launched a new trust brochure.

We continue to promote vacancies through numerous channels including social media, NHS Jobs, linked in and the BMJ.

4.0 BANK AND AGENCY USAGE

The trust has an established medical and dental staff bank, all doctors employed by the trust or on placement can register to cover shifts through the bank. We are currently finalising a campaign to recruit bank doctors.

The medical bank rates are determined through the temporary staffing policy and no escalation of rates can happen without Executive approval. There is an ICS wide agreement to standardise rates across our region.

The hours worked through the bank are recorded and monitored and the following table shows hours worked

Table 5 – Hours worked per grade through the medical and dental bank.

Medical and Dental Staff Bank Hours worked	FY1	FY2	ST1	ST2	ST3	Specialty Doctor
2022 – Oct	219	5,203	1,434	983	1,313	2,075
2022 – Nov	236	3,600	273	865	2761	1,793
2022 – Dec	259	4,575	384	17	2,089	2,226
2023 – Jan	499	6097	439	106	2,484	2,483
2023 – Feb	241	4,788	331	270	1,775	2,148
2023 - Mar	248	4,398	323	237	2,016	2,219
2023 – Apr	264	6,510	393	278	2,153	2,304
2023 – May	254	6,216	416	111	2,222	2,004
2023 - Jun	329	4,666	450	108	2,140	2,319
2023 – Jul	309	7,098	705	234	2,847	3,038
2023 – Aug	75	5,345	30	1568	3671	2,456
2023 - Sept	79	5,795	0	5,795	1,549	2,397

NB – All booking are placed according to grades defined in the table above but these are not just filled by trainees working bank but trust doctors and those doctors who are registered as pure bank.

4.1 Medical and Dental Agency Usage

In addition to the medical and dental bank – shifts that cannot be filled using bank are filled through agency. In the hours filled though agency can be found below.

Table 6 – Hours worked through agency

Staff Bank plus and Agency	FY2	ST1	ST2	ST3
2022 – Oct	590	0	1,301	2064
2022 - Nov	114	0	1,383	1,841
2022 – Dec	163	49	2,102	3,178
2023 – Jan	220	0	2,789	3,827
2023 – Feb	45	0	2,363	3,658
2023 - Mar	113	0	2,895	3,172
2023 – Apr	85	91	2,224	3,988

2023 – May	0	154	2,799	3,676
2023 - Jun	0	52	2,354	3,779
2023 – Jul	0	82	2,497	3,694
2023 – Aug	0	129	1,045	2,286
2023 - Sep	0	296	707	2,692

NB – Please note that this table shows hours invoiced in a month so may not be representative of what has been worked in that month

5.0 JUNIOR DOCTOR FORUM

A forum was held on 26th September 2023 (minutes attached) via Microsoft teams. Staffing levels on the RPH medicine rotas (all rotas) were highlighted as being an issue and access to catering facilities and good quality food in the out of hours period was also reported.

7.0 LEGAL IMPLICATIONS

None

8.0 RISKS

The main risks identified in this report are the high number of exception reports in RPH FY1 and FY2 surgical specialties.

9.0 IMPACT ON STAKEHOLDERS

Not applicable.

10.0 RECOMMENDATIONS

- Note the contents of the report,
- Confirm they are assured that the issues identified are being addressed through escalation of the concerns to the appropriate management teams by the work of the Guardian,
- Escalate discussions regarding the report to the Board of Directors as appropriate.

11.0 APPENDICES

1. Minutes of JDF September 2023

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Junior Doctor Forum Minutes

Tuesday, 26th September 2023
1pm – 2pm
Microsoft Teams Meeting

	Item	Time	Format	Purpose	Owner
1	Introductions and Apologies	1pm	Verbal	Noted	DK
	Attendees Dr D Kendall Dr S Leifer Peter Jackson Dr M Chiu Dr A Spicer Dr B Liu Dr M Ali Dr C Dale Chris Davies Natalie Simpson		**Apologies** Dr K Kidner Lisa Eccles		
2	Minutes and actions from previous meeting	1.15pm	Verbal	Discuss	DK
	7th June via Teams – Annual Report now been sent to the group and attached to this meeting invite email Action: General Medicine RPH, 4 consecutive nights on the rota were discussed in the last meeting. Dr Hafiz was to take back to colleagues for further discussion – Not had my follow up from this as yet.				
3	GOSW quarterly report April-June 2023	1.25pm	Verbal	Discuss	all

	171 exception reports in this period which has gone up from the previous quarter (131). There were 7 immediate safety concerns, 5 of those from Drs in T&O. Some also from Acute Medicine at RPH – All reports actioned and taken up with the relevant departments – No fines. High number of exceptions in Surgical Dept - FY1/FY2 – Current review of work schedules in the Surgical Specialties – Awaiting outcome on this. 15 exceptions from the Plastic Surgery Non-Res on call Rota (NROC) – Data is being collated and then to review with department – there's a possibility that these are finable reports as they have not had the required rest overnight and may have breached 48 hours.				
4	Feedback from trainees regarding current work schedules, any issues etc.	1.35pm	Verbal	Discuss	all
	Dr Spicer advised she is feeding back from colleagues in her last dept – Medicine @RPH - On call – There are issues with low staffing levels from FY1 all the way through to Reg level. This is a small team and there are usually gaps in the rotas. The main concerns are the weekend, night and out of hours staffing – Anytime after 5PM. Some shifts there is only 1 Reg level Doctor and the rest FY2 level, which puts a huge amount of strain on the Reg. Dr Spicer raised safety concerns from a shift she worked on a bank holiday. Bank holidays appear to be less-staffed than weekends. It would be beneficial to have backup plans if there are apparent gaps on the Rota. Dr Kendall advised that this is something that needs to be investigated and evidence collected. Peter Jackson recommends a review on the Rotas for the Juniors in the Medicine Dept – The Junior Doctors Forum is a useful platform to discuss. Dr Leifer said that escalating the locum rates is a problem for all and especially when neighbouring trusts pay more and only the Medical Director could approve escalating rates for gaps on Rotas. Dr Kendall said this has been raised and it has gone through LNC multiple times and Trust Board have not approved. Dr Chiu discussed minimum safe staffing levels. Dr Spicer said Dr Ben Phillips, Senior Reg is conducting an audit, focusing on the on call team. **Action: Dr Spicer to request data from Dr Phillips and copy Dr Kendall into comms on this.** **Action: Dr Kendall to raise with Clinical Director and request possible work schedule review – To highlight issues around minimum staffing levels, pay**				

	escalation and short-term gaps and how they can be better managed. Peter Jackson suggested a 3 month review on this and to be picked up at the next Junior Doctors Forum so we can see action/change. Chris Davies discussed LTFT Rotas as being a challenge – Work Schedules should be issued 8 weeks before Drs starting in post, but this is very difficult to achieve due to last minute notification of LTFT status. If Drs know they are going to be LTFT they need to liaise with Rota Co-Ordinator's as soon as possible to ensure Medical Workforce have chance to link in with departments and get the Rotas built in good time.				
5	Feedback from trainees for any training and teaching issues	1.55pm	Verbal	Discuss	DK
	Nil				
6	SOP for rota design	2pm	Verbal	Discuss	DK
	Dr M Chiu is working on this.				
7	Facilities Update	2.05pm	Verbal	Discuss	DK
	Dr Kendall advised she attends the rest and recreation steering group meetings – Going forwards the group are looking at improving some of the rest areas within the Trust and the outdoor area as well, funding via charitable funds. Catering issues are still a problem – possible staff survey to assess what the staff want from the catering services. **Action: Dr Spicer volunteered to conduct a survey monkey for the Drs which she can post on whatsapp groups which will capture most people.** **Action: Dr Leifer said that this would also link in with the well being Fellows and they might like to work with Dr Spicer on this.**				
8	Any other business				
	None				
9	Date/Time of next Meeting				
	Tuesday 12th December 1pm– Face to Face – Room TBC.				

Chair's Report

Lancashire Teaching Hospitals NHS Foundation Trust

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	25 September 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 25 September 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 22nd August 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review:

- Identified gaps in assurance, particularly in controls, workforce management, and non-pay controls.
- Emphasized the need for reporting and action to ensure effectiveness, especially in workforce controls amidst increased agency spend.
- Explored transformation programme growth, highlighting the necessity of better articulation of benefits and assurances for both internal and cross-system programmes.

Financial Performance:

- Outlined financial performance for 2023/24, noting challenges in deficit, CIP delivery, and workforce-related costs.
- Mentioned improved risk forecasts but highlighted ongoing pressure on cash positions.
- Discussed deficit finance protocol enactment criteria and ongoing efforts to minimise prior year charges.

Operational Performance:

- **Performance Assurance Progress:** Highlighted progress in cancer care initiatives but expressed concerns about certain areas witnessing performance drops. Addressed challenges in managing mental health patients and stressed the importance of planning for upcoming winter pressures.

- **Contract Performance:** Raised concerns about perceptions of overfunding and the need for balanced approaches in managing increasing Urgent Care demands. Stressed ongoing conversations with stakeholders to ensure financial sustainability.

Strategy and Planning

- **Planning Framework**: Addressed concerns about planning guidance's robustness due to financial constraints and complexity in collaborative models. Emphasised the importance of readiness for different operational approaches.
- **Continuous Improvement & Transformation**: Stressed the need to focus on tangible outcomes of transformation programmes and to understand "what good looks like" in various areas. Highlighted areas requiring further assurances and alignment with targets.
- **Financial Improvement Plan**: Recognised progress made but highlighted a forecasted delivery gap and high-risk schemes impacting financial obligations. Emphasised the need for a clear trajectory and understanding of recurrent positions.

In addition, the Committee received reports for consideration/discussion for:

Use of Resources:

- Addressed reliance on existing measures due to the absence of annual site visit assessments.
- Discussed measures from the model hospital system, focusing on improvements and the need to integrate benchmark improvements into the Transformation Programme.

Challenging Decisions:

- Discussed significant decisions impacting the organisation's financial position and the necessity of prioritisation and clarity in decision-making criteria.

Items for the Board's attention

Positive escalation

- Acknowledgment around risk articulation to drive home internal controls and assurances; reviews commissioned.
- Deployment of Pride and Joy software: use of AI to help drive intervention actions.
- PTL work for cancer.
- Positive assurance on activity underperformance; getting to root cause factors and driving out actions of intervention.
- Community Hub going live with a single point of access.
- Teams co-locating for the 1st time. Virtual ward.
- Acknowledgment of the need for a full discussion/debate around challenging decisions.
- 1st steps in relation to a medium-term financial plan on the back of what is being done across the ICS.

Negative escalation

- Worsening position of financial performance in terms of CIP.
- Need to strengthen assurance around programmes of work and the contribution that they are making.

Committee to Committee escalation

Capital Planning Forum: continued to escalate around prioritisation of resources and undertaking a further review. Previously referred to Safety and Quality, but further escalation was thought to be needed.

Items recommended to the Board for approval

None
Committee Chairs reports received
(a) Capital Planning Forum (inc. TOR) (b) New Hospitals' Programme flash report (c) ICS, ICP, PCB system update
Items where assurance was provided and/or for information
Exception Reports from Divisional Improvement Forums
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 23 October 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Finance and Performance Committee agenda (*25 September 2023*)

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tim Watkinson, Non-Executive Director
Date(s) of Committee meeting(s):	23 October 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 23 October 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 25th September 2023 and reviewed updates on associated committee actions. Mr T Watkinson, Non-Executive Director deputised for Mrs T Whiteside as Chair. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review: Discussions highlighted risks associated with delivering the financial plan, emphasising potential impacts on organisational commitments and the System Oversight Framework (SOF) rating. Conversations addressed external controls and the potential re-establishment of a Programme Management Office.

Financial Performance: Noted a £31.7 million operating deficit, primarily due to various operational pressures and system stretch targets. Emphasis on workforce cost reduction for financial recovery and proactive measures in future recovery actions.

Operational Performance:

- **Performance Assurance Progress:** Highlighted performance challenges and improvement measures across the services. Concerns addressed ED performance and the financial impact of cancellations.
- **Costings Update:** Reviewed National Cost Collection (NCC) Pre-Submission Report and Service Line Reporting. Discussions focused on improving coding accuracy, reviewing loss-making services, and utilizing the EVO model for improvement work.

Strategy and Planning

- **Planning Framework**: Highlighted planning efforts at both organisational and system levels. Discussions centred around balancing ambition with realistic goals and improving productivity metrics.

- **Continuous Improvement & Transformation**: Outlined decision-making processes and oversight within the Continuous Improvement Programme. Discussions focused on transparency, alignment with established processes, and capturing decisions made.

- **Financial Improvement Plan**: Outlined progress against financial targets, workforce reductions, and challenging decisions under consideration. The recurrent deficit had reduced from £97 million to £65 million, indicating positive direction, but the necessity for continued organisational efforts over the next two quarters was acknowledged.

In addition, the Committee received reports for consideration/discussion for:

Lancashire Procurement Collaborative Update: Focused on collaboration efforts, staff understanding of procurement processes, and efforts to reduce single tender waivers.

Income Strategy: Emphasised creating margin from services, improving income collection, and addressing loss-making services. Integrated actions with the Financial Recovery Plan were endorsed.

Winter Plan: Discussed managing demand, community healthcare beds, and risks associated with patient care during the winter. Allocation of funds and concerns regarding patient care decisions were highlighted.

Maternity Investment: Discussed financial implications and challenges in meeting CNST and Ockenden standards, emphasising the need for careful financial planning and prioritisation of investments.

Items for the Board's attention

Positive escalation

- CIP exceeded target for non-recurrent for current month.
- Good progress around cancer performance
- Ongoing procurement work – integration with ICB and achievement of savings
- Workforce task and finish group showing early signs of benefits.
- Improved reporting of the transformation plans into the CIP.

Negative escalation

- Ongoing financial challenge is significant.
- Productivity: relative deterioration in the high-level productivity metrics for the NHS and LTHTR – input costs have risen faster than weighted activity.

Committee to Committee escalation

None

Items recommended to the Board for approval

None

Committee Chairs reports received

a) Capital Planning Forum (inc. TOR) b) New Hospitals' Programme full report c) ICS, ICP, PCB system update d) SIRO/AIO Working Group e) IG Records Committee f) EPRR Committee g) ELFS Management Board Minutes
Items where assurance was provided and/or for information
• Exception Reports from Divisional Improvement Forums • Contract Performance • Controls Overview
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 28 November 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 2 – Finance and Performance Committee agenda (*23 October 2023*)

Finance and Performance Committee

25 September 2023 | 1.00 pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Information	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Information	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 22 August 2023	2.03pm	✓	Decision	T Whiteside
5.	Matters arising and action log	2.04pm	✓	Decision	T Whiteside
6	Strategic Risk Review	2.10pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M5 Finance Report (inc. deficit protocol)	2.20pm	✓	Assurance	A Mulholland-Wells
7.2	Use of Resources Report	2.40pm	✓	Information	G Doherty
8.	OPERATIONAL PERFORMANCE				
8.1	a) Performance Assurance Progress Report (inc. Specialty Based Recovery Plans and Cancer) b) Activity Underperformance Report	2.50pm	✓	Assurance	F Button
8.2	Contract Performance	3.05pm	✓	Assurance	A Mulholland-Wells
9.	STRATEGY AND PLANNING				
9.1	Financial Improvement Plan	3.20pm	✓	Assurance	A Mulholland-Wells
9.2	Challenging Decisions	3.40pm	✓	Assurance	A Mulholland Wells
9.3	Planning Framework Update (inc. glidepath to annual planning cycle and 3-5 year view)	3.55pm	✓	Assurance	G Doherty
9.4	Planning Framework Review	4.10pm	Verbal	Assurance	G Doherty

9.5	Continuous Improvement and Transformation update	4.25pm	✓	Information	A Brotherton
10. GOVERNANCE AND COMPLIANCE					
10.1	Items for escalation to the Board or items to/from other Committees	4.40pm	Verbal	Information	T Whiteside
10.2	Reflections on the meeting and adherence to the Board Compact	4.50pm	✓	Information	T Whiteside
11. ITEMS FOR INFORMATION					
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	**Chairs' reports**: (a) New Hospitals Programme flash report (b) ICS, ICP, PCB System update (c) Capital Planning Forum		✓		
11.3	Date, time and venue of next meeting: *23 October 2023 1.00-4.00pm* *Microsoft Teams*	4.55pm	Verbal	Information	T Whiteside

Finance and Performance Committee

23 October 2023 | 1.00 pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	T Watkinson
2.	Apologies for absence	1.01pm	Verbal	Information	T Watkinson
3.	Declaration of interests	1.02pm	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 25 September 2023	1.03pm	✓	Decision	T Watkinson
5.	Matters arising and action log	1.04pm	✓	Decision	T Watkinson
6	Strategic Risk Review	1.10pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M6 Finance Report (inc. deficit protocol)	1.20pm	✓	Assurance	C McGourty
7.2	Costings Update a) NCC Pre-Submission Report b) Service Line Reporting	1.35pm	 ✓ ✓	Information	C McGourty
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report (inc. Contract Performance)	1.45pm	✓	Assurance	E Ince/I Devji
8.2	Lancashire Procurement Collaborative update (incorporating supplier scores)	1.55pm	✓	Assurance	S Robson
9.	STRATEGY AND PLANNING				
9.1	Financial Improvement Plan – including Challenging Decisions	2.05pm	✓	Assurance	J Wood

9.2	Income Strategy	2.15pm	✓	Information	J Wood
9.3	Winter Plan	2.25pm	✓	Information	I Devji
9.4	Planning Framework Update (inc. glidepath to annual planning cycle and 3-5 year view)	2.35pm	✓	Assurance	G Doherty
9.5	Maternity Investment	2.45pm	✓	Assurance	S Cullen/G Doherty
9.6	Continuous Improvement and Transformation update	2.55pm	Verbal	Information	A Brotherton
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items for escalation to the Board or items to/from other Committees	3.05pm	Verbal	Information	T Watkinson
10.2	Reflections on the meeting and adherence to the Board Compact Items for escalation to the Board or items to/from other Committees	3.15pm	✓	Information	T Watkinson
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) New Hospitals Programme full report (b) ICS, ICP, PCB System update (c) Capital Planning Forum (d) SIRO/AIO Working Group (e) IG Records Committee (f) EPRR Committee (g) ELFS Management Board Minutes		✓		
11.4	Controls Overview		✓		
11.5	Date, time and venue of next meeting: *28 November 9am-12pm Microsoft Teams*	3.25pm	Verbal	Information	T Watkinson

Board of Directors Report

Integrated Performance Report							
Report to:	Board of Directors			**Date:**	7th December 2023		
Report of:	Executive Team			**Prepared by:**	Executive Directors		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

The purpose of this report is to provide the Board with an update on the Trust's performance as at the end of October 2023, unless otherwise stated.

- **The report reflects the revised 2023/24 Big Plan measures agreed by each sub-committee.**

Consistently Deliver Excellent Care

Operational Performance

Emergency care performance headlines:

- In October, 266 patients waited between 30-60 minutes: a decrease of 9 from last month. 265 patients waited over 60 minutes to be handed over from NWAS to the Trust in October, an increase of 144 from last month. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- 4 Hour ED performance is showing a continuing deterioration in performance, with October at 69.4%, (September 71.0% and August 72.5%), just below the national average position of 70.2% and 6th out of the acute trusts in the North West. This will be a focus to achieve the 76% target for March 24.

- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for October has seen a further deterioration to 11.1% compared to previous months.

- The occupancy metric has been updated to reflect the new requirement to *reduce adult general and acute (G&A) bed occupancy to 92% or below*, with Trust occupancy for October at 96.9%, a slight reduction compared to last month's occupancy level of 97.4%.

- The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has increased to an average of 86 patients this month. There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub at Finney House.

Unfunded capacity and operational changes:

There have been a number of changes to processes and services, including Finney House, improved utilisation of Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	Completed – require COO/CMO approval to open
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	Completed
Establishment of Acute Assessment Unit	Reduced ED footprint, reducing long waits in ED	Apr-23	Completed
No overnight escalation into Same Day Emergency Care	Reduced need for additional staffing, protects SDEC function	May-23	Completed
No ED escalation into CT wait area in hours	Reduced need for additional staffing, protects CT function	Jun-23	Completed
Closure of additional acute ward	Reduction of 11 G&A beds	October-23	Emergency pathway pressures have delayed delivery.
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Nov-23	Initial capital bid unsuccessful – new round of national funding has opened and a bid has been submitted.
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – planning underway

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement and in addition to system plans, the Trust has its own internal programme of improvement being delivered through the Urgent Care Transformation Board. Details of progress with the work streams is provided in the transformation update.

Local winter resilience planning is being concluded with a system winter taskforce in place that has senior representation from partner organisations and reports through to the Central Lancashire Urgent and Emergency Care (UEC) Board to the L&SC Collaborative Improvement Board. Central Lancashire and ICB level winter events took place on the 9th and 16th of November to develop further mitigation across key areas of pressure both in and out of hospital, including mental health, frailty and respiratory conditions. There are also ongoing discussions regarding operational and tactical escalation responses and the implementation of the new NHS England Operational Pressures Escalation Level (OPEL) framework. Detail relating to the Winter Plan is set out below.

Care ConneXion, has been established to support demand management, admission avoidance and supporting people to stay safe and well at home. The team is an integrated single point for all professionals to access services, with co-location of teams to accept referrals for time-limited, physical health and care to enable people to remain safe and well at home with a level of support appropriate to meet their needs in the least intrusive way - including for those people where an admission to hospital can be avoided or a discharge facilitated. The initial phase is in place and includes the co-location of 2 Hour Urgent Crisis Response; Virtual Ward, Same Day Emergency Care and NWAS.

Internal operational programmes of work have been introduced with a focus on inflow (attendance to ward admission) and flow (admission to discharge) with teams across the organisation working together to improve processes and streamline business as usual activity.

Winter Plan 2023

The key winter planning pressures are detailed below. Following the system wide events ICB, ICP and Trust plans have been developed, along with key internal Divisional plans.

The financial context: Insufficient funding to support identified schemes to strengthen winter preparedness and resilience, reduction of unfunded G&A bed capacity

Workforce: Industrial action, recruitment and retention, wellbeing and resilience, sickness, mandatory vaccinations

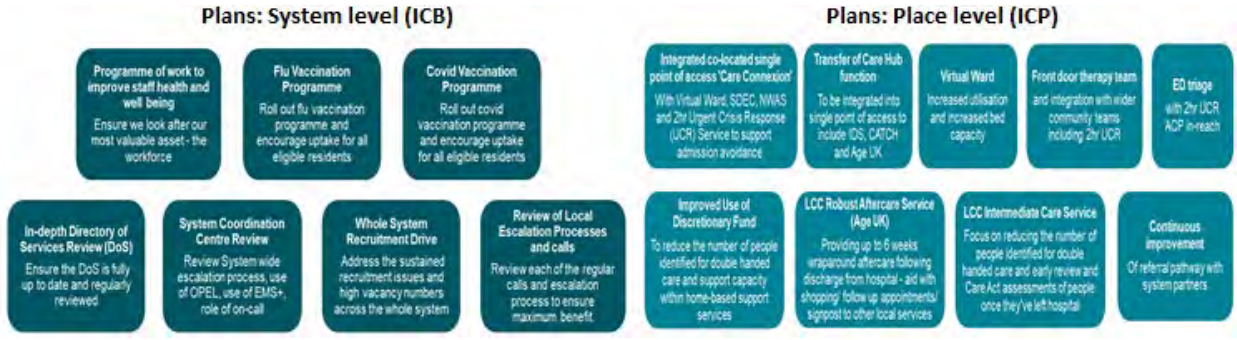
High demand for health and care services: Across acute, community, mental health, primary and social care

Recovery: Restoration of services and backlogs, balancing elective and non-elective pressures, pressure on out of hospital services with higher complexity/acuity, mental health demand, respiratory, social isolation, people waiting to present/not accessing services until at crisis point

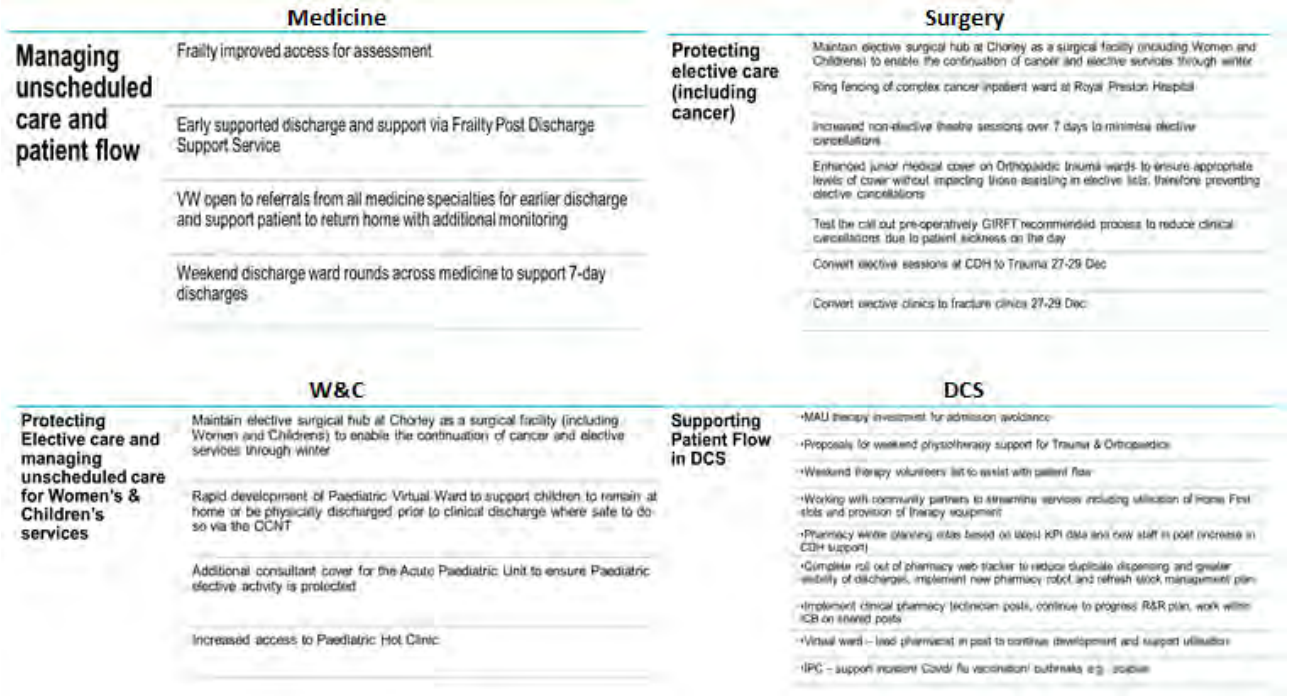
Challenging operational environment: IPC issues, boarding, changes to delivery e.g. walk-in to book-in, estate limitations

Major challenges in social care: Pressures in both domiciliary and care home markets locally, mirroring LSC, regional and national landscape

System and Trust level plans are in place with a focus on:



Agreed plans at Divisional level are:



Medicine

Managing unscheduled care and patient flow	Frailty improved access for assessment
	Early supported discharge and support via Frailty Post Discharge Support Service
	VW open to referrals from all medicine specialties for earlier discharge and support patient to return home with additional monitoring
	Weekend discharge ward rounds across medicine to support 7-day discharges

Surgery

Protecting elective care (including cancer)	Maintain elective surgical hub at Chorley as a surgical facility (including Women and Childrens) to enable the continuation of cancer and elective services through winter
	Ring fencing of complex cancer inpatient ward at Royal Preston Hospital
	Increased non-elective theatre sessions over 7 days to minimise elective cancellations
	Enhanced junior medical cover on Orthopaedic trauma wards to ensure appropriate levels of cover without impacting those assisting in elective lists, therefore preventing elective cancellations
	Test the call out pre-operatively GIRFT recommended process to reduce clinical cancellations due to patient sickness on the day
	Convert elective sessions at CDH to Trauma 27-29 Dec
	Convert elective clinics to fracture clinics 27-29 Dec

W&C

Protecting Elective care and managing unscheduled care for Women's & Children's services	Maintain elective surgical hub at Chorley as a surgical facility (including Women and Childrens) to enable the continuation of cancer and elective services through winter
	Rapid development of Paediatric Virtual Ward to support children to remain at home or be physically discharged prior to clinical discharge where safe to do so via the CCNT
	Additional consultant cover for the Acute Paediatric Unit to ensure Paediatric elective activity is protected
	Increased access to Paediatric Hot Clinic

DCS

Supporting Patient Flow in DCS	•MAU therapy investment for admission avoidance
	•Proposals for weekend physiotherapy support for Trauma & Orthopaedics
	•Weekend therapy volunteers list to assist with patient flow
	•Working with community partners to streamline services including utilisation of Home First slots and provision of therapy equipment
	•Pharmacy winter planning aims based on latest KPI data and new staff in post (increase in CDH support)
	•Complete roll out of pharmacy web tracker to reduce duplicate dispensing and greater visibility of discharges, implement new pharmacy robot and refresh stock management plan
	•Implement clinical pharmacy technician posts, continue to progress R&R plan, work within ICB on shared posts
	•Virtual ward – lead pharmacist in post to continue development and support utilisation
	•IPC – support increase Covid/ flu vaccination/ outbreaks e.g. scabies

Overall risks to delivery are:

Demand and capacity	**Demand on services outweighs capacity which will impact on patient experience and potentially quality of service delivered.**	*Maximise Virtual Ward capacity and utilisation *Conveyance and hospital avoidance work streams *Flu planning for health and social care staff and population *Mutual aid / escalation plans *Recovery and transformation plans *Escalation capacity *Extended opening hours over the winter period *Additional staffing over the winter period *Delivery of UEC transformation plans to support winter pressures *Use of market sustainability and investment funds to support viable and stable provision
Intermediate care and social care provision	**Fragility of care market and provision with high demand during winter.**	*Re-procurement of home care provision across the county looking at new and different ways of working with providers, that is much more dynamic and flexible to ensure best use is made of the current capacity. *Utilisation of technology to create more capacity within home care sector for patients with lower level needs. *Re-procurement of an end-to-end service within the Intermediate Care provision
Funding	**Specific funding available to deliver system/ local place-based schemes to support winter pressures.**	*£40,147m received from NHS England for LSC, allocated for UEC investment funding and virtual wards *Funding locally included a proportion of AFU, Finney House and Virtual Ward *Utilisation of external funding opportunities as they arise, internal and system plans in place that can be mobilised quickly
Workforce (inc. social care)	**Workforce challenges (sickness/ recruitment/ Covid +/ Flu/ Industrial action) impacts on aims and objectives to build resilience in teams, which has wider impacts on system flow and performance and accessing key services.**	*Staff offered Flu and C19 vaccinations *Encouraged to take annual leave as well as regularly breaks on shift. *Regular conversations/meetings with managers and supporting teams *Staff have access to additional resilience training, staff welfare, self-help modules and access to work and life coaching *Recruitment to ensure resilience is within teams to cover staff absences *Regular bulletins/newsletters and useful information shared. *Use of digital in care models *Prioritising services to redeploy staff into these where necessary *Mutual aid

Escalation and Surge

Joint escalation and surge plans have been developed enabling a joint and cohesive approach through internal bed meetings, daily system discharge meetings, LSC System Control Centre, and the Central Lancashire UEC Board. At organisation level this is managed through the Strategic Operational Group. The Trust Escalation Plan including Full Capacity Protocol in place. The internal UEC Transformation Board tracks the delivery and impact of capacity generating and demand reducing initiatives.

Cancer recovery:

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 5th November:

Suspected Tumour Type	Total waiting list	Number past day 62	Number past day 62 - DTT	% of waiting list past day 62	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)	England % of waiting list past day 62	Distance from England average (>62 days)
Lower Gastrointestinal	622	85	9	13.7%	12	35	10.3%	21
Sarcoma	32	8	6	25.0%	3	3	13.5%	4
Haematological	2	1	0	50.0%	0	-3	15.6%	1
Lung	58	9	3	15.5%	-1	-1	14.3%	1
Children's	8	0	0	0.0%	0	0	4.5%	0
Other	12	1	0	8.3%	0	1	4.6%	0
Upper Gastrointestinal	117	10	2	8.5%	0	2	8.4%	0
Urological	237	35	3	14.8%	0	-15	14.8%	0
Breast	145	4	2	2.8%	-6	-5	3.4%	-1
Head & Neck	175	11	1	6.3%	-1	-12	7.4%	-2
Brain/Central Nervous System	107	0	0	0.0%	-2	0	3.6%	-4
Gynaecological	162	11	5	6.8%	-14	-13	9.2%	-4
Skin	588	32	25	5.4%	-9	1	7.1%	-10
All Suspected Cancers	2,265	207	56	9.1%	-18	-7	8.8%	6

2023/24 Cancer National targets:

Performance against the tumour group specific trajectories for the Cancer 62 day recovery plan, to March 24 is below:

Speciality		Recovery period	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Position at 15 Nov 2023	Dec 23	Jan 24	Feb 24	Mar 24
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	Brain	Trajectory	2	2	2	2	2	2	2	2	2	2	2	1
		Actual	8	0	0	1	1	3	0	0				
	Breast	Trajectory	8	7	7	7	7	6	6	6	6	6	6	6
		Actual	4	6	2	8	13	6	5	4				
	Colorectal	Trajectory	53	52	50	48	46	44	42	41	42	44	40	38
		Actual	42	39	51	41	42	67	81	83				
	Gynaecology	Trajectory	28	27	26	25	24	24	23	22	22	24	21	20
		Actual	34	27	29	34	23	17	12	9				
	Haematology	Trajectory	10	9	9	9	9	8	8	8	8	8	8	7
		Actual	4	7	7	5	3	1	1	0				
	Head & Neck	Trajectory	25	24	23	22	21	21	20	19	20	21	19	18
		Actual	13	15	22	22	20	18	10	12				
	Lung	Trajectory	13	13	12	12	12	11	11	10	11	11	10	10
		Actual	12	10	6	13	11	7	7	8				
	Sarcoma	Trajectory	4	4	4	4	4	4	4	3	4	4	3	3
		Actual	3	9	8	9	3	5	6	8				
	Skin	Trajectory	25	24	23	22	21	20	20	19	20	20	19	18
		Actual	22	23	37	47	26	48	32	24				
	Upper GI	Trajectory	8	8	7	7	7	7	6	6	6	7	6	6
		Actual	8	12	19	15	8	11	15	10				
	Urology	Trajectory	74	72	71	68	65	63	60	58	59	63	56	53
		Actual	71	87	76	50	42	37	32	38				
	Total	Trajectory	250	242	234	226	218	210	202	194	200	210	190	180
		Actual	221	235	257	245	192	220	201	196				

The performance reflects achievement against the trajectory to the end of October. The target for 2023/24 is 180 and is achievable with support from the Cancer Alliance, agreed tumour group specific trajectories for FDS and 62 day are detailed in the report.

- 62-day performance - the number of patients over 62 days decreased in October to 201 from a September position of 220. The Trust has tumour site specific actions plans that are monitored weekly, with additional input from the Cancer Transformation Director supporting faster recovery.

Cancer FDS actual position against trajectory to October 2023:

	Apr-23			May-23			Jun-23			Jul-23			Aug-23			Sep-23			Oct-23		
Tumour Group	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var
Brain	40.8%	41.5%	0.7%	46.3%	64.1%	17.8%	52.6%	56.8%	4.1%	62.1%	57.6%	-4.5%	70.5%	42.0%	-28.5%	75.8%	53.7%	-22.1%	75.8%	59.3%	-16.5%
Breast	93.0%	98.2%	5.2%	93.0%	96.6%	3.6%	93.0%	95.1%	2.1%	93.0%	98.1%	5.2%	93.0%	96.8%	3.8%	93.0%	95.8%	2.8%	93.0%	98.0%	5.0%
Breast Symptomatic	94.3%	94.6%	0.2%	94.3%	96.6%	2.3%	94.3%	98.9%	4.6%	94.3%	99.0%	4.7%	94.3%	95.1%	0.8%	94.3%	100.0%	5.7%	94.3%	98.3%	4.0%
Colorectal	50.0%	50.2%	0.2%	55.6%	44.2%	-11.4%	61.1%	59.0%	-2.1%	66.7%	52.3%	-14.3%	72.2%	22.5%	-49.7%	75.1%	10.1%	-65.0%	75.1%	32.0%	-43.2%
Gynaecology	49.5%	46.4%	-3.1%	52.2%	55.8%	3.6%	54.9%	67.5%	12.5%	60.4%	65.3%	4.9%	65.9%	50.5%	-15.5%	71.4%	67.5%	-4.0%	75.3%	76.6%	1.3%
Haematology	0.0%	20.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Head and Neck	70.9%	77.5%	6.6%	71.8%	74.6%	2.8%	72.7%	76.9%	4.1%	73.6%	83.0%	9.4%	74.5%	80.1%	5.5%	75.0%	79.9%	4.9%	75.0%	81.0%	6.0%
Lung	65.2%	67.4%	2.2%	68.1%	73.2%	5.1%	71.0%	74.0%	3.0%	73.9%	93.3%	19.4%	73.9%	74.2%	0.3%	73.9%	83.3%	9.4%	75.4%	76.1%	0.7%
NSS	75.0%	80.0%	5.0%	75.0%	80.0%	5.0%	75.0%	85.7%	10.7%	75.0%	25.0%	-50.0%	75.0%	72.7%	-2.3%	75.0%	56.5%	-18.5%	75.0%	50.0%	-25.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Paediatric	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	88.9%	13.9%	75.0%	40.0%	-35.0%
Sarcoma	59.5%	68.2%	8.7%	61.9%	52.0%	-9.9%	64.3%	60.7%	-3.6%	66.7%	62.5%	-4.2%	69.0%	75.0%	6.0%	71.4%	56.7%	-14.8%	76.2%	63.6%	-12.6%
Skin	90.0%	93.4%	3.4%	90.0%	95.7%	5.7%	90.0%	94.3%	4.3%	90.0%	91.2%	1.2%	90.0%	86.8%	-3.2%	90.0%	51.6%	-38.4%	90.0%	73.2%	-16.8%
Upper GI	75.4%	69.6%	-5.8%	75.4%	71.8%	-3.6%	75.4%	66.1%	-9.3%	75.4%	72.5%	-2.9%	75.4%	69.5%	-5.8%	75.4%	72.1%	-3.3%	75.4%	76.0%	0.6%
Urology	45.8%	44.9%	-0.9%	51.9%	38.7%	-13.2%	55.7%	46.2%	-9.5%	61.1%	25.6%	-35.5%	67.2%	36.1%	-31.1%	72.5%	28.1%	-44.4%	75.6%	28.1%	-47.4%
Grand Total	70.1%	72.8%	2.7%	72.4%	73.5%	1.1%	74.4%	77.7%	3.3%	75.0%	75.8%	0.8%	75.0%	68.3%	-6.7%	75.0%	56.2%	-18.8%	75.0%	67.2%	-7.8%

A Cancer Transformation Plan is in place to support delivery in 2023/24.

NHS England Financial and Performance Assurance:

The NHS England letter of 8th November 2023 set out assurance expectations in relation to financial and performance pressures. Trusts were asked to provide assurance in relation to key headline and enabler performance objectives as follows:

<table>
<tr><th>Expectation</th><th>Current Status</th><th>Update</th></tr>
<tr><td colspan="3">Headline Objectives</td></tr>
<tr><td>The 4 hour system A&E performance as described in the winter plan</td><td>Confirmed Delivery of original plan</td><td>
<table>
<tr><th colspan="2">Actuals</th><th colspan="5">Plans</th></tr>
<tr><th>Period</th><th>Value</th><th>Nov-23</th><th>Dec-23</th><th>Jan-24</th><th>Feb-24</th><th>Mar-24</th></tr>
<tr><td>Sep-23</td><td>71.0%</td><td>95.5%</td><td>75.8%</td><td>75.8%</td><td>76.1%</td><td>76.1%</td></tr>
</table>
</td></tr>
<tr><td>The March 2024 cancer 62 day backlog position set out in the 2023/24 operational plan</td><td>Confirmed Delivery of original plan</td><td>
<table>
<tr><th colspan="2">Actuals</th><th colspan="5">Plans</th></tr>
<tr><th>Period</th><th>Value</th><th>Nov-23</th><th>Dec-23</th><th>Jan-24</th><th>Feb-24</th><th>Mar-24</th></tr>
<tr><td>Sep-23</td><td>222</td><td></td><td></td><td></td><td></td><td>180</td></tr>
</table>
</td></tr>
<tr><td>The March 2024 cancer Faster Diagnosis Standard performance set out in the 2023/24 operational plan</td><td>Confirmed Delivery of original plan</td><td>
<table>
<tr><th colspan="2">Actuals</th><th colspan="5">Plans</th></tr>
<tr><th>Period</th><th>Value</th><th>Nov-23</th><th>Dec-23</th><th>Jan-24</th><th>Feb-24</th><th>Mar-24</th></tr>
<tr><td>Sep-23</td><td>69.1%</td><td></td><td></td><td></td><td></td><td>75.0%</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Key Enablers</td></tr>
<tr><td>Core G&A bed capacity growth committed to within the winter plan</td><td>Amendment to original plan - Core G&A bed capacity has been amended in the activity spreadsheet to 862. This reflects a change of -17 to the adult G&A bed figure of 849 to bring that to 832, reflecting the delivery of UEC transformation plans, including the establishment of Care Connexion to support demand management and the implementation of Pride and Joy, an enabler to reduce length of stay. The successful delivery of Finney House has also contributed to the delivery of planned bed reductions to unfunded G&A capacity over the summer period.</td><td>
<table>
<tr><th colspan="2">Actuals</th><th colspan="5">Plans</th></tr>
<tr><th>Period</th><th>Value</th><th>Nov-23</th><th>Dec-23</th><th>Jan-24</th><th>Feb-24</th><th>Mar-24</th></tr>
<tr><td>Sep-23</td><td>865</td><td>879</td><td>879</td><td>879</td><td>879</td><td>879</td></tr>
<tr><td>Revised Submission</td><td></td><td>862</td><td>862</td><td>862</td><td>862</td><td>862</td></tr>
</table>
</td></tr>
<tr><td>Escalation capacity committed to within the winter plan</td><td>Confirmed Delivery of original plan</td><td>
<table>
<tr><th colspan="2">Actuals</th><th colspan="5">Plans</th></tr>
<tr><th>Period</th><th>Value</th><th>Nov-23</th><th>Dec-23</th><th>Jan-24</th><th>Feb-24</th><th>Mar-24</th></tr>
<tr><td></td><td></td><td>6</td><td>0</td><td>0</td><td>17</td><td>0</td></tr>
</table>
</td></tr>
<tr><td>An ambulance handover average delay trajectory, that is consistent with the overall system-level trajectory, has been agreed by the trust Board</td><td>Confirmed Delivery of original plan</td><td></td></tr>
<tr><td colspan="3">Discharge</td></tr>
<tr><td>A discharge ready date metric was published for the Trust in November, and the trust Board is regularly reviewing this metric as part of a performance dashboard to drive improvement</td><td>Confirmed DRD metrics will be included in Nov 23 Finance & Performance Committee and Trust Board performance reports</td><td>
<table>
<tr><th>Summary</th><th>Oct-23</th><th>Trust Compliance</th><th>National Compliance</th><th>Variance</th></tr>
<tr><td>Total Discharges in DRD Cohort</td><td>3705</td><td></td><td></td><td></td></tr>
<tr><td>Discharged on DRD</td><td>3295</td><td>88.9%</td><td>86.40%</td><td>2.53%</td></tr>
<tr><td>Discharged after DRD</td><td>410</td><td>11.1%</td><td>13.60%</td><td>-2.53%</td></tr>
</table>
<table>
<tr><th>Discharges by DRD to Discharge Days</th><th>Oct-23</th><th>Trust Compliance</th><th>National Compliance</th><th>Variance</th></tr>
<tr><td>1 day</td><td>153</td><td>37.32%</td><td>33.10%</td><td>4.22%</td></tr>
<tr><td>2-3 days</td><td>107</td><td>26.10%</td><td>23.90%</td><td>2.20%</td></tr>
<tr><td>4-6 days</td><td>72</td><td>17.56%</td><td>16.10%</td><td>1.46%</td></tr>
<tr><td>7-13 days</td><td>53</td><td>12.93%</td><td>15.30%</td><td>-2.37%</td></tr>
<tr><td>14-20 days</td><td>17</td><td>4.15%</td><td>5.50%</td><td>-1.35%</td></tr>
<tr><td>21 days or more</td><td>8</td><td>1.95%</td><td>6.20%</td><td>-4.25%</td></tr>
</table>
<table>
<tr><th>Average Days from DRD to Discharge Date (incl. 0 Days)</th><th>Average Bed days per discharge</th><th>Total Bed Days</th></tr>
<tr><td>Average Days from DRD to Discharge Date</td><td>2.3</td><td>1755</td></tr>
<tr><td>Bed Days in Oct 23</td><td>1.8</td><td>1405</td></tr>
<tr><td>Beds in Oct 23</td><td></td><td>45</td></tr>
</table>
</td></tr>
</table>

Elective restoration 78 and 65 weeks:

Clearing the 78 and 65-week waits is a priority for the divisional teams with performance under constant review. Additional capacity continues to be required both in-house and through utilisation of Independent Sector and mutual aid, to clear the backlog of long waits with insourcing arrangements in place to provide longer term support and resilience in the most pressured areas, and plans have been stressed tested.

A small residual number of 78 week waits remained in October due to the impact of the ongoing industrial action, and a day zero PTL approach is being applied.

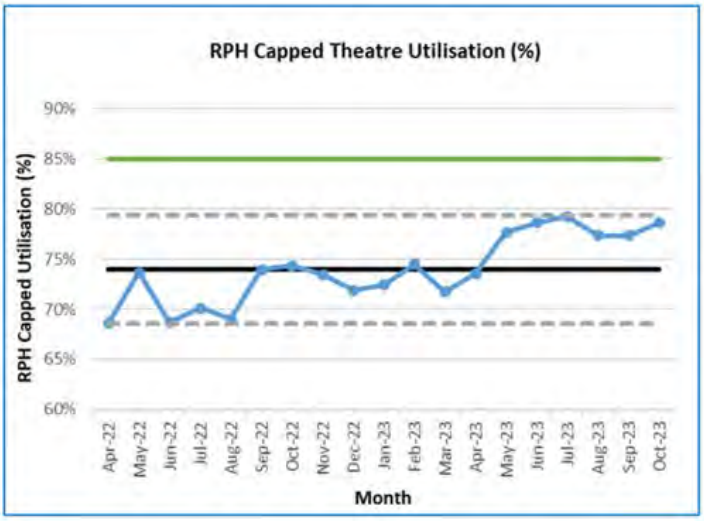
The 65-week trajectories factor in the impact of improved theatre productivity, utilisation of the independent sector and waiting list initiatives. A Theatre Efficiency Programme reports progress through the Elective Care Transformation Board.

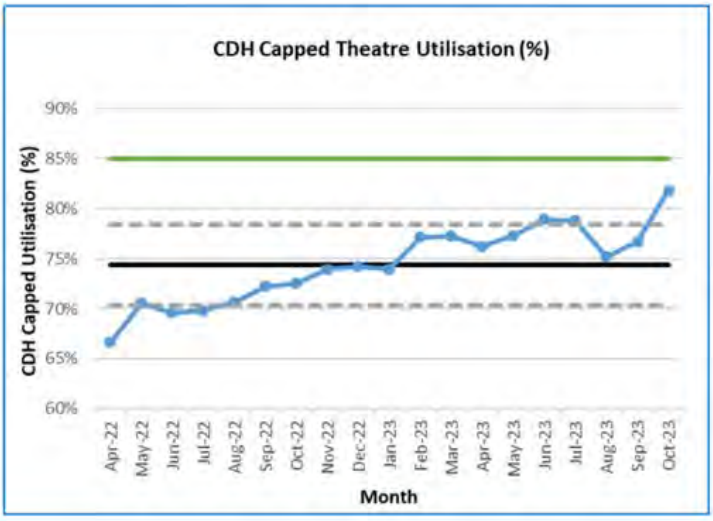
- Diagnostics performance beyond 6 weeks was 46.09% for October. Urgent and cancer patients are seen within 2 weeks.

- Endoscopy remains pressured, Changeology continue their work with the Trust, to review waiting lists and booking processes. Agreed capital bids will provide additional capacity on the Preston site in 2023/24.

- Elective and outpatient activity has been significantly affected by periods of industrial action. The recent Junior Doctors and Consultants action during October resulted in the cancellation of 44 (IP/DC) and 1343 (OP/D). The reduction in the number of cancelled elective inpatient and day case activity compared to previous strikes is not an improvement but rather reflects a reduction in planned lists during the period of industrial action, so that patients are not booked, rather than booked and then cancelled.

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance: Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.





The current 65-week specialty cohort month end trajectories to March 2024 are detailed below with actual end of October position:

		30/04/2023			31/05/2023			30/06/2023			31/07/2023			31/08/2023			30/09/2023			31/10/2023		
Division	Specialty	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
DCS	C Immunology	846	787	-59	762	718	-44	670	628	-42	582	540	-42	447	468	-22	285	380	52	191	326	135
DCS	Pain Management	766	664	-102	690	576	-114	606	473	-133	526	410	-116	403	337	-105	256	264	-30	171	220	49
Medicine	Cardiology	1185	1036	-149	1068	820	-248	938	612	-326	815	464	-351	625	335	-350	398	232	-228	266	154	-112
Medicine	Diabetes	74	59	-15	67	51	-16	59	39	-20	51	25	-26	39	20	-23	25	12	-15	17	9	-8
Medicine	Elderly Care	48	37	-11	43	23	-20	38	12	-26	33	8	-25	26	6	-22	16	1	-17	11	1	-10
Medicine	Endocrinology	588	572	-16	530	485	-45	466	371	-95	405	321	-84	311	235	-106	198	114	-47	133	58	-75
Medicine	Gastroenterology	1059	964	-95	954	791	-163	839	590	-249	729	422	-307	560	275	-339	357	179	-235	239	109	-130
Medicine	General Medical	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1
Medicine	General Medicine	1787	1752	-35	1610	1556	-54	1415	1338	-77	1229	1133	-96	943	861	-173	601	688	11	402	482	80
Medicine	Neurology	4891	4613	-278	4407	3762	-645	3874	3086	-788	3365	2536	-829	2583	1968	-864	1645	1423	-402	1102	792	-310
Medicine	Rehabilitation	24	17	-7	22	10	-12	19	6	-13	17	6	-11	13	2	-12	8	2	-10	6	2	-4
Medicine	Renal	213	113	-100	192	76	-116	169	55	-114	147	33	-114	113	8	-116	72	3	-95	49	2	-47
Surgery	Clinical Oncology	206	189	-17	186	164	-22	164	134	-30	143	133	-10	110	116	-5	71	83	14	48	72	24
Surgery	Colorectal Surgery	1560	1455	-105	1406	1220	-186	1236	991	-245	1074	803	-271	825	677	-227	525	519	-72	352	418	66
Surgery	Dermatology	490	426	-64	442	359	-83	389	189	-200	338	104	-234	260	69	-216	166	45	-169	111	36	-75
Surgery	ENT	1235	1064	-171	1113	850	-263	978	583	-395	850	480	-370	652	373	-342	416	281	-216	278	197	-81
Surgery	General Surgery	924	795	-129	833	701	-132	732	554	-178	636	276	-360	488	388	-147	311	311	-57	208	266	58
Surgery	Maxillo-Facial	426	411	-15	384	316	-68	338	264	-74	293	197	-96	225	164	-83	143	121	-42	96	66	-30
Surgery	Medical Oncology	35	25	-10	32	25	-7	28	20	-8	24	19	-5	18	15	-5	11	13	-1	7	10	3
Surgery	Neurosurgery	2842	2637	-205	2561	2163	-398	2252	1724	-528	1956	1336	-620	1502	1094	-553	957	838	-282	641	625	-16
Surgery	Ophthalmology	1940	1780	-160	1748	1442	-306	1536	1090	-446	1334	874	-460	1024	634	-488	651	500	-308	436	384	-52
Surgery	Oral Surgery	341	295	-46	307	216	-91	270	175	-95	234	143	-91	180	108	-89	114	46	-57	76	32	-44
Surgery	Orthodontics	241	250	9	217	240	23	191	234	43	166	220	54	128	214	74	81	204	99	55	191	136
Surgery	Orthopaedics	1432	1277	-155	1290	1015	-275	1134	811	-323	985	647	-338	756	525	-304	482	378	-175	322	254	-68
Surgery	Plastic Surgery	1581	1492	-89	1424	1241	-183	1252	1069	-183	1087	938	-149	835	857	-58	531	709	87	356	608	252
Surgery	Surgical Dentistry	1481	1445	-36	1334	1253	-81	1173	1137	-36	1019	989	-30	783	887	29	499	709	168	334	531	197
Surgery	UGI	473	457	-16	426	379	-47	374	313	-61	325	243	-82	249	196	-77	159	146	-32	106	123	17
Surgery	Urology	1799	1734	-65	1621	1460	-161	1425	1227	-198	1237	1071	-166	950	863	-178	604	599	-5	404	446	42
Surgery	Vascular Surgery	1677	1640	-37	1511	1404	-107	1329	1133	-196	1155	1138	-17	888	825	-148	566	630	-3	380	519	139
WCS	Breast Surgery	57	56	-1	51	53	2	45	45	0	39	36	-3	30	31	-2	19	28	3	13	23	10
WCS	Gynaecology	619	550	-69	558	451	-107	490	363	-127	426	309	-117	327	214	-144	208	128	-83	139	61	-78
WCS	Neonatology	1	1	0	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1
WCS	Paed. Cardiology	72	59	-13	65	40	-25	57	18	-39	50	12	-38	38	10	-32	25	7	-26	17	2	-15
WCS	Paediatrics	805	737	-68	725	591	-134	637	411	-226	553	268	-285	424	212	-253	270	147	-175	180	99	-81
Total	**Total**	**31719**	**29389**	**-2330**	**28581**	**24451**	**-4130**	**25125**	**19695**	**-5430**	**21825**	**16134**	**-5691**	**16757**	**12987**	**-5382**	**10672**	**9740**	**-2350**	**7148**	**7118**	**-30**
	Monthly reduction				-3138			-3456			-3300			-5068			-6085			-3524		

- The 65-week snapshot position on 16th November was 1,104, with a cohort (end March 2024) position of 5671 – 2,162 admitted and 3,509 non-admitted cases

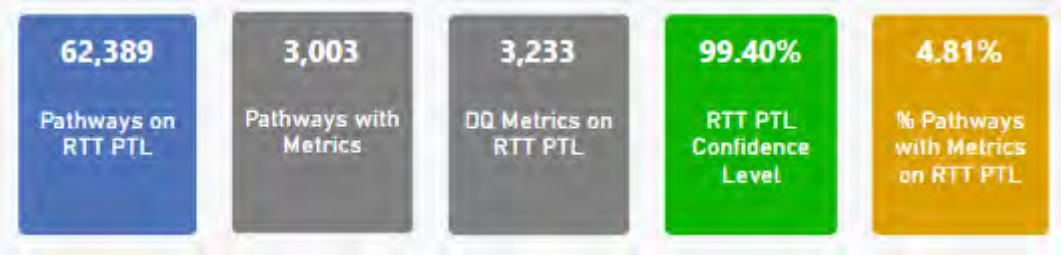
- The 65-week cohort position on the 30th September was 9,740 – 3,134 admitted and 6,606 non-admitted, the position shows a reduction of 2,622 during the 4 week period to the 31st October.

There are a number of risks to delivery of the required reduction in the number of patients waiting in excess of 65 weeks, these include:

- Further Junior Doctor and Consultant industrial action impacting on activity.
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Urology, Colorectal and Orthodontics.

RTT PTL Validation

Referral to Treatment Time PTL data quality assurance is reported through the bi-annual Data Quality Assurance Report to Board. This details Trust compliance via the national LUNA data quality solution. Current information indicates a very high data quality confidence level with a further improvement to the proportion of records with data quality queries.



The Trust has been utilising the Chatbot patient contact solution to meet the national requirement to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023. The current Trust compliance rate for patients in the eligible cohort is 60%.

The Trust has sent over 63,000 messages to patients via the Chatbot rolling programme since August 2022, current responses in relation to the current active PTL are summarised below.

Specialty	Exclusions	Language Barrier	Leave	Leave - Division State to Remain	No Contact	No_Contact	Other	Remain	Review	Total
Breast Surgery	-	-	-	-	2	1	-	14	2	**19**
Cardiology	-	-	26	10	184	-	11	684	2	**917**
Clinical Immunology	1	-	3	-	225	-	14	489	-	**732**
Colorectal Surgery	-	-	27	-	97	12	6	279	34	**455**
Dermatology	-	-	19	-	65	-	4	219	-	**307**
Diabetes	-	-	-	-	13	-	1	36	-	**50**
Elderly Care	-	-	1	-	2	-	-	9	-	**12**
Endocrinology	-	-	7	-	98	-	5	257	-	**367**
ENT	1	-	4	-	36	8	1	166	13	**229**
Gastroenterology	-	-	27	-	149	2	11	445	1	**635**
General Medicine	1	-	49	-	309	-	16	728	1	**1104**
General Surgery	-	-	11	-	26	8	3	114	11	**173**
Gynaecology	-	-	16	-	98	5	6	253	21	**399**
Maxillo-Facial Surgery	1	-	6	-	40	2	1	97	-	**147**
Neurology	-	-	6	28	767	7	52	2086	22	**2968**
Neurosurgery	-	1	51	-	309	6	32	1158	32	**1589**
Ophthalmology	-	-	27	-	164	18	18	565	18	**810**
Oral Surgery	-	-	2	-	27	2	2	76	2	**111**
Orthodontics	-	-	2	-	33	-	4	59	-	**98**
Orthopaedics	-	-	5	-	69	28	12	299	176	**589**
Pain Management	-	-	2	1	72	18	7	354	189	**643**
Plastic Surgery	1	-	49	-	172	51	11	597	76	**957**
Surgical Dentistry	-	-	3	-	26	1	1	50	1	**82**
Upper Gastrointestinal Surgery	-	-	10	-	20	7	4	84	17	**142**
Urology	1	-	28	-	130	10	4	396	60	**629**
Vascular Surgery	-	-	67	-	319	7	32	1016	19	**1460**
Total	**6**	**1**	**448**	**39**	**3452**	**193**	**258**	**10530**	**697**	**15624**

Outpatient transformation

Progress on the Outpatient Transformation Programme is reported through the Transformation Board and is focussed on reducing follow ups (PIFU), reforming triage before appointment bookings and digital to support patients' portals.

Safety and Quality

Pressure Ulcers
In October, the NHS National Wound Care Strategy: Pressure Ulcer Recommendations and Clinical Pathway was published and the gap analysis of this against Trust current practice has informed additional actions and focus within the Trust's pressure ulcer reduction action plan. The data to inform compliance with risk assessments and care plans are live in the safety surveillance systems at ward level to give real time information supporting clinical care. Actions to reduce device related pressure ulcers (DRPU) are included in the plan. At LTHTR, device related pressure ulcers currently account for circa 1/3 of all trust acquired pressure ulcers. The care plan to reduce device related pressure ulcers has been developed using the acronym DEVICE and asks whether the device is necessary, guides the essentials of care to manage skin integrity including repositioning and securing the device. In Critical Care device related pressure ulcers have reduced from 7 in June 2023 to 3 in month since implementation of the care plan. The compliance with the pressure ulcer reduction plan is tracked through divisional and Trust wide Always Safety First Committees.

The pressure ulcer data shows a shift as there are 7 data points below the median, indicating improvement. Further reduction in pressure ulcers is required to meet the target. The improvement work is focused standardising best practice. This remains a priority area of work within the Always Safety First strategy.

Falls
The falls data shows a shift as there are 7 data points below the median, indicating improvement. Whilst the target reduction has not yet been achieved, this level of improvement work moves closer to the target reduction. The improvement work is focused standardising best practice. This remains a priority area of work within the Always Safety First strategy.

HSMR
Mortality metrics remain stable and within expected parameters. In recognition of the mortality data continuing to demonstrate performance within expected range, the Safety and Quality committee have requested and received for assurance, a data quality deep dive review for both adult and paediatric mortality and confirmed it is assured of the data quality and approach to mortality.

STAR
STAR Quality assurance accreditation awards of silver and above is consistently higher than target. Analysis of this identifies an opportunity to undertake some further focused improvement work in ward areas where there is the most opportunity to improve. A STAR GOLD reward and recognition event was held on 24.10.23 where a further 5 areas have achieved a GOLD star. These are;

- Ward 3
- Broadoaks Child Development Centre
- Sharoe Green Ultrasound
- Cardiorespiratory Dept CDH
- Critical Care Unit

Clostridium *difficile*

The data is demonstrating continued elevated levels of C. *difficile* this consistent with a noted northwest increase. The chart shows increased variation over the last 5 months, this month has shown a decrease on the previous month however remains a special cause. Enhanced executive oversight meetings are in place given the increased incidence and the Board Assurance Framework this month includes a review of the IPC BAF issued by NHS England.

Actions taken to date include:

a) Removal of cefuroxime for treatment of unexplained sepsis in July 2023
b) Introduction of a sporicidal agent for general cleaning on wards in September 2023
c) Refresh of ward staff cleaning checklists
d) Gradual roll out of national cleaning standards by domestic services, 13 areas are now fully compliant, a further 27 areas require implementation.
e) New system to track fogging compliance and bed movement
f) Refresh of mattress audit process
g) Strengthened assurance of IPC/cleaning standards through the “STAR” assurance framework
h) New IPC risk flag for estates remedial work requests from wards
i) Improvements in electronic “Side-room audit” which lists everyone in hospital who is in a side-room and why they were placed in the side-room

Registered Nurse and Midwifery Fill Rates

The RN fill rates continue to reflect positive staffing levels at >95% overall, there continues to be fluctuations day to day. Staffing is closely monitored on a three times daily basis with mechanisms to escalate and request support when required. The safety and Quality committee continue to review the detail of this on a monthly basis.

Always Safety First

The annual target for level 1 and executive and senior leaders safety training is achieving the required standard. The Trust has now launched level 2 patient safety training as part of the Patient Safety Incident response Framework (PSIRF) launch.

Complaints and friends and family experience feedback

The complaints data is demonstrating a sustained reduction in complaints due to communication.
Patients reporting their experience of good or very good has remained consistent.

A Great Place to Work

There was a slight improvement in the overall sickness absence rate and the short-term absence rate in September, although long-term absence increased. The Workforce Advice team are prioritising their capacity to support managers with the resolution of long-term absence cases and in the last three months there has been a positive reduction in the number of cases with a duration of over 6 months. Our winter vaccination campaign for colleagues is important, as we try to mitigate the impact of seasonal viruses and uptake at the end of October was 25.9% for flu jabs and 15.8% uptake for Covid-19 vaccination. We continue to offer a 7-day vaccination service, including drop-in clinics and mobile rounds, and our communications are being refreshed to try and reach workforce groups who may be more resistant to vaccination.

Violence and aggression incidents reduced in September, following the peak experienced during July and August 2023, although incident levels remained high. Our Violence Prevention and Reduction 'Big Room' has now met a number of times, and at the end of November we will be launching a survey to learn more from colleagues about their experience of violence, aggression and abuse at work, the contributing factors to incidents and how we can improve our approaches.

Our overall Trust vacancy rate continues to fall. Clinical colleagues continue to co-ordinate redeployment, on over established ward areas. Plans have been enacted for RNs on over established wards to provide support to care to reduce our unregistered bank demand. We continue to review our workforce controls and assurances around bank and agency usage and vacancy control. This is to supplement existing internal and ICB controls which have already been enacted. We continue to regularly monitor and review ward-based nurse agency escalations with clinical colleagues to ensure necessity and to control nursing demand pushed to agency and have reduced these by 50%. We have held the line on all ICS planned rate card drops for nursing to date.

Delivering Value for Money

Income and Expenditure

The Trust reports a YTD Month 7 deficit position for 2023/24 of £19.4m against a £35.1m deficit plan, this gives a YTD Variance on Plan of £15.7m. This can be explained mainly by the £8.2m System Support Gap (£18.5m for the year), £5.4m under-delivery of CIP, £4.2m of double running nursing costs, £1.8m for the cost of strikes, £1.5m activity impact of strikes, £1.1m shortfall in pay awards, £0.6m technical from 22/23 and £3.2m of net restoration adverse impact offset by £9.7m of operational underspends.

Capital Position

Capital expenditure in the year to date is behind plan. This is management of projects in the early part of the year to create capacity to deal with emergency requirements as they arise during the year. Projects are planned for the latter part of the year to deliver the plan in full by the year-end. No issues are anticipated with achieving the plan for the year.

Cash Position

The Trust has drawn down cash support amounting to £35.0m in the year to date with a further amount of £6.8m requested for December. An application for further support in quarter 4 will be submitted and this will be in the form of working capital support if it is approved by NHSE.

Cost Improvement Programme

The Trusts core 2023/24 Financial Improvement Plan (FIP) target is £48.5m or 6.2% of total OPEX, of which £5.9m is carry forward of undelivered recurrent FIP from 2022/23. The total FIP target is £67m which includes the system gap of £18.5m.

As at Month 7 (October 2023), YTD delivery of FIP is £17m against a plan of £30.6m, an adverse variance of £13.6m. The Year To Date (YTD) variance is made up of two elements; £8.2m of unidentified system gap and £5.4m under delivery of the £48.5m element of the FIP target . Slippage in delivery of FIP programmes is mainly due to the planned closure of beds, covid defund from ED, procurement schemes and divisional schemes all impacted by the operational challenges relating to industrial action.

The forecast FIP delivery for the year is estimated at £38.8m, with full year recurrent benefit forecast c£36.9m. There continues to be a focus on transacting existing schemes and addition of new plans so forecast delivery could increase.

Use of Resources

The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested.

The Agency spend in 2023/24 in YTD Month 7 was £14.1m against an Agency Ceiling of £10.5m. This is an overspend of £3.6m mainly due to a slower than expected benefits from international recruitment the Trust, cost of industrial action cover and significant costs of agency spend associated with some service developments such as CDCs, Finney House as well as some legacy issues.

Fit for the Future

These qualitative indicators will be reported separately to board within the normal cycle of board business.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance.

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

Excellent care with compassion

Always Safety First

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Performance to October 2023

INTRODUCTION

Performance to 31st October 2023

Mission

To provide excellent care with compassion

Strategic Aim

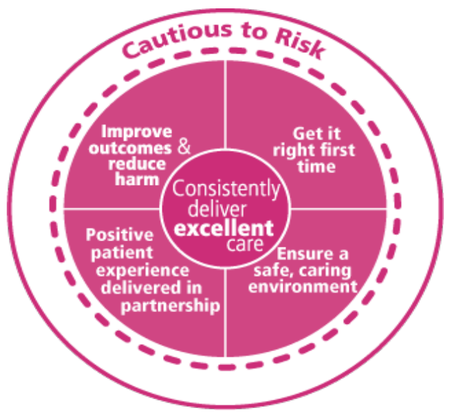
To provide excellent healthcare to our local communities

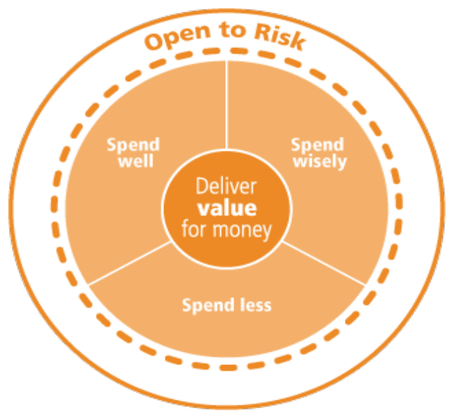
Strategic Aim

To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Strategic Aim

To drive innovation through world class education, training and research*





In order to ensure that the we are continually monitoring delivering against our Big Plan, the metrics within the Integrated performance report for the Board of Directors are aligned to the Big Plan 2021/24 outcomes and provide details of performance against the agreed KPIs. Each of the ambitions upon which our Big Plan is founded is aligned to a board sub committee which will undertake more detailed scrutiny of progress in achieving the identified outcome, understand risk and seek assurance against delivery.

Kevin McGee
Chief Executive

Continuously deliver excellent care

Together

1

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve a rating of good with one outstanding service	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	100%	100%	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)**	M | T-D-S | TB-SQ | SC	No	F	+		1.68	2.86	3.69
	Big Plan	Reduce the number of device related pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)		No				0.21	0.57	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	80.0%	-
	Big Plan	Deliver year 1 of the national maternity & neonatal improvement plan		UNDER DEVELOPMENT						
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		10 safety actions created for children and Young people, reported through the Divisional Improvement Forum						
Contribute to PLACE Adult and Children CORE20 PLUS 5 strategy	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – Adults and maternity. Deliver year 1 actions		Delivery Plan in place						
	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – CYP. Deliver year 1 actions		Delivery Plan in place						
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected				75.8	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No		-		76%	69.4%	74.2%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No	F	-		2%	11.1%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No	F			65%	51.4%	52.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No	F	-		95%	78.3%	86.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No		-		98%	89.2%	96.0%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No		+		4316	3715	4449
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No	F			481	1112	1246
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No	F	+		0	82	195
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB		F			82%	67.2%	68.7%
	Key Metric	**Number of patients waiting over 62 days**	M | T-D-S | FPC | FB	No				202	200	233
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	No				5%	3.76%	4.23%
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels**	M | T-D-S | FPC | FB	No	F			-25%	-13.64%	-1.36%
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				92%	97%	96%
	Key Metric	**Achieve 5% of patients in hospital who no longer meet the criteria to reside**	M | T-D-S | FPC | FB-SC	No	F			5.00%	9.44%	8.69%
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	Logic Under Review						
SDEC	Big Plan	Divert 10 ambulances a day from ED (to SDEC or the appropriate service; SAU, MAU AAU, 2hr UEC response) (Target of 1924 ambulance arrivals per month based on a reduction of 10 amulance arrivals per day on 2022/23 actuals)	M | T-D-S | FPC | FB	No	F	-		1924	2448	2228
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery	M | T-D-S | FPC | FB	No				0.15	0.11	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to unplanned surgery	M | T-D-S | FPC | FB	No		+		0.50	0.26	0.66
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery	M | T-D-S | FPC | FB	No				3.3	2.1	3.1
Cancer	Big Plan	Implement pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result)	M | T-D-S | FPC | FB	No	F			80%	32.73%	36.07%
	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	75.97%	58.49%
	Big Plan	Full implementation of the Best Practice Timed Pathway for prostate cancer	M | T-D-S | FPC | FB	No	No Patients Currently on this Pathway					

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

Variation Icon \ Assurance Icon	F – Will consistently fail target within expected variation	Could both pass or fail target within expected variation	P – Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Continuously deliver excellent care

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No	F	+	⚑	3.72	4.49	5.84
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F	−	⚑	10	20	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	Last reported case Sept 2023
Safety	Big Plan	Maintain 90% staff trained in level 1 safety training	M | T-D-S | ETR | NL	No	P	+	-	90%	98.1%	96.1%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P	+	-	90%	94.5%	92.3%
Segment Four – Work in partnership to deliver a positive patient experience										
Complaints	Big Plan	Reduce the number of complaints relating to communication.	M | T-D-S | SQ | SC	No			-	22	16	13
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No			-	90%	89.4%	90.7%
Candour	Big Plan	Maintain >90% compliance with duty of candour for all moderate and above harm incidents.	M | T-D-S | SQ | SC-GS	No			-	90%	93%	96%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No		+	-	95%	96%	93%

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
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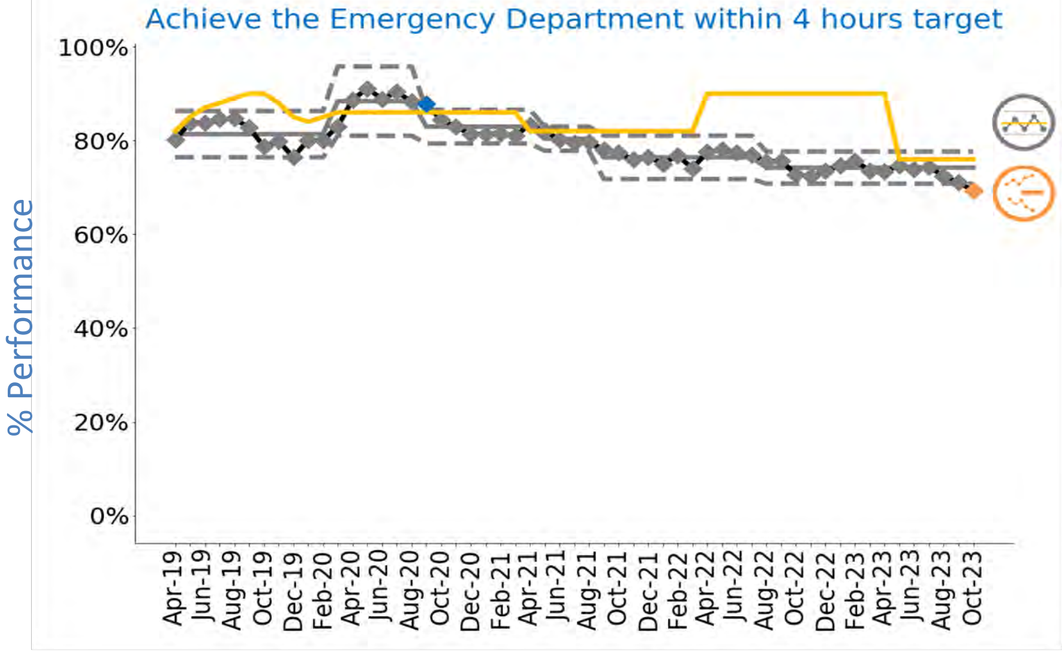
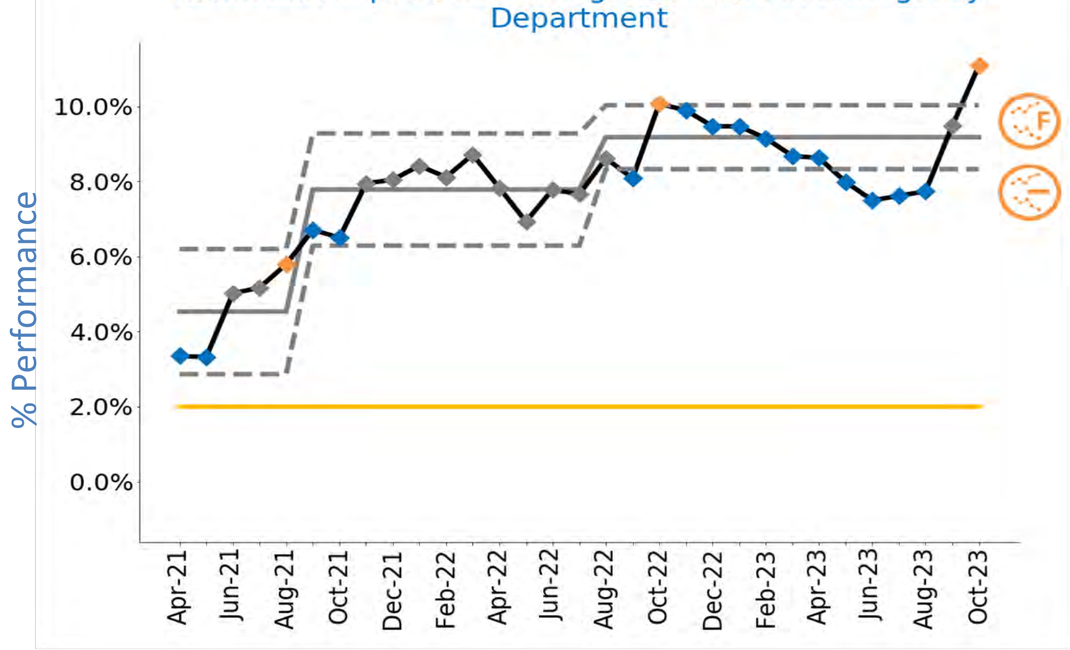
		SQ = Safety & Quality Committee	NL = Nicki Latham	

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

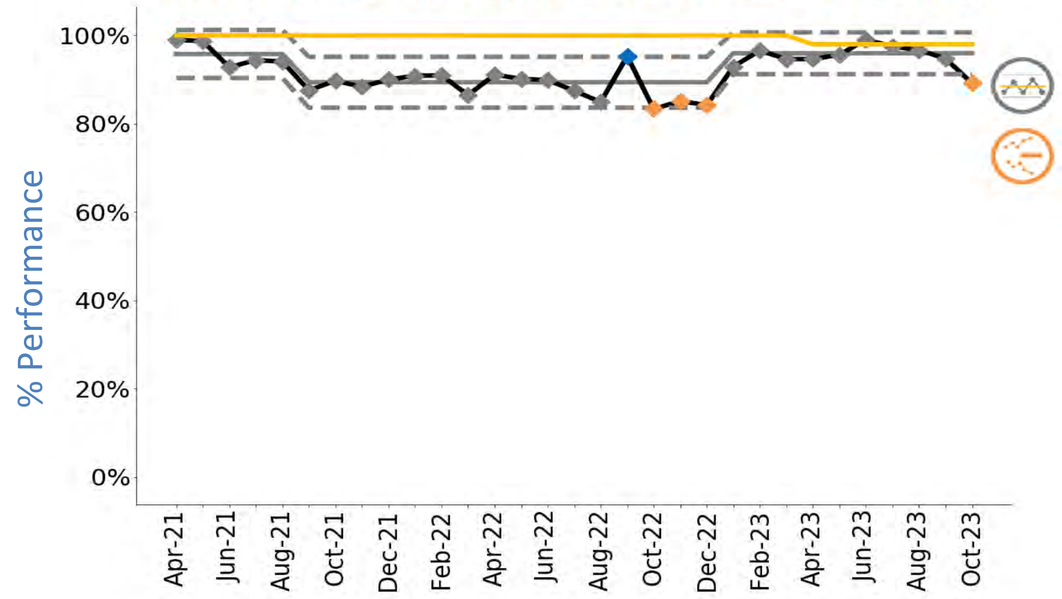
Achieve the Emergency Department within 4 hours target



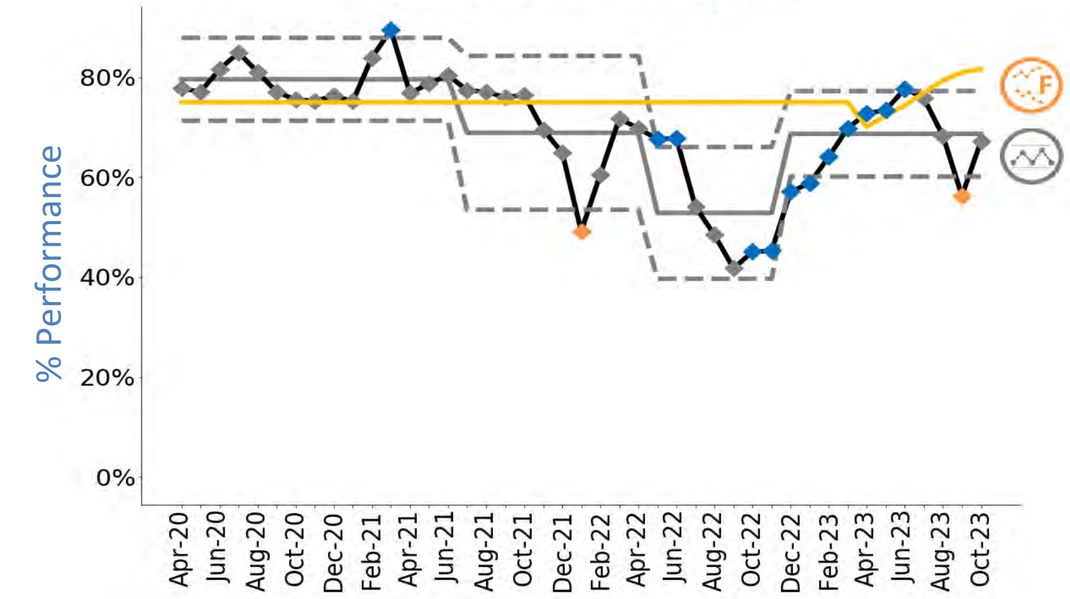
Reduction in patients waiting +12 hours in Emergency Department



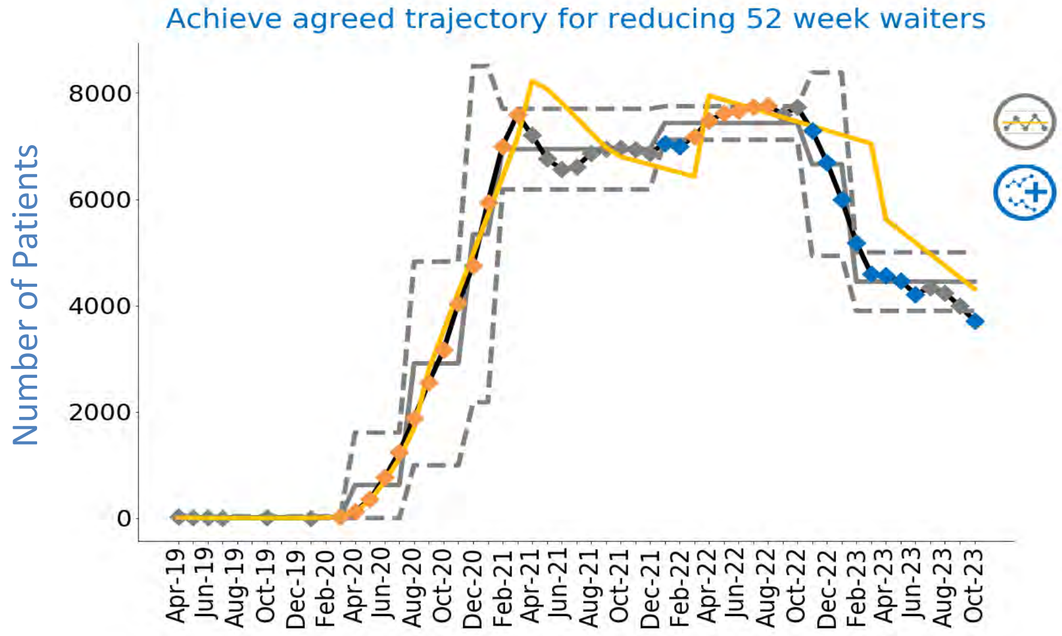
Reduction in ambulance turnaround times - 60 minutes



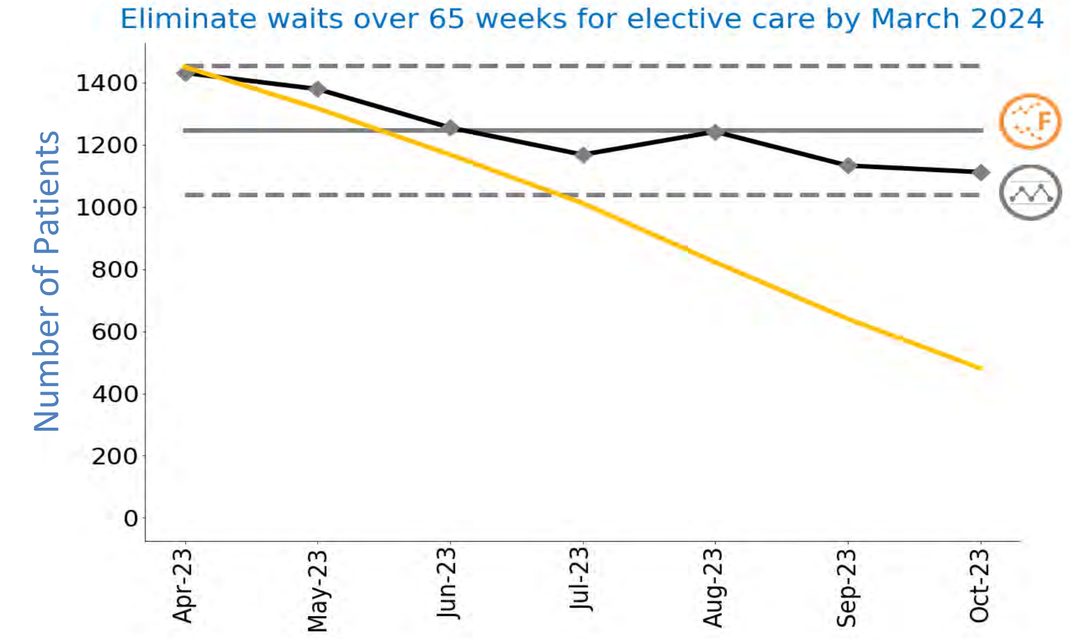
Achieve Cancer - 28 day FDS



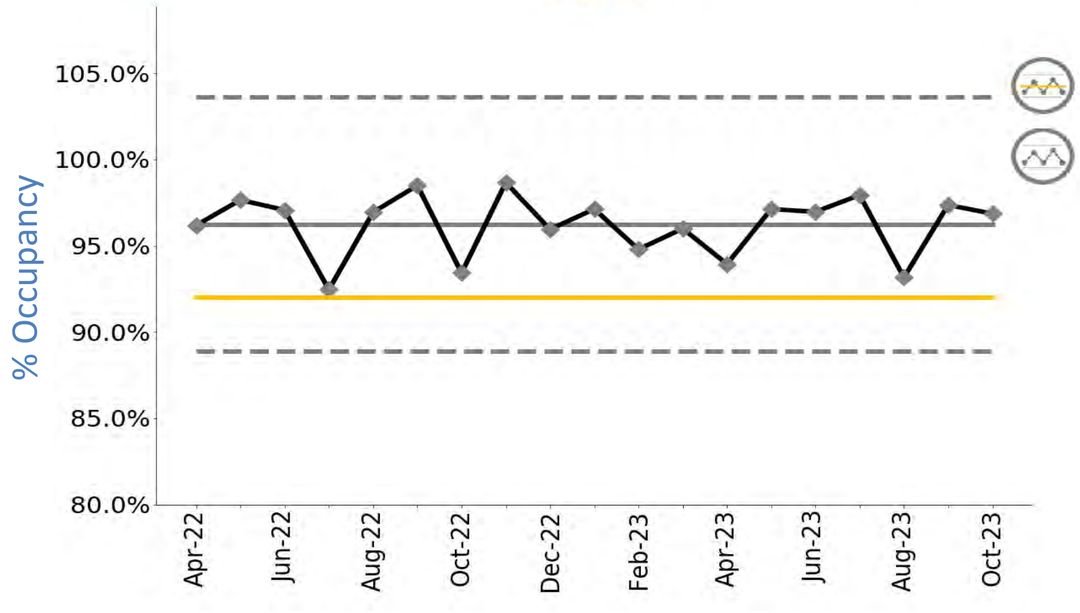
Achieve agreed trajectory for reducing 52 week waiters

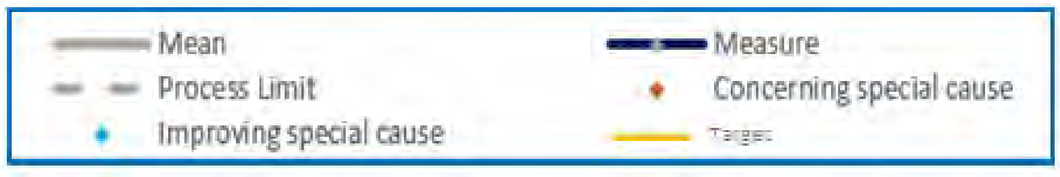


Eliminate waits over 65 weeks for elective care by March 2024



Reduce adult general and acute (G&A) bed occupancy to 92% or below





Assurance Icons – How likely are we to hit the set target in future?

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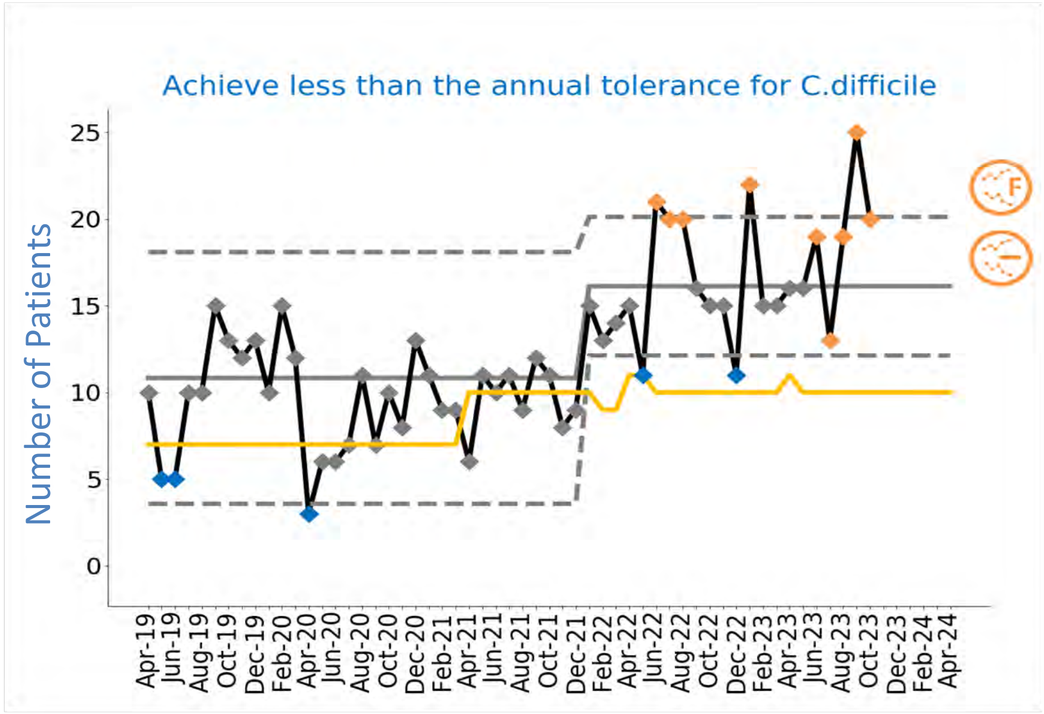

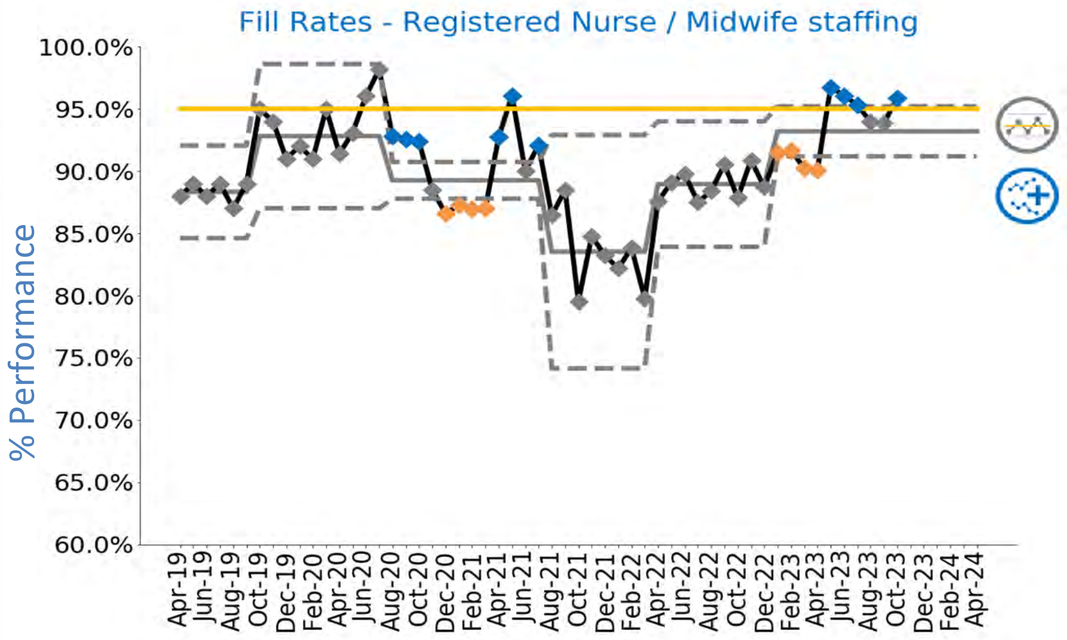

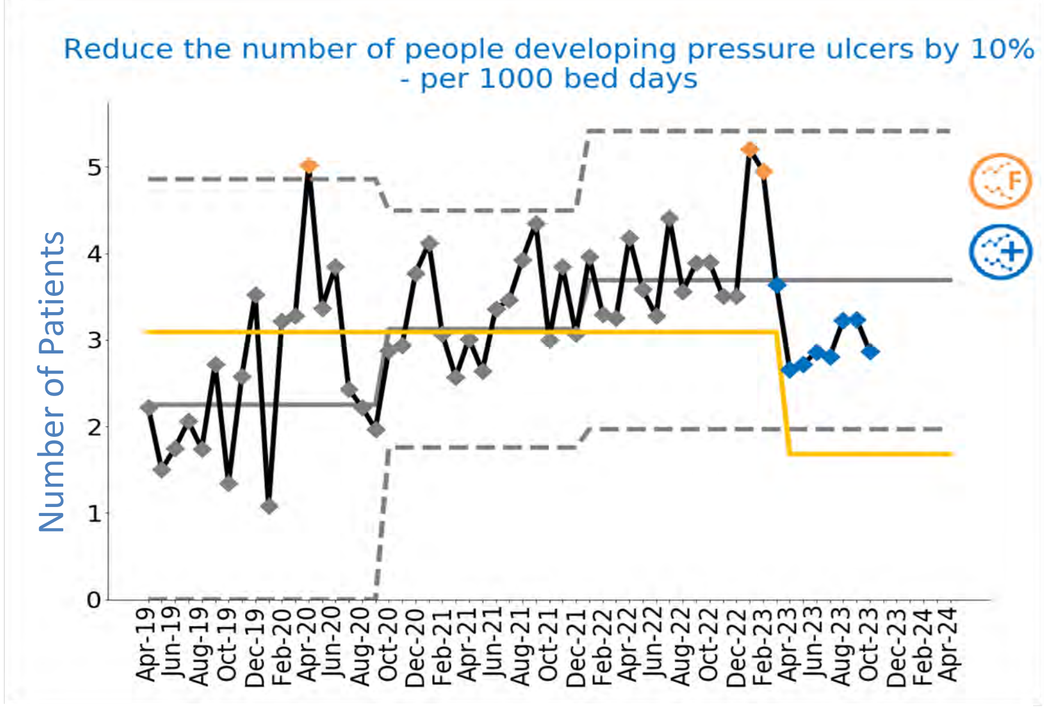

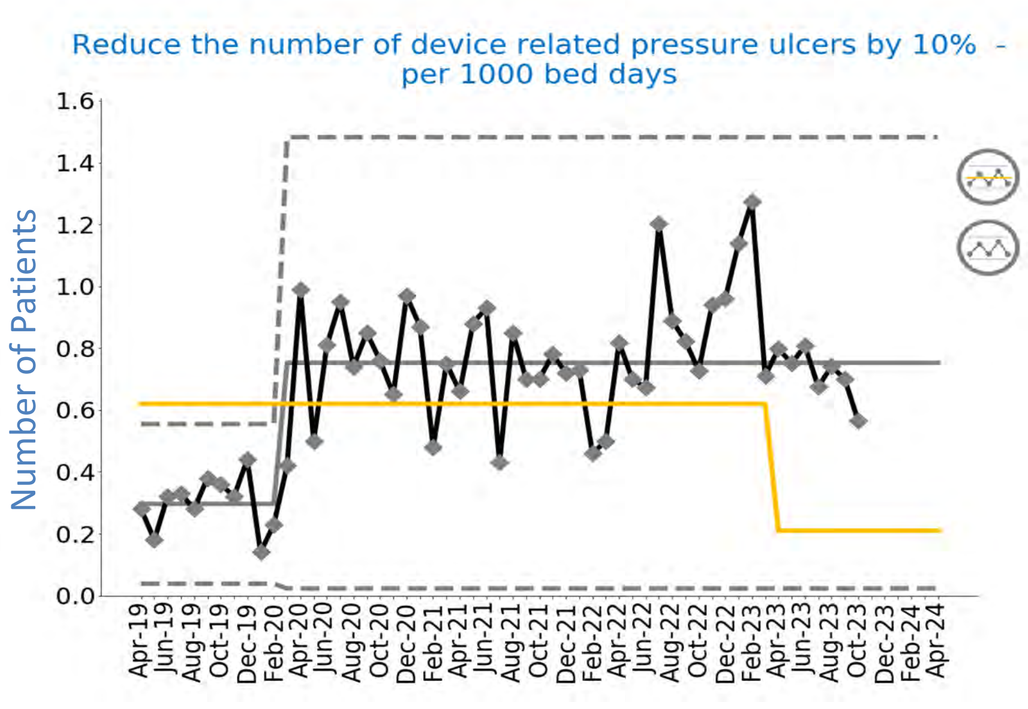

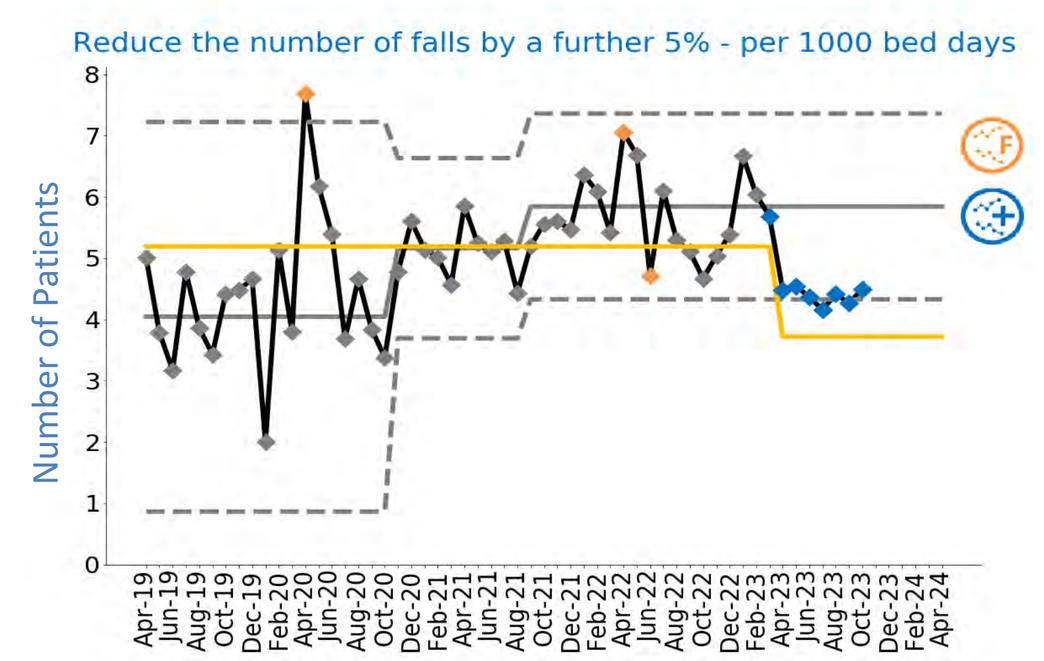

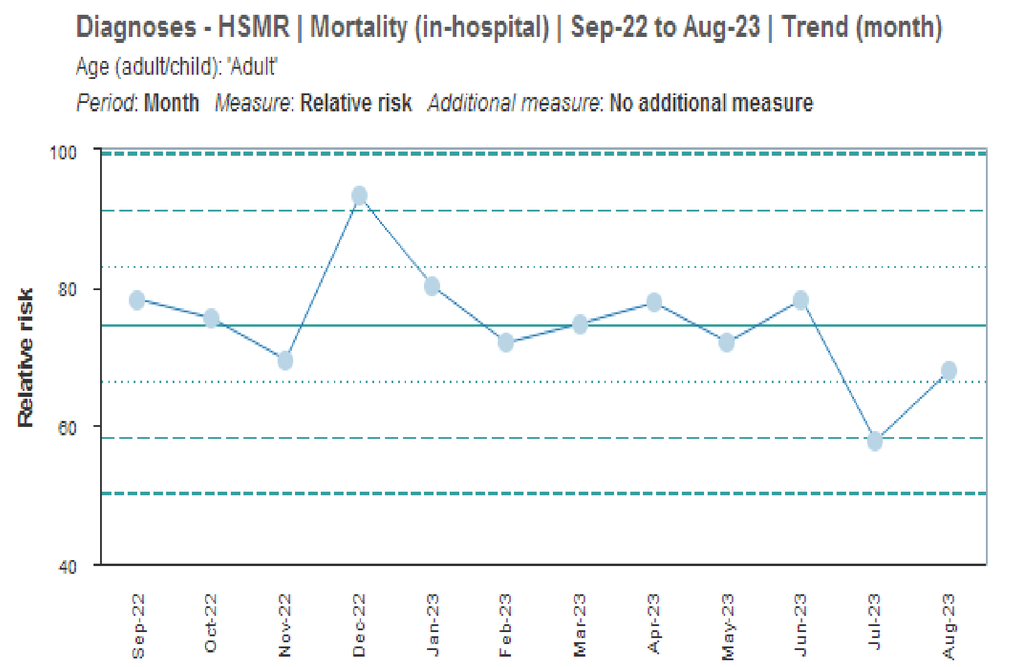

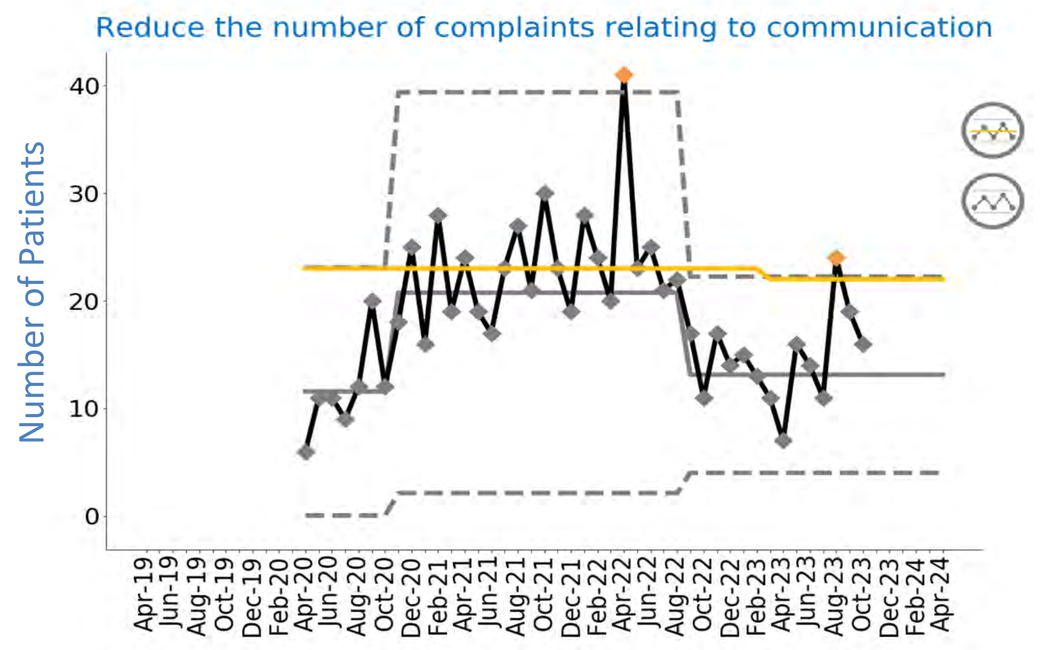

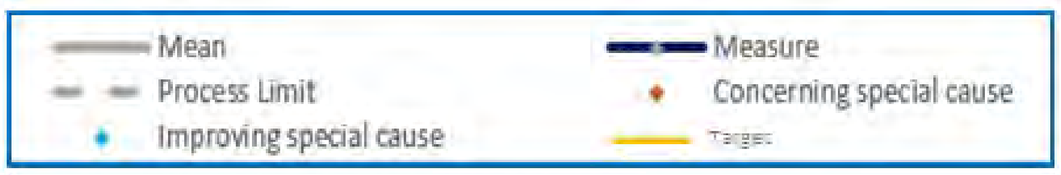

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A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 5.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 5%	7.10 %	6.14 %
	Reduce short-term sickness absence to 1.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 1.75%	2.62 %	1.99 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 3.25%	4.48 %	4.16 %
Health & Wellbeing	Reduce average duration of psychological health related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 33.11	36.14	37.07
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 20.11	31.46	22.54
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 73	77	59.00
Develop People									
Turnover	Maintain annual staff turnover between 8% and 11% FTE (annual assessment; ESR in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 0.83%	0.64 %	0.76 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 6%	5.25 %	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	88.91 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	94.43 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	86.19 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 15% (annual assessment; in-month reported)	M | T-D | W | KS	-			-	≥ 17	5	7.92
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	58.09 %	61.79 %

Assurance Icon / Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Reporting Requirements Key

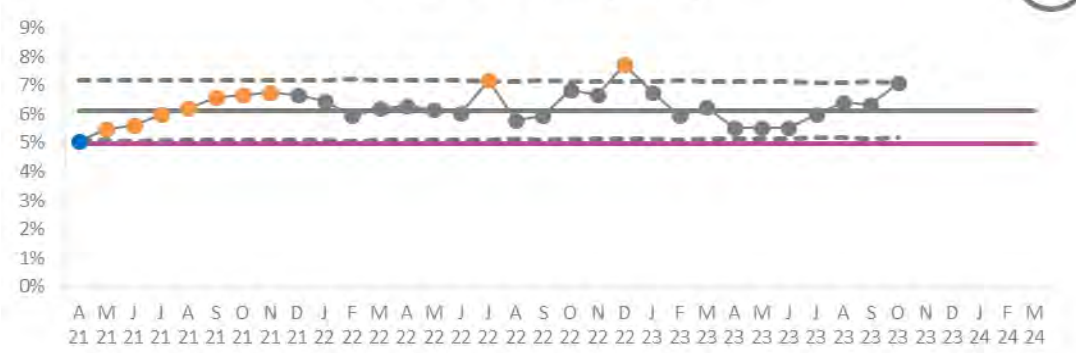
Frequency	Level	Sub-Committee	Responsible Executive
A = Annual	T = Trust	W = Workforce Committee	KS = Karen Swindley
B = Bi-annual	D = Division	ETR = Education, Training & Research Committee	JW = Jonathan Wood
M = Monthly	S = Specialty		All = All Exec Team
Q = Quarterly	C = Cost Centre		

A GREAT PLACE TO WORK
Reviewed via committee cycles of business

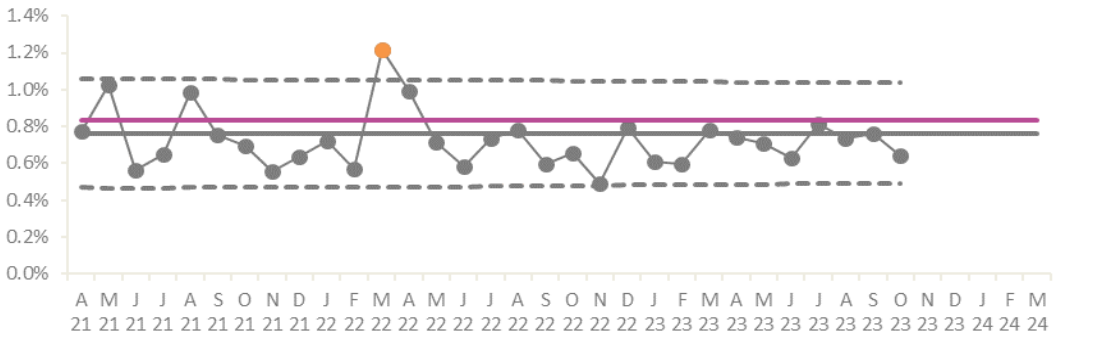
Together

	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW							
	Create five agile activity based workspaces	B | T | W | JW							
	Create outdoor recreational space on both the Chorley and Preston sites	B | T | W | JW							
Health & Wellbeing	Increase staff perception that the organisation takes positive action on health and wellbeing to 40%	A | T-D-S-C | W | KS							
	Support staff to stay well by ensuring adequate rest and recuperation in line with working time regulations	B | T-D-S-C | W | KS							
Develop People									
Appraisals	Improve staff perception of the quality of appraisals by 5%	A | T-D | W | KS							
Inform, Listen and Involve									
Just Culture	Reduce further the number of grievances that are managed through formal processes to monitor the move to a just culture	B | T | W | All							
	Reduce the gap between the scores achieved in the annual culture survey between staff perception of the current and desired culture	A | T-D-S | W | All							
Freedom to Speak Up	Ensure all staff accessing the Freedom to Speak Up team are satisfied with how their concerns were managed	A | T | W | KS							
Staff Engagement & TED	Increase the staff engagement score, as measured by the annual staff survey, to 7 out of 10	A | T-D | W | KS							
	Ensure 50% of our staff complete the annual staff survey	A | T-D | W | KS							
Value Each Other									
Race Equality	Reduce the number of staff from BAME backgrounds that have personally experienced discrimination at work to be in line with that of their white colleagues	A | T | W | All							
	Increase the number of colleagues from a BAME background in senior roles (AfC Band 8a and above)	A | T | W | All							
Disability Equality	Reduce the number of disabled staff that experience harassment, bullying and abuse from managers to be in line with the experience of non-disabled colleagues	A | T | W | All							
Corporate Social Responsibility	Engage with our local communities through a range of workforce and education programmes	A | T | W | KS							

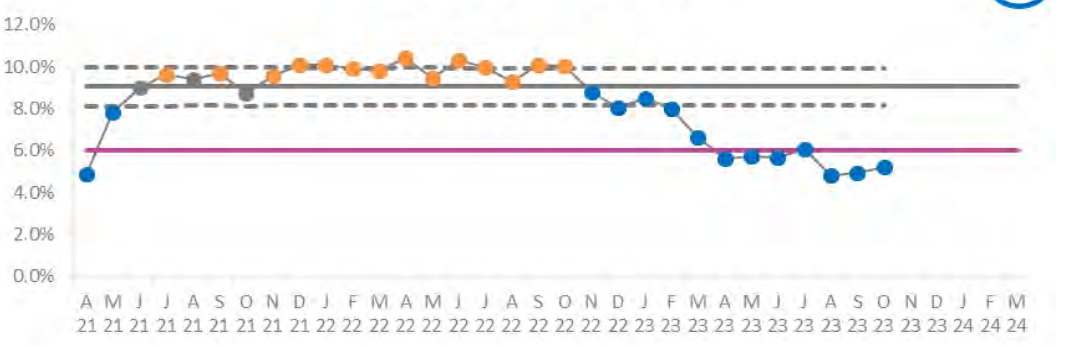
Overall Sickness (% FTE)



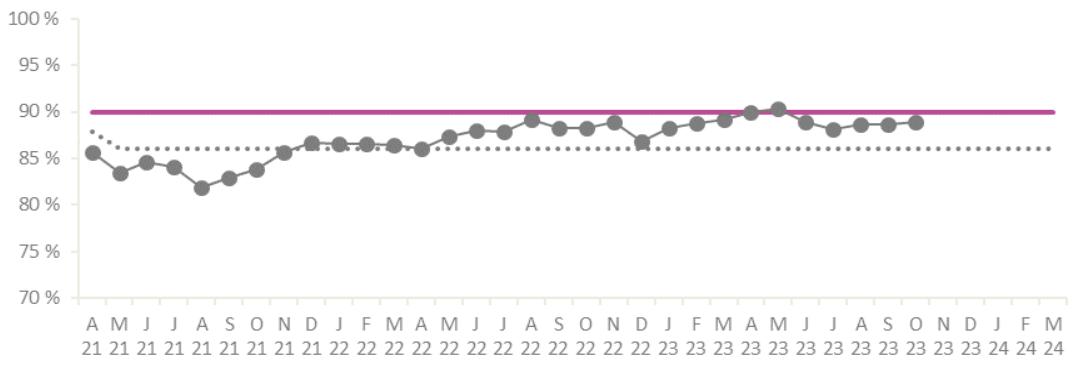
ESR Turnover (% FTE)



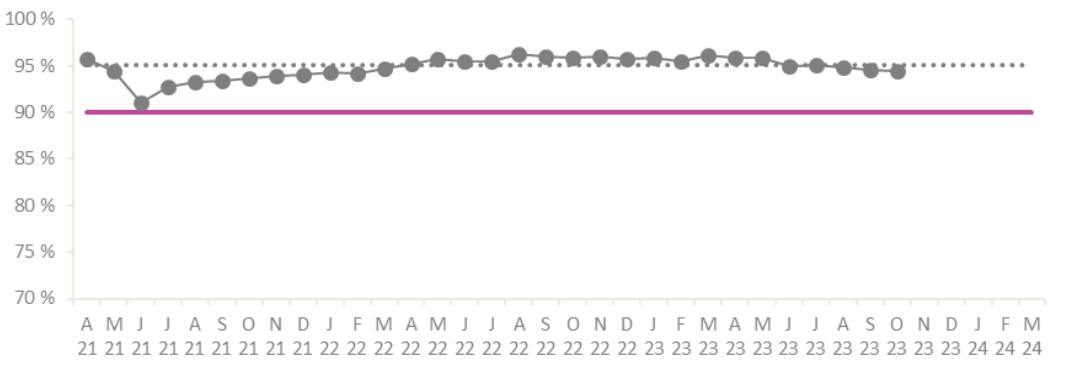
GL Vacancy Rate (% FTE)



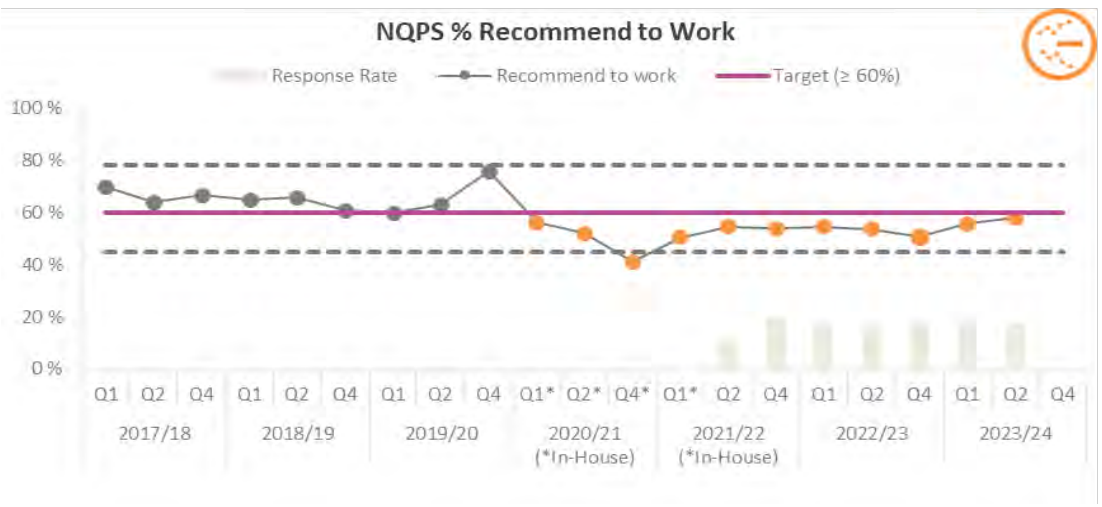
Appraisal Compliance (% HC)



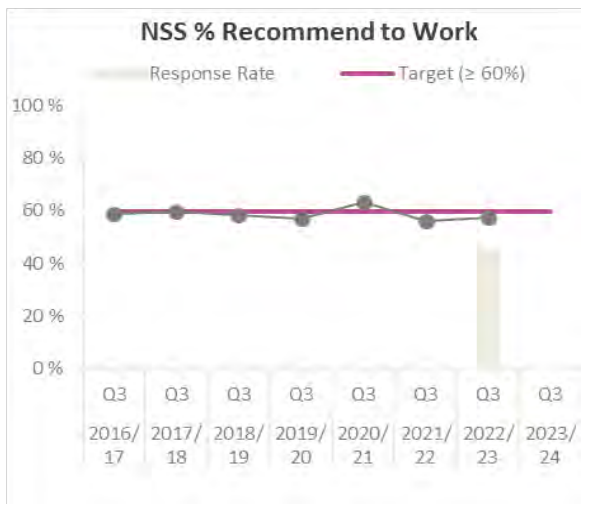
CSTF Compliance (% modules)



NQPS % Recommend to Work



NSS % Recommend to Work



Deliver Value for Money

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**		Deliver 100% of the agreed targeted reduction in our underlying financial deficit	A | T | TB - FPC | JW	This indicator is reported separately agreed at Trust level at budget setting							
Deliver agreed cost improvement delivery target	**Key Metric**		To deliver 100% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-	-	5211	3090	-
Segment Two - Spend Well (Efficiency)												
Bed Occupancy Rate (Including Escalations)	Big Plan		Achieve a bed occupancy rate of no higher than 90%	M | T-D-S | FPC | FB	No				90%	96.4%	94.3%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	78.6%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	81.8%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day case basket using GIRFT	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
OP Follow Ups	Big Plan		Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels	M | T-D-S | FPC | FB	No				-25%	-13.6%	-1.4%
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	91.4%	-
Segment Three - Spend wisely (Effectiveness)												
Agency costs	Big Plan		Reduce agency costs to 3.7% of the total pay bill	M | T-D-S | W | SC-GS	No	-	-		3.7%	4.52%	-
Delivery of Activity and Revenue Plan	**Key Metric**		To ensure 100% delivery of the Trust's activity and revenue programme	M | T | FPC | JW	No	-	-	-	-19444	-35189	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	12035	10036	-

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Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FB = Faith Button	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	SC = Sarah Cullen	

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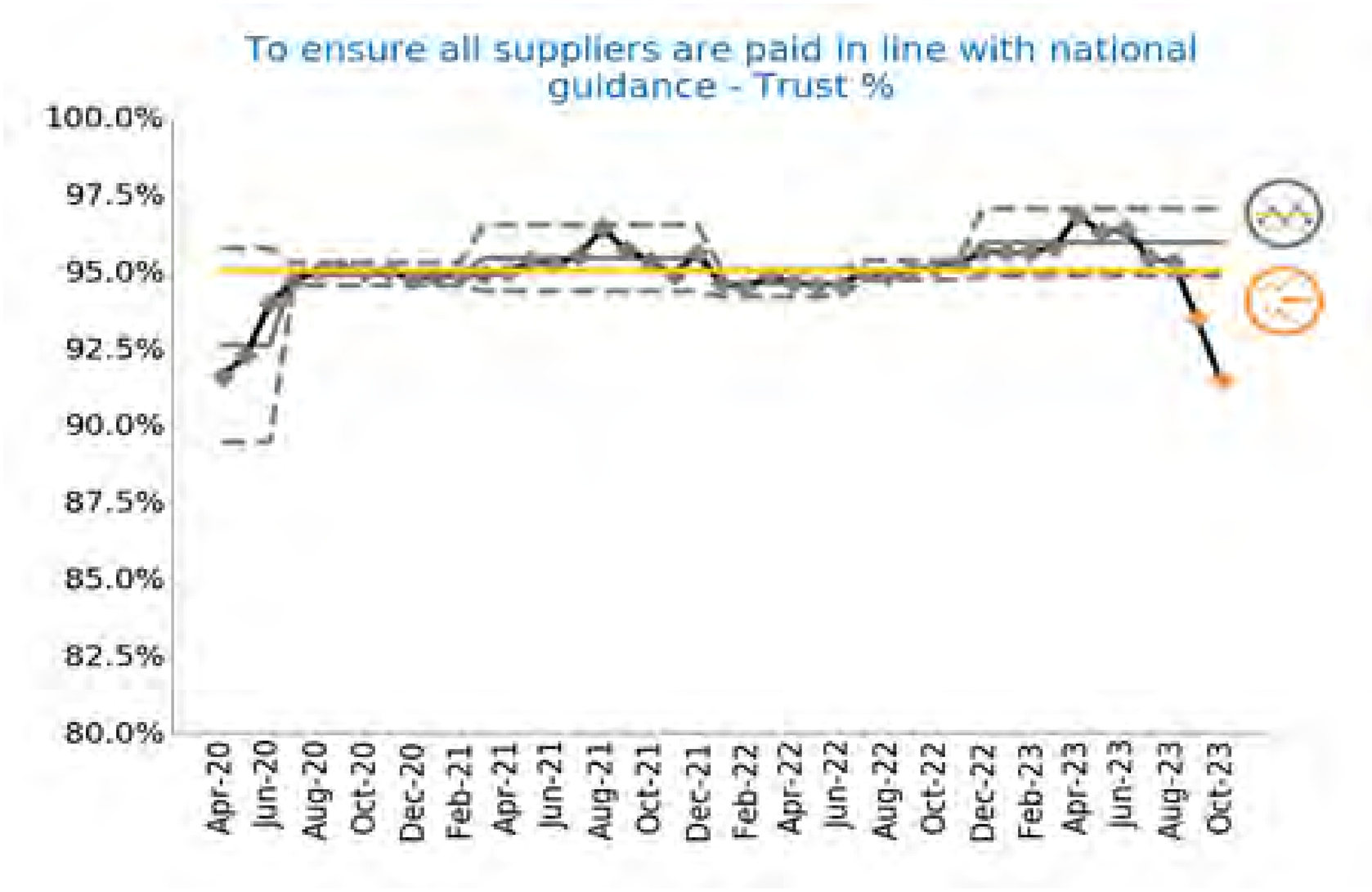

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Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment One – Strategy and Transformation												
Clinical Services Strategy	Big Plan	FFTF-1	To deliver the 23/24 actions in the LTH clinical services strategy, including addressing the challenges and opportunities of multi-site working:	B | T-D | TB | GS							
			To provide outstanding, sustainable healthcare to our local communities and in our tertiary services								
			To drive health innovation through world class education, teaching and research								
			System working in a new NHS landscape								
Outpatients Transformation	**Key Metric**	**FFTF-2**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | GS							
			Deliver Personalised Outpatient Care (Patient Initiated Follow up & Patient Stratified Follow Up)								
			Referral optimisation and demand management								
			Deliver our follow up reduction target to drive the outpatient element of our Financial Improvement Plan								
Elective Care Transformation	**Key Metric**	**FFTF-3**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan**	M | T | FPC | FB							
			Deliver agreed national waiting list improvement targets and productivity benchmarks								
			Develop our elective strategy to include repatriation of activity from the independent sector and other regions, and the maximisation of our surgical hub capacity								
			Deliver our planned care financial targets in support of the Financial Improvement Plan								
Urgent and Emergency Care Transformation	**Key Metric**	**FFTF-4**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | AB							
			Focus on pre hospital pathway/front door to include integrated mental/physical health services and a 40% reduction in ambulance conveyances								
			Reduce Lengths of stay by 10% reduction in LoS on 10 pilot wards and reduce Not Meeting Criteria to Reside reduced to 5% (system aim)								
			Deliver agreed financial benefits to support Financial Improvement Plan								
Unwarranted Variation	Big Plan	FFTF-5	Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:	M | T | FPC | GD							
			Fully establish and embed the programme governance			▲	▲	▲			Programe fully established
			Undertake deep dive reviews into the 9 identified priority specialities, agreeing and deliver the consequent improvement plans			▲	▲	▲			Reviews undertaken and actions underway- however, financial benefits are below target
			Deliver agreed financial benefits to support Financial Improvement Plan								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Financial Improvement Plan	Big Plan	FFTF-6	Deliver the 23/24 actions and outcomes from the agreed Improvement Plan:	M | T | FPC | JW							
			Fully embed FIP governance & reporting								
			Fully embed FIP delivery framework								
			Develop and agree 3 year FIP								
Segment Two – Place Based Partnership											
Collaboration and Integration at Place	**Key Metric**	**FFTF-7**	**Fully establish the required governance structure and processes for Place based working, agree and deliver the 23/24 agreed Place strategies, actions and outcomes**	Q | T | TB | GD							
			Agree a comprehensive set of priorities & programmes								
			Deliver the Core20PLUS5 action plan and outcomes								
			Deliver the Frailty improvement action Plan & Outcomes								
Social Value	Big Plan	FFTF-8	Building on our Social Value Framework, work with partners to develop a Social Value Strategy driving a place based focus on equality, wider determinants of health, poverty and social capital:	B | T | TB | GD							
			Review and refresh Green Plan and deliver agreed actions/metrics								
			Prepare for Level 2 Social Value Quality Mark accreditation application in 2024/25								
			Deliver the Core20PLUS5 action plan and outcomes								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment Three – System Working												
ICB Joint Forward Plan	**Key Metric**	**FFTF-9**	**Deliver the 23/24 actions and outcomes from the agreed JFP. Work with ICB to:**	Q | T | TB | GD		▭	▭	▭			
			Finalise the JFP			▲	▲	▲			JFP signed off by the ICB Board
			Align strategies and plans with the JFP priorities			▭	▭	▭			
			Develop detailed delivery plans			▭	▭	▭			
Clinical Collaboration	Big Plan	FFTF-10	Deliver the 23/24 actions and outcomes from the agreed Clinical Collaboration work plan including:	M | T | FPC | GS		▭	▭	▭			
			Develop & deliver implementation plans for new models of care in Vascular, Head & Neck, Urology, Stroke and Elective Hubs			▭	▭	▭			
			Agree next set of specialties for the implementation of new models of care and develop implementation plans			▭	▭	▭			
			Undertake challenged services review of fragile and financially challenged services, and deliver agreed action plans			▭	▭	▭			
Central Services Collaboration	Big Plan	FFTF-11	Deliver the 23/24 actions and outcomes from the agreed Central Services Collaboration work plan including:	M | T | FPC | JW		▭	▭	▭			
			Target Operating model agreed and mobilised			▭	▭	▭			
			Phase 1 transactional services (Payroll and General Ledger provision) underway			▲	▲	▲			
			Bank and Agency Collaborative proposal sign off/implementation			▲	▲	▲			
Digital Northern Star / EPR Convergence	Big Plan	FFTF-12	Deliver the 23/24 actions and outcomes from the agreed Digital/EPR work plan	M | T | FPC | SD-GD		▭	▭	▭			
			EPR tenders evaluated, and preferred supplier awarded			▲	▲	▲			Scripts and videos scored, awaiting final moderation and on track for a preferred supplier status in quarter 2. OBC progressing.
			Digital Convergence programme governance reviewed and revised			▲	▲	▲			Governance in place.
			Implement Secure data Environment			▭	▭	▭			14M allocated through treasury. FBC progressing through North West Approval process.
Elective Recovery	Big Plan	FFTF-13	Deliver the 23/24 actions and outcomes from the agreed ECRG work plan – maximise system working to deliver:	M | T | FPC | GD		▭	▭	▭			
			National waiting times targets			▭	▭	▭			
			National productivity targets			▭	▭	▭			
			Surgical Hub Strategy			▲	▲	▲			
New Hospitals Programme	Big Plan	FFTF-14	Milestones and metrics to be finalised following further discussions with national teams	M | T | FPC | JW							

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	K JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	J\ FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	Fl SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

Green Delivering actions and outcomes

Amber On track to recover actions & outcomes

Red Significantly off track with actions & outcomes

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

CQC 2023 Inspection Report			
Report to:	Board of Directors	**Date:**	7th December 2023
Report of:	Chief Nursing Officer	**Prepared by:**	H.Ugradar
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to provide the Board of Directors with a summary of findings from the Care Quality Commission's (CQC) Inspection of Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) that took place on 31 May 2023, 1 June 2023, 12 June 2023, 13 June 2023, 26 June 2023, 27 June 2023, 28 June 2023, 29 June 2023, 3 July 2023 and 4 July 2023.

The CQC published their findings on 24 November 2023. A copy of the report can be found in Appendix 1 with a letter summarising next steps.

Areas inspected

As part of their inspection CQC carried out:

- Unannounced inspections of Urgent and Emergency Care on both sites, Medical Care at Royal Preston Hospital and Surgery at Royal Preston Hospital. This was part of CQC's continual checks.
- Focused inspection of Maternity on both sites. This was part of CQC's national maternity services inspection programme.
- An inspection of how well-led the Trust is overall.

Findings and Ratings

The overall rating for LTHTR was again rated requires improvement. Safe, effective and responsive were also again rated requires improvement. Caring was re-rated as good, and well-led has declined from good to requires improvement.

From a site ratings perspective, Chorley and South Ribble Hospital has seen a decline in safe from good to requires improvement and a decline in its overall site rating from good to requires improvement. The site ratings for Royal Preston Hospital remain unchanged.

The ratings for the core services inspected are detailed in Section 2.2.3 but in summary, there has been:

- A decline in safe across 3 core services (Maternity both sites and Urgent and Emergency Care at Chorley and South Ribble Hospital) from good to requires improvement.
- A decline in effective in 1 core service (Urgent and Emergency Services at Royal Preston Hospital) from good to requires improvement and an improvement in 1 core service (Surgery at Royal Preston Hospital) from requires improvement to good.
- No changes in the caring domain.
- A decline in responsive in 1 core service (Surgery at Royal Preston Hospital) from good to requires improvement.
- An improvement in well-led in 1 core service (Medical Care at Royal Preston Hospital) from requires improvement to good.

Rationale for Ratings

Although all core services across the Royal Preston and Chorley sites have been rated as good for well-led, CQC have confirmed that the overall well-led rating for the Trust remains as requires improvement due to the findings in maternity and urgent and emergency care, elective recovery, financial challenges, the thrombectomy service, the need for and importance of Governor-Board relationships and stability of the Board following retirement of the Chief Executive Officer and challenges in recruiting to a substantive Chair. Since the inspection a number of key Board appointments have been made including a new Chief Executive Officer and Chair.

Letter of Concern and Letter of Intent

During the inspection of urgent and emergency care, CQC issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly initially and then monthly and shows assurance about the actions that were taken to address these issues.

Following the inspection of maternity and a review of trust data, CQC issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

Outstanding Practice and Good practice

A number of examples of outstanding and good practice were noted within the report. A summary of these is detailed in Section 2.5 of the paper.

Recommendations

In total, the Trust received 54 recommendations in the form of Must Do's* or Should Do's** (18 Must Do's and 36 Should Do's). Some recommendations are duplicated across the different core services. Upon streamlining, there are 44 recommendations in total (13 Must Do's and 31 Should Do's). A full breakdown of Must Do's and Should Do's can be found in Appendix 2 of this paper.

Next Steps

Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust are expected to submit a written report of the action the Trust is taking to meet the Health and Social

Care Act 2008, associated regulations, and any other legislation CQC have identified the Trust to be in breach of. The Trust will submit an action plan within 28 days of receipt of the report. This will be reviewed by the Board prior to submission and continue to be monitored at Safety and Quality committee as part of the Trust's Quality Improvement Plan, the vehicle for overseeing the recommendations from CQC reports. The Trust understands the actions that are now required and is fully committed to getting to good.

It is recommended that the Board of Directors:

I. Receive and discuss the findings from CQC's inspection of Lancashire Teaching Hospitals NHS Foundation Trust following the publication of their report on 24 November 2023

Appendix 1 – Inspection letter and Final Report
Appendix 2 – Summary of Must and Should Do's

**Must Do's' are actions which have been identified by the CQC as being in breach of the Health and Social Care Act 2008, associated regulations, and any other legislation the Trust has been identified as being in breach of during the inspection.*

***'Should Do's' are minor breaches that did not justify regulatory action, but failure to address may lead to a full breach in future or may prevent improvement of services.*

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Board of Directors – 22nd November 2023

1. Background

1.1 The purpose of this paper is to provide the Board of Directors with a summary of findings from the Care Quality Commission's (CQC) Inspection of Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) that took place on 31 May 2023, 1 June 2023, 12 June 2023, 13 June 2023, 26 June 2023, 27 June 2023, 28 June 2023, 29 June 2023, 3 July 2023 and 4 July 2023.

1.2 The CQC published their findings on 24 November 2023. A copy of the report can be found in Appendix 1 with a letter summarising next steps.

2. Discussion

2.1 Areas Inspected

2.1.1 As part of their inspection CQC carried out:

- Unannounced inspections of Urgent and Emergency Care on both sites, Medical Care at Royal Preston Hospital and Surgery at Royal Preston Hospital. This was part of CQC's continual checks.
- Focused inspection of Maternity on both sites. This was part of CQC's national maternity services inspection programme.
- An inspection of how well-led the Trust is overall.

2.2 Findings and Ratings

2.2.1 The overall rating for LTHTR was again rated requires improvement. Safe, effective and responsive were also again rated requires improvement. Caring was re-rated as good, and well-led has declined from good to requires improvement.

2.2.2 From a site ratings perspective, Chorley and South Ribble Hospital has seen a decline in safe from good to requires improvement and a decline in its overall site rating from good to requires improvement. The site ratings for Royal Preston Hospital remain unchanged.

2.2.3 The ratings for the core services inspected were as follows:

- **Urgent and emergency care at Royal Preston Hospital –** has again been rated requires improvement overall and for being safe and responsive. Caring and well-led have again been rated as good. Effective has declined from good to requires improvement.
- **Urgent and emergency care at Chorley and South Ribble Hospital** – the overall rating, as well as effective, caring, responsive and well-led have again been rated as good. Safe has declined from good to requires improvement.
- **Medical care at Royal Preston Hospital** – overall, safe, effective and responsive have again been rated as requires improvement. Well-led has improved from requires improvement to good. Caring has been re-rated as good.
- **Surgery at Royal Preston Hospital** – this has again been rated good overall and for being safe, caring and well-led. Effective has improved from requires improvement to good, and responsive has declined from good to requires improvement.
- **Maternity services at Royal Preston Hospital** – this has declined from being good to requires improvement overall and for being safe. Well-led has again been rated as good.
- **Maternity services at Chorley and South Ribble Hospital** – overall and well-led were re-rated as good. Safe has declined from good to requires improvement.

2.2.4 In summary, for the core services there has been:

- A decline in safe across 3 core services (Maternity both sites and Urgent and Emergency Care at Chorley and South Ribble Hospital) from good to requires improvement.
- A decline in effective in 1 core service (Urgent and Emergency Services at Royal Preston Hospital) from good to requires improvement and an improvement in 1 core service (Surgery at Royal Preston Hospital) from requires improvement to good.
- No changes in the caring domain.
- A decline in responsive in 1 core service (Surgery at Royal Preston Hospital) from good to requires improvement.
- An improvement in well-led in 1 core service (Medical Care at Royal Preston Hospital) from requires improvement to good.

2.3 Rationale for ratings

2.3.1 Although all core services across the Royal Preston and Chorley sites have been rated as good for well-led, CQC have confirmed that the overall well-led rating for the Trust remains as requires improvement due to the findings in maternity and urgent and emergency care, elective recovery, financial challenges, the thrombectomy service, the need for and importance of Governor-Board relationships and concerns about stability of the Board following retirement of the Chief Executive Officer and challenges in recruiting to a substantive Chair. Since the inspection a number of key Board appointments have been made including a new Chief Executive Officer and Chair.

2.4 Letter of Concern and Letter of Intent

2.4.1 During the inspection of urgent and emergency care, CQC issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly initially and then monthly and shows assurance about the actions that were taken to address these issues.

2.4.2 Following the inspection of maternity and a review of trust data, CQC issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

2.5 Outstanding Practice and Good practice

2.5.1 A number of examples of outstanding practices were identified within the report. These are:

- Team Engagement and Diagnostic Tool (TED) tool supporting improvements in levels of team satisfaction and engagement (Trust wide)
- Opening of Finney House (Trust wide)
- Collaborative working with ICS and other Trusts to test Engineering Better Care model (Trust wide)
- Royal College of Emergency Medicine award for work to improve the 'green footprint' in the department (Urgent and Emergency Care at Royal Preston Hospital)
- Quality Improvement engagement with Northwest Ambulance Service (NWAS) reducing ambulance handover times (Urgent and Emergency Care at Royal Preston Hospital)
- Engagement with women, birthing people, families and the wider community to promote birth choices for women and birthing people (Maternity at Royal Preston Hospital)

2.5.2 Other positives from the report include:

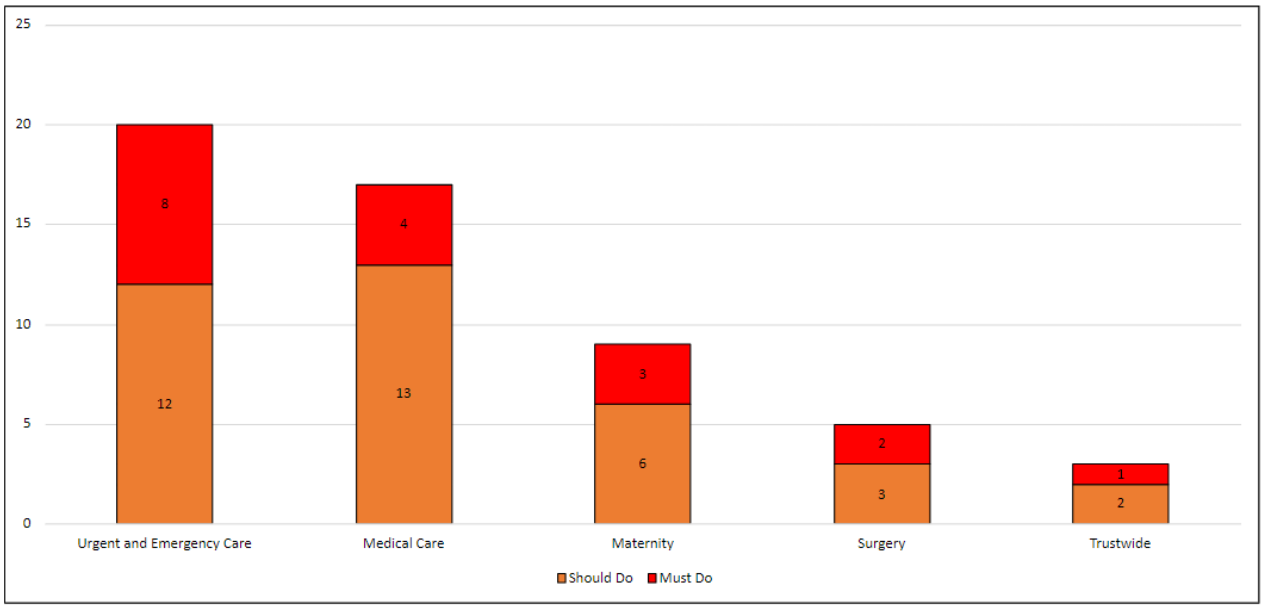
- Leaders showed adequate experience, knowledge and skills to be able to run the trust. Although it has been noted that some staff felt leaders weren't always visible in services where there were greater pressures, which left some staff feeling unsupported.

- The Trust had processes in place to escalate relevant risks and identified actions to reduce their impact.
- The Trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Most staff felt respected, supported, and valued. They were focused on the needs of people receiving care.
- The Trust promoted equality and diversity in daily work and provided opportunities for career development. The trust supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities
- The Trust collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for people.
- The Trust had a good understanding of quality improvement methods and the skills to use them.

2.6 Areas of Improvement

2.6.1 In total, the Trust received 54 recommendations in the form of Must Do's or Should Do's (18 Must Do's and 36 Should Do's). Some recommendations are duplicated across the different core services. Upon streamlining, there are 44 recommendations in total (13 Must Do's and 31 Should Do's). A full breakdown of Must Do's and Should Do's can be found in Appendix 2 of this paper.

2.6.2 The graph below gives a summary of the number of recommendations by Core Service:



2.7 Next Steps

2.7.1 Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust are expected to submit a written report of the action the Trust is taking to meet the Health and Social Care Act 2008, associated regulations, and any other legislation CQC have identified the Trust to be in breach of. The Trust will submit an action plan within 28 days of receipt of the report. This will be reviewed by the Board prior to submission and continue to be monitored at Safety and Quality committee as part of the Trust's Quality Improvement Plan, the vehicle for overseeing the recommendations from CQC reports. The Trust understands the actions that are now required and is fully committed to getting to good.

3. Financial implications

3.1 There may be some financial implications in delivering some of the Must Do's and Should Do's. These costs are yet to be determined.

4. Legal implications

4.1 See Section 2.6 for summary of recommendations (Must Do's and Should Do's).

4.2 Must Do's' are actions which have been identified by the CQC as being in breach of the Health and Social Care Act 2008, associated regulations, and any other legislation the Trust has been identified as being in breach of during the inspection.

4.3 Should Do's' are minor breaches that did not justify regulatory action, but failure to address may lead to a full breach in future or may prevent improvement of services.

4.4 The Trust will submit an action plan to the CQC within 28 days of the final report.

5. Risks

5.1 The risk of not complying with requests of the CQC report remains a significant risk on the risk register with a score of 12. This risk is likely to remain the same until the Trust achieves a rating of good or demonstrates sustained progress against delivery of the 'Must Do's and 'Should Do's'.

6. Impact on stakeholders

6.1 The findings and key highlights from the CQC report has been shared both internally and externally following publication.

7. Recommendations

7.1 It is recommended that the Board of Directors:

I. Receive and discuss the findings from CQC's inspection of Lancashire Teaching Hospitals NHS Foundation Trust following the publication of their report on 24 November 2023.

Appendix 1 – Inspection Letter and Final Report

Appendix 2 – Summary of Must and Should Do's

CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 03000 616161
Fax: 03000 616171
www.cqc.org.uk

Faith Button
Interim Chief Executive
Lancashire Teaching Hospitals NHS Foundation Trust
Sharoe Green Lane
Fulwood
Preston
Lancashire
PR2 9HT

15 November 2023 Our reference: INS2-15227142721

Care Quality Commission
Health and Social Care Act 2008
Inspection report and report on the action you plan to take

Organisation name: Lancashire Teaching Hospitals NHS Foundation Trust
Organisation ID: RXN

Dear Ms Button

Following our recent inspection of Lancashire Teaching Hospitals NHS Foundation Trust, we have enclosed a copy of our report of the findings. This report includes our rating of the care provided. Please make this report readily available for people who use the service.

We reviewed your comments relating to any factual inaccuracies in the draft report and have made changes in the enclosed report.

The changes made as a result of your comments relating to factual accuracy did not impact on the overall ratings contained within the final report, however the ratings for Medical Care Well Led went from requires improvement to good.

We will publish this report on our website. When we have published this report you can see the contents and download a PDF version by clicking on this link.

www.cqc.org.uk/directory/«CQC_ENFORCEMENT_PROVIDER_ACCOUNT_NUMBER_»

Once published, you can see this at any time by following these steps:

- Go to the CQC website www.cqc.org.uk.

- Click the appropriate tab for your type of service.
- Type in the name of your trust – if it appears automatically, click on it to jump to your profile page or click the 'search' button.
- Click on your trust, your report will be on your profile page.

As a result of the judgement(s) made in our inspection, we have set actions we require the trust take. These can be found at the back of the report.

Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, you must send us a written report of the action you are going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation we have identified you are in breach of. We have enclosed a template that you may wish to use.

If you have already sent us an action plan after this inspection about any of these actions, you do not need to include them in your action plan.

You must return the action plan to us no later than 28 days after receipt of this letter.

We would prefer you to send your report to us by email to:

HSCA_Compliance@cqc.org.uk
If you are unable to do so, please post it to the address below.

Please include our reference number INS2-15227142721 in any letter or email you send with the report.

You should inform us in writing when you have completed the actions in your plan. We will check to make sure that you have completed your actions and will report on our judgements.

Challenging the rating(s)

A rating review involves checking whether or not CQC followed its process for making ratings decisions, as explained in the guidance published on our website. If you think that we have not followed the process you can request a review. You cannot ask for a review of ratings on the basis that you disagree with our judgements.

You must submit your request for review, using the online form, within 15 working days of the publication of your report(s). You must say in what way we have not followed the process, and which ratings you think have been affected.

Please use the following link to access the form:
http://www.cqc.org.uk/content/requesting-review-one-or-more-cqc-ratings

Please note that a rating review does not involve a reconsideration of the evidence and ratings awarded, unless we find the process has not been followed.

You can only request a review of ratings once after each inspection. Please note that requests for reviews of ratings can lead to ratings going down as well as up, or they can remain the same.

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely

Sean O'Kelly
Chief Inspector of Hospitals

Lancashire Teaching Hospitals NHS Foundation Trust

Inspection report

Royal Preston Hospital
Sharoe Green Lane, Fulwood
Preston
PR2 9HT
Tel: 01772716565
www.lancashireteachinghospitals.nhs.uk

Date of inspection visit: 31 May 2023, 1 June 2023, 12 June 2023, 13 June 2023, 26 June 2023, 27 June 2023, 28 June 2023, 29 June 2023, 3 July 2023 and 4 July 2023
Date of publication: N/A (DRAFT)

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our findings

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.
- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Leaders showed adequate experience, knowledge, and skills to run the service. They mostly understood and managed the priorities and issues the service faced, however during some interviews leaders could not clearly or consistently articulate certain business details.

Some staff felt leaders were less visible in services where there were greater pressures.

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks and identified actions to reduce their impact. However, during our inspection of urgent and emergency care we issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly and shows assurance about the actions that were taken to address these issues.

Also, following our inspection of maternity and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The trust supported staff to develop their skills and take on more senior roles. Mandatory training for medical staff needed improvement.

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

The service collected reliable data and analysed it.

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a good understanding of quality improvement methods and the skills to use them.

How we carried out the inspection

Our findings

During our inspection we spoke with a variety of staff including nurses, doctors, therapists, healthcare support workers, pharmacists, patient experience staff, domestic staff, administrators, and the trust's board. During the inspection we also spoke with patients and relatives. We visited clinical areas across the hospital sites. We reviewed patient records, national data and other information provided by the trust.

We held several staff focus groups with representatives from across the trust to enable staff who were not on duty during the inspection to speak to inspectors.

The inspection was overseen by Sarah Dronsfield deputy director and included an operations manager, inspectors, and specialist advisers. An executive reviewer supported our inspection of well-led for the trust overall. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Trust Wide

- The trust had developed and used a team engagement and development tool (TED) to support improvements in levels of team satisfaction and engagement as measured through the trust annual staff survey. The tool was embedded across the trust in leadership development, continuous improvement, and the Star Ward Accreditation programmes. In 2022-2023 the trust completed 175 TEDS, which engaged with 1,523 colleagues. The tool had been recognised by NHSE as an example of excellent practice and the trust was supporting other organisations to do this.
- In November 2022, the trust opened Finney House, a 96 bedded location, which includes 32 residential beds and 64 intermediate care beds. This addresses a long-standing gap in community provision in Central Lancashire and has reduced patients who do not meet criteria to reside from 12% to 5.2%. Since opening, 808 patients have been cared for in Finney House, the home has an average length of stay (LOS) of 10.5 days, ranging from LOS 2.5 to 18 days. To date there has been only one formal complaint, family and patient feedback remains consistently positive.
- The trust was working with the ICS, other trusts and in partnership with the Engineering Design Centre from the University of Cambridge to test their 'Engineering Better Care' model. The trust had adopted this approach and was currently applying the model to 3 programmes, frailty, thrombectomy and complex death notifications.

Royal Preston Hospital

Urgent and Emergency Care

- The department had been recognised with a Royal College of Emergency Medicine award for work to improve the 'green footprint' of the department.

Our findings

- The department had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. Data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

Maternity

- The service used innovative ways to engage with women, birthing people, families and the wider community to participate in activities outside of the hospital to promote birth choices for women and birthing people. For example, the maternity unit took part and had a stall and float at the local festival promoting birth choices for women and birthing people.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure staff complete mandatory training in accordance with the relevant schedule and receive sufficient training, supervision, and appraisal to perform their duties competently. (Regulation 18 (2)(a)).

Location/core service

Royal Preston Hospital

Urgent and Emergency Care

- The trust must ensure that medical staff complete all required mandatory training. (Regulation 18 (1)(2)(a).
- The trust must ensure that risk assessments are fully completed for patients attending with mental health needs and mitigating actions to limit identified risks are implemented. (Regulation 12 (1)(2)(a).
- The service must ensure that staff complete patient records accurately and in a timely manner. (Regulation 17(2)(b)).
- The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a)).

Medical Care

- The service must ensure patients receive antimicrobials in line with the national guidelines. (Regulation 12).
- The service must improve compliance for resuscitation training for medical and nursing staff and compliance for sepsis training for medical staff. (Regulation 12).
- The service must ensure that patient records are kept secure. (Regulation 17).
- The service must ensure they have enough medical staff to keep patients safe. (Regulation 18).

Our findings

Surgery

- The trust must continue to take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12(1)).
- The trust must continue to take actions to improve the number of patients receiving a clinical assessment and daily review by a senior decision maker within target timescales. (Regulation 12(1)).

Maternity

- The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training. (Regulation 18(2)(a)).

Chorley and South Ribble Hospital

Urgent and Emergency Care

- The trust must ensure that all staff, including medical staff, complete mandatory training requirements. (Regulation 18(1)(2)(a)).
- The trust must ensure that checks of consumables are completed including integrity of packaging and within expiry dates. (Regulation 12(1)(2)(e)).
- The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a)).
- The trust must ensure patients with a mental health concern are cared for in a room that is free from objects that could be used to self-harm (Regulation 12(1)(2)(d)).

Maternity

- The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training. (Regulation 18(2)(a)).
- The service must ensure equipment is secure, suitable for the purpose for which it is being used and properly maintained. This includes but is not limited to emergency equipment and firefighting equipment. (Regulation 15(1)(b)(c)(e)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that it continues to monitor pharmacy staffing to support continued improvement in medicines optimisation (Regulation 18).
- The trust should monitor the administration of files for the fit and proper persons checks.

Location/core service

Royal Preston Hospital

Our findings

Emergency Urgent and Emergency Care

- The service should ensure that patient identifiable details are not displayed on public boards. (Regulation 17).
- The service should continue its focus on establishing sufficient numbers of medical staff and managing any risks occurring as a result of staffing lack in medical workforce. (Regulation 18(1)).
- The service should continue its focus on improving local audit (STAR accreditation) outcomes.
- The service should ensure that patients' nutrition and hydration needs continue to be regularly monitored whilst they are waiting for treatment and care.

Medical Care

- The trust should ensure patients receive daily, timely review when not being provided care and treatment on the correct medical speciality ward. (Regulation 12).
- The service should ensure that staff follow infection prevention control principles. (Regulation 12).
- The service should ensure that premises are safe to use for patients. (Regulation 12)
- The service should ensure risk assessments, care plans and intentional rounding is completed regularly for all patients. (Regulation 12).
- The service should continue to monitor the correct recording of NEWS2 observations. (Regulation 12).
- The service should ensure that equipment is properly maintained, including the patient call bells and showering facilities. (Regulation 15).
- The service should ensure that complaints are managed in a timely manner. (Regulation 16).
- The service should continue to improve waiting times for patients accessing neurology cancer treatment.
- The service should improve staff attendance at governance meetings.
- The trust should continue to improve the provision of single sex washing facilities for patients.
- The Trust should continue to recruit allied health professions within medical care.
- The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed.
- The trust should continue to use medicines data to support improvement in medicines safety.

Surgery

- The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed.
- The trust should continue to use medicines data and keep pharmacy staffing under review to support continued improvement in medicines safety, including medicines reconciliation.
- The service should consider how wards and theatre areas can be made more dementia friendly.

Maternity

Our findings

- The service should ensure the maternity assessment service has the right number of qualified staff and the triage telephone line is answered and monitored by a trained midwife.
- The service should improve the culture where staff feel listened to.
- The service should ensure they monitor delays in the induction of labour process and all reasons for the delays are documented.
- The service should ensure there is an accurate overview of risks faced, including the monitoring of delays in induction of labour, monitoring of missed telephone calls and telephone call drop off rates within triage and to rate all 3rd and 4th degree tears and post-partum haemorrhages as incidents.

Chorley and South Ribble Hospital

Urgent and Emergency Care

- The trust should ensure that all conversations with patients, and their families take place in an environment where they are not overheard (Regulation 10).
- The trust should ensure that all noticeboards include current information such as safeguarding. (Regulation 13).
- The trust should ensure that all patients with protected characteristics are supported such as availability of information in formats that patients understand. (Regulation 9).
- The trust should ensure that complaints are managed in a timely manner (Regulation 16).
- The trust should consider including checks of the transfer bag with other daily checks.
- The trust should consider locating paediatric emergency information where children would be treated.
- The trust should consider reviewing the environment where paediatrics are treated to be more child friendly.
- The trust should consider sourcing comfortable chairs appropriate for patients with additional needs such as mobility or bariatric.

Maternity

- The service should review use of patient group directions and storage of aromatherapy oils to assure themselves medicines management is in line with best practice.
- The service should ensure staff carry out newborn observations using track and trigger system in a timely way in line with local guidance.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders showed adequate experience, knowledge, and skills to run the service.

They mostly understood and managed the priorities and issues the service faced, however during some interviews leaders could not clearly or consistently articulate certain business details.

Our findings

Some staff felt leaders were less visible in services where there were greater pressures.

The trust supported staff to develop their skills and take on more senior roles**.**

The executive team spoke of a unitary board, therefore worked to a collective responsibility for aspects such as finance, patient quality, and safety.

Most of the executive directors had been in post since the last inspection in 2019. The chief executive officer joined the trust in 2021. The CEO was experienced in their role with a background in finance and had held various director and chief executive posts. The CEO played a key role in the whole system as chief executive lead for the Lancashire and South Cumbria Provider Collaborative.

Following our inspection, we were informed the CEO was leaving to take up another post. We were cognisant of the potential impact this could have on the stability of the board. The trust appointed an interim Chief Executive Officer (the current COO) on the 1 October 2023 whilst recruitment to the CEO took place. The trust formally announced the appointment of a new CEO on 2nd October 2023.

Executive directors had varied portfolios. The Chief Nurse was supported by a Deputy Chief Nursing Officer, a Chief AHP, two Associate Directors of Governance and Divisional Nurse/Midwifery Directors for each Clinical and Corporate Division. Governance was shared with the medical director. Support for the medical director had been strengthened with 3 deputies soon to be 4. An interim Chief People Officer had been appointed following the retirement of the previous post holder.

The trust's Chief Finance Officer had been in post since August 2019. Prior to this they had held roles at Chief Finance Officer level since 2007 at several hospital trusts.

The Board invested in the establishment of a Director of Strategy and Planning in January 2022 and a planning team in response to the refreshed national approach to planning introduced by NHS England post-pandemic, to ensure that the organisation had the resources required to further strengthen its approach to strategic and operational planning.

We found the leadership team had the knowledge of the main priorities and challenges facing the services, however during some interviews leaders could not clearly or consistently articulate certain business details. For example, the board signed off a cost saving target of £67m without a plan detailing how this would be achieved. Together with the local health economy, the Trust Board accepted a stretch target from the ICS and at the time of the inspection there was little assurance of schemes that supported this. This represents a significant risk to the trust delivery of its financial plan. This was agreed on the assumption that a mitigating 'Memorandum of Understanding' would be put into place, together with a system 'Road Map'. This had yet to be finalised at the time of the inspection.

The ethnic diversity of the board was not representative of the staff as a whole or the local population. Board members acknowledged that the board lacked ethnic diversity with no executive or non-executive members from racially minoritised groups.

The CEO told us until recently, there had been no vacancies to support the Board in addressing this; however, the Board were currently recruiting to a Non-Executive Director position and were aiming to recruit a board member from minority groups.

Our findings

It was anticipated the trust would make the appointment in August which would address the gap. The Board included a non-executive and an executive director with protected characteristics which added significant value to the representation of the wider community and staff diversity.

The current chair was an interim post pending an imminent permanent appointment. They had been acting chair since August 2022 and were a consultant physician with a special interest in elderly care, stroke, and medical education. After the well led inspection, we were informed a substantive appointment had been made to the position of chair starting on 1 August 2023 and the appointment had been ratified by the Nominations Committee and the Governing Body.

There were currently 6 non-executive directors (NEDs) with an advert out to recruit to a vacancy. The NEDs had a diverse range of leadership experience in the sectors of health, local authority, finance, and business. Most of the NEDs had been appointed in the time since our last inspection. The most recent appointments included bringing in expertise as a senior leader from the public sector and commercial environment. The NEDs chaired the trust committees, which reported to the trust board.

The recruitment and induction of non-executive directors was positive. There was a varied mix of skills and experience across directors and a considered approach to the skill set requirements when new directors were recruited.

Non-executive directors reported that relationships with the executives were supportive and there was sufficient challenge and influence to drive improvements. They were clear about their roles and responsibilities and played a large role in chairing committees.

The trust operated through 4 divisions; medicine; surgery; women's and children's and diagnostics and clinical support. Each division was led by a triumvirate of a divisional director, medical director, and a director of nursing or equivalent role. The divisions were supported by service managers.

We spoke with the divisional leads who had a good awareness of the challenges, including quality, workforce, performance, and finance. The leads were positive about the support from the executive team.

There was time set aside for board development which included workshops to review the strategy. The trust had a well organised talent management programme with support for career development and creating a coaching culture for staff who wanted to progress into senior roles.

The trust tried to ensure fairness and equity by working with inclusion leads to provide career opportunities for people from all backgrounds and protected characteristics where necessary. Most staff told us that opportunities for career development had improved but this was dependent on the role and department they worked in.

Some staff groups provided mixed views regarding the visibility of the leadership team, particularly at Chorley Hospital. Also, staff in areas where there were greater pressures, due to challenges recruiting medical staff, financial restraints, and patient demand, felt less supported by the senior leadership. This feedback was like that we received at the last inspection. Some staff also said on some wards there was a culture of silo working.

The Board had a bi-monthly structured walk around where they visited clinical areas and spoke to staff. The Chief Executive worked shifts in different parts of the hospital as part of the 'back to the floor' initiative and was involved in meetings and events with different staff on both sites. The Chief Nursing Officer and Chief Medical Officer also worked shifts in different parts of the trust and carried out visits (with the Chief Medical Officer having a regular clinic on the Chorley site every Tuesday).

Our findings

As part of our well led inspection, we observed the public and private board meeting on 3 August 2023. The acting chair allowed members to engage and apply scrutiny to agenda items. Those attending were able to seek assurance and there was sufficient challenge on the key areas of risk.

The trust had acknowledged the high-level feedback given by the CQC following the recent site inspection visits and informed the board that a specific action plan with regards to concerns we had raised about maternity was to be monitored by the Safety and Quality Committee and would be reported to Board.

Pharmacy Leadership

The executive team had good oversight of the staffing challenges within pharmacy informed through the monitoring of pharmacy KPI's at divisional performance review meetings. New pharmacy team structures were being embedded following staff engagement and formal staff consultation (Q2 2022). There was constant reassessment of deployment and utilisation of pharmacy staffing budget, for example the employment of analysts to strengthen governance.

Similarly, the medicines management associate's team had been expanded to support improved adherence with standards for the safe handling of medicines, whilst releasing technician and pharmacist time to clinical roles. Recruitment and retention plans were being refreshed to help close pharmacy vacancy gaps (~40% band 6/7 pharmacists, 20% technical staff). Recent successful recruitment should reduce pharmacist vacancies from August 2023.

However, we found for example, that limited pharmacy capacity on MAU impacted upon rates of prescription verification, a clinical assessment to ensure safe and optimal use of medicines and medicines reconciliation.

The recent opening of AAU further reduced clinical pharmacy performance on admission wards, due to trust expansion into this area, without increased pharmacy capacity. Similarly, 24h medicine reconciliation rates below trust target were attributed to 'a lack of pharmacy input at early stages in the surgical admission pathway'.

There was also variation between the two hospital sites in performance against key medicine safety metrics on admission wards. Continuous improvement work was underway focussing on expanding the role for pharmacy technicians in completing medicines reconciliation.

Fit and proper persons

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed staff files for members of the board of directors. We found documents such as annual fit and proper persons self-declaration, disclosure and barring service, registration checks were compliant with Regulation 5. However, in 2 files confirmation of qualification checks were missing and in 3 files confirmation of occupational health checks were absent.

Our findings

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and most staff understood and knew how to apply them and monitor progress.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust launched its five-year strategy Our Big Plan in 2019. The divisional business plans were aligned to the Big Plan. The business plans set out the actions, finance and workforce implications and business cases for each of the objectives in the Big Plan

There was a vision, values and focus on people, safety of services and patient experience. There were several enabling strategies which supported the overall strategy. The Director of Strategy acknowledged there was a good range of strategies and signalled that going forward they wanted to build on this strength to make the process for developing them and their contents more consistent.

The trust had a process to monitor progress against the plan. There were a set of metrics which were reviewed annually to consider changing national policy requirements and local circumstances.

Metrics were cascaded through the organisation and reviewed by each divisional improvement forum. Staff were aware of and knowledgeable about the trust's core values and spoke readily of how these related to the work in their services.

There was a greater emphasis for directors to be more outward facing and partnerships were beginning to be embedded and strengthened with the ICS and other national work programmes. Executive and non-executive directors were engaged in wider system developments. Leaders understood the benefits of system wide working to improve patient care for people across the Lancashire and South Cumbria area. Integration had good coverage in the minutes of board meetings we reviewed.

The Big Plan metric was being refreshed in September 2023 with a full review to set the next 3 years taking account of related key developments such as the Integrated Care Board Forward Plan and the development of Place (Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community).

Since the last inspection the trust had launched its clinical services strategy 2022/2025 which was aligned with the system level New Hospitals Programme Framework Model of Care. The key areas included reduction of waiting lists, changes to urgent and emergency care, community integration, health inequalities and workforce and financial challenges.

The trust was also part of longer term and system wide strategies such as the new hospitals programme. As part of a rolling programme of national investment in capital infrastructure beyond 2030 it was announced that a new hospital would be built to replace the Royal Preston Hospital.

Our findings

A financial strategy had been in place since 2021 with a branding of 'Knowing the Business'. This detailed an action plan to support the overall infrastructure and underpinning strategies to provide the right environment to identify and deliver productivity and reduction in unwarranted variation. It was regularly updated but did not specifically quantify schemes to deliver an underlying breakeven position. The trust has commissioned 2 external reviews to support its work.

The trusts Pharmacy and Medicines Optimisation Strategy, aligned with the trust 'Big Plan' had been redrafted for 2023-2027. There were plans (following sign off) to raise pharmacy and wider awareness and engagement with year 1 priorities. Key deliverables for 2022/23 included the successful roll out EPMA to the emergency department, closing identified risks at the interface between paper and electronic records and implementation of the new pharmacy team structure to support patient flow.

Culture

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff felt respected, supported, and valued. Staff were positive about their departments and the local leadership teams; they were able to speak to local leaders about difficult issues when things went wrong.

The 2022 staff survey results showed the trust scored above the benchmark median for each of the areas in the NHS Staff Survey. The trust was placed 13th out of 65 trusts in overall positive scores up from 24th in 2021.

There was a 4% improvement from 2021 in colleagues feeling unwell due to work related stress in the last 12 months. There was no improvement recommending the trust as a place to work and/or care. The most significant fall in satisfaction was around the level of pay. The results were shared with the divisional teams and actions to improve identified.

Colleagues respected one another to achieve the desired outcomes for patients, relatives, and carers. All staff were committed to improving the quality of care and patient experience.

Senior leaders were proud of the transparent culture, which was reflected by staff, at different levels, across the trust, who were honest and open.

Board members and senior leaders were consistent that patient safety was always a priority and had agreed investment to safeguard patient safety despite the difficult financial position of the trust.

Data from the most recent workforce race equality standard (WRES) report showed positive performance. Of the 4 questions asked in the NHS Staff Survey 2022 the trust scored better than, or in line with, the average for all 4.

Action was needed to increase the representation of ethnic minority colleagues in more senior roles alongside the trust's WRES positioning in terms of the likelihood of white staff accessing non–mandatory training and continuing professional development (CPD) compared to staff from ethnic minority groups.

The trust had implemented a plan to identify the cause and implement corrective action where necessary.

Our findings

In the Workforce Disability Equality Standard (WDES) of the 8 questions asked in the NHS Staff Survey 2022 the trust scored better than, or in line with, the average for all 8. However, the metrics had deteriorated since the previous year.

The trust had an equality diversity, and inclusion (EDI) network with a broad range of representation. Members from the different networks spoke with enthusiasm and positivity about their work and the support offered by the trust. They shared examples of joint working to challenge inequalities and discrimination. As part of every divisional people plan there were dedicated divisional level EDI actions with increased representation from the workforce with specific protected characteristics.

During the inspection we spoke to chairs of the staff network groups including ethnic diversity, LGBTQ+, menopause, disability, and carers. The networks were involved in actions to improve EDI across the trust. The chairs spoke of a positive culture at the trust and felt supported in their roles by trust leaders. The networks were involved in the development of the EDI strategy and inputted into education and employment management programmes to ensure inclusive recruitment. The CEO was the executive sponsor for the ethnicity council. Several events were planned for the next 12 months by the different networks. The LGBTQ+ network was aiming for the rainbow badge accreditation to monitor how well the trust cared for LGBTQ+ patients. Areas currently under review included declaration rates for a disability and why people did not disclose.

Non-Executive Directors were positive about the culture of the organisation. They had a good working relationship with the CEO and other executive directors.

However, governors gave mixed views about how effective the culture was. Some reported they felt marginalised, and this had been further impacted by the absence of a permanent chair. We found that some relationships between the board and governors was dysfunctional. This had been a long-standing issue. The trust responded to our feedback after the inspection and confirmed that various work streams were underway to address these issues including a recently drafted cultural improvement action plan using the trust's team Engagement and Development Tool, work focusing on the clarity of the role of governors and a review of administrative and wider support around the governing body.

There were formal mechanisms and regular dialogue with staff side representatives and the executive team. Staff reported positive relationships and support for trade union activities.

There was a Freedom to Speak Up (FTSU), Raising Concerns and Whistleblowing Policy. An interim FTSU guardian had been in post for 3 weeks. The guardian had protected time of 3 days a week for the role. There were 30 FTSU champions across the organisation. The Chief People Officer was the executive lead and the guardian had access to the Chief Executive.

The guardian attended a bi-monthly raising concerns meeting chaired by the Chief People Officer. The group identified themes and organisational learning, reporting to the trust's Workforce Committee, which was chaired by a non-executive director and, through the guardian, to the board.

Governance arrangements were strengthened during 2022 with the inclusion of concerns being raised into the divisional improvement forums. An external audit of the FTSU processes showed substantial assurance. The FTSU guardian linked in with regional and national networks to share good practice and learning.

During the inspection staff said they were aware of how to contact FTSU champions and felt they could raise any concerns.

Our findings

The June 2023, FTSU annual report to the Board showed 204 concerns were raised with the FTSU guardian during 2022-2023. The most frequently stated reasons for contacting FTSU were concerns about patient safety, unfair treatment, bullying and harassment and other professional concerns. Several organisational development programmes to provide staff with opportunities to speak up and address concerns regarding culture, behaviour and leadership had developed across several teams. Although challenges remained in some areas with ongoing concerns about the pace of change. In some cases, concerns raised had led to reviews of medical and nurse staffing levels.

One area for improvement identified by the Workforce Committee chair was closing the loop on concerns raised through FTSU and showing staff the trust had acted on and addressed their concerns.

The trust had 8 whistle-blowers in the last 12 months, 4 of which related to the same service within the surgical division, which was the focus of improvement activity. Three concerns related to women and children's health and the other in estates and facilities. Themes included staffing levels, departmental culture, and leadership. The guardian had provided a response to the National Guardians Office and responses and action plans had been shared with CQC.

We met with the guardian for safer working. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian was allocated 2 PAs in their job plan for the role, this was described as manageable. Themes from exception reports were mainly around gaps in the medical and surgical staffing rotas.

There were monthly junior doctors' forums and attendance had improved. All the junior doctors were invited to the meetings which gave them an opportunity to discuss their concerns. A quarterly report was presented to the Medical Workforce Committee and annually to the Board.

The guardian reported good working relationships with the Medical Director and Chief People Officer. The trust had refurbished the doctors mess at the Preston and Chorley sites and provided 6 sleep pods to ensure staff wellbeing. One area of concern was food provision for staff out of hours, this was currently being reviewed.

Cultural ambassadors worked across pharmacy to collectively agree team culture and to embed the cultural behaviours into all aspects of pharmacy work. Following a review of pharmacy internal space, additional staff rest areas and offices for agile working had been established.

The trust offered a range of leadership and management development programmes to support staff at all levels, which was supported by the trust's leadership framework. This included culture and wider leadership programmes, inclusive leadership, clinical director development and divisional action learning programmes.

In 2022 417 members of staff who were identified as 'Rising Stars' (up to band 8a) were offered a place on the talent management programme. This was an increase from 382 (8.4%) in 2021. When reviewing the proportion of staff who were 'Rising Stars' across all bands at an organisational level Band 2 and Band 5 in both clinical and non-clinical roles had the highest proportion of ethnic minority colleagues, however these two groups had the lowest number of Rising Stars identified in the last 12 months.

Band 3, 4 and 7 had the highest proportion of colleagues who had disclosed they had a disability or long-term condition. With Band 7 having 12.3% of colleagues with a disability, this was the highest proportion out of all Bands 1 – 7, equally this was the second lowest proportion of Rising Stars. Further work was being undertaken in these areas.

Our findings

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

The trust had structures, systems, and processes to support the delivery of its strategy including board committees, divisional committees, and team meetings. There was an established set of board committees and arrangements for reporting to the Board. Meetings were replicated and standardised from ward to board.

The company secretary had been in post since 2022. They had good oversight of the board assurance framework (BAF) and were responsible for organising the board papers and committees. Management of the BAF sat within the chief nurse's portfolio.

Since the last inspection the trust had reviewed committee papers. Governors now received copies of the Board agendas and chairs reports from the private board meetings. The Chairs Report (Part I) provided an overview of items discussed in the previous Board meeting (Part II). Chairs reports from subcommittees were included in Part I of Board. Since August 2020, the Board Assurance Framework (BAF) had been reported in Part I of the Board. The Board had developed the format in which the BAF was reported, to ensure it was accessible to the public and the governors.

An external risk and assurance review 2022 was positive overall about the trust's governance arrangements with some recommendations to improve the effectiveness of board committees and reporting lines. In response to the review the trust was looking to create a risk management group to strengthen the discussion of risk in the trust.

This would mean escalation of high risks scoring 15+ from divisions into the group and then into committees of the Board instead of through the Senior Leadership Team meeting. The meeting would start in August 2023 in line with the annual review of the Risk Management Policy.

Operational accountability was through the divisional improvement forums chaired by the Chief Operating Officer.

The BAF identified risks to the implementation of the trust's strategy and was linked to relevant corporate risks. The framework was supplemented by a corporate risk register which captured significant risks and reported to the Board. Relevant sections of the BAF were allocated to each of the board committees for review with a focus on gaps and remedial action.

The trust's Risk Appetite Statement for 2022/23 outlined the level of risk the trust was willing to take to achieve its objectives. The risk appetite formed part of the BAF and was used to inform discussions about strategic risk. The Board had agreed the Risk Appetite Statement and Risk Tolerances would remain the same for 2023/24.

Performance against the corporate objectives was reviewed by the board. The objectives were aligned to the trust's strategic aims.

The Audit Committee was chaired by a non-executive director. This committee was responsible for providing assurance to the Board on the trust's system of internal control through independent review of corporate governance and risk management arrangements. The Audit Committee reviewed its effectiveness with input from the trust's internal and external auditors.

Our findings

The consensus from most staff attending the focus groups held by the CQC following the inspection was that governance structures had improved. Although in some areas with the greatest challenges staff reported that although issues were raised appropriately to senior levels of the trust, there was a perceived lack of priority to focus on the immediate service issues.

To support the governance agenda, in the last 12 months the trust had restructured the department appointing 2 Associate Directors, one of which was the Associate Director of Safety and Learning, with a supporting team.

Overall arrangements for financial governance were strong, with opinions from the internal auditors reflecting this position. The Financial Strategy and the Annual Plan (the Big Plan) were overseen at the Finance and Performance Committee and through the full Board in both workshops and formal Board meetings.

The trust has established a Transformation and Recovery board to strengthen the oversight of delivery of the transformation programmes. This reported to the Finance and Performance Committee. Enhanced financial improvement monitoring was in place with bi-weekly meetings to review delivery of financial improvement plan by division. This allowed for any blockages/decisions to be expedited. All meetings were attended by members of the executive team. There was development of a system wide financial recovery plan for September 2023.

The trust medicines governance committee focussed on all aspects of trust medicines safety, including audit, incident reporting and review providing a trust wide oversight of performance. Medicines assurance reporting and learning at directorate and speciality level had been strengthened. Pharmacy Teams aligned with the Divisional Triumvirates provided specialist support around performance and risks associated with medicines in the divisions.

In addition to the monthly medicines' safety reports shared at divisional Always Safety-First meetings, biannual Medicines Assurance Reports were submitted to Divisional Safety and Quality meetings. The trust Acute Pharmacy Team (ED and MAU) was also piloting speciality level medicine assurance reporting to stimulate specialty level data led discussions and gain agreement for improvement actions.

The trust's-controlled drugs accountable officer ensured that the required controlled drugs quarterly reports were submitted to the Local Intelligence Network.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks, but we found risks in the management of mental health patients were not always dealt with appropriately or quicky enough. There were other examples where we saw a breakdown in processes which led us to question the robustness of existing systems and wider organisational learning. Processes for ensuring that learning had been embedded were not always clear.

Not all patient safety incidents were reported to the national reporting and learning system in a timely manner.

The trust had plans to cope with unexpected events.

Our findings

In interviews with executives and senior leaders, they reported on the trust's top risks. These included finance, long waiting lists; workforce shortages and patient flow particularly its impact on the emergency department. This reflected the risks identified in the BAF.

The trust had significant challenges around elective recovery and performance against the 62- and 31-day cancer treatment targets, this meant the trust was in the lowest 25% of trusts nationally for these metrics. Though the trust had made progress, there was still much to do to achieve the new national targets. The trust had not yet delivered 6 of the 10 requirements set out by the NHS for cancer waiting lists and although they were making improvements with some of the cancer waiting targets, others were lengthy.

There were processes for risk stratification of the backlog for elective waiting lists. This included the harm review group which was chaired by the chief nurse and included characteristic based reviews for example patients with learning disabilities. The chief operating officer felt there was good visibility of waiting list numbers and patients. Oversight of priority codes were reviewed in the Performance Recovery Group and Trust Finance and Performance Committee

The trust delivered a financial deficit in 2022/23 following two years of breakeven or better and it was subject to a level of scrutiny through NHS England's Strategic Operating Framework level 3. The breakeven position in 2020/21 and 2021/22 was achieved largely due to the financial regime in operation during the COVID19 pandemic which ensured that provider costs were covered whilst the NHS was in the high levels of escalation. The trust has assessed its underlying financial deficit (before CIP) at c£91.3m.

For 2022/23, the trust's external auditor issued an unqualified opinion on the trust's accounts and for ensuring value for money. One significant risk relating to the trust's arrangements for ensuring financial sustainability had been identified. This was in relation to achievement of the financial plan and the significant levels of savings required in 2023/24. The Head of Internal Audit had issued a substantial assurance opinion for 2022/23.

Following a protracted planning process, the trust set a final plan for 2023/24 at a deficit of £15.3m which was a significant improvement on the initial submission of £65.2m deficit. This plan however assumed a total cost saving of £67m which was significantly higher than levels previously delivered. Whilst in the past, the trust had successfully delivered its cost savings programmes – albeit with significant non recurrent schemes – delivery of this level of savings in a single year was extremely challenging. Within this total was an element of system stretch (£18.5m) for which (at the time of the inspection) there had yet to be any detailed plans developed. The Trust's Financial Improvement Plan was transformational and included £37m savings in Urgent and Emergency Care bed optimisation and the de-escalation of beds opened to support ED pressures.

At the June Finance and Performance Committee FIP (Finance Improvement Plan) update a total saving of £27m was identified as being delivered or at low or medium risk, £17m high risk and £22m remaining unidentified. The financial plan also assumed a net reduction in staffing of c100 WTE.

During our inspection of urgent and emergency care at Preston we issued the trust with a letter seeking immediate assurance following review of 3 patients attending with mental health needs. This was specific to variations in the assessment of mental capacity, risk management plans not being completed, reduction in the risk to self-harm and documentation of routine observations following rapid tranquilisation. Working with the neighbouring mental health trust the trust had sent a response to the concerns raised. This included an action plan to mitigate the risks with fortnightly reports being sent to CQC. Performance showed assurance about the actions that were taken to address these issues.

Our findings

The trust had an Incident Management policy which was validated in April 2022. It was an interim policy due for review in October 2023 to accommodate the introduction of Patient Safety Incident Review Framework (PSIRF). The trust's proposed implementation date of PSIRF was October 2023.

The trust Safety and Learning Group met weekly and provided oversight and approval of incident investigations including inquests or other external scrutiny. There was good attendance of staff from across the trust at all levels.

However, although the systems for managing incidents and serious incidents was clearly identified and appeared appropriate, we found in maternity the service did not report all patient safety incidents to the National Reporting and Learning System (NRLS), in a timely way. This included 3rd and 4th degree tears and post-partum haemorrhage. However, we saw evidence that each of the cases were reviewed using a thematic review approach and discussed at specialty level governance meetings. The trust acknowledged this and would now report these incidents. The trust provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust had taken action to address this.

We reviewed 3 never events of inadvertent connection to medical air through a flowmeter. The first incident was 18 January 2022; this was not picked up at the time subsequently there were 2 further incidents in January 2023. The trust has taken steps to review and consider where the breakdown in processes occurred and the actions taken as a result. However, this led us to question the robustness of existing systems and wider organisational learning.

We looked at a sample of 6 incident investigation reports from different areas. We found staff support was inconsistent regarding the level of documentation provided in the reports. Organisational and learning across divisions was not always explicit. The process for ensuring that learning had been embedded was not always clear. But there was good involvement of the family in contributing to the terms of reference. The key contributory factors and incidental findings were all well analysed. Actions were generally completed within the timeframe.

A report was commissioned by the medicine division in response to the incidents that had been reported regarding the lack of a seven-day thrombectomy service at the Royal Preston Hospital. The trust was only able to operate the service for 5 days due to insufficient staffing levels over the weekend days.

An expert panel reviewed the impact on patients who presented because of the thrombectomy service not being available at the time of their presentation. 67 patients were reviewed, 8 out of the 22 patients who presented to Preston within the commissioned service hours had sustained severe harm because of the services not being available.

There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7-day week.

The trust had a safety and quality dashboard which was reported to the Safety and Quality Committee. This included positive and negative risk escalation data. It was used as a measure of performance and improvement for different safety metrics including staffing, falls and pressures ulcers. However, during our inspection of services such as medicine trust targets for pressure ulcers, patient moves, falls, stranded patients (14 to 21 days) and super stranded patients (21 days and above) had not been achieved, despite actions taken.

Our findings

The trust had a learning from deaths policy which was comprehensive and followed the nationally recommended template. It set out the processes for patients with a learning disability, infant or child death and still born or maternal death. The policy set out how to manage the 3 levels of scrutiny, with clear reasoning for each. The trust had achieved 100% scrutiny.

The process of reviewing deaths linked to the Adverse Incident Reporting Management and Investigation policy. The policy set out the reporting expectations both internally and nationally.

An annual mortality report went to the Safety and Quality Committee and up to the Board. The purpose was to provide assurance that governance arrangements were in place for the reporting, review and learning from patient deaths. The report was also considered by the Mortality and End of Life Committee.

We reviewed 9 structured judgement mortality reviews (SJRs). The purpose of the SJR is to provide information from which local teams or the organisation can learn. This approach requires reviewers to make safety and quality judgements over phases of care.

The SJRs reviewed used a standard template, using the recognised headings as set out in Royal College of Physicians (2016) Using the Structured Judgement review method Royal College of Physicians. The systems and processes were in line with national guidance and from the sample reviewed the processes were being followed.

There were 12 medical examiners (ME) covering 15 sessions. The ME showed us the learning from deaths process on the 'live' system.

The ME went through 6 reviews, which were completed in line with the trust policy. Examples of raising an incident report and requesting a structured judgement review were noted.

The MEs provided internal reports and reported quarterly to NHS England. Work had started on comparing completed ME reports against SJRs to provide additional assurance.

The trust had an accreditation system to monitor and assess standards in clinical areas across the trust called the safety triangulation accreditation review (STAR) quality assurance framework. The 2022/23 STAR annual report showed of the 126 clinical areas registered there was an increase in silver ratings from 76% to 82% against a target of 75%. There were 54 clinical areas who had achieved gold ratings. The themes identified correlated with CQC inspection findings of inconsistent mental health assessments and infection prevention and control.

The trust had an annual clinical audit and effectiveness plan for the year which incorporated national audits, corporate audits, audits for the trust wide priorities and audit of national guidelines. Audit plans and actions were reviewed by the audit committee.

The chief nurse was the executive director for safeguarding adults and children. There was a clear accountability structure for safeguarding from operational level to the Trust Board. The deputy chief nursing officer was the operational lead for safeguarding and managed the lead for safeguarding children and adults.

There was a named lead for mental health, autism and dementia with practitioners that sat under these. The trust recently appointed an occupational therapy practitioner for people with dementia, the post gave a different perspective and additionality to the team. The head of safeguarding post had been vacant since March, this had been appointed to.

Our findings

An annual safeguarding report was presented to the Board. The team reported good external overview with partners including collaborative working with system partners such as the police, and other safeguarding teams in the local authority multi agency services.

Safeguarding teams worked across the Preston and Chorley sites. The chief nurse and deputy chief nurse met with clinical leaders each week to share learning and information. There were 20 external safeguarding boards which aligned with the trust, it was acknowledged this was too large and the trust was working with the ICS to review the safeguarding agenda.

The director of infection prevention and control (DIPC) was a microbiologist and reported to the deputy chief nurse. The DIPC was supported by a team of senior nurses and doctors. The Associate Director of Infection Prevention Control post was currently vacant. The IPC committee reported to the Safety and Quality Committee, which then reported to the Board.

The prevention of C. difficile infection was a key priority for the trust. In the year 2022/23, the national objective set by NHSE for the trust was no more than 122 hospital associated cases. There was an increase in hospital associated cases during 2022-23 in comparison to previous years with a total of 196 cases. The trust ranked highest of major trusts for C. difficile rates per 100,000 bed days.

All cases were reviewed by the infection prevention control team. Some of the common themes were poor hand-hygiene audit results, delay in isolation and non-compliant antimicrobials. The trust was working with IPC leads in the Northwest to address these areas.

To support continuous improvement mandatory medicines management training was kept under review and refreshed to include learning identified through incident reports and medicines audit.

The risk that essential pharmacy services would 'not be fully provided due to gaps in Pharmacy Staffing Pharmacy' was captured on the trust risk register (Score 15 – High Risk May 2023). In addition to clinical risk-based deployment of staff, the trust was collecting baseline data for example, to demonstrate the impact of pharmacy support as service demand increased for example in AAU.

The antimicrobial stewardship team (AMS) team undertakes quarterly prescription audits to promote good antimicrobial stewardship. The Trust reported good overall compliance with documenting the indication and choice of antimicrobial.

The AMS Team provided feedback to specialities with low compliance and action plans were completed.

The trust achieved the 4.5% reduction in use of antimicrobials which fall into 'Watch' and 'Reserve' categories (as defined by the World Health Organisation) from 2018 baseline (NHS Standard Contract 2022-23). Additionally, the antibiotic guidelines for sepsis of unknown origin had been reviewed to optimise choice of antimicrobials, whilst minimising the use of medicines most associated with increased risk of infection with Clostridium difficile.

The trust scored below average in the CQC adult inpatient survey question: 'If you brought medication with you to hospital, were you able to take it when you needed to'. The trust self-administration policy was under review focusing on medicines where timing was important to ensure most benefit from the medicine.

Our findings

There were continued challenges around the maintenance of an aging estate and compliance with the latest statutory guidance. There were 26 operational risks on the risk register relating to the estate some of which were from 2017. The Director of Estates reported high levels of backlog maintenance. The trust used a risk-based approach to prioritise high, medium and low risk areas. The largest risk was the main hospital drainage system. The cost of completing all the tasks was estimated to be in the region of £60 million. Resource constraints were evident in the condition of the estate and frustrations were expressed at the lack of capital for renewal of key infrastructure.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had a digital strategy which had been signed off by the Board. Updates were reported to Finance and Performance Committee every six months. The trust worked closely with the ICB digital priorities for the ICS which included programmes the trust was leading on. Each digital project was monitored and included success measures and any risks or issues. The trust was mostly on track for each project.

The management of information was said to be fit for purpose. Operational teams had access to the trust's safety surveillance system which gave a range of information in real time to support them with their management role. This included information on the performance of the service, staffing and patient care.

The format and content of the performance reports had been revised and included the use of statistical process control (SPC) charts in line with good practice.

Then trust made good use of electronic systems and data to support medicines optimisation and was continuing to develop business intelligence reporting to track medicines optimisation activity at ward level.

The use of a web-based audit tool meant that compliance with medicines safety and controlled drugs audits and actions was easily and immediately accessible to clinical areas. Audit findings were also shared at divisional 'Always Safety First' meetings.

The trust made good use of medicines optimisation data from the electronic patient record and prescribing systems. Development of a 'live data' pharmacy clinical prioritisation tool enabled the targeting of clinical pharmacy capacity based on the risk of medicines related harm.

The trust had also successfully delivered a 'safety first' improvement programme to reduce missed doses of critical medicines to ~2%, tracked via EPMA (electronic prescribing and medicines administration) data informing a Business Intelligence App. Continuous improvement methodology had also improved compliance with oxygen prescribing with the roll out of a digital solution.

Electronic prescribing was not yet fully rolled out to maternity, paediatrics, and neonates.

The information governance steering group reviewed incidents on information governance breaches. These were reported to the Finance and Audit Committee. There were 300 incidents reported in the last 12 months, 4 of which were referred to the Information Commissioners Office, no further action was needed.

Our findings

General Data Protection Regulation arrangements were embedded.

All board members were required to complete Information Governance and Data Security as part of the NHS Data Security and Protection Toolkit (DSPT). As of April 2023, all Board members were compliant with training as reported in the 2022-2023 DSPT.

Information technology systems were secure, to prevent unauthorised access to information. Cyber security updates were presented to the Finance and Performance Committee, including the controls, improvements, and challenges.

The Caldicott Guardian worked with the senior information risk owner and processes were in place to ensure data was protected.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had refreshed its Patient Experience and Involvement Strategy 2022-2025 which was developed with patients, relatives, staff, and partner organisations. The strategy aligned to the trust ambition to consistently deliver excellent care to patients. The board received an annual patient experience report.

The new patient experience lead had been in post for 5 months and was driven and focused to deliver the strategy.

Each clinical and several administrative areas had trained patient experience champions. The trust held 2 champions events in partnership with advocacy services, patients, and colleagues. The days were used to emphasise the importance of the patient's voice and 140 champions had signed up.

There were several patient forums which enabled the trust to understand the experience felt by patients and work with them to ensure pathways and services were designed to meet expectations. Examples of improvements through the forums included ward activity boxes, design of the new renal centres and Lancashire eye centre, multi-faith guidebook and patient contribution to the policy for registered assistance dogs.

There was a well-established patient experience and involvement group. The group focus was on the services within the hospital and through working with representatives from departments and external representation. This included, Lancashire Carers Service, Healthwatch, and patient and carer voices.

The trust had a three-year plan to support patients who had a learning disability. The plan was led by patients, family, carer, and staff feedback. The trust held annual 'Our Health Day' events, these were co-produced with people with a learning disability to inform the community about different health needs, and to ensure access and reduction of health inequalities. However, there were some areas which were behind with the Oliver McGowan statutory learning disability and autism training.

Our findings

The trust had 371 volunteers who worked across both sites. The trust had a recruitment and induction process for volunteers.

The board recognised the importance of partner organisations to support them in providing safe and effective care. Engagement with the integrated care system and integrated care partnership had increased. The integrated care board linked with the trust involvement lead to ensure wider promotion and delivery of engagement and feedback with patients and relatives.

The trust worked closely with the local NHS mental health provider and was part of several joint groups and meetings.

The chief pharmacist was engaged with ICB pharmacy and medicines optimisation forums including medicines governance, workforce, and aseptic services. The ICS has taken a collaborative approach to the roll out of the NHS Discharge Medicines Scheme across ICS footprint, with roll out at the trust planned for August 2023.

Staff Engagement

The trust's People Plan 2023-2026 was aligned to the trust's vision, strategy, and objectives and set out 6 strategic aims. One of the key strategic aims of the Workforce and Organisational Development Strategy was to 'engage, retain, reward, and recognise colleagues. The strategy had been developed with staff engagement and feedback from national staff surveys and cultural values assessments. Progress against the strategy was monitored by the Workforce Committee.

The trust had developed and used a team engagement and development tool (TED) to support improvements in levels of team satisfaction and engagement as measured through the trust annual staff survey. The tool was embedded across the trust into a range of areas such as leadership development programme, continuous improvement programmes and the Star Ward Accreditation programme. In 2022-2023 the trust completed 175 TEDS, which engaged with 1,523 colleagues. The tool had been recognised by NHSE as an example of excellent practice and the trust was supporting other organisations to do this.

The trust's staff engagement score was 6.9 which was above the national average. Satisfaction had mostly improved regarding motivation and involvement. The trust performed higher than the average in 3 questions on motivation with a 3% increase from 2021 in response to 'colleagues often/always look forward to going to work' (56%). Staff feeling able to make improvements had also increased by 3% compared to 2021.

Satisfaction had fallen by 2% to 60% (and below the national average (61%)) in response to the question 'if a friend/ relative needed treatment, they would be happy with standard of care provided by organisation'. The trust had identified areas for improvement and developed action plans which were monitored and reported to the Workforce Committee.

There were various engagement channels and activities. Staff had opportunities to meet with the executive team to hear about the latest developments and ask questions. The CEO and senior leadership team visited areas in the trust, and this was reported in the CEO's Monday Message recognising teams and showcasing learning.

The chief pharmacist was engaged with ICB pharmacy and medicines optimisation forums including medicines governance, workforce, and aseptic services. The ICS has taken a collaborative approach to the roll out of the NHS Discharge Medicines Scheme across ICS footprint, with roll out at the trust planned for August 2023.

Our findings

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. The trust had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust showed strong commitment to continuous learning, improvement, and innovation. Continuous improvement programmes were aligned to the trust's Continuous Improvement Strategy.

There was an experienced Director for Continuous Improvement and Transformation and a team of professionals trained in line with the national improvement dosing formula to deliver the organisations improvement strategy at department, pathway, and system level, along with executive sponsors for different work streams.

The trust's approach to continuous improvement aimed to deliver improvements at macro (organisational and system), meso (pathway) and micro (local wards and departments) levels. Each division took part in continuous improvement programmes and activities.

The trust was part of the Health Foundation funded Flow Coaching Academy. Since the last inspection in 2019 the number of coaches had increased from 10 to 60, from different areas and professions with a further 21 coaches in training this year. The trust has also made a submission to this year's Patient Safety awards for the Microsystem Coaching Academy programme.

Training on continuous improvement was delivered as part of all accredited leadership programmes to train leaders in basic improvement skills and raise their awareness of continuous improvement methodology.

There were also two newly created posts for clinical fellows appointed to the continuous improvement team in the last 6 months. This had expanded clinical leadership capacity and capability to support safety improvement work and organisational learning, including the work to improve 'Safety II' learning.

We saw continuous improvement was starting to flourish and embed across the organisation with several programmes and projects already established resulting in positive outcomes.

The trust was working with the ICS, other trusts and in partnership with the Engineering Design Centre from the University of Cambridge to test their 'Engineering Better Care' model. The trust had adopted this approach and was currently applying the model to 3 programmes. Frailty, thrombectomy and complex death notifications.

There was evidence of integrated working across the ICS. For example, medical staff from paediatrics and community paediatrics were involved with the ICS working on a project to introduce a new neurodevelopmental assessment pathway across Lancashire and South Cumbria. There was also a project looking at Physical Neurodisability to establish consistent working across the ICS.

Regular meetings were held with the Northwest Coast clinical research network to look at equity of research access and funding for all patients in the ICS. The trust had a specialty lead for cancer research and site-specific tumour research leads in the network.

Our findings

The trust had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. Data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

The trust has been participating in a Magnet4Europe research study for 4 years. The aim of the research programme was to gain insight into how hospital care may be improved. Clinical staff from nursing and medical professions were invited to participate in the survey to benchmark against the other 14 trusts taking part from England and organisations from across Europe.

The outcomes from both the 2021 and 2022 survey showed the trust was the top scoring UK hospital and third of 67 European hospitals for nurses rating overall safety on their ward or unit. When rating the quality of care delivered nurses rated the trust second of 14 UK hospitals and fifth of sixty 67 European hospitals**.**

Since June 2019 the trust had established 'big rooms'. This programme used an evidence-based quality improvement methodology involving a wide range of staff of different disciplines. Examples included national improvement collaborative for frailty within renal patients, patient flow, and mental health.

To support delivery of the "Our Culture Counts" workplan, the trust had committed to using a culture diagnostic tool to support measuring, reviewing, and acting on its organisational culture. This proactive approach allowed the trust to manage its understanding of its culture, using data driven insights to develop organisational and team culture.

The trust had been awarded the NHS Pastoral Care Quality Award recognising the quality and delivery of pastoral care for 600 internationally educated nurses and midwives.

The trust had processes to ensure managers and leaders at all levels reviewed complaints alongside other forms of feedback. They were responsible for ensuring action was taken on identified learning arising from complaints so that improvements were made to services.

Overall responsibility and accountability for the management of complaints was with the chief nursing officer on behalf of the chief executive. The head of patient experience was responsible for the daily management of complaints and currently triaged all complaints to understand the issues and themes.

The trust held weekly complaints update meetings with each division to monitor progress and support timely completion. The weekly Safety and Learning Group also included an agenda item where updates on complaints and concerns were discussed, and any actions captured and tracked. Learning from complaints was evident and appropriate actions for wider learning taken.

Between 1st May 2022 – 30th April 2023 of 436 complaints identified trust wide 36 complaints were upheld following investigation. There were 6 referrals to the PHSO, of which 5 were still being investigated and 1 was not upheld. The main themes from complaints that ran across all divisions were communication, consent, confidentiality, clinical assessment, and nursing care.

At the time of inspection 24 complaints were breaching timescales to respond. This was being addressed and numbers were to be cleared within 4 months.

Our findings

We reviewed a sample of complaints from across the trust and saw the trust supported people to make complaints. Themes and trends were identified from complaints and lessons learned were noted and shared with staff. The number of complaints had reduced by 93 when comparing 2021/2022 and 2022/2023.

During 2022/2023 2,664 compliments were received.

There were plans (2023/24 Q2) to bring pharmacy, ward-based nursing teams and matrons together using a Rapid Improvement Cycle' (RIC) approach to drive improvement in performance against key medicines management metrics on the wards including medicines audits, medicines reconciliation, and performance in the pharmacy clinical prioritisation whiteboard.

The trust sepsis guidance had been reviewed to adopt new guidance released by the Academy of Medical Royal Colleges in May 2022. The sepsis audit had been updated to reflect new sepsis tool rolled out at the end of November 2023. Although performance against the previous standards was maintained, compliance with the new standards was poor. Then trust was using continuous improvement methodology to better understand the current situation and performance to inform, implement and sustain change.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chorley and South Ribble Hospital	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023
Royal Preston Hospital	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023
Finney House	Requires improvement Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Requires improvement Aug 2022	Requires improvement Aug 2022
Overall trust	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Chorley and South Ribble Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Nov 2019	Good Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019
Critical care	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
End of life care	Good Nov 2014	Good Nov 2014	Good Nov 2014	Outstanding Nov 2014	Good Nov 2014	Good Nov 2014
Surgery	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Urgent and emergency services	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023
Maternity	Requires Improvement ↓ Nov 2023	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good →← Nov 2023	Good →← Nov 2023
Outpatients	Good Oct 2018	Not rated	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023

Rating for Royal Preston Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good ↑ Nov 2023	Requires Improvement →← Nov 2023
Services for children & young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Critical care	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
End of life care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Surgery	Good →← Nov 2023	Good ↑ Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023
Urgent and emergency services	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023
Maternity	Requires Improvement ↓ Nov 2023	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good →← Nov 2023	Requires Improvement ↓ Nov 2023
Outpatients	Good Oct 2018	Not rated	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023

Rating for Finney House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Requires improvement Aug 2022	Requires improvement Aug 2022

Chorley and South Ribble Hospital

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Description of this hospital

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Our findings

- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Leaders showed adequate experience, knowledge, and skills to run the service. They mostly understood and managed the priorities and issues the service faced, however during some, interviews leaders could not clearly or consistently articulate certain business details.

Some staff felt leaders were less visible in services where there were greater pressures.

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks and identified actions to reduce their impact. However, during our inspection of urgent and emergency care we issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly and shows assurance about the actions that were taken to address these issues.

Also, following our inspection of maternity and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The trust supported staff to develop their skills and take on more senior roles. Mandatory training for medical staff needed improvement.

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

Urgent and Emergency Care

This emergency department was classed as a type 1 service.

The department had 16 individual bed areas to care for patients. These were a combination of cubicles with doors and spaces with privacy curtains. These were designated as majors and included a resuscitation area. The service was co-located with an urgent care centre where services were delivered by an independent healthcare provider for adults and children 24 hours a day, seven days a week.

Our findings

At the time of the last inspection, the emergency department treated both adults and children. However, the service is now available for patients over the age of 18 years between 8am and 8pm daily. This included minor injuries. Patients needed to attend the trusts emergency department in Preston when the Chorley department was closed. All children, requiring emergency care and treatment both for illnesses or accidents needed to attend the emergency department at Preston or other hospital that had an emergency department that accepted paediatrics.

We visited the service as part of our unannounced inspection on 26 June 2023. We inspected the urgent and emergency care services at the hospital as part of a trust inspection. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The inspection was carried out by two CQC hospital inspectors, a medicines inspector, and a specialist advisor. We observed care, spoke with eight patients and their relatives, reviewed care records for four patients. We spoke with 18 members of staff of different grades including nurses, doctors, allied health professionals, support staff and senior managers.

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, offered patients food and drink, and gave them pain relief in a timely manner. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week between 8am and 8pm.
- Staff treated patients with compassion and kindness, did not always respect their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it, between 8am and 8pm, and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff generally felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- We found that not all staff, particularly medical staff had completed all mandatory training requirements.
- We found that there were consumables, in the resuscitation area that were passed their expiry dates and the airway drawer in the emergency trollies were overcrowded. The transfer bag, for emergencies, was not included in daily checklists.

Our findings

- We observed consultations with patients and their families that were overheard by other patients. Noticeboards, that were visible to public visitors included patient identifiable information.
- The cubicle identified as the room to support patients with a mental health concern included equipment that could be used to cause self-harm.

Maternity

We inspected the maternity service at Chorley Birth Centre, at Chorley and South Ribble District General Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Chorley and South Ribble District General Hospital is 1 of 2 sites for maternity services for the trust. Chorley Birth Centre is a stand-alone midwifery led unit adjacent to the hospital in Chorley, Lancashire. The birth centre has 3 ensuite birthing rooms with birthing pools and 2 clinic rooms. It is staffed by the continuity of carer team who provide a continuity of carer service to women and birthing people across Lancashire, as well as staffing the birth centre. Between June 2022 and May 2023 there were 186 births at Chorley Birth Centre, which is 4.5% of all births at the trust.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Following our inspection and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust. The letter of intent requested further information around delays within reporting incidents and the grading of incidents. The trust responded quickly to the concerns raised and provided the required assurances.

We also inspected 1 other maternity service run by Lancashire Teaching Hospitals NHS Foundation Trust. Our report is here:

Royal Preston Hospital – https://www.cqc.org.uk/location/RXN02

Our rating of this service stayed the same. We rated it as good because:

- Staff received training in key skills, such as responding to obstetric emergencies.
- Staff understood how to protect women and birthing people from abuse and worked well together for the benefit of women and birthing people.
- The service controlled infection risk well.
- Staff assessed risks to women and birthing people, acted on them and managed safety well. They kept good care records. They managed medicines well.
- The service had enough suitable skilled, trained and competent midwifery staff to keep women, birthing people and babies safe from avoidable harm.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.

Our findings

- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

- Not all staff had training in life support, compliance with life support training was below trust targets.
- Staff did not always ensure all equipment was available, in date and safe for use.
- The service did not consistently report incidents to the National Learning and Reporting System (NRLS) in a timely manner.

Maternity

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, not all staff had completed required life support training.

Staff were up-to-date with mandatory training. Mandatory training compliance for midwifery staff was good across most modules with overall compliance at 91%, against a trust target for training compliance of 90%. However, the service did not split mandatory training compliance data by location, therefore we could not ascertain if areas of lower compliance related to maternity services at Chorley Birth Centre.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency and skills and drills training. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Midwifery staff compliance with CTG update was 99%, CTG and fetal monitoring competency was 99% and CTG equipment competency was 99%

The service had a practice development midwife who supported staff to access training and facilitated face to face fetal monitoring, obstetric emergency and public health training days. Staff told us the annual training day included human factors training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff completed regular skills and drills training. Ninety-nine percent of midwifery staff had completed obstetric emergency training.

Staff told us they completed skills and drills in pool evacuation. However, the service did not provide information to show that staff had completed pool evacuation training or compliance rates. Therefore, we could not be assured there would be enough staff trained to evacuate women, birthing people and babies from the birthing pool in an emergency.

However, not all midwifery staff had completed required resuscitation training. For level 2 immediate life support, only 66% of midwives had completed the training and only 64% of midwives had completed paediatric immediate life support training. Newborn life support was included in mandatory multidisciplinary team obstetric emergency training. This meant that staff did not have the appropriate level of training to provide lifesaving treatment to women and birthing people and babies in their care.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Level 3 safeguarding training was provided to staff in line with national intercollegiate guidelines. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training.

Nursing and midwifery staff compliance with training targets was 95% for safeguarding adults and children level 3. This met the trust target.

Support staff/unregistered nursing staff completed level 2 safeguarding adults and level 3 safeguarding children training. The compliance with training targets was 100% and 94%. This met the trust target.

However, the service was not able to split safeguarding training compliance data by location, therefore we could not ascertain exact compliance rates for staff at Chorley Birth Centre.

The service had not yet fully implemented the Oliver McGowan Learning Disability e-learning. This is required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. At the time of the inspection the service had not yet fully implemented the Oliver McGowan or equivalent learning disability eLearning. This was required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The service provided information that showed the training had been agreed by the trust. Following the inspection, the service provided information which showed staff had met the trust target in learning disabilities, autism and neurodiversity training."

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. They told us the Enhanced Support Midwifery Team (ESMT) provided support and were always available for staff to turn to when they had concerns. All staff said the ESMT team were very accessible and contacted the birth centre daily, also attending the daily huddle. Staff could access safeguarding supervision through this team.

The safeguarding team and maternity services had developed and piloted "HOPE" boxes for those women who were separated from their babies either permanently or temporarily. This was being used across local maternity and neonatal systems (LMNS) and nationally to support loss and grief for mother and the child if a long-term separation is the final outcome.

The lead midwife for safeguarding represented the trust at the ICON babies cry, you can cope task and finish group within the local area, which then fed into the national ICON steering group. ICON provided key messages and awareness to women, birthing people and their families to show babies crying is normal and there are methods which could be taken to help parent and families' cope. To educate parents and to reduce head trauma in babies.

The service worked with local partnerships to provide community based simulation training to support midwives to recognise areas of risk and safeguarding concerns during home visits. For example, post-natal follow up care

Care records detailed where safeguarding concerns had been escalated in line with local procedures. Where safeguarding concerns were identified women and birthing people had birth plans with input from the ESMT team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse. This was a mandatory field in the electronic records system and was completed in all 3 records we reviewed.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics, for example by holding additional parent education sessions and workshops for parents who needed additional support.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy. We saw how babies were tagged with an electronic tag which shut down the doors if baby was moved past a certain point. The birth centre was secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The birth centre was visibly clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards.

The service generally performed well for cleanliness. The birth centre had dedicated domestic staff. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw cleaning checklists were completed in every room.

The service had effective processes in place to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and saw action plans developed to improve compliance with infection prevention and control standards. Actions were monitored through the divisional infection prevention and control meetings.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed ‘bare below the elbows’ guidance. Each birthing room had hand wash sinks with posters displaying correct handwashing technique and alcohol hand gel dispensers. The service had effective processes in place to monitor hand hygiene. We looked at the audit for March to May 2023 which showed 100% compliance in all areas.

Staff cleaned equipment after contact with women and birthing people. Staff completed checklists to show equipment in the birthing room was cleaned after use. They used green ‘I am clean’ stickers to indicate equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment was checked regularly to ensure it was available and safe.

The birth centre was situated in a residential area adjacent to the hospital with a secure entrance and exit. It opened in December 2021 and was specifically designed as a birth centre to meet the needs of women and birthing people. It had 3 birthing rooms with birthing pools, chairs and equipment and 2 clinical rooms. The rooms were large, nicely decorated and well maintained. Birthing rooms had adjustable ambient lighting and built in Bluetooth speakers for women to play their own music during birth.

Access to the unit was through a buzzer, which was monitored by staff. The premises were also monitored by CCTV. Staff told us they never lone worked within the birth centre.

The service had suitable facilities to meet the needs of women and birthing people and their families. The birth partners of women and birthing people were supported to attend the birth and provide support and there was no restriction on the number of birth partners allowed. Each birthing room had a fold away double bed so families could stay overnight. There were kitchen facilities for women, birthing people and their families to use and designated free car parking spaces. Women, birthing people and their families could access a well-kept, secure garden area.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

Staff regularly checked birthing pool cleanliness. All water outlets had an automatic flushing system to prevent the spread of legionella and the estates team visited regularly to test the water supply for legionella.

All birthing rooms had piped oxygen and nitrous oxide, as well as portable cylinders which were securely stored. There was a nitrous oxide scavenging system in place in each birthing room. Midwives were tested earlier in the year for nitrous oxide exposure and no high readings were found.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins in an external secure compound while waiting for removal. Porters collected the clinical waste 3 times a day Monday to Friday and daily at the weekend.

Staff carried out daily safety checks of specialist equipment. However, we found out of date and missing equipment and the adult resuscitation trolley was not secure. Though it was stored in line with Resuscitation Council (UK) guidelines with the drawers closed with a tamper evident tag, the tag had been incorrectly attached and the serial number recorded incorrectly. This meant the trolley drawers could be accessed without breaking the tag and there was risk unauthorised people could access the drawer and remove equipment without staff being aware. We informed a senior midwife who took immediate action to ensure the trolley was correctly sealed and the tag number recorded. We found 2 out of date syringes on the emergency trolley and a saturation monitor missing from the neonatal resuscitaire. We informed a senior midwife who removed the out-of-date items and replaced the missing monitor immediately.

The service mostly had enough suitable equipment to help them to safely care for women and birthing people and babies. The service had a system to monitor equipment safety checks completed and due. All new equipment underwent acceptance testing and was placed on an asset database which generated a schedule for preventative maintenance. We reviewed records of portable appliance testing and saw 100% had been completed.

However, we found some out-of-date items including pool evacuation nets and fire extinguishers beyond their service date. The birth centre had 2 pool evacuation nets stored next to the emergency equipment trolleys with labels stating they should be serviced every 6 months by the manufacturer and not used beyond their service date. Both were 6 months overdue the manufacturers service. We informed a senior midwife who removed the nets and the service took immediate action to purchase 3 new nets to arrive that week.

There were 4 fire extinguishers in the birth centre and labels indicated they were last serviced in October 2020. We escalated this immediately to managers. They explained annual checks of fire equipment were carried out by an external contractor and overdue checks monitored by the fire safety officer for the trust. They arranged for the contractor to carry out checks on the extinguishers that week.

Maternity

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Risk was assessed at each maternity contact/appointment. We reviewed 3 maternity care records. In each record, risk factors had been defined and identified at the booking appointment, and risk assessments were completed at each maternity contact. This ensured women and birthing people were allocated to the right pathway so the correct team were involved in leading and planning their care.

The service had clear criteria for staff to assess if women and birthing people would be suitable to give birth at the birth centre. The operational guideline for Chorley Birth Centre gave clear guidance to staff which supported women and birthing people's choice and outlined the risk assessment and planning place of birth processes. There were also clear guidelines for the transfer of care due to maternal condition or an obstetric emergency. All women and birthing people who wished to use the birth centre, but did not meet the guidance, were reviewed by a consultant midwife or obstetrician and a multidisciplinary team plan put in place, which was reviewed regularly with the woman or birthing person and consultant midwife.

The service achieved 100% compliance with provision of one to one care in labour between September 2022 and April 2023.

The service used a nationally recognised tool called Maternal Early Warning Scores (MEWS) in detecting the seriously ill and deteriorating. The MEWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. The audit of MEWS completion and escalation between April and June 2023 did not include Chorley Birth Centre. However, we saw these had been appropriately completed in records we reviewed.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used a situation, background, assessment and recommendation (SBAR) tool to hand over care to staff at the obstetric led unit. The service did not provide an audit of compliance with SBAR completion for Chorley Birth Centre.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn observations using track and trigger system (NOTTS) is designed to be used by healthcare professionals working in areas caring for newborns in the early postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NOTTS completion. We looked at the audit for the April to June 2023 and found 29% of observations were not performed on time. Most delays were for observations due to be performed within the first hour of life and at 12 hours. The audit identified 100% compliance with appropriate escalation to the neonatal team. However, it was not clear which maternity service location the audit results related to.

Staff knew about and dealt with any specific risk issues. Midwives used intermittent auscultation to listen to the fetal heart rate during labour. This was peer reviewed every hour by another midwife and if any concerns were identified a telephone consultation held with the obstetric led unit at Royal Preston Hospital.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The birth centre had remained open at all times since opening in December 2021.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough midwifery staff to keep women, birthing people and babies safe. The birth centre was staffed by a midwife and maternity support worker from the continuity of carer team, 24 hours a day, 7 days a week. They were overseen by a manager who managed the birth centre and continuity of carer team. A second midwife from the continuity of carer or community team was called in when a woman or birthing person attended in labour.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance. The service had completed a maternity safe staffing review at the end of 2022, which was reported to the trust board in July 2023. This showed the establishment of 8.4 whole time equivalent midwives for Chorley Birth Centre was allocated from within the continuity of carer team and this was in line with the requirements identified through the safe staffing review.

The birth centre manager had the resources to adjust staffing levels daily according to the needs of women and birthing people. There had been only 1 incident where a person was diverted to Preston Birth Centre due to Chorley Birth Centre being full since it opened in December 2021. The manager rostered staff at a monthly team meeting using a self-roster model, which staff reported was working well.

There were no vacancies in the continuity of carer team which staffed the birth centre. The sickness absence rate across all maternity services was 7.9% and the service was working to improve this through strengthened leadership, core roles and reward and recognition activity.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Ninety-one per cent of midwifery staff had received an appraisal. However, the service did not break down compliance rates by location, so it was not possible to ascertain appraisal compliance for this location.

A practice development team supported midwives. Staff told us the practice development midwife regularly visited the birth centre.

Managers made sure staff received any specialist training for their role. For example, 6 midwives had received professional midwifery advocate training with a further 3 being trained.

Maternity

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive and all staff could access them easily. We reviewed 3 records and found records were clear and complete. The service audited records every 3 months. We looked at audits and saw areas of lower compliance related to documentation of postnatal care at Royal Preston Hospital, not Chorley Birth Centre.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. The trust used electronic records which had a 'break glass' system to view electronic records held by other trusts. This system meant if a women or birthing person transferred to another team, even if that team was part of a different provider, the records were available to anyone providing maternity care.

Records were stored securely. Staff locked computers when not in use and had individual computer tablets to use in the birthing rooms.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines administration charts for medicines that needed to be administered during admission were completed in women and birthing people's electronic record. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff mostly stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

However, in the emergency trolley we saw intravenous plasma lyte stored, which had a sticker advising it should not be used as there was not a patient group directive (PGD). PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. We asked managers who told us the fluid was still available in the trolley as it could be used in an emergency via a verbal order from a doctor who would then prescribe after the event.

In the emergency post-partum haemorrhage (PPH) box we found misoprostol, which is a medicine which can be used in the treatment of PPH. However, staff told us midwives could not use this medicine as the PGD had expired and it was unclear why the medicine was still available. We escalated this to managers who told us they would take action to investigate and correct this.

We saw aromatherapy oils used during labour were stored in the medicine fridge alongside medicines. This is not in line with Royal Pharmaceutical Society guidance which stated fridges used for the storage of medicines should not be used to store any other items. However, the aromatherapy oils were packaged and segregated appropriately meaning there was little risk of cross-contamination. We escalated this to managers who contacted the trust pharmacy to gain further advice.

Maternity

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The birth centre manager attended key governance meetings such as perinatal mortality reviews to ensure learning from incidents across the trust maternity services was shared. They shared learning from incidents at regular team meetings.

There were no serious incidents in the last 6 months related to Chorley Birth Centre. However, staff could explain how to report serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff described learning from trust wide cardiotocography (CTG) monthly review meetings where any incidents which featured CTG were discussed and learning from those. Staff received a monthly safety briefing which included lessons learnt form incidents and investigations.

However, the service did not consistently report incidents to the National Learning and Reporting System (NRLS) and not all incidents were reported in a timely manner. We reviewed the maternity dashboard and saw the service reported a rate of 3rd and 4th degree tears of 2.7% up to May 2023. However, we reviewed NRLS for January to June 2023 and found only 4, 3rd or 4th degree tears had been reported.

We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measures to ensure all patient safety incidents were reported to NRLS. In the response, the service provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust took immediate action to ensure all staff reported incidents of 3rd and 4th degree tears to the online reporting system and that patient safety incidents were reported to NRLS accurately and in a timely manner in accordance with guidance.

Maternity

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The service was within the women's and children's division. This was led by a divisional director, divisional midwifery and nursing director, divisional medical director and divisional nursing lead for children and young people, also known as the 'quad'. The quad were supported through clear professional arrangements and had professional reporting lines to the medical director and chief nurse. Chorley Birth Centre had a manager who managed the birth centre and continuity of carer team and reported to the matron for midwifery led services.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. There was a divisional governance group in place which consisted of a divisional governance lead, 2 divisional governance facilitators and 2 band 7 governance risk managers. Relevant information was escalated to the relevant trust quality and safety committees.

Leaders were well respected, approachable, and supportive. There was a maternity leadership team which consisted of a clinical director, associate medical director, deputy divisional midwifery and nursing director, consultant midwife, clinical business manager and clinical governance lead. The leadership team also included the safety and quality matron, lead midwife for safeguarding, matron for midwifery led services, complex care matron and specialty business manager. There were clear lines of reporting from the maternity leadership team to the quad. The maternity leadership team managed a team of band 7 specialist midwives, managers and coordinators.

Leaders were visible and approachable in the service for women and birthing people and staff. The birth centre had a manager based at the centre who also managed the continuity of carer team. They were supported by the midwifery led care matron. Staff told us they were well supported by their line manager and matrons. They told us matrons and senior maternity leaders visited the birth centre regularly.

The service was supported by maternity safety champions and non-executive directors. Maternity safety champions carried out regular visits and walk rounds at Chorley Birth Centre.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy covered 2021 to 2024 and was called 'Our Big Plan'. It had been developed in consultation with key stakeholders and staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies, and we saw infographics about the strategy throughout the unit.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and revised the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity service strategy linked to the overarching trust strategy. Within the strategy the stated aim was to provide choice to women and birthing people by offering 4 places of birth, this included Chorley Birth Centre.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued**.** Staff were positive about the birth centre and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. The service provided an overview of the main themes from the most recent staff survey in 2022. They identified the lowest and highest scoring teams and analysed the reasons for those scores. The survey showed the maternity continuity team and specialist midwives were highest scoring teams in the division with high scores for working with colleagues and support from managers.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed people's care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Families we spoke to told us they were treated with dignity and respect by staff at Chorley Birth Centre.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. For example, they had used this data in the annual review of still births to identify any themes or trends for women, birthing people and babies from ethnic minority and disadvantaged groups. The service recently carried out a mapping exercise with the local maternity and neonatal system to look at how they could provide enhanced continuity of carer teams in geographical areas of greater deprivation or greater numbers of women and birthing people from ethnic minority and disadvantaged groups lived.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff could access translation services for women and birthing people when required.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There had been no complaints about the care received at Chorley Birth Centre between April and June 2023. We saw staff and services at the birth centre had been praised within some complaints regarding maternity services we reviewed.

All complaints and concerns were handled fairly, and the service used the approach ,most applicable to deal with complaints and progressed complaints through formal processes where appropriate. The service gave information about how to raise a concern in welcome packs in each birthing room. Staff understood the policy on complaints and knew how to handle them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a clear governance structure which outlined how key information and risks flowed from maternity speciality level through divisional committees, boards and improvement forums to the executives, board committees and board of directors. The divisional governance structure reflected the requirements of the Ockenden report. There was a clear structure for escalating higher scoring risks from divisional board to the trust board through the senior leadership team and board committees.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. This included metrics for Chorley Birth Centre. The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff. There were opportunities for managers to meet with the senior management team each month, and key areas including performance, staffing and incidents were discussed in these meetings. Staff and leaders could clearly articulate the governance framework for the division and how information flowed between maternity services and the board.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies we reviewed were in date, had clear review dates and referenced relevant national guidance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 safety initiatives. Within 2 safety initiatives there was an exception, 1 relating to one to one care in labour and the other to antenatal corticosteroids. The service had submitted action plans to board to address these areas an ensure they met required compliance levels. This meant they declared fully compliant with the scheme. We saw they provided sufficient evidence of their compliance to the trust board in February 2023.

Maternity

The service provided up to data to the national MBRRACE survey. The service was an outlier for still birth, neonatal mortality and perinatal mortality rates, for data submitted for 2021 and was more than 5% higher than the average for a similar trust in all 3 measures. The stabilised and adjusted still birth rate was 4.5 per 1,000 births, the stabilised and adjusted neonatal mortality rate was 2.09 per 1,000 births and the stabilised and adjuster perinatal mortality rate was 6.57 per 1,000 births. The neonatal mortality rate had worsened over the last 3 years of the MBRRACE report.

We reviewed board papers related to the MBRRACE survey. We saw the service had identified the increased still birth rate prior to the survey publication and carried out a review and identified no themes or trends. They identified the need to make improvements to triage and an action plan was in place for this. The service had a still birth outlier action plan which was monitored and updated regularly, and all still births were reviewed through the perinatal mortality review process.

The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

There was a system for local manager's audits which were recorded on the AMaT system. Managers gave examples of actions taken to improve audit results, for example refresher training with midwives to improve compliance with carbon monoxide monitoring at booking. There was a ward accreditation programme with Chorley Birth Centre currently rated as silver. The service had a action plan to address areas of lower compliance and improve the accreditation score.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. We saw changes following safety champion walk rounds were communicated to staff using a 'you said we did' format.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register in place. We reviewed the risk register and saw it identified 6 high risk, 9 moderate risk and 1 low risk items across both maternity locations, of these 2 risks related to Chorley Birth Centre as well as the rest of maternity services. These were risks relating to staff exposure to nitrous oxide and regular checks of neonatal emergency trolleys. Each risk was clearly defined with controls and assurances and any gaps in these identified. The risks aligned with challenges we found during our inspection and mitigating actions described by staff. Senior managers reviewed risks regularly and each risk had a clear set of actions taken to reduce it, with clear action owners and target dates. The risk register clearly outlined where action had been taken to address identified risks.

Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months and saw they comprehensively covered expected areas of safety and quality. This included clinical effectiveness, audits and performance dashboards, key risks including risk register review and safeguarding, incidents and lessons learnt, staffing and feedback from women, birthing people and their families. The meeting was attended by relevant managers, midwives and stakeholders and the Maternity Voices Partnership chair was invited to each meeting.

Maternity

The maternity and neonatal safety champions met every 2 months. We looked at meeting minutes for the last 6 months and saw they were comprehensive, with a set agenda aligned to the key lines of enquiry. They covered all key safety elements such as incidents, staffing, mortality reviews and equality and diversity. Clear actions were recorded in minutes and the dates for future safety champion walk rounds, which included Chorley Birth Centre.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators, and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

The information systems were integrated and secure**.** The service had a digital midwife to support staff accessing electronic information systems and they visited the birth centre regularly.

Data or notifications were consistently submitted to external organisations as required. The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that required local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity and Neonatal Voice Partnership (MNVP) to contribute to decisions about care in maternity services. The chair of the MNVP had left but the service was involved in the recruitment of a new chair and had engaged with the chair of a neighbouring MNVP to ensure women and birthing people’s voices were still heard in the interim. The MNVP had completed a 15 Steps visit and report and had been involved in the design of Chorley Birth Centre, attending the opening of the new building in 2021. Staff from the continuity of carer team had developed an infographic about latent labour for women and birthing people in collaboration with the MNVP and service users.

Maternity voices partnership engagement meetings were scheduled quarterly and included all key partners from health and the third sector. The service had a Maternity and Neonatal Voice Partnership (MNVP) work plan based on the

principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trusts. We reviewed the plan and saw all actions had deadlines set, were monitored and were fully or partly achieved. The service told us that once the new MNVP lead was appointed that actions would be adjusted to ensure that the plan was co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Leaders understood the needs of the local population. They took opportunities to engage with the local population and promote the centre as a birth option. Staff from the service had taken part in the Leyland festival, to promote birth options and key health promotion messages such as infant feeding. Staff had taken part in the pregnancy circles research project where midwives combined clinical care with antenatal education and peer support. This was done in partnership with local family centres and has shown group antenatal care has a positive impact on women's experiences of antenatal services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Quality improvement was routinely discussed at team meetings. We saw that what was not working well was discussed at team meetings for midwifery led services and staff engaged in conversation about their ideas and innovations. For example, during the Maternity Summit held in June 2023 the service held a 'Flashes of Brilliance' competition. This was to encourage staff to suggest service improvements or changes to way of working and encouraged staff to submit any ideas no matter how big or small.

Following a response from women, birthing people and their families the maternity service developed the maternity pregnancy schedule. The schedule provided information on the named midwife and consultant for women and birthing people. There were two pathways, one for a standard pregnancy schedule and the other was for women and birthing people who required multiple scans during pregnancy. The schedule provided information as to the pregnancy journey, including routine scans and antenatal checks.

The maternity service had developed and displayed a number of infographic information for women, birthing people and their families. This information was displayed throughout the maternity unit. Information displayed showed information learning posters on neonatal seizures, extreme prematurity, as well as sharing learning with families that had been developed from incidents. For example, aspirin in pregnancy and the importance of routine urine testing.

Leaders encouraged innovation and participation in research. The service was part of the Health Foundation Flow Coaching Academy Big Rooms & Microsystem Coaching Academy and meetings were held weekly. The purpose of the weekly meetings was to coach improvement and design tests of change, review results and plan next steps and action notes were taken to record improvement. A number of staff received training and coaching to lead and facilitate improvement at ward and department level through the microsystem coaching academy. This trained staff to be coaches trained to internal quality expert level (as defined in the NHSI national guidance). We saw examples of improvement projects led by these staff.

Maternity

The service took part in continuous improvement programmes and activities aligned to the trust-wide continuous improvement strategy for 2021 to 2023.

The service took part in wave 1 of the national MatNeo programme on the optimisation and stabilisation of the pre-term infant and shared learning regionally and nationally.

Urgent and emergency services

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however; not all staff had completed it.

Staff completed training as part of mandatory requirements, that were aligned to the core skills framework, with a trust target of 90% with the exception of information governance at 95%. All trust staff were required to complete conflict resolution, equality, diversity and human rights, fire safety, fraud and bribery in the NHS, health, safety and welfare, information governance, patient safety, and speak up - core training.

There were other modules specific to the emergency department (ED). These included moving and handling to level 2 for clinical staff, preventing radicalisation awareness, module for chemical biological radioactive nuclear explosion, consent, aseptic non-touch technique, medicines management, blood transfusion, vital signs scoring and care of the dying modules.

Nursing staff received and kept up to date with their mandatory training. Staff were allocated protected time to complete mandatory modules, although expressed concern that the reduction in the staffing establishment may impact on their ability to complete the training. Nursing staff were compliant with the trust target for all mandatory modules.

Medical staff received mandatory training, however; were only compliant with fire safety and equality, diversity, and human rights. Conflict resolution was 88%, fraud and bribery in the NHS was 68%, moving and handling level 1 was 84% and patient safety was 76%. An additional programme, of ED specific topics, had been prepared, by senior medical staff, and had been scheduled to commence from July 2023. There was a dedicated training room that had been identified where specific training, with necessary equipment, could take place in the department.

The trust had implemented an equivalent course to the Oliver McGowan learning disability e-learning. Compliance was not available at the time of inspection due to the inability to download this, however the trust has since confirmed compliance was 91% in September 2023.All clinical staff were required to complete level 2 adult basic life support (ABLS) and paediatric basic life support (PBLS). Overall compliance was below the trust target of 90% with medical staff at 71% and registered nurses at 83%. These figures were for both hospital ED sites.

Registered nurses completed level 3 immediate life support (ILS) training and level 3 paediatric life support (PILS) training. Compliance was 58% for ILS and 75% for PILS. For level 4 advanced life support (ALS) training and level 4 advanced paediatric life support (APLS) training, compliance for medical staff was 83% for ALS and 84% compliant for APLS. Registered nurses were 60% compliant for ALS and 53% compliant for APLS.

There were staff members on each shift who had competed advanced life support training (ALS) and advanced paediatric life support (APLS) training.

Senior staff told us there had been some delays in training due to the availability of courses. The trust reviewed staffing rotas and confirmed there were no incidents were there was no staff on duty that had not completed appropriate resuscitation training in the 9 months prior to inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training co-ordinator was based at the trusts other hospital site but had oversight of both trust hospitals. Staff we spoke with told us that they received email alerts when training refreshers were due.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff received training specific for their role on how to recognise and report abuse in line with intercollegiate guidance for adults and children. Registered clinical staff received safeguarding level 3 training for adults and safeguarding level 3 training for children. Other staff received safeguarding level 2 for adults and level 3 for children.

Registered nurses and other staff were compliant with the trust target for all levels of safeguarding. However, medical staff were 74% compliant with safeguarding level 3 for adults, 88% compliant with safeguarding level 2 for children and 71% compliant for safeguarding level 3 for children. This data was for both ED sites.

Between July 2022 and June 2023 there was a total of 16 safeguarding incidents of which 10 were adults and six were children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were supported by safeguarding specialists to ensure best practice.

Staff followed safe procedures for children visiting the department. Notice boards included safeguarding information for staff although it was not clear when last updated. Link nurses and champions had been identified for a range of responsibilities included safeguarding and domestic violence.

The trust completed safeguarding audits and reported 100% compliance in safeguarding vulnerable patients across both hospital sites in the six months prior to inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning schedules were in place and demonstrated that all areas were cleaned regularly.

Infection, prevention and control (IPC) level 2 was included in mandatory training requirements for all staff. Registered nurses were compliant with training, however; medical staff were 77% compliant against a trust target of 90%. For aseptic non-touch technique there was a compliance of 68% for medical staff and 91% for registered nurses. A link nurse had been identified to support IPC.

We saw that personal protective equipment (PPE), was readily available in all areas. Staff followed infection control principles including the use of PPE, hand washing and use of hand sanitisers.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed 'I am clean' stickers on equipment.

There were cubicles, with doors, that could be used when patients needed to be isolated.

The privacy curtains were disposable and included recent dates when last changed. Domestic staff told us that curtain changes were included in the deep cleaning of areas following the discharge of patients.

Staff we spoke said that IPC concerns had been included in initial feedback from an inspection visit at the trust's other hospital ED. We observed staff being reminded to maintain standards of hygiene following the handover meeting.

The service generally performed well for cleanliness. Across both ED sites, there was 100% compliance with control of substances hazardous to health (COSHH) audits and an average compliance of 84% for PPE and 80% for environment audits. Between December 2022 and May 2023 there was an average compliance of 97% for hand hygiene audits for this location.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe with the exception of consumables and the area for mental health patients. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The service was co-located with an urgent care centre that was managed by an independent provider.

There was a dedicated area, in the ED, where ambulances were received and another area where patients self-presented. There was one entrance for patients who self-presented, for the ED and the Urgent Care Centre (UCC. The reception area was divided for patients according to need.

There were hospital trolleys available to transfer patients from ambulance stretchers as well as an incubator for any babies in the department.

The service had enough suitable equipment to help them to safely care for patients. Equipment we saw had been maintained and serviced within the 12 months since inspection.

Patients could reach call bells and staff responded quickly when called. Patient call bells and emergency bells were present in patient cubicles.

Staff carried out daily safety checks of specialist equipment and a link nurse had been identified to support resuscitation and checks.

For one of the two emergency trolleys, we observed three omissions of daily checks in six months. We found consumables, in the resus area, that were passed their expiry dates. These included endotracheal tubes, intubation stylets, connector taps and bungs.

We escalated to senior staff, whilst on site. A full check of consumables was completed by trust staff and removed for disposal. Staff disposed of clinical waste safely and appropriately.

For the emergency trollies all equipment was within their date of expiry. There was a drawer that contained airway equipment. We observed that this drawer was difficult to open. We escalated on site and the contents were reviewed by trust staff.

Audits of emergency trolleys had been completed in December 2022, January 2023 and April 2023 with 100% compliance.

We were told that the combined adult and paediatric emergency trolley was under review either to include only essential paediatric emergency equipment or whether a separate trolley should be introduced.

There was a display board, in the resuscitation area, to support staff during a paediatric emergency, however this was positioned in an area where adults were treated rather than children.

There was an emergency grab bag that although was complete, was not included in the daily checks. This was escalated during the inspection.

There were no dedicated mental health suite facilities in the department. There was a cubicle that was nominated for patients identified with a mental health concern. This had two doors that were appropriate, however; there were items in the room that could potentially be used if a patient was at risk of self-harm. This same risk was identified at the Preston site during the inspection in 2022.

At Chorley, the cubicle was located next to the nurse's station and the door was kept open if a patient was present, which allowed staff to observe the patient closely. There were no toilet facilities in the cubicle meaning patients had to use the public toilets where there were potential self-harm risks.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Patients who self-presented were triaged by the urgent care staff that was managed by an independent health provider. There was a separate rapid assessment and treatment (RAT) area, where ambulances were triaged by department staff. There was prompt handover of patients who were transferred into the department.

The trusts patient safety surveillance dashboard for the ED's displayed data about patients and capacity in the departments. They included numbers in the department, patients who had a decision to admit, status of ambulances, nurse staffing, any patients identified with a mental health concern and patients that were potentially deteriorating using NEWS scores. The service could also view the whiteboard for Preston and for the urgent care centre.

Urgent and emergency services

Staff used the nationally recognised national early warning score tool (NEWS2) to identify deteriorating patients and escalated them appropriately. The NEWS score is a system for scoring the vital signs that are routinely recorded at the patient's bedside.

Staff completed training for NEWS2; with a compliance of 81% for registered nurses. For blood transfusion training, there was a compliance of 59% for medical staff and 81% for registered nurses. There was a compliance of 93% for staff who had completed sepsis training in the ED.

The trust monitored compliance with administration of antibiotics within an hour. There was an improving trend over the year with the latest quarterly results of 89% compliance.

The trust completed quarterly audits of NEWS2. Between April 2022 and March 2023, there was an average compliance of 87% for the emergency observations and fluid balance element and 82% for the critical care outreach team (CCOT) escalation element. Action plans to improve compliance where being monitored trust wide.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues including reporting sepsis, VTE, falls and pressure ulcers. We observed that, in the records we reviewed, risk assessments had been completed. There were yellow wristbands available for patients identified as a potential risk of falling as well as identification of an enhanced level of care.

There were link nurses that had been identified for sepsis and pressure area care. There were public noticeboards that displayed a variety of information including NEWS, pressure ulcers, blood transfusion, always safety first and mental health care.

The emergency nurse practitioners (ENP's) were available to support any junior members of staff in the event of an emergency. The ENP's saw, treated, and discharged all minor injuries for patients over 18 years old. Paediatric minor injuries were treated at Preston. Children with minor illnesses were seen in the urgent care centre. For maternity patients, there was a GP-led facility at Chorley; any obstetric emergency needed to attend in Preston.

There was an on-site intubation team who could be contacted if needed as well as the CCOT, based at the trust's other hospital.

The CCOT could either verbally review or provide support to the department if needed. There was a process in place for the safe transfer of patients both, adults, and children for acute physical or mental health concerns and actions to take dependent on acuity of the patient.

Senior leaders told us that children who self-presented at the department was one of their top risks for the department. The ED reviewed approximately 150 children a year that needed to be transferred to an alternative appropriate hospital location. Transfers were either self-presenting with family or by ambulance dependent on the assessed condition of the child.

Critically ill children continuing to present at this ED where there were inadequate paediatric facilities was included as a moderate risk in the ED risk register. There were staff, with appropriate skills, who were trained in the care, stabilisation and transfer of children if needed.

Urgent and emergency services

There were pathways, agreed with the local NHS ambulance service where patients identified with certain conditions, such as stroke or cardiac, were transported directly to the acute centre in the region. This could be the trust's other hospital location, a hospital within the integrated care system or wider in the North West. Patients presenting with stroke symptoms, for example, being conveyed by ambulance were directed to the trust's other hospital. Any patient self-presenting with stroke symptoms was urgently transferred by ambulance to Preston hospital.

There was a policy in place to transfer medical patients across the two locations as well as a standard operating procedure for handover of patients to the ED and urgent care centre whether self-presenting or arrival by ambulance.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed training in the mental health risk identification and management tool. There was 90% compliance for registered nurses. The mental health team were based at Preston. This meant that patients who required specialised assessment needed either to be transferred to the other hospital ED or be reviewed virtually on the trusts 'attend anywhere' service.

Following the inspection of the trust's other hospital ED, concerns were raised with the trust about the care and treatment of patients with mental health symptoms. Staff we spoke with at Chorley were aware of the concerns and had been shared the feedback verbally and written.

Senior managers told us that access to and delays in the mental health pathway were one of the ED's top risks.

The ED was supported by security staff when open. They completed enhanced training in control and restraint techniques, conflict resolution and breakaway techniques. Staff had either completed necessary refresher course or were booked to attend in July 2023.

Between June 2022 and May 2023, there were no incidents identified where there were insufficient numbers of staff to undertake restraint if required in the ED at Chorley.

Staff shared key information to keep patients safe when handing over their care to others.

Handovers included all necessary key information to keep patients safe. We observed the daily multi-disciplinary handover where all patients and any concerns were discussed.

Staff we spoke with told us that they tended to have a surge of patients in the early evening. There had been incidents where patients were in the department after 8pm meaning delays in patients being seen and treated as well as staff working longer than their planned shift. These were reported on daily shift forms completed by the nurse in charge and incident reported. Following the opening of the Williams triage facility, we were told that the incidences had reduced mainly for medical patients. Staff from the triage facility came to the department from 7pm and transferred patients if needed to in-patient beds.

The trusts had a full capacity protocol including how, when, and where to escalate patients and covered both hospital locations.

Urgent and emergency services

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The establishment had been reviewed and the number of registered nurses and healthcare assistants had been reduced to 8 registered nurses and 4 healthcare assistants on each shift. Senior leaders told us that this was to align to pre-COVID staffing levels.

Between November 2022 and April 2023, registered nurse fill rates were between 110% and 129% and unregistered nurse fill rates were between 87% and 116%.

For the same period turnover figures for both ED's for the trust were low. For allied health professionals (AHP's) this was 0% and for medical staff and registered nurses' turnover was 0.9%.

Between May 2022 and April 2023 sickness rates were an average of 4.3% for AHP's, 2% for medical staff and 6.3% for registered nurses across both ED's.

The ED's, across both locations were funded for 131 registered nurses and had 15 vacancies. For unregistered staff, funding was for 63 but there were 31 vacancies.

Substantive staff worked either 7.30am until 8pm or 9.30am until 10pm.

The service was supported by regular bank staff and agency if needed. Agency staff could be booked to start at 2pm although it had been agreed they could start now at 12 midday as there had been concerns about late cancellation of shift.

All staff received an induction and staff we spoke with told us they were supported during that time. Link nurses and champions had been identified to support student nurses in the department.

There had been rotation of registered nurses, band 6 and 7 levels, across the two locations to ensure competencies and skills were maintained as well as integration of the staff across both locations. Senior leaders had received mixed feedback from staff regarding rotation and this was under review.

Between January 2023 and June 2023 there were six incidents reported for staffing concerns in the ED; five were graded as no harm and one incident as low harm.

There were plans in place to manage any shortfalls in staffing numbers. Staff could be redeployed across the two ED's dependent on need. Senior managers could support staff as necessary. Meetings were held throughout the day where staffing levels were discussed. Bank and agency could be utilised if needed.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Staffing was planned across both hospital ED's. The services were funded for 106 medical staff; there were 23 vacancies.

Managers could access locums when they needed additional medical staff. There was support from advanced clinical practitioners (ACP's) that worked in the department as well as ACP's who in-reached to support alternative pathways for patients.

Managers made sure locums had a full induction to the service before they started work and were monitored to ensure they had the appropriate skill set for the department.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We were told that there were challenges in middle grade doctors at this hospital as there were more learning opportunities at the trust's other hospital where patients, following trauma or presenting with a surgical speciality were routinely treated.

Senior leaders told us that staffing was one of the main risks in the department. The potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies was included in the ED risk register.

The service had consultants on duty Monday to Friday. At weekends, and after 5pm during the week, there was senior leadership from associate specialist doctors.

There was a cohort of doctors who worked mainly in the department, but most doctors worked at both locations. Doctors in training roles were based at the other hospital ED although GPs in training worked in the department.

Doctors worked closely across locations to ensure patients were in the right place and receiving appropriate care. Doctors we spoke with felt supported by senior clinicians for the service.

As part of the people strategy there were plans increase the numbers of advanced practitioners and non- medical consultant positions across urgent and emergency care to support the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, notice boards displayed confidential information.

Patient records were a combination of paper and electronic. Patient notes, at the location were comprehensive, to a good standard and all staff could access them easily. We observed that, for the four records we reviewed, these were completed in a timely manner.

When patients transferred to a new team, there were no delays in staff accessing their records. We observed that paper care records were transported with patients so available to continue care.

The trust completed audits of risk assessment and care plan completion and reported an average of 78.8% compliance across both hospital ED locations.

Records were stored securely. Between December 2022 and April 2023 there was an average 96% audit compliance for storage in the ED. We observed, however; that patient identifiable information was visible, on patient boards to visitors as well as staff. This was highlighted at the last published inspection of the other ED location.

Medicines

The service used systems and processes to safely prescribe and administer medicines but compliance with trust standards for the safe handling of medicines, including Controlled Drugs were not met. There were plans for Rapid Improvement Cycles to help support improvement in this area. Capacity within the pharmacy team to provide clinical support to the department was limited, but several vacant positions had been successfully recruited to.

Staff followed systems and processes to prescribe and administer medicines safely.

Doctors had access to the local care record to view patient's current medicines when patients were clerked in. The senior pharmacist aligned to the acute medical team visited ED to provide proactive clinical pharmacist review, when possible, limited by pharmacy team capacity. There were plans to increase pharmacy presence following the recent successful recruitment to several vacancies in the pharmacy team.

Since our previous inspection, the trust's electronic prescribing and medicine administration (ePMA) system had been rolled out to the adult emergency department. A trust improvement programme had resulted in rapid improvement and continued good compliance with oxygen prescribing.

Trust sepsis policy had been updated in line with the Academy of Medical Royal Colleges sepsis guidance (May 2022), supporting the appropriate use of antimicrobials in sepsis. The sepsis audit had been updated to reflect these changes and the sepsis group was focussed on supporting improved compliance with this.

Staff generally stored and managed medicines and prescribing documents safely.

Performance with the trust's own quarterly controlled drugs (CD) audit (70% 12 months to date) and monthly safe medicines storage audit (81% 12 months to date) was below the trust 90% standard. Recent action to improve this included a review of stock management process, and fitting of additional stock cupboards. Staff had been reminded to alert pharmacy to any CD concerns. Discussions had started to explore piloting an electronic controlled drug register in Q3 2023-24.

Staff learned from safety alerts and incidents to improve practice.

The trust's Medicines Safety Team provided oversight of medicines incidents across the trust. We saw that appropriate action was taken to learn from medicines incidents in ED, reducing the risk of reoccurrence.

The trust had policies to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. The trust had taken prompt action to review these across the trust in response to concerns we shared with the trust at other locations.

Medicines management was included in mandatory training requirements. Compliance was 81% for registered nurses against a trust target of 90%. We were told that there had been an updated module with a strengthened internal mandate since May 2023.

Link nurses and champions had been allocated to support medicines management.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust had an electronic incident reporting system. Incidents were identified on daily shift reports and reported on the electronic system.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Between July 2022 and June 2023 there was a total of 643 incidents across both the ED and the urgent care centre, that was managed by an independent provider, of which one was reported as a serious incident. There were no never events reported for this location.

Staff told us that incidents where the department was open past the closing time were reported on the trusts incident reporting system. Between July 2022 and June 2023 there were 28 incidents reported in relation to the late closure of the ED. There were 24 of these incidents graded as no harm, three were low harm and one was moderate harm. The moderate harm incident was in relation to a patient referred late to the department from the urgent care centre (UCC). The incident was assigned to the UCC for investigation.

Incidents where security staff were involved that included any patients who presented with mental health concerns were reported across the ED's. Between December 2022 and May 2023, there was a total of 70 restraint incidents of which eight related to the Mental Health Act and 45 related to the Mental Capacity Act. In the six months prior to inspection there were no incidents relating to patients with a mental health concern that were graded as moderate or above. As incidents were recorded across the location it was difficult to review the incidents for this location.

The department monitored incidents reported for pressure ulcers, falls and venous thromboembolism (VTE). Between July 2022 and June 2023 there were 11 pressure ulcers incidents reported. There were 2 that were not present on admission, three that were present on admission and six that were recorded as unknown whether present on admission. All incidents were recorded as no or low harm and investigated by the unit manager.

There were eight falls incidents reported; four were recorded as no harm, three were low harm and one was reported as moderate harm. The moderate harm incident related to a patient who slipped on ice when leaving the hospital grounds following discharge and was brought to the ED for treatment. Risk of falls was included in the ED risk register.

There were no VTE incidents reported.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. Senior leaders told us that following a late closure incident, when a patient was delayed in transfer, there was a concern that staff allocated from the hospital did

not have the required skills to allow the emergency nurse to leave the shift while the patient was in the department. The late closure standard operating procedure was reviewed to ensure the right skills and competencies. Late closure was included as significant in the ED risk register. Learning was shared at staff meetings, by emails, memos and social media groups. Matrons and ward managers had been shared information at leaders forums.

We spoke with staff regarding the inspection of Preston ED. Staff we spoke with had been shared the initial feedback from the inspection and aware of proposed changes in processes.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Of the copies of policies and procedures that we were provided with all were within their date of review. The department had a booklet that included any updates in protocols for staff to access.

Any changes in national guidance, such as the National Institute for Health and Care Excellence (NICE), were discussed at monthly governance meetings that covered both ED locations.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At the handover meeting, staff referred to the psychological and emotional needs of patients, their relatives and carers.

The department was included in the trust's safety triangulation accreditation review (STAR) process. This system monitored performance in all areas of the trust and reported results monthly. There were two elements. The first included monthly reviews undertaken by peer review matrons. The second element were accreditation visits by the quality assurance team.

Quality metrics were reviewed including infection prevention and control, medicines safety, record keeping, emergency equipment, safeguarding vulnerable adults and children, and safe storage of equipment including control of substances hazardous to health (COSHH). STAR information was stored in the trusts electronic audit management and tracking system. Dependent on the outcome of visits, improvement action plans were implemented and monitored by the local teams.

Compliance in STAR audits at the location had varied in the six months prior to inspection from 73% to 96%. However, staff had achieved silver status prior to the inspection visit.

Urgent and emergency services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff provided drinks and sandwiches to patients who were waiting for treatment plans in the department. Vending machines were available for public use in the waiting room.

Staff completed training in food safety level 1. There was a compliance of 92% for registered nurses.

We observed in patient records, that staff fully and accurately completed patients' fluid and nutrition charts where needed.

The trust risk assessments included the calculation of a malnutrition universal screening tool (MUST) score. The MUST score was triggered once patients were admitted to the hospital and therefore compliance with MUST completion was not audited in the ED. However, a system was in place to allow the nursing team in the ED to make electronic referrals for patients to see a dietitian.

The ED carried out monthly audits on completion of fluid balance documentation that included vital signs recording, completion of fluid balance charts, totalling of the fluid balance every four hours and urine output being included on the vital signs. Between July 2022 and June 2023 there was an average monthly compliance of 85%. An action plan that included transferring documentation to electronic and re-audits was in place to improve compliance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Patients we spoke with told us they had been offered and received pain relief in a timely manner. The trusts STAR quality assurance framework included pain management audit. Between July 2023 and June 2022 there was 100% compliance when patients were asked if their pain had been managed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust had an electronic audit tracking system that monitored the audits for the service. This included both national and local audits as well as re-audits that were either active or closed and the audit forward plans.

Between April 2022 and May 2023 there were 18 audits registered under the Emergency Department speciality in the trusts electronic audit tracking system (AMaT).

Urgent and emergency services

The trust's clinical audit and effectiveness department facilitated the programme of national and clinical multidisciplinary audit activity. The service participated in national mandatory clinical audits. These included the Royal College of Emergency Medicine (RCEM) audits and the Trauma Audit and Research Network (TARN) audit. The data was across both hospital ED locations.

The latest TARN results showed the trust was above the national average for both data accreditation and case ascertainment.

For 2022 to 2023 the service participated in two RCEM audits. These were RCEM 2022: Mental health self-harm audit and RCEM 2022: Consultant sign-off audit.

For the period 2022 to 2023, the RCEM audits that were reported on were: Fractured neck of femur (NOF), pain in children and infection, prevention and control.

For fractured NOF, the trust performed better than the national average for three of the four standards. There was no national result for the fourth standard. For standard 1: Pain is assessed immediately upon presentation at hospital, the trust average result was 72% compared to the national mean result of 48%. For standard 2: Patients in moderate or severe pain (e.g., pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or accordance with local guidelines) unless there is a documented reason not to, the trust scored an average of 56% compared to the national mean of 15%. For standard 3: Patients should have an x-ray at the earliest opportunity (within 90 minutes), the trust scored an average of 61% compared to a national mean of 56%. There was an action plan aligned to the report recommendations, that showed the progress with the implementation of changes.

For pain in children, the trust performed better than the national average in all three standards. This hospital did not routinely see children in the ED.

For infection prevention and control, the trust performed worse than the national average for the first two standards but better for the third standard. Standard 1: Patients should have documented evidence of infection screening for: 1. Symptoms of Covid 19 2. For conditions considered to make them extremely vulnerable (and who will have been shielding themselves at home) 3. For other infectious diseases requiring isolation, the trust average was 9% compared to the national mean of 25%. For Standard 2: Patients with an identified vulnerability isolated in a side room, the trust average was 17% compared to the national mean of 23%. For Standard 3: Patients identified as potentially infectious moved to an appropriate area, the trust average was 81% compared to the national mean of 80%.

We did not observe any concerns with IPC at this location.

The physiotherapy service completed audits in the ED. These had highlighted that therapy provision assisted in admission avoidance. Patients could be seen in the therapy trauma clinic. Out of the 571 patients that were seen by physiotherapists over a third were referred on for further therapy. Just over half of the patients seen were discharged directly.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support in development.

Managers gave all new staff a full induction tailored to their role before they started work.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The clinical educators supported the learning and development needs of staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We were told that bank nursing staff completed mandatory training. Any role specific competencies were agreed locally with the mangers at Chorley.

The service ensured staff with certain competencies were on each shift in case a patient needed stabilising prior to transfer.

Staff participated in monthly child and adult resuscitation simulation exercises as well as regular resuscitation skills training provided by the ED clinical educator. These were multi-disciplinary and either classroom or department based.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. In the staff induction checklist, all staff were advised not to use any medical device which they did not feel competent to use.

Managers made sure staff received any specialist training for their role. There was a range of competencies that were required to work in the ED including telemetry (monitoring of the heart remotely), non-invasive ventilation (NIV), tracheostomy and electrocardiographs (ECG).

For telemetry, nursing staff from band 3 to 7 were required to complete this competency. At the end of June 2023, there was 82% compliance.

For NIV nursing staff from band 5 to 7 were required to complete this competency. At the end of June 2023, there was 66% compliance. Of the 109 staff, 68 were compliant. Staff attended resuscitation skills study days provided by the ED clinical educator. These included NIV policy, pathways and ongoing care of patients during NIV.

There were sufficient staff with NIV competency to ensure there was cover on each shift. Support was also available from the cardiac unit which had staff with NIV competency. There was seven-day consultant on call provision for the respiratory team who also provided support.

For tracheostomy, all band 6 and band 7 staff in the ED completed advanced life support (ALS) training which included advanced emergency airway management including tracheostomy. Band 6 and band 7 nurses were 83% compliant. ED consultants had emergency airway management skills meaning that there was always a staff member on duty with the ability to maintain a patent tracheostomy.

Nursing staff within the ED also attend a tracheostomy awareness study day, which had been developed by the ED clinical educator, the critical care outreach team and simulation services. Band 6 and 7 nurses had attended the course. There was at least one band 7 and 2 band 6 nurses in the ED at all times who had these skills. Patients with tracheostomy were admitted to three designated speciality wards or the critical care unit if needed.

For ECG, training was provided for band 3 -7 nurses on recording an ECG. A total of 139 staff in ED had completed ECG training.

For taking blood samples, all registered nurses and doctors completed training and competency assessments for taking blood during their initial professional training. On commencing at the trust staff were competency assessed utilising aseptic non-touch technique (ANTT). Compliance with ANTT competency was at 84% for the ED.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance rates for both medical staff and registered nurses was 89% across both hospital ED's. However, bank nursing staff we spoke with told us that they had not had an appraisal.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed the staff meeting that was held daily, including at weekend, to discuss all patients in the department. This meeting included doctors and the nurse shift manager. Any concerns or plans were shared.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us that there was a good working relationship with the independent provider for the urgent care services that were co-located.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were available seven days a week, from 8am until 8pm, to support timely patient care.

The service was open seven days a week but not available overnight. The department was open to patients from 8am until 8pm. There were no patients who had arrived by ambulance after 6pm; The service accepted patients who self-presented between 6pm and 8pm. Staff remained in the department until 10pm.

There was physiotherapy support in the department Monday to Friday but also supported some weekends.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle.

Emergency nurse practitioners (ENP's) signposted patients they saw as appropriate to smoking cessation or the trust alcohol team. There were identified link nurses and champions to support triage, minor injuries and wound management.

For minor injuries, there were leaflets available to support verbal advice given.

Physiotherapists worked closely with the ENP's to support appropriate treatment pathways. Leaflets were available to access exercises or self-referrals to physiotherapy.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Training for Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoL's) was included as part of mandatory safeguarding training requirements.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining verbal consent during care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

The trust completed audits for Do not attempt cardiopulmonary resuscitation (DNACPR) decision and reported 100% compliance across both hospital ED locations.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, took account of their individual needs but did not always respect their privacy and dignity.

Urgent and emergency services

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients and their relatives described staff as amazing, brilliant, calm and provided care that was above and beyond.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We observed discussions about individual care took place in a cubicle where other patients and relatives were waiting. This meant that confidential patient information could be overheard by others.

The trust participated in the NHS Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Between May 2022 and April 2023 there was an average of 73% positive response for patients attending the emergency department. There was no response rate provided and data was presented across both hospital locations.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. There was a chaplaincy and spiritual care department that was accessible 24 hours a day available across the trust including a chapel and multi faith room and representatives from faiths including Islam and Christianity including volunteers.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Urgent and emergency services

Staff supported patients to make informed decisions about their care. We observed that families were involved in the care and treatment of the patient.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Between April 2022 and April 2023 there were approximately 28650 attendances for the Chorley emergency department with an average of 2000 per month. This excludes Chorley urgent care centre attendances.. Managers planned and organised services, so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered.

The service was available for patients over the age of 18 years between 8am and 8pm for patients who self-presented. The last ambulance to the service was at 6pm daily. Any paediatric patients were transferred or signposted to either the other ED or a paediatric facility, dependent on the acuity of the child. The service was co-located with an urgent care service that was managed by an independent health provider that was available for all age groups 24 hours a day, 7 days a week.

The signage was not clear when approaching the department, although there was no feedback from patients that they were unable to locate the department.

The trust website outlined for patients where to access treatment dependent on their individual medical condition, injury or age group signposting either to an ED or urgent care centre (UCC).

Reception staff who took patients' details on entry to the hospital departments had allocated reception desk areas. The patient waiting area was shared between the ED and UCC services. This had seating and vending machines for patients and their relatives waiting to be seen.

For patients who we saw were taken to wait into a cubicle in the department, with other patients, there was only waiting room chairs rather than more comfortable patient armchairs.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were no mixed sex breaches reported for the ED.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access emergency mental health support, when open, 7 days a week for patients with mental health problems, learning disabilities and dementia. Patients with mental health needs needed to be transferred to the other ED location to be assessed by colleagues from the mental health team there.

The service relieved pressure on other departments when they could treat patients in a day. The minor injuries service could signpost patients to alternative outpatient services or therapies.

Meeting people's individual needs

The service was inclusive but did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a trustwide strategy and a process to support patients with enhanced care needs.

The toilet facilities, close to the waiting room were spacious, wheelchair accessible, dementia friendly and non-gender specific.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There was a box that included items to support patients identified with cognitive impairment, however the contents were being reviewed by the dementia champion to ensure these were appropriate.

Link nurses and champions had been identified to support patients with dementia, learning difficulties and mental health needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We observed staff speaking with patients and their relatives in caring and appropriate ways. However, we did not see any hearing loop in the department.

The service displayed information leaflets that were written in English. We did not see leaflets written in languages other than English, alternative formats or the inclusion of how to access them.

The trusts website had a range of accessibility features to meet patient needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a trust wide service for accessing interpreters as well as staff members who were available to support on site if needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences if they needed to wait in the department.

There was a process to support patients deemed as high intensity users (HIU). The core principles of the HIU service were to identify, personalise, de-escalate, discharge and manage relapse. The team worked with patients, their families and other professionals to identify needs and implement a care plan to help reduce the need to attend the ED.

There was an area in the department where any children that needed to be treated or stabilised prior to transfer to a hospital with paediatric facilities were cared for. This was a re-purposed area that did not include any décor that was child-friendly or an area where the family could wait.

Urgent and emergency services

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were below and better than national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Triage of patients who self-presented were triaged by the urgent care centre staff. This was managed by an independent health provider. The trust monitored ambulance attendances and handover times. Between February 2023 and June 2023 there was a total of 41022 attendances of which 2552 were ambulance attendances. These varied from four to 38 attendances daily. The hospital was consistently below the England average for handover that took over 30 minutes and the best performing with the region. Between March 2023 and June 2023 between 80% and 93% of patients spent less than four hours in the ED that was consistently above the region and England times. There were no children routinely seen in the ED. However, children that attended were transferred to the appropriate department dependent on condition.

Staff we spoke with told us that in addition to patients, from the locality, they had seen an increase in numbers of patients from out of the area. Between July 2022 and June 2023, there were approximately 2390 patients who attended that did not have a local postcode. This meant that staff did not have access to all information recorded on electronic systems by community staff including GP's.

Managers and staff worked to make sure patients did not stay longer than they needed to. There was a standard operating procedure for closure of the department. There had been incidences when patients remained in the department after the closure time. This meant that staff were delayed in finishing their shifts.

Between April 2022 and April 2023 there were 173 patients who were in the department after closure at 10pm. The trust had identified the two main reasons for late closure were patients who self-presented near to the 8pm cut off time with outstanding areas of their assessment or treatment by 10pm and delays with patients being transferred to inpatient beds at both hospital locations. When patient flow was under pressure the ED was used overnight as an escalation area as per the trust wide escalation plan.

Since the opening of the Williams triage facility, staff we spoke with told us there had been improvements for patients with a medical condition. There had been some concerns that patients presented for surgical specialities could still be delayed. Plans were in place for escalation if needed.

The clinical site team visited the department to speak with the department leaders. There were bed meetings that occurred at regular times throughout the day where any concerns could be raised. The trust had introduced the trust operational officer team to support access and flow. We were shared an example of where this team had supported the service to promptly action the transfer of a surgical patient, out of the ED, that had been delayed. Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Urgent and emergency services

Between July 2022 and June 2023 there were patients transferred from the department either to the trusts other hospital ED or to an appropriate healthcare setting to meet their care and treatment needs. There were 240 patients with acute needs and 91 patients with mental health concerns transferred to the other ED. For the same time period there were 52 patients with acute needs and seven patients with mental health concerns transferred to an alternative healthcare setting.

Between April 2022 and April 2023 there were a total of 389 acute adult patients and 30 adult patients with a mental health concern who left the department before being seen. Following the inspection of the trusts other ED location a letter of concern was sent to the trust regarding patients with a mental health concern resulting in an action plan to address concerns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. A link nurse had been identified to support patient experience.

Compliments were displayed on the patient experience notice board.

The service clearly displayed information about how to raise a concern in patient areas. There were patient leaflets that included details of the patient advice and liaison service (PALS).

Between July 2022 and June 2023, there was a total of 10 complaints for the service, two of which were upheld and two were partially upheld. There were no complaints referred to the Parliamentary and Health Service Ombudsman (PHSO).

The list of complaints provided did not include the length of time taken to manage the complaints. Three complaint responses were provided; two took seven and nine months to complete. This was outside of the trusts complaint policy of a maximum of 60 days for complex complaints.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. There was a governance board where feedback could be shared.

Is the service well-led?

Good 

Urgent and emergency services

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was senior leader presence at the hospital at least once a week.

Staff we spoke with told us that they were supported by their managers at the hospital, however they told us that senior managers were not visible and visited only ad hoc times.

Shift leaders were skilled and focused on the priorities in the department. They were sighted on the particular risks in the department as well as the other hospital ED.

Staff worked well as a multidisciplinary team and supported each other. Local clinical leads were available and accessible in the emergency department and provided support to junior team members.

Leaders were aware of staff competencies and assigned tasks appropriately. Staff we spoke with told us their managers recognised their skills and helped them with development needs.

The trust's people plan had a focus on career structures throughout the ED pathway so that staff could move between specialist and advanced practice and leadership careers across each part of the pathway.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Senior leaders told us that the strategy for the emergency department covered both hospital sites. There was an urgent and emergency care strategy, dated 2023 to 2025. This outlined the plans for delivering and the recovery of the services. There was also the emergency services clinical service strategy, dated 2021 to 2024 that was aligned to the divisional and trust strategies.

For the ED's the vision was "… for patients to receive the right pathway first time, from pre-hospital to in hospital. For the Emergency Department to resuscitate, treat the trauma and acutely unwell, save lives through outstanding timely patient-centred care that is driven by educational innovation, high performing teams and practice-changing research. This will be supported by system care delivery closer to home."

Urgent and emergency care was one of the trust and divisions strategic priorities that included:

- Providing the right pathway.
- Delivering high quality safe and effective care.
- Reducing mental health delays.

- Obtaining a right sizing of estate to improve patient flow.
- Being responsive to surges in demand.
- The development of a workforce that enabled front end assessments, with a clear roadmap of development opportunity for nursing, medics and allied health professionals.
- Providing a well-defined wellbeing strategy.

The divisional strategic objectives for the ED's included the provision of outstanding and sustainable healthcare to the local communities, offering high-quality specialist services to patients in the integrated care system (ICS) region and to drive health innovation through world class education, training and research. There was a recognition for the need for safe levels of appropriately trained and skilled staff, particularly as a trauma centre, and to ensure that patients were streamed to the most appropriate pathway so the most acutely ill were seen in the ED.

The strategy followed the same principles as the trusts big plan of consistently delivering excellent care, being a great place to work, delivering value for money and being fit for the future. There was a recognition that a two location ED model had challenges. However, there were more strengths than weaknesses identified such as teamwork, delivery of pathways and streaming, ambulance handovers, zero corridor care and wellbeing of staff.

Leaders measured the strategy against key health outcomes. These included the monitoring of clinical outcomes, life expectancy, mortality and morbidity and reduction in health inequalities between regions, improvement of health and well-being of the local population and positive experiences both for patients and staff as well as measuring financial sustainability.

The ED recovery strategy outlined the trusts transformation plans. There was a recognition of the unprecedented challenges particularly since the COVID pandemic but also identified that there is a need for a system -wide approach to improving the service. The strategy outlined the ambitions to improve waiting times and continue to participate in the ambulance collaborative programme. The plan focused on key areas including:

- Increasing capacity by reviewing models of care including participating in NHS England's new improvement programme to support standardisation of care, working with clinical leadership to set out common principles for providers.
- Growing the workforce by supporting career progression, increasing the numbers of advanced practitioners positions, skills to support patients with mental health needs, and use of allied health professional (AHP) skills.
- Improving discharge by working collaboratively with system partners and use of digital systems.
- Expanding and better joining up health and care outside hospital by supporting social care and virtual ward expansions and working with the community.
- Making it easier for our population to access the right care such as urgent care services or alternate pathway.

There was a delivery plan on a page that summarised the strategy and included key performance indicators used to monitor outcomes.

The department had a noticeboard that included the services goals alongside the trust goals and values. However, this was dated for 2022 to 2023. We were told that the departmental goals were under review for the upcoming year.

Urgent and emergency services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive culture in the department. Staff we spoke with told us they enjoyed working in the department with good team working. They told us that there was a friendly atmosphere, and they were well supported by their local managers. Staff worked in a department where they were valued and respected by their line managers.

We observed a diverse team of staff who worked together to meet the needs of the patients in the community. All staff we spoke with were encouraged to develop and expand their skills. The trust had an equality, diversity and inclusion strategy group that had management representation from the medical division. Updates of plans were shared at monthly meetings as well as the presentation of patient stories. The trust also had forums for ethnicity, LGBTQ Plus Ambassadors and living with disabilities.

Most of the doctors worked at both ED's and reported good working relationships. Some of the nurses we spoke with reported they felt isolated at times as the other hospital ED had a dedicated trauma centre and was open 24 hours a day. Registered nurses had been asked to work across both hospitals. This meant there was a sharing of skills across locations and staff could maintain their competencies. It was hoped that the cross cover would help staff to feel integrated across the trust.

Senior managers told us there had been some communication concerns regarding the initial co-location of the urgent care service, that was managed by a different provider, particularly triage issues. However, staff on-site told us there were now good working relationships with the service.

Speak up core training was included from 1 May 2023 following an external requirement from the Office of the National Guardian. Compliance was recorded across both hospital ED's. For medical staff compliance was at 29%, registered nurse compliance was 35% and other staff was 44%. This was an average of 37%. Staff had been given a three-month grace period for this module (Until 31st July) to achieve the 90% trust target.

In the staff survey, for 2022, responses for the ED's were for the ED's at both sites. There were 85% of the 240 staff, who had responded, that reported their last experience of physical violence. There were 58% of staff who had reported their last experience of harassment, bullying or abuse. There were 35% of staff who said relationships at work were unstrained and 39% who said they didn't often think about leaving the organisation.

Governance

Local leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework was across both EDs with representation from both locations. The senior leaders covered both locations including medical and nursing leads in order to have oversight of the whole service and support the integration of the departments.

The department participated in the trusts safety triangulation accreditation review (STAR) process that monitored a number of quality metrics on a monthly basis. Patient areas were awarded a rating dependent on performance. The department had achieved silver status.

Urgent and emergency services

The clinical audit and effectiveness team monitored the performance of national and local clinical audits that were indicated in relation to governance requirements. They provided reports to the trust's safety and quality committee.

The ED's held monthly minuted governance meetings. We were provided copies for February 2023, March 2023 and April 2023. There was a standardised agenda that covered both ED's. Leaders discussed audit progress, any guideline changes, complaints, patient experience, reviewed risks, any medicine concerns, performance including the dashboard, improvement work, training needs and lessons learned and shared.

There were monthly divisional board meetings. These had standardised agenda items that included feedback reports from divisional safety and quality, workforce and finance and performance committees. Any key issues for escalation both positive and negative were discussed as well as items for information or approval.

There were monthly divisional always safety first meetings. These had agenda items for patient story, discharge processes, safeguarding, medicines and incidents.

The service worked closely with the co-located urgent care centre that was manged by an independent provider. They collaborated to ensure the most appropriate pathways for patients.

The trust linked in with the other trusts in the integrated care system (ICS) through the provider collaboration board. In these meetings there were discussions about activities that could assist in reducing the demands on the ED's across the region.

Management of risk, issues and performance

Local leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust maintained a risk register that included the divisional and departmental risks. The ED risk register included risks from both hospital locations. There were six risks graded as high, 15 as significant and two that were graded moderate. The copy of the risk register, that we were provided with included the target scoring for each of the risks, showed that they had been reviewed within the 6 months prior to inspection. tThe risk register included the controls and mitigations for the risks.

The ED's risks graded as high included falls, the lack of available beds and delays for patients with mental health concerns and the potential risk to patient safety due to medical staff vacancies.

Risks graded as significant included late closures, stabilisation and transfer of critically ill patients to a receiving hospital and the risk that critically ill children continue to present at the hospital where there are inadequate paediatric facilities.

Risks were discussed at monthly ED governance meetings that were for both locations.

Senior leaders were well sighted on their top risks and articulated processes in place to mitigate risks including escalation and transfer protocols and arrangements.

The urgent and emergency transformation programme board monitored the delivery of the ED strategy and monitored outcomes under the aims to consistently deliver excellent care, a great place to work, delivery of value for money and fit for the future. This board reported to the board of directors through the finance and performance committee.

The organisation monitored progress through its safety triangulation accreditation review (STAR) process. This STAR process was a quality assurance framework that commenced in June 2017 that provided an evidence based approach in demonstrating the standard of care delivered. It identified what worked well and where further improvements were required. There were monthly reviews that were undertaken by matrons, in divisions, who peer reviewed their departments. There were also accreditation visits that were undertaken by the quality assurance team supported by governors and other staff in the trust.

The results of the STAR monthly audits were used to monitor safety standards within each clinical area. The outcomes formed part of the monthly assurance report completed by the Matron. These were monitored at both divisional committee and board level, as part of the safety and quality dashboard. The aim was to provide ward to board assurance on a monthly basis. The results were also included in the monthly divisional improvement forums and in divisional meetings.

The unannounced comprehensive accreditation gave additional assurances by providing a report based on the outcome and findings of the visit. The STAR comprehensive accreditation visits frequency was based on a risk profile, linked to the previous score. The accreditation visits included monitoring of quality metrics such as infection prevention and control, medicines safety, record keeping, emergency equipment, safeguarding, and patient call bells. The ED had achieved silver status. Environment was one of the metrics covered, including storage checks. However, the star policy did not include expiry date checks. We had e identified consumables that were passed their expiry dates.

Results from STAR were recorded in the trust's audit management and tracking (AMaT) system. This issued a monthly STAR report that was presented at the divisional safety and quality meeting, the divisional always safety first meetings and the nursing, midwifery and allied health professionals board. The monthly and accreditation visit outcomes were reported through the divisional improvement forums and to safety and quality committee. Staff were able to access results on the trust intranet.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

There were dashboards for the trust that showed live information about patient numbers and any concerns. These could be viewed for both departments meaning that support could be given as appropriate. This meant there was continuous oversight of the department as well as an awareness of the other hospital ED.

For patients who attended from out of area, the service could not access any previous records including GP information.

Information management was included in mandatory training requirements with a trust target of 95%.

National and local audit data was submitted to the trusts electronic audit tracking system and monitored both locally and trust wide.

Engagement

Leaders and staff actively and openly engaged with staff to plan and manage services.

Staff we spoke with told us they received feedback from managers via different platforms including team meetings, governance board that included 'you said, we did,' a booklet with any updates to be aware of and by social media groups. We requested copies of team meetings, however; did not receive any to review.

The trust issued a monthly newsletter, the best version of us, to leaders in the organisation and the chief executive sent his Monday message newsletter to all staff. Staff have been contacted regarding plans to build a new hospital and were invited to attend summit events. Staff also received a bi-weekly bulletin of health matters.

Engagement with public groups, with the exception of the NHS Friends and Families Test, had been stopped prior to the COVID pandemic although there had been a day dedicated to learning disabilities. An event had been held, in the local area for patients with kidney disease with a presentation and information available.

A revised patient experience and involvement strategy was launched in 2022 with contributions from patients, relatives and carers as well as staff, governors, and partner organisations. Following feedback from patients changes had taken place such as a remembrance garden at the hospital that could provide a quiet, reflective space.

Of the 4440 responses in the 2022 staff survey, there were 240 responses from the ED and acute medicine division. The responses were rag rated in comparison to the whole organisation. There were six responses rated green, 42 that were amber and 49 that were red. There were 80% of staff who thought there were opportunities to show initiative frequently in their role. There were 65% who said that team members often meet to discuss the team's effectiveness. There were 62% of staff who responded that said the organisation acts fairly with career progression and 57% said they were involved in deciding changes that affected their work. However, of the responses that were worse than the average for the organisation, there were 14% who said that they are never or rarely worn out at the end of work, 20% who said they were satisfied with their pay and there was 32% who said their appraisal left them feeling that the organisation valued their work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

There was a collaborative approach to research and innovation and staff we spoke with told us that continuous improvement was in place across the departments and up to trust level. One of the ED strategic objectives was to drive health innovation through world class education, training and research. The trust was committed to quality improvement, throughout the departments, divisions, trust level and the integrated care system. The trusts big plan objectives were to provide safe and reliable care with good and improving outcomes for patients by continuous improvement programmes. These were at system and department level with divisional priorities. There was a range of programmes in the ED's such as weekly meetings with the NHS ambulance provider, working groups for frailty and mental health and big room work. There were local department level improvements through he trusts microsystem coaching academy programme. They had shared work with external providers and stakeholders to share best practice.

The trust's always safety first was embedded in the department. The trust's big room programme included topics such as sepsis. The department supported the other hospital ED particularly when escalation was needed and to support the ambulance collaborative to improve ambulance handover times across the ED's. The service supported the other trust ED by seeing and treating patients in the local community that helped with capacity and flow.

Therapy provision had been shown to help with admission avoidance and there were plans to expand this service.

Royal Preston Hospital

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www.lancsteachinghospitals.nhs.uk

Description of this hospital

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Our findings

- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Urgent and Emergency Care

At the Royal Preston Hospital, the urgent and emergency service operates 24 hours a day, seven days a week. The emergency department is also a major trauma centre, accepting adult patients with more serious injuries. The service also has a separate children's emergency department for children in need of urgent care. Patients are triaged in designated assessment areas and in cubicles or rooms for more seriously unwell patients. An urgent care centre was co-located in the department, with services delivered by an independent healthcare provider for adults and children, 24 hours a day, seven days a week. Following triage, patients are treated in one of four main areas: the minor injury/illness unit, the ambulatory care unit, A&E majors, or A&E resuscitation.

We visited the service as part of our unannounced inspection on 31 May & 1 June 2023. We inspected the urgent and emergency care services at the hospital as part of a trust inspection. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The inspection was carried out by two CQC hospital inspectors, a medicines inspector, and two specialist advisors. We observed care, spoke with ten patients and their relatives, reviewed care records for 13 patients. We spoke with 26 staff of all grades including senior leaders, medical staff, nurses, domestics, allied health professionals, practice educators, children's nurses, and pharmacists. We attended a range of meetings including, bed management meetings, ward handover meetings and senior leadership interviews.

Our rating of this location stayed the same. We rated it as requires improvement because:

- Compliance for some areas of mandatory training was low for medical staff; the design, of the department made it difficult to keep people safe; Staff did not always assess risks to patients, act on them or keep care records updated. Staff did not always complete medicines records accurately or kept them up to date although they managed medicines well.
- Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff did not always follow up if patients had enough food and drink whilst waiting for treatment.
- People could not always access the service when they needed it and patients often had long waiting times for treatment.
- The service did not always take account of patients' individual needs.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical Care

Medical care services at Preston Royal Hospital are provided by Lancashire Teaching Hospitals NHS Trust.

We visited Royal Preston Hospital as part of our unannounced inspection from 31 May to 1 June 2023. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Medical care services are part of the division of specialist medicine at Lancashire Teaching Hospital.

The inspection was carried out by 2 CQC hospital inspectors, a medicines inspector and 2 specialist advisors. We observed care, spoke with 15 patients and their relatives and reviewed care records for 15 patients. We spoke with staff of all grades including senior leaders, medical staff, nurses, allied health professionals and practice educators. We attended a range of meetings including, bed management meetings, ward handover meetings and senior leadership interviews.

During our inspection we visited and inspected the acute assessment unit, the acute medical unit, the frailty assessment unit, respiratory, the coronary care unit, the discharge lounge, Fell View, a general medical ward, and the stroke unit. We visited Finney House to review how patients move from the hospital to the step-down rehabilitation centre .

We previously inspected the medical division at Preston Royal Hospital in 2019.

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not always control infection risk well. The environment did not always keep people safe. Staff did not always identify and quickly act upon patients at risk of deterioration and did not always have the resources available to them to support patient's needs. The service did not have enough established medical staff to keep patients safe from avoidable harm.
- The service did not always achieve good outcomes for patients. Not all services were available 7 days a week.
- The services facilities and premises were not always appropriate for the services being delivered.
- The service did not always meet the needs of local people and the communities served.
- People could not always access the service when they needed it and sometimes had to wait longer than national targets for treatment.

However:

Our findings

- Staff completed their mandatory training in a timely manner. Staff understood how to protect patients from abuse, and managed safety well. The service had enough nursing staff to keep patients safe from avoidable harm. Staff kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and supported patients to make informed decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service identified relevant risks and issues and implemented timely actions to reduce their impact. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

We inspected the service with two inspectors, a medicines inspector and a specialist advisor.

During our inspection we visited the main theatres; a specialist plastics theatre; pre-operative assessments; the surgical assessment unit and 13 wards, including those with specialities in major trauma, vascular surgery, orthopaedics, general surgery and neurosurgery.

We spoke with 68 staff from a range of roles, including nurses, support workers, medical staff, ward managers, matrons, governance staff and senior leaders. A further interview with the senior leadership team was conducted off site following the inspection.

We also spoke with 9 patients and 2 relatives. We reviewed 5 patient records and attended a team handover/safety huddle and a bed meeting.

We reviewed policies and procedures and a range of data and other documents.

We previously inspected the surgery division at Preston Royal Hospital in 2019.

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They mainly managed medicines well. The service managed safety incidents well and learned lessons from them.

Our findings

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always ensure that medicines with a minimum dosage interval were administered as prescribed.
- People could not always access the service when they needed it and waiting times for treatment were above the England average.

Maternity

We inspected the maternity service at Royal Preston Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions. We last carried out a comprehensive inspection of the maternity service in October 2018.

Royal Preston Hospital provides maternity services to the population of central Lancashire.

Royal Preston Hospital is 1 of 2 sites for maternity services for the trust. On site there was both an obstetric led unit as well as a midwifery led birthing unit. The obstetric led service had a delivery suite and two wards, ward A (antenatal care) and ward B (postnatal care), maternity theatres, antenatal clinic, maternity assessment suite which incorporated maternity triage and maternity day unit. The trust had approximately 4,125 deliveries per year across both sites.

Following our inspection and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust. The letter of intent requested further information around waiting times and staffing within the maternity triage, delays within the induction of labour, as well as delays within reporting incidents and the grading of incidents. The trust responded quickly to the concerns raised and provided the required assurances.

We also inspected 1 other Maternity service run by Lancashire Teaching Hospitals NHS Foundation Trust. Our report is here:

Our findings

Chorley and South Ribble District General Hospital - https://www.cqc.org.uk/location/RXN01

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors and 4 specialist advisors including midwives and an obstetrician. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

We provided the service with 2 working days' notice of our inspection.

We visited the delivery suite, midwifery led birthing unit, maternity theatres, antenatal ward, postnatal ward and maternity assessment unit.

The inspection was carried out using a pre-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

During the inspection we spoke with staff including the divisional nursing and midwifery director, deputy director, and midwives. We reviewed records and spoke with women, birthing people and their families.

We received over 100 give feedback on care forms through our website. Feedback received indicated women and birthing people had mixed views about their experience. Feedback included about concerns about communication.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

Our rating of this service went down. We rated it as requires improvement because:

- Staff training compliance for life support, compliance with life support training was below trust targets and medical staff was below the trust target for all training other than Cardiotocography (CTG) training.
- The service did not consistently report incidents to the National Learning and Reporting System (NRLS) in a timely manner.
- Not all staff felt that were listened to by senior leaders when highlighting concerns around staffing.
- The service reported women had experience long delays in the induction of labour and not all reasons for the delays were documented.
- Audits showed compliance with hourly CTG reviews continued to not meet the trust target of 85%.
- From November 2022 to May 2023 data showed there was a declining performance in relation to the time taken from making the decision to carry out a category 1 (urgent) caesarean section to delivery in line with clinical guidance.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment. and all staff were committed to improving services continually.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills. Staff met the compliance rates for mandatory training but did not always complete the training specific to their roles in a timely manner.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules consisted of the following:

- Conflict resolution
- Equality, diversity, and human rights
- Fire safety
- Fraud and bribery in the NHS
- Health, safety, and welfare
- Infection prevention control (level 1 and level 2)
- Moving and handling (level 1 and level 2)
- Patient safety for all staff
- Patient safety board and senior leadership teams

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were accountable for keeping up to date with mandatory training and any gaps would be reviewed during their yearly appraisals.

The trust target for the mandatory training modules listed above was 90%, nursing staff had a completion rate of 97%, 'other staff' including support staff had a completion rate of 97% and 89% of medical staff had completed the training.

The trust had updated the medicines management module and included another training module called 'Speak Up' in May 2023. A 3-month grace period had been provided for staff to build compliance.

Non mandatory training was offered to staff on the division. This included training for end-of-life care, blood transfusions and the aseptic non touch technique.

Although staff told us they did not have time to complete training during scheduled shifts, the trust provided the opportunity for training to be completed as overtime.

The division had practice-based educators who had good insight into the challenges staff faced and had plans to resolve them. They provided development opportunities for international nurses and other nurses wishing to progress their career. They had also arranged additional training courses for some staff on the Acute Assessment Unit (AAU) who had recently moved from another area of the hospital and lacked acute experience.

The trust was unable to provide data for the Oliver McGowan Learning Disability E – learning as this was not yet available to staff but there were plans to provide this. The Oliver McGowan Learning Disability E Learning training should have been available to staff sooner, as from 1 July 2022, all CQC-registered health and social care providers had to make sure their staff received training on learning disabilities and autism appropriate to their role.

Nursing and medical staff did not always keep up with the resuscitation training. Medical staff on the division had a compliance rate of 78% for level 2 adult basic life support and paediatric basic life support whilst nursing staff had a 65% compliance rate for intermediate life support training.

Nurse and medical staff completed training in the recognition and treatment of sepsis. The trust target of 90% compliance was exceeded by the nursing staff (92%) but not achieved by medical staff (54%).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Medical staff did not always meet the compliance target for safeguarding training.

The trust had safeguarding policies for safeguarding children and young people and safeguarding adults which incorporated the PREVENT procedure (government counter terrorism strategy which aims to stop people becoming terrorists or supporting terrorism). The policy had arrangements in place to safeguard women or children with, or at risk of Female Genital Mutilation (FGM). The policies included information to support staff to protect patients from abuse. These were available on the trust intranet.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of the safeguarding leads within the service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us they could speak with the ward manager, the co-ordinator, the safeguarding lead, or the matron for support. They knew how to access the reporting system and report safeguarding incidents when they arose.

The trust had an established safeguarding team, with named doctors and named nurses as safeguarding leads for children and adults. Staff told us the safeguarding team were visible and accessible.

Safeguarding training on how to recognise and report abuse was mandatory for all staff. There was an expectation that staff in clinical areas would have level 1 and 2 for safeguarding adults and children. The courses included some classroom-based training. Managers above ward manager level were expected to undertake safeguarding courses to level 3. Safeguarding training covered the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS).

Nursing staff exceeded the trust's target compliance rate of 90% for the training. Safeguarding training compliance for level 2 safeguarding adults training was 99% and for level 3, 98%. Nursing staff's compliance for level 2 safeguarding children was 99%. However, medical staff did not always achieve the 90% target, 82% of medical staff had completed level 3 safeguarding adults training and 89% had completed level 2 safeguarding children training.

The trust provided 'PREVENT duty training' (a course that teaches about radicalisation, extremism and terrorism and concerning behaviours to look out for) as a stand-alone course. The overall compliance for staff on the division of medicine was 98% for the basic awareness module and 96% for the follow up module.

Safeguarding information was displayed on notice boards throughout the hospital.

Staff followed safety procedures for children who may be situated on the division or visiting the wards. Matrons completed daily reviews of 16- and 17-year-old patients who were based on the adult medical wards. The safeguarding leads had daily reviews with these patients and escalated concerns appropriately.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Leaders did not always equip staff with the equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

The leaders did not always support staff to follow infection control procedures. We did not see the 5 stages of hand washing posters situated above hand wash sinks. These posters act as a reminder to staff to wash their hands in line with the world health organisation's (WHO) guidance. The trust's infection prevention control (IPC) team had identified that there were not enough hand sanitising stations located on the Acute Assessment Unit (AAU) but had plans to resolve this. Despite this, the division were audited monthly for hand hygiene compliance and had achieved above the target of 94.4% between February and May 2023.

All wards had privacy curtains around patient bed spaces. At Fell View (a step-down facility on the Preston site), we found curtains that were labelled with a date from last year (9/11/22). This was not in line with the provider's policy and best practice guidelines.

We saw out of date information posters on ward 19 telling patients what to wear regarding COVID – 19. We raised this with staff who told us this information was out of date and removed it soon afterwards.

The trust had an internal accreditation process for wards/divisions called the safety triangulation accreditation review (STAR). The division achieved 83% compliance for the environmental STAR assurance audit for May 2023 against the trust target of 95%. Actions were identified and included daily spot checks for hand hygiene and personal protective equipment (PPE) compliance, maintaining a clutter free environment and regular infection control education sessions.

Following our inspection, the service provided information around infection rates. We received data from April 2022 to May 2023 which showed the division had reported 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA). However, In February 2023, the trust was ranked highest of the major trusts in the Northwest in terms of Clostridium difficile (a bacterium in the gut that can cause mild to severe diarrhoea) incidences. The medical division had 110 cases of healthcare associated Clostridium difficile between 2022 and 2023. Patients with Clostridium difficile were reviewed on a case-by-case basis. The infection prevention and control committee identified lapses in care were the cause of 75% of the cases identified. The infection prevention and control annual report highlighted how the lapses in care will be

reviewed in the trust's Antimicrobial Management Group, the divisional infection prevention and control meetings and a review is due to be undertaken during meetings with the Clinical Commissioning Group (CCG). An action plan had been agreed. Actions included business cases for equipment to rapidly decontaminate the environment, more domestic resource and to maintain and potentially increase isolation capacity.

However, the trust monitored outbreaks of infections and had policies and procedures for staff to follow when patients tested positive. We reviewed the outbreak procedure which had adequate preventative measures and information for staff to follow to escalate patient cases.

All patients were screened for infectious diseases, such as MRSA when they arrived on the wards. Infectious patients were provided with individual side rooms to reduce the chance of transmission to other patients. We witnessed that the doors to the side rooms were closed on the wards we inspected.

Medical wards were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were housekeepers assigned to most wards.

We checked 10 pieces of equipment on various medical wards, and 8 had been labelled with 'I am clean' stickers to show they had been cleaned.

The endoscopy unit was compliant with the management and decontamination of flexible endoscopes standards. The unit's monthly decontamination audits had been completed.

Staff followed infection control principles including the use of PPE. We observed staff wearing the correct PPE and washing their hands between patient contact. There were adequate amounts of PPE available. An audit of PPE compliance was completed monthly. The division scored above 90% compliance between January and April but were between 80% and 85% for May 2023.

The trust completed surveillance of their water treatment system. An external audit took place in January 2023 which tested the water treatment system and they passed with 100% compliance.

Nursing staff had a 96% compliance rate for level 2 infection prevention and control training. Medical staff had a 94% compliance rate for level 1 infection prevention and control training and 83% were compliant for level 2. The trust target was 90%.

Environment and equipment

The design of the premises and the environment did not always keep people safe. However, staff were trained to use equipment, it was maintained well, and they managed clinical waste effectively.

The design of the environment did not always follow national guidance. There was 1 shower situated on the Acute Frailty Unit (AFU)) and Acute Assessment Unit (AAU). The 2 wards were mixed gender wards. Patients using services should have access to segregated showering facilities to maintain their dignity and respect. The AAU did not have any side rooms for patients with infectious diseases and therefore tents were used when a patient had an infectious disease to reduce the chance of transmission. On 2 of the bays, this was not possible as they were too small and therefore patients were moved to larger bays or different wards. Several wards had bays and side rooms which were not visible from the nurse's station. Staff told us that bay nursing was used for increased observations of patients and some of the wards such as the hyper acute stroke unit and respiratory unit had specialist equipment that allowed for remote monitoring.

On the AAU there was no door to the ward which meant patients could potentially abscond. The flooring on the AAU was damaged in patient areas including on entry to the patient toilet and on entry to the bay. Senior staff explained that one of the main risks for the AAU was falls and the environmental issues were a contributing factor. The AAU was in its infancy and a business plan had been approved for improvements to be made to the estate. In July 2023, following the inspection, substantive floor repairs to the AAU were completed.

We observed a corridor between the medical assessment unit (MAU) and the stroke unit that had been blocked with chairs and a metal cage with laundry in. In the case of an emergency, this posed an evacuation risk.

Staff told us the shower on the AAU department flooded each time it was used and a shower on ward 17 had not been working for the last 2 weeks. There was not a patient toilet on the coronary care unit, however the CCU was in the middle of a larger ward which had a patient toilet. . We observed poor maintenance of wheelchairs on the stroke unit.

Medical staff told us that the department had leaks in the roof which was causing hot water to pour into certain areas, although we did not see this on the inspection.

Patients could reach call bells and staff responded quickly when called. Between April 2023 and May 2023, the medicine division was 91% compliant with nurse call systems. However, 2 call bells on the stroke unit were not working and the call bells on the AAU were temporary and not fixed into the wall. The system had not been embedded due to the ward being newly established and was still connected to the urgent and emergency care department (previously COVID resus). Staff were therefore responsible for responding to urgent and emergency care call bells which took time away from caring for patients on the AAU. The call bell in the shower on the AFU was broken which restricted the use of the shower unless the patient was supported by a member of staff. Environmental risks were identified on the divisions risk register meaning that leaders had oversight of them.

The service did not always have facilities to meet the needs of patients' families. Some wards that we visited did not have rooms for relatives or for breaking bad news to patients.

The medical wards had a clean and dirty utility room. The clean utility rooms were used to store medicines and medical equipment and had a lockable door which had a pass code. The dirty utility was used for the disposal of clinical waste, almost every dirty utility was clean and well organised.

There were clearly signposted fire exits on all the wards we inspected. The wards had evacuation slides and chairs to move patients in an emergency. Each ward had fire extinguishers which had been serviced in the last 12 months.

Staff carried out daily safety checks of specialist equipment. There were resuscitation trolleys on all the medical wards we visited. Each trolley had a suction unit and a defibrillator which had been serviced within the last 12 months. We observed that oxygen cylinders on each trolley were full. However, on ward 19 we found forceps that had passed their expiry date. This was escalated and replaced at the time of our inspection. Emergency trolleys were securely tagged so that staff knew when the trolley had been last opened and if it had been replenished correctly. We reviewed audits for emergency equipment for the division and found they had met or exceeded 90% between February and May 2023.

The division had over a 90% compliance rate between February and May 2023 for completing daily checks of clean utility temperatures, fridge temperatures and intravenous (IV) fluid storage temperatures.

The service had enough suitable equipment to help them to safely care for patients. When new equipment was introduced, medical engineers trained staff before them being able to use it. We saw that there was adequate stock, and a process of regular review was in place to ensure that patient consumable equipment was within their expiry date.

We checked 10 items of equipment, and all had been safety checked. This had been completed by the estates department.

We observed that items with the potential to be hazardous to health (COSHH) were locked away securely. The division had scored an average of 87.5% for COSHH compliance between April 2022 and March 2023.

We observed that waste was managed appropriately by staff. Audits for appropriate management of waste had been 100% for the division between January and April 2023, however in May was 82%.

Assessing and responding to patient risk

Staff did not always identify and quickly act upon patients at risk of deterioration. Staff did not always have the resources to support patient's needs. Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff did not always identify and quickly respond to patients at risk of deterioration. Staff used the nationally recognised early warning scoring (NEWS2) tool to identify deteriorating patients. Despite staff having a good knowledge of the NEWS2 tool and 89% of nurses having completed the NEWS2 optional training module we reviewed an audit completed between January and March 2023 that showed that 12 out of 32 sets of observations had been recorded incorrectly.

The trust had a sepsis pathway which was in accordance with the United Kingdom's Sepsis Trust guidelines. There was a sepsis lead nurse and a consultant for the organisation who provided training to the "sepsis champions" on the division. The sepsis leads and champions shared information around best practice about sepsis. We reviewed data from the last quarter of 2022. Staff provided antimicrobials within 1 hour of a suspected sepsis diagnosis to 78% of patients and 82% of patients within 90 minutes. New national guidance which now takes into consideration the time a patient deteriorates, instead of a suspected sepsis diagnosis has been introduced meaning the data from the last quarter of 2022 now shows that 58% of patients received antimicrobials within an hour. The trust had identified this fall in performance and had implemented actions including an electronic dashboard with the aim of identifying and escalating patients quicker based on their NEWS2 score and further sepsis education delivered by the sepsis lead nurse.

Staff did not always have the resources to support patients when they were at risk of deteriorating. Staff were not able to support patients who required thrombectomies (a type of surgery to remove a blood clot from inside an artery or vein) at weekends, despite being commissioned to do so, which had led to 8 incidents of severe harm between March 2021 and December 2022. There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7 – day week.

Patients were not always reviewed by senior decision makers in a timely manner. We saw evidence from the Same Day Emergency Care (SDEC) Unit which showed between December 2022 and February 2023 that an average of 42% of patients had been reviewed every 24 hours by a senior decision maker compared to the trusts 90% target. In the same time period, an average of 82% of patients had a clinical assessment by a consultant within 14 hours compared to the trust's target of 90%. However, staff did have access to out of hours consultants, registrars, and junior doctors if they had urgent concerns regarding patients.

Enhanced patient observations or 1 to 1 nursing was used for patients who were at risk of falls but were being cared for in side rooms, however staff told us that due to health care assistant shortages 1 to 1 nursing could not always be guaranteed.

Some staff told us they had concerns regarding the competency of staff on the AAU. They explained that many of the staff had been redeployed from a general medical unit and did not have experience in acute medicine. Four training days had been arranged by the practice educator for the division including acute internal medicine training (AIMS) and intermediate life support (ILS).

Staff told us how they felt unequipped to manage certain patients' mental health needs and the number of patients with mental health needs and eating disorders entering the division was causing staff to feel "burned out." These risks were identified on the divisions risk register. Leaders for the division acknowledged that some patients with mental health needs were not being assessed daily by psychiatrists due to the demand and lack of resources but were assured there was appropriate support available from the safeguarding team and mental health leads. The trust had provided a training package so staff could complete a mental health risk scoring tool with patients before they were assessed by the mental health liaison service. The completion rate for the mental health risk identification and management tool for the division was 92%. The trust was working closely with the mental health trust through improvement groups to manage these risks.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Updates to risk assessments due for each patient were detailed on the handover document for each patient. Risk assessments carried out included risk of pressure ulcers, malnutrition, and falls. There were nursing assessments for each patient that included hygiene, cannulas, and physiological observations. During the inspection, we reviewed patients' risk assessment processes and management. The care provided was safe and appropriate with most documentation being detailed, and outcomes recorded in a timely manner.

Stroke clinical nurse specialists provided 24-hour cover for the emergency department. They administered thrombolysis (a clot busting drug) to patients who had suffered ischemic strokes. The imaging department kept 4 transient ischemic attack slots for magnetic resonance imaging (MRI) and 2 doppler ultrasound scan slots open for emergencies.

The division had access to the critical outreach team 24 hours per day should a patient suddenly require emergency intervention.

On the endoscopy unit, staff had a gastrointestinal endoscopy checklist that they followed when the patient signed in, before them being administered medication and when the patient was leaving the procedural area.

Staff were able to inform us of patients on the ward with identified risks, such as vulnerability and existing pressure sores.

Staff had a good understanding of how to resolve conflicts and the compliance rate for conflict resolution training was 90%.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Medical care (including older people's care)

The overall staffing fill rate for adult inpatient wards in April 2023 was 92%. We reviewed the staff fill rate for 10 of the wards on the medical division. We found that 9 out of the 10 wards had a fill rate of over 80%. For example, the AFU had a 98% fill rate for registered and unregistered staff for the day shift. The fill rate was 90% for registered nurses and 101% for unregistered staff for the night shift. Ward 24 had over a 100% fill rate for registered and unregistered staff on the night shift. The AAU was the only outlier from the 10 wards we reviewed. The fill rate was 74% for unregistered nurses for day shifts and 77% for both registered and unregistered staff for the night shift.

The leaders of the division told us they were fully established for registered nurses due to an international recruitment programme which had reduced nurse vacancies from 350 whole time equivalent to 0 whole time equivalent on the division.

The trust had a 12.3% vacancy rate for band 2 and band 3 health care assistants (HCA). According to leaders, the medical division had 120 health care assistant positions that were vacant. 45 of these positions had been recruited to and staff were currently in training. This vacancy rate had improved since March 2023 when there were 250 vacancies. Staff on ward 17 (elderly ward) expressed concern about enhanced care being difficult to maintain due to the shortage of HCA's. However, leaders told us that the HCA vacancy rate was mitigated by an over establishment of registered nurses, who whilst in training and awaiting registration would support 1 to 1 care provision. This was evidenced by 14 of the 24 medical wards being over established. The leaders of the division were recruiting more HCA's as part of their workforce plan (people plan).

Managers attempted to accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used an electronic system called "safe care." The system reviewed electronic rosters, staff working on that day and the acuity of patient's and was able to indicate "red flags" which included when there were less than 2 registered nurses on a ward during any shift.

Matrons reviewed the staffing levels at staffing meetings which occurred twice daily, in the morning and late afternoon.

Specialist areas such as the coronary care unit, the respiratory high care ward and stroke unit had the appropriate levels of staffing planned for patients. Leaders had changed staffing assessments to ensure these areas always had 2 senior nurses on shift.

Managers gave all new staff a full induction tailored to their role before they started work. The induction programme included the mandatory training staff needed to complete within the first month of working for the trust and key policies and procedures that staff had to familiarise themselves with.

We held focus groups following the inspection with clinical and non-clinical staff. Staff told us nurse staffing had become more robust, there was good cross divisional working and regular workforce reviews. However, they felt the skill mix on the medical wards needed resolving and agency and bank staff were used too regularly.

The medical division had a low but variable turnover rate for nursing staff between November 2022 and April 2023. It ranged from 0.84% (full time equivalent) to 0.33% (FTE). In April 2023, the turnover rate for nursing staff was 0.55%.

Shift changes and handovers included all necessary key information to keep patients safe. We attended nursing and medical handovers and observed them being well attended by staff, that all patients were discussed in detail (including their psychological needs) and the purpose and outcomes were clear.

The division had 2 occupational therapists and 4 physiotherapists. At the time of our inspection there were approximately 220 patients on the medical division. Leaders told us that there would be 2 further occupational therapists joining the team in due course.

Core therapy services were provided by the diagnostic support division. The physiotherapy vacancy rate was small. There were some challenges including the recruitment of occupational therapists, but the chief allied health professional was looking at innovative ways to resolve issues including proposals for different models of care which had gone to the board for approval.

The trust had an absence rate of 6.3% for March 2023 which was higher than the sector average (5.3%). The main reason for absence from work was anxiety, stress, depression, or other psychological symptoms. In April 2023, nursing staff had a 5.16% (FTE) absence rate, whilst AHP's had a 1.49% absence rate for the medical division.

Medical staffing

The service did not always have enough registered medical staff but used locum staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The leaders for the medical division told us one of their biggest risks was the shortage of medical staff on the division. They told us there were gaps in medical cover for the respiratory service and an insufficient amount of consultant cardiologists and registrars to meet the demands of the service. In the April 2023 workforce committee meeting minutes for the medicine division, it was reported there were 'almost 84' whole time equivalent medical vacancies for the division. The risk was reported on the risk register and the leaders were discussing with executives how they could change job plans and look to increase resources.

The division did not have enough neuro interventional radiographers to provide a 7-day thrombectomy service which had led to 8 severe incidents directly related. The division had recently employed 1 member of staff and were awaiting another to return to work following parental leave. The division had plans to offer a 7-day thrombectomy service from September 2023.

The vacancy rates in March 2023 for junior clinical fellows was 29%, senior clinical fellows 26%, consultants 14% and Speciality and Specialist (SAS) doctors 16%. We were told there was 7 vacancies on the elderly medical ward and 5 vacancies on the respiratory ward which included 3 consultants and 2 senior clinical fellows.

The division had low turnover rates for medical staff. In March 2023, the turnover rate was 1.04% and in April 2023 it was 1.31%.

The division had low and reducing rates of sickness rates for medical staff. In April 2023, the sickness rate was 1.96%.

Managers made sure locums had a full induction to the service before they started work.

Staff told us that trainee doctors working on the MAU were missing valuable training opportunities as they were covering the MAU and AAU.

Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment and records and were clear, easily available to all staff providing care and up to date. Records were not always stored securely.

Patients' notes were updated by nursing staff through an electronic patient record (EPR). Staff we spoke to told us the system was easy to use, and they had been sufficiently trained.

The EPR system was username and password protected. We observed staff locking computers when they were not being used.

Most patient records were stored online. On most wards, sophisticated systems were in place which ensured data was easily accessible for staff. However, on the AAU, staff told us they used paper-based assessments which they said was time consuming as they had to be scanned onto the EPR system.

Patients' observational charts and intentional rounding tools were completed in line with trust policy.

Patients identified with a dementia, a learning disability, autism, or a physical disability were identified in the clinical electronic records using a flag. The flag indicated that reasonable adjustments were needed which ensured that the patient's care was not compromised due to their cognitive or functioning impairment.

We reviewed the records of 15 patients across the medical inpatient wards. Records were completed appropriately and included the relevant assessments and observations. Staff recorded risk assessments that had been completed when a patient was admitted to a ward and the EPR system would then alert them when they needed to be repeated. However, audit results for the division from both sites for risk assessments and care plans being completed was under 80% between February and May 2023 and below 70% for intentional rounding documentation (process that nurses follow to carry out regular checks) in the same time period.

Patient records were not always stored securely, we saw 2 patient records outside side rooms on ward 20 and a letter containing confidential details regarding a patient at an unmanned reception desk on ward 23. The division was audited for storing notes safely and had scored 83.2% for April 2023 and May 2023 compared to the trusts target of 90%.

Medicines

Staff did not always follow systems and processes to prescribe and administer medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. The service had electronic prescribing and medicine administration (ePMA). We found medicines were prescribed safely. The trusts medicine safety improvement work had resulted in a reduction in the number of missed doses of critical medicines.

Audit results showed the missed doses had reduced from 4.20% December 2022 to 2% in April 2023. However, we saw evidence of medicines not always being administered as prescribed. We found 1 person was prescribed antimicrobials for an infection however they did not receive the first dose of their medicine for 4 hours. We saw another person did not get their once weekly medicine for osteoporosis. We also found a person who was prescribed a medicine with a minimum time interval between repeated doses, was given repeated doses of their medicine too close together. This placed the person at risk of unnecessary overdose.

We raised this with the nursing staff during the inspection so steps could be taken to address this. The trust had a self-administration policy, however the medicines included in the policy were limited and did not promote and support people to self-administer their medicines. We found one person was self-administering one of their medicines that was not included in the trust's policy.

We found people's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine they had previously reacted to. Information provided by the trust showed staff reported medicine related incidents and near misses. The Medication Safety Team review and monitor types, trends, and rates of errors.

Staff stored and managed all medicines and prescribing documents safely. We found medicines were stored safely and securely. Medicines were available to staff out of hours and an on-call rota for pharmacy staff was in place to provide pharmacy support. The pharmacy team attended the wards at regular intervals to ensure stock was appropriately managed and checked medicine expiry dates. We randomly checked expiry dates of medicines and found no issues. However, information provided by the trust showed poor compliance with the trust's medication safety audit at 79.4% in March 2023 identifying as red, with the green target at 90.1%. The service had been within the red or amber results in the previous 4 months. The trust pharmacy had plans to roll out rapid improvement cycles focuses on medicines safety, targeted toward areas with poor compliance.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff were present on several wards to review and reconcile people's medicines to ensure the medicines they were prescribed were correct (50% Medicines Histories, 34% Medicines Reconciliation completed in 24hours, trust data May 2023). This meant there was a risk people may not be prescribed all their medicines as they had not had a medicines reconciliation within 24 hours of admission (National Institute for Care Excellence Guidance NG5). This was linked to pressures within the pharmacy department, with the trust confirming they had an approximate 40% vacancy rate of some pharmacist roles and approximately 30% of pharmacy technician roles in the year to March 2023. A number of these vacancies had been recruited to, commencing in Q2/Q3 2023.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We found 2 people on the medical wards were prescribed a medicine to control their behaviour. We found the documentation to support the reasoning for doses being administered were not always thorough and clear. However, clinical staff had requested the support of the mental health team for 1 person.

The trust was developing a policy to support staff to safely prescribe, administer medicines and monitor people with acute and severe agitation. Staff will receive training following the development and implementation of the new policy.

Incidents

The service mainly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had an incident reporting policy which was up to date at the time of the inspection. Most staff knew what incidents to report and how to report them. When staff completed an incident report on the trusts electronic reporting system it was then reviewed by the ward manager or sister. However, on the inspection we became aware of a medication incident in which a patient had not been provided with vital medication for a condition and was self-administering it instead. This incident was not reported, we raised this with the matron for the ward who quickly resolved this.

Medical care (including older people's care)

The medical division had reported 8906 incidents between 1 June 2022 and 30 May 2023. From those incidents 42 were reported as serious incidents. The 3 highest ranking categories for serious incidents were pressure ulcers (8), slips, trips, and falls (7) and sub optimal care of a deteriorating patient (6).

We saw evidence of incidents being discussed in committees and being escalated. The medical division reported 46 incidents of violence and aggression towards staff in May 2023. This was reviewed in the safety and quality committee in May 2023. Actions to identify the categories of abuser was suggested and the theme would be escalated to the health and safety governance committee.

We found an increased number of severe harm cases between 1 January and 31 March 2023. This was due to an incident panel review which had identified 8 cases of severe harm which related to the thrombectomy service not being available out of hours. We reviewed the investigation and found detailed explanations of the incidents, causes and proposed actions.

The medical division (including ED) had reported 3 'Never Events' in the last 12 months. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. These incidents were related to the emergency department, please see the emergency department report for more details.

The medical division reported 53 incidents relating to 'insufficient numbers of healthcare professionals' or 'insufficient numbers of support staff' between 1 December 2022 and 31 May 2023.

Ward managers shared incidents and findings with their staff through team meetings, team huddles and via group communication routes. Patient safety bulletins were published twice a week in line with the trust's 'Always Safety First' strategy and contained learning identified through the safety and learning group and updated staff on urgent safety bulletins. We reviewed the safety and quality committee meeting minutes from May 2023 which showed that lessons learned from the Never Events was discussed in a presentation format and shared on the trusts intranet page for staff to review.

Each ward had a governance board which staff, patients and visitors could observe on entering the ward or unit. Incidents was one of the topics on the board. Some areas such as the stroke unit had up to date incident information including patient falls, medication incidents and violence and aggression. In contrast, the AAU displayed 0 incidents despite the ward manager reporting there had been approximately 10 falls in May 2023.

On wards that had an increased number of hospital acquired pressure ulcers or falls we observed information boards specific to those areas that acted as a reminder for staff.

Staff understood the duty of candour. They were open and transparent and gave families a full explanation when things went wrong. Clinical meetings were held regularly to discuss incidents triggering duty of candour. Evidence from the trust showed that the medical division was over 90% compliant with the duty of candour for moderate and above incidents in February 2023. We reviewed evidence of letters apologising for treatment that patients had received whilst in hospital.

Most staff on the division had completed non mandatory training for serious investigations (83% medical staff, 82% nursing staff and 85% nurse support staff).

Medical care (including older people's care)

The trusts mortality meetings had been replaced by another process called a Structured Judgment Review (SJR). Reviews of SJR's were carried out monthly. We received data from April 2022 to March 2023 and saw the medical division had exceeded the trust target of completing 20% of reviews for deaths that had occurred.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a list of current policies, procedures, and clinical guidelines that the trust sent us following our inspection and all the documents were in date. The trust had a process for renewing policies in line with their review date. The author and relevant manager were alerted 6 months before the review date and asked to review the content which ensured the document remained valid.

Staff had access to a range of evidence based clinical care pathways with relevant conditions. These included sepsis, atrial fibrillation, stroke, frailty, and inflammatory bowel disease. Patients with alcohol dependency were treated on the alcohol detoxification pathway. The service had a frailty pathway and a virtual ward facility for patients with complex care needs, this pathway reduced the length of stay of frail patients.

Patients with alcohol dependency were treated following an alcohol detoxification pathway. The service had a frailty pathway which identified patients with higher or more complex care needs, and we saw evidence that use of this pathway had helped to reduce length of stay of frail patients.

There was a sepsis standard operating procedure and flowcharts for staff to follow in case of suspected sepsis.

Patients receiving acute non-invasive ventilation (NIV) were treated in a designated respiratory ward in line with British Thoracic Society (BTS) quality standards for acute non-invasive ventilation in adults.

Nurses on the acute stroke unit, had been trained to use the National Institute of Health Stroke Score (NIHSS) which was used to evaluate the neurological status of acute stroke patients.

Specialist stroke consultants assessed patients who were thought to be having a stroke. Following the assessment, if a stroke had been confirmed they were put on to the stroke pathway.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

The division took part in national audits. See patient outcomes section of the report.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required. Staff asked for support from mental health liaison specialists when providing care and treatment for patients with mental ill health.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs. However, the Speech and Language Therapy service was not available 7 days a week.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection, we saw staff providing patients with food and drinks.

Staff fully and accurately completed patients' fluid charts when needed. A learning improvement group, which met monthly had been put in place following substandard fluid balance compliance scores in 2021. Since then, actions had been taken, such as updating the patients' electronic record to include a cumulative running total of fluid balance for staff to see. Since these actions had been embedded, records reporting patient output had been more accurate and between 85 to 90% for April and May 2023. Audits for eVital signs and fluid audits had also improved and were between 80 and 90% between February and May 2023.

Nutritional status boards were situated on the wards we visited. This included information about patients' dietary requirements including if they required soft food or were 'nil by mouth.'

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST). The MUST was a five-step screening tool which identified adults who were malnourished, at risk of malnourishment or at risk of obesity. If patients scored highly on the MUST they were referred to a dietician or the nutritional support team.

Patients had a good choice of food, including optional menus for patients who had specific dietetic or religious requirements. The division operated protected mealtimes to encourage patients to eat without interruption. We observed patients had access to water at their bed side. We observed patients being assisted to an upright sitting position to eat their meal during lunchtimes. Patients were helped to feed themselves or assisted appropriately if needed.

Specialist support from staff such as speech and language therapists were not always available. The speech and language team operated a 5-day service and did not work on Bank Holidays.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed and monitored patients regularly to see if they were in pain. Pain was assessed as part of the NEWS2 score. We reviewed 15 patient records and found that pain scores were recorded for all patients and that pain relief had been administered timely and appropriately.

Patients told us they were regularly asked whether they required pain relief and received it soon after requesting it.

The trust had pain assessment tools on the trust intranet for patients who could not communicate verbally.

The hospital had an inpatient pain team which included 4 specialist nurses and was led by a consultant with a special interest in acute pain.

Patient outcomes

Relevant national and local audits did not always show good outcomes for patients. However, the service did use the findings to make improvements and had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national and local audits. Out of 113 audits, 18 were classed as national mandatory audits, 6 national audits and 88 local audits. 28% of the audits had been completed. The audit results for the service were mixed and some had been impacted upon by the COVID – 19 pandemic. We did see evidence that managers used the results to improve patient outcomes.

The trust took part in the Myocardial Ischaemia National Audit Programme (MINAP) between 2020 and 2021. MINAP contains information about the care provided to patients who are admitted to hospital with acute coronary syndromes. The trust scored 64% which was below the national aggregate of 102% for case ascertainment (a metric which shows the proportion of eligible cases submitted to the audit), 73% for the proportion of patients receiving appropriate secondary prevention medications against the national standard of 80% and the national aggregate of 90% and 84% for the rate of referral to a cardiac rehabilitation programme following discharge compared to a national aggregate of 81% and a national target of 85%.

The care organisation had exceeded 3 out of 6 metrics for the 2021 National Heart Failure Audit but were below national targets for the other 3. The trust had implemented actions such as maintaining some of the heart failure nursing team who were redeployed during the Covid 19 pandemic to increase the number of patients who can be reviewed.

The respiratory department met 1 out of 5 (25%) of the key standards set out in the national adult asthma audit between 2020 and 2021. The administration of systemic steroids within 1 hour of arrival at hospital was 24% and respiratory reviews within 24 hours of arrival at hospital was 21%. One of the standards, regarding peak flow recordings was at 0%, this was due to it being stopped for IPC reasons during the COVID-19 pandemic. The division had ensured that peak flow rate was now available in the electronic recording system and there was a respiratory inreach team who reviewed the administration of steroids within 1 hour of arrival. The respiratory department also scored 98.6% regarding the prescription of oxygen on ward 23 and 100% for a DNACPR audit that was completed on 19 patient records.

The general medicine department were audited for blood culture collection in the treatment of sepsis patients. From 25 patients, 11 had ‘Blood culture’ in their initial medical plan (44%), 15 from the 25 had their blood cultures taken (60%) and 5 from 25 (20%) had their blood cultures taken before the first dose of antibiotics administration. The findings were presented at meetings across the relevant wards to raise awareness of the importance of blood cultures being completed.

The areas on the medical division were audited monthly, as part of the safety triangulation accreditation review (STAR). Within the division, 30 out of 35 clinical areas submitted their review for April 2023 and demonstrated 87% compliance for April 2023. Between February 2022 and February 2023, the division had not achieved the trusts target of 95% and had scored under 80% on 4 occasions. The MAU and the cardiac catheterisation laboratory required escalation to divisional leadership as they had scored under the expected range for 3 consecutive months.

Medical care (including older people's care)

The wards also took part in a ward accreditation scheme which was unannounced and undertaken by a member of the quality assurance team, governors, volunteers, and colleagues. The wards were assessed in various areas including the environment, documentation, infection prevention and control and listening to patients. Wards were graded from red, amber, or green depending on the level of assurance gained. Those rated red or amber achieved a bronze star, those who had achieved green were awarded a silver star and a gold star was given when there were 3 consecutive green ratings. In April 2023, 6 medical wards from the Royal Preston Hospital took part in the accreditation scheme and either maintained their score or improved it. Between April 2022 and February 2023, the division had an average of 58% of its wards and units rated silver or above, compared to the trust target of 75%.

Patient falls had been worse than the monthly target for the division for 17 of the past 20 months between October 2021 and May 2023. A falls 'Big Room' had commenced to look at ways to reduce incidents. Progress was monitored via the Divisional Always Safety-First meetings.

Pressure ulcers had been worse than the monthly target for the division for the last 18 months between December 2022 and May 2023. The division had a plan to reduce pressure ulcers by 10%. The target between April 2022 and April 2023 was 343. We reviewed data between April 2022 and February 2023 and found there had been 541. Pressure ulcer reduction and improvement was included as part of the Always Safety-First Improvement Programme.

The Sentinel Stroke National Audit Programme (SSNAP) data showed that, overall, The Royal Preston Hospital achieved grade B between Jan and March 2023 which had improved from April 2022 when they had an overall rating of D. SSNAP scores range from A (best) to E (worst).

The stroke team had implemented several initiatives which improved the rating including recruitment to core therapy services, speech, and language therapy and to nurse consultants. They had implemented an internal SSNAP dashboard which allowed the team to monitor progress in real time and a daily multi – disciplinary board round which included the community team on the acute stroke unit. These improvements had positively impacted upon some of the individual SSNAP domains including thrombolysis, occupational therapy, physiotherapy, speech and language therapy and multi-disciplinary team working.

The care organisation recognised that the 'stroke unit' domain was consistently scored as E. This domain showed how 38% of patients were directly admitted to the stroke unit within 4 hours, that the median time for a patient to arrive on the stroke unit after the clock had started was 6 and a half hours and that 76% of patients spent 90% of their stay on the stroke unit. Although the care organisation had made improvements from April 2022 to March 2023, they consistently achieved an E rating for this domain. The division and trusts risk register had the SSNAP data recorded as a risk and actions were in place.

The endoscopy service had completed monthly audits which ensured they were compliant with 6 World Health Organisation (WHO) checklists including when the patient signed in and signed out. They scored a mean average of 97.88% for compliance with the checklists and actions had been identified to improve performance.

The trust had introduced an initiative which had reduced waiting times on gastroenterology from 72 hours to 33 hours (a 54% reduction).

Venous Thromboembolism (VTE) Prophylaxis prescribing for out of hours acute admissions was at 100%.

Medical care (including older people's care)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. From the division, 96% of medical staff, 91% of nursing staff and 89% of the supporting staff had completed their appraisal. The overall compliance rate was 90%. During our focus groups, following the inspection, most staff groups spoke positively about the appraisal process.

Managers provided examples of instances in which they had identified poor staff performance promptly and supported staff to improve. They told us they would involve their matrons, seek support from human resources when required and look to support the member of staff through various means including increasing the period of supernumerary status (not counted as part of the workforce whilst they are learning or on placement in a clinical setting) for those who were training.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. For example, the band 5 and band 6 nurses had monthly 1:1's with their matron and the nurses on the stroke ward received clinical supervision twice a month. However, from the focus groups completed following the inspection, staff had mixed responses regarding whether they felt supported to develop in their roles. They told us how it was dependent on the ward manager and the areas of the medicine division that they worked on.

Managers made sure that temporary staff, including bank and agency staff had access to an information pack on every ward which provided them with the appropriate processes to complete their roles competently.

Managers ensured that staff received specialist training for their role. All 9 stroke clinical nurse specialists, who provided 24-hour cover to administer thrombolysis, had completed an advanced thrombolysis module within their supernumerary period. All band 3 to band 7 nurses and care assistants had completed face to face or e learning for recording electrocardiograms (ECG's). The sepsis pathway, including the "sepsis six" was included as part of the newly qualified nurse's preceptorship (a structured period for newly qualified staff when they start their employment in the NHS).

However, the overall compliance rate for non-invasive ventilation (NIV) competency assessments was 41%. We were told that this was due to an increased number of new starters, including internationally recruited nurses who were about to complete their preceptorship period. The unit had been provided with 2 ward managers to help increase the compliance rate by October 2023. Band 6 nurses, who were 88% compliant for the NIV competency assessments were rostered on to each shift.

The clinical educators were available for staff to support them in achieving competencies or training goals. They maintained records of role specific training for staff, for example, dementia awareness training, pressure ulcer training and diabetes training. Staff we spoke with said they had good access to the clinical educators and felt supported.

We saw there was a wide range of specialist nurses, for example the pain management team, infection control team, palliative care team, diabetes nurses, safeguarding and dementia leads, who supported staff in ensuring they were delivering competent care. Staff told us they valued the input of these teams who were proactive at team meetings and on the wards.

Medical care (including older people's care)

Some doctors from the focus groups that we completed told us there was a lack of support for junior doctors within the medicine division. They explained this was due to consultants being asked to do more than expected and them not getting the training opportunities due to overcrowding and service demand.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked closely with social care organisations and community healthcare services when planning discharges of patients with complex needs. Staff could refer to a dedicated discharge team if required. We reviewed discharge letters which contained appropriate clinical information about patients' hospital stay, which were shared with the general practitioner.

We were told about and saw various example of staff working well as a team across the division. We saw positive interactions between staff, including senior staff and students. Doctors told us that microbiology and the infectious disease team supported them well regarding the sepsis pathway and the in-reach service was excellent. The stroke unit told us how they worked closely with the local ambulance trust to provide timely care to stroke patients. The enhanced high care unit worked closely with non-medical consultant practitioners from the trust specialist ventilation team.

Staff had regular multidisciplinary meetings to discuss patients. Board rounds took place daily which included all members of the multidisciplinary team (MDT) such as occupational therapists, physiotherapists, nursing, and medical staff. On the medical assessment unit handovers occurred at key points during the day. These included nursing to nursing team handovers, pre-ward round handover, a post ward round multidisciplinary handover and an afternoon wrap around handover focusing on any cases of concern. We observed handovers of patients and found them to be well attended, clear and concise, with appropriate discussion of the holistic needs of each patient.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. Leaders recognised the mental health service was under pressure currently and as such were working with the mental health trust to improve processes. The trust had recently provided the local mental health trust access to the electronic patient record system which allowed them better access to assessments, risks, and plans for medication and supported the delivery of timely patient care.

Consultants reviewed patients to ensure their care and treatment was effective. Records showed that patients treatment plans were co-ordinated to support their individual needs.

Some staff voiced concerns regarding the medical outlier teams not always sharing the outcomes from consultations with patients on their wards. Staff explained that they would be expected to read the patients notes for updates instead of being given a summary verbally.

Seven-day services

Not all key services were available 7 days a week.

The division had systems to help care for patients in need of additional support or specialist intervention, but these services were not always available 7 days a week. The trust provided a dedicated stroke service to patients for Lancashire and South Cumbria and saw on average between 3 – 5 suspected or confirmed acute stroke admissions per

day, however the Thrombectomy service which was commissioned to be delivered over 7 days from 8am – 6pm was only available from Monday to Friday between those times due to workforce limitations. There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7 – day week.

Consultants led daily ward rounds on all wards, but this did not include the weekends, meaning they did not meet the NHS services, 7-day services clinical priority standards for time to first consultant review. A consultant review could be requested for patients that required one via an electronic system which staff had access to. Out of hours, staff could contact a senior house officer (junior doctor) or a registrar (a doctor in the middle of their training) if they needed support. There was also a consultant on call 24 hours a day.

On the stroke unit, telemedicine was in place so that patients could be reviewed out of hours, additionally consultants could access patient scans remotely out of hours.

Staff could call for support from mental health services, discharge facilitators and diagnostic tests, 24 hours a day, seven days a week.

The physiotherapy team worked 6 days a week and the speech and language and palliative care team worked 5 days a week. The occupational therapy team had a limited service at the weekend and prioritised discharges.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The division had information promoting healthy lifestyles and support on the wards/units including information leaflets on smoking cessation, diabetes, and coronary heart disease.

Staff assessed patients' health when admitted and gave support to them to live healthier lifestyles.

Patients with a history of drug or alcohol abuse were referred to the alcohol and drug liaison team, which provided support to the patient and liaised with community services regarding ongoing support on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients were risk assessed with regards to their mental capacity and deprivation of liberty safeguards (DoLS). Staff who assessed patients as lacking capacity would then make a referral to the safeguarding team who carried out a more detailed mental capacity assessment.

We reviewed 3 do not attempt cardiopulmonary resuscitation (DNACPR) forms during our inspection. The forms included why the DNACPR had been put in place, whether a discussion had been held with the patient and the clinician and if this had been communicated with a family member. All were completed correctly, apart from 1 which had not recorded the discussion held with the patient which indicated whether they were aware of the decision. We reviewed an audit which reviewed the DNACPR decisions and found that staff on the medical division had achieved or exceeded the target of 90.3% between February 2023 and May 2023.

Medical care (including older people's care)

We observed several patients on the medical wards under a DoLS order. We found that the documentation had been completed correctly in all patient records that we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They told us that they would speak with the safeguarding leads for the division if they needed support.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training for staff covered consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. MCA and DoLS was included in the safeguarding adults' modules that staff completed. See the safeguarding section of the report for compliance rates.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and took account of their individual needs.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw numerous examples of staff having positive interactions with staff, including a matron taking time out from a busy schedule to speak with a patient living with dementia.

We spoke with 15 patients who told us that staff treated them with kindness and respect. One patient said that staff were 'caring, friendly, devoted and attentive.'

During consultations with nursing or medical staff, curtains and doors were closed which ensured privacy for patients.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw examples of staff assisting patients who were distressed in an open setting. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Medical care (including older people's care)

We observed an interaction between a matron and a patient living with dementia. The matron, who was busy, ensured she took time out of her day to speak to the patient and attend to their needs.

Staff demonstrated empathy when having difficult conversations with patients and told us they would utilise private rooms (such as the relatives' rooms) when delivering bad news to patients or their relatives. The relative's room on ward 20 (care of the elderly) was also used for family to stay overnight if patients were receiving palliative care.

Patients or their relatives could be referred for access to psychological support if required. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement. The care organisation had a multi-faith chaplaincy service which was available for spiritual or religious support to patients of all faiths and beliefs.

We observed a 'treatment dog' on ward 20. We spoke with staff who told us they arranged regular visits as it was associated with a reduced state of anxiety for patients.

Understanding and involvement of patients and those close to them

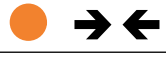
Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their families shared their experience of the hospital via the friends and family test. Patients and families gave positive feedback about the service. between January and May 2023, the inpatient wards had consistently achieved over 85% which is the trusts expected percentage.

Staff supported patients to make informed decisions about their care. We spoke with 15 patients. Most patients, 12 out of 15 said that nursing and medical staff fully explained the care and treatment options which allowed them to make informed decisions. However, the further 3 patients told us they had to continuously ask for updates and when they were communicated with the information was provided too quickly.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people.

The services facilities and premises were not always appropriate for the services being delivered. The service did not always meet the needs of local people and the communities served.

The premises and facilities were not always appropriate for the services being delivered. There was pressure for beds on the division which included cardiorespiratory services were the demand was higher than the capacity that facilities could provide. This caused some patients to be based on nonmedical wards as outliers which meant that care was not

always being delivered to patients by the right ward speciality. The trust provided us with data which showed that medical reviews for medical outliers were not always completed, in May 2023, 23% of medical outlier reviews for the trust had not been completed. The risks regarding bed capacity were identified on the divisional and trust wide risk registers and the leaders were aware when we spoke with them.

The stroke unit no longer had a hyper acute stroke unit (a unit dedicated to monitoring and stabilising a patient newly diagnosed with a stroke), although there were plans to open this in June 2023, or a gymnasium for physiotherapy.

The showering facilities on the AAU, AFU and Ward 17 were either not in good working order or breached the mixed sex standard.

The division's ability to discharge patients was impacted upon due to challenges for the provision of care in the community. Wards had discharge coordinators whose role was to plan discharges and liaise with other bodies to ensure safe discharge. The trust also attempted to lessen the impact of the external difficulties with flow by introducing an acute assessment unit and by utilising the acute frailty unit and the same day emergency care (SDEC) unit. The SDEC had 20 beds which relieved pressure on other departments such as the emergency department when they could treat patients in a day. The division also had access to a 7 day discharge lounge.

Virtual wards across frailty, respiratory and SDEC focused on using digital support for patients at home during their recovery were in place.

The division had a step-down unit on site called Fell View for patients who were medically optimised but required support before them returning into the community. The trust had also opened a community health care hub at 'Finney House' for patients who no longer met the criteria to reside in an acute hospital but required support such as rehabilitation or a package of care before them returning into the community. Finney House offered individual rooms which were finely decorated for 64 patients. Finney House offered a library, cinema room and hairdressers which was available for patients.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Patient's individual needs were identified through comprehensive admission assessments which took into consideration patients physical needs, mental health needs and social needs.

Automatic doors were in place throughout the hospital which ensured access for patients and visitors using wheelchairs. There were enough lifts to all medical areas.

Staff did what they could to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Patients with learning disabilities were supported by the learning disability lead nurse if required. Staff told us that patients with learning disabilities could also be supported more frequently by carers and loved ones under 'John's Campaign.' (This is a nationally recognised campaign which promotes the rights of people in hospital, who are living with dementia to be supported by their family carers).

The trust had dementia champions based on the divisions and offered dementia conferences for staff to attend. Patients living with dementia were highlighted on the medical wards via a blue forget me not flower next to their name on the main patient details board. We observed pledges by staff on different wards of how they would improve care for people living with a dementia diagnosis and artwork which encouraged people to see the person behind the diagnosis of dementia. China tea sets were available for some patients with dementia to make them feel more comfortable and there were open visiting times so they could be supported appropriately.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports which highlighted to staff any impairments and reasonable adjustments required to support them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a sensory loss. The division had activity boxes for partially sighted or blind patients.

The service had information leaflets available in languages spoken by the patients and local community and access to British Sign Language interpreters if needed.

Patients told us they were given a choice of food and drink to meet their cultural and religious preferences.

Chaplaincy facilities were available within the hospital to meet the needs of people with different faiths. These facilities were open to patients and visitors 24 hours a day and located near the entrance to the hospital for ease of access.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were sometimes worse than national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. The division had opened a 20 bedded acute assessment unit which had been running since March 2023. The unit was designed to reduce long waits in the urgent and emergency department and staff told us that this had helped. The unit was run by advanced clinical practitioners and had a different admission criterion than the SDEC. The AFU had 64 admissions in May 2023 and 74% had been discharged without admission to hospital. The SDEC had a standard operating procedure with the local ambulance trust in which some patients were taken directly to this ward instead of ED. On average, 6 patients per day were being taken directly to one of the assessment units and not through ED which meant patients got to the right speciality quicker.

The trust provided data for May 2023 that showed the average length of stay on most wards on the medical division including Fell view, Ward 21 and Ward 24 was shorter than the national average for elective and non-elective patients.

The average length of stay on the SDEC was half a day and on the MAU was 1.9 days, however over 80 patients had breached the 72-hour target on the MAU in March, April, and May 2023. We also saw evidence of a patient being on the AAU for 4 days, despite this being a 24 to 48-hour service.

Medical care (including older people's care)

Staff told us there are not enough beds on the medicine division and there were too many medical outliers (patients admitted to a ward that is not associated with their specific problem). At the time of the inspection, there were 21 medical outliers for the division**.** We observed the demand for patient beds on the division. We attended bed management meetings and heard that wards had reached and exceeded their capacity. Staff told us they had considered completing a thrombolysis procedure on the MAU on the 1st day of our inspection as there were no critical care beds available at the time. Although this did not go ahead, it emphasised the demand on the division. We also spoke to a ward manager on Ward 17 (care of the elderly) who had a patient on the ward who was awaiting a mental health bed and had been waiting just over a week.

The bed capacity for the respiratory high care ward (NIV) was full and therefore patients had to be situated on ICU (Intensive Care Unit) whilst they waited for a bed to become available. There were no 'ring fenced beds' (ensuring acute medical patients have access to surgical beds) for the stroke unit. Finney House, the step-down facility for patients who were medically optimised, was full on the day we inspected.

Staff said they tried to keep moving patients at night to a minimum, however there were times due to service demands that they needed to do this. Incident reports were completed if bed moves at night were completed. The division of medicine had moved 238 patients after 8pm in May 2023 which was an improvement in comparison to April (258) and March (301). From December 2022 to June 2023 there had been 1686 bed moves after 8pm. 1338 of the moves for both Preston and Chorley site have been due to capacity and flow site issues, 567 were due to patients needing a specialist ward and 178 were for a side room.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. They had 2 dedicated teams to review and treat medical outliers. However, medical reviews were not always completed.

The trust had developed their bed escalation and surge plan. It was used alongside the operational pressures escalation level (OPEL) actions cards to ensure all actions, in addition to the escalation of beds, was taking place as appropriate across all areas. (OPEL is a method used by the NHS to measure the stress, demand, and pressure a hospital is under.)

Managers and staff started planning each patient's discharge as early as possible. Staff, including discharge facilitators, planned patients' discharge carefully, particularly for those with complex mental health and social care needs. In handovers, huddles and bed meetings staff discussed patients ready to be discharged and referred to a gold, silver, and bronze system. A gold discharge referred to a patient being discharged before 10am, a silver was 10am onwards and a bronze was a patient who was ready for discharge but awaiting interventions.

The discharge lounge was open Monday to Friday 8am to 8pm and Saturday and Sunday from 8am until 6pm and had space for 20 patients. In April 2023, the discharge lounge discharged 806 patients compared to 554 patients the previous year. Since 2019 there has been a 50% uptake on patients attending the discharge lounge.

Managers monitored the number of patients whose discharge was delayed and knew which wards had the highest number. In May 2023 there were 46 patients who were deemed medically fit for discharge who could not leave the hospital safely. The main reasons were that patients were awaiting care homes, support from the local authority or awaiting joint care from the local authority and NHS. The amount of medically fit patients awaiting discharge had improved, in comparison to the previous 4 months. In April 2023 there were 80 patients who had spent 21 days or more in hospital (super stranded) for the medical division. This had increased from March 2023 but had decreased in comparison to January and February 2023.

The cancer specialities for the division of medicine were lung and neurology. In April and May 2023, the division performed better than its predicted trajectory for patients waiting 63 days or more following an urgent suspected lung cancer referral and for patients waiting for neurology following 65 weeks. Following the inspection, we received data which showed a continuous reduction of patients from the 65 week wait cohort awaiting their neurology appointments. Despite the division achieving the plan towards zero 65-week waiters for neurology by February 2024, the amount in May 2023 was considerable (3762).The division had implemented virtual wards which had helped people with care in their own home.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

From April 2022 to March 2023 the division of medicine (including ED) received 189 complaints which was better than their target of 264. From those complaints 7 had been upheld and 3 cases had gone to the Parliamentary and Health Service Ombudsman (PHSO).

As the medical division covers the emergency department, the main theme for complaints is the length of stay and delays. The trust had implemented actions such as the introduction of Finney House, which had led to almost a 7% reduction in patients who no longer meet the criteria to reside. Other actions will be described in the emergency department section of the report.

We reviewed a list of all complaints for the medical division that had been responded to in the last 6 months. The main themes from the complaints were poor staff attitude, failure to update the family regarding the patient and delays in patients receiving the appropriate treatment.

The division responded to 50% of complaints within 35 days in April 2023. In comparison, they responded to 95% of complaints within 35 days in April 2022. Leaders said this deterioration in performance was due to a period of restoration following the COVID – 19 pandemic in which most complaint responses had been paused. Meetings between the divisional governance team and Patient Advice and Liaison Service (PALS) team have been taking place to ensure oversight of the current position.

Patients, relatives, and carers knew how to complain or raise concerns. The service had a patient advice and liaison service (PALS) and displayed information in patient areas on how patients could make a complaint. Leaflets and posters provided advice on how to give feedback or raise a concern. We saw that on some of the notice boards on the wards they had a section with “you said, we did” where staff had actioned patients’ suggestions.

Staff understood the policy on complaints and knew how to handle them. They were aware of trying to resolve the complaint in the first instance before providing the patient or family member contact details for PALS. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Ward managers and matrons monitored complaints, identified themes, and fed back any learning to their staff.

We reviewed minutes for the last 3 months from the trusts weekly safety and learning group which included an agenda item where complaints were discussed. Learning from complaints was welcomed for discussion and appropriate actions for wider learning taken.

Medical care (including older people's care)

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. Leaders were visible and approachable in the service for patients and staff.

The leadership triumvirate for the division of medicine and emergency and urgent care consisted of a medical director, director of nursing and a director of operations. The triumvirate team had experience in their roles and had worked for the trust for several years. The divisional leadership team oversaw the accident and emergency department and medicine at the Royal Preston Hospital and a further care organisation within the trust.

Nursing leadership was provided at a ward level by a team of charge nurses and matrons who led and supported staff during their daily activities. Staff working at charge nurse level and above were supernumerary and were not counted in ward staffing numbers, however, some charge nurses informed us that if there was an urgent shortage of staff, they would support the ward.

Leaders told us that the main challenges to quality and sustainability for the division were safely maintaining the flow of patients, the workforce and retaining staff, and sizing the environment appropriately following the COVID19 pandemic and the Sentinental Stroke National Audit Programme (SSNAP) compliance. Leaders were knowledgeable about the actions to address these concerns, some of which were longer term, and some were impacted by financial limitations.

Most staff told us that opportunities for career development had improved but this was dependent on the role and department they worked in. Staff were supported to develop and progress into leadership roles as part of succession planning. Staff had access to leadership programmes provided by the NHS Leadership Academy. The trust also offered ward managers leadership and coaching training via a coaching academy.

Ward managers had regular contact with the matrons, sometimes twice daily. We saw evidence of close working relationships between ward managers and matrons.

Most staff told us they were supported and valued by leaders, and they were proud of the work that they did. We saw strong clinical leadership from the ward managers, lead nurses and matrons. During the inspection we saw the director of nursing on the medical wards and found they had a good rapport with staff. However, some staff told us on some wards there was a culture of silo working and how they did not feel listened to by executives regarding issues on the division, including ongoing estate problems due to financial restraints.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Medical care (including older people's care)

The trusts clinical strategy, which was developed in collaboration with staff, people who use services and external partners was called “Our Big Plan.” The mission was to provide excellent healthcare to local communities, to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria and to drive innovation through world class education, training, and research.

The vision and strategy for the division was to enable staff to exceed local and national targets with care and compassion. The vision and strategy had 6 objectives/priorities which were to provide safe care and offer a good patient experience, to respond to COVID-19 concerns, to deliver more elective care and reduce the backlog, to support the patient pathways and ensure the right sizing so that the patient is in the right place at the right time, to provide a 24/7 workforce and retain staff and recruit staff accordingly and to support education and innovation. The priorities outlined within the divisional strategy aligned to the trust strategy.

Metrics were used to compare the measure progress against the division and trust strategy. Progress against the delivery of the strategy and the objectives was reviewed yearly. A yearly report on each strategy was completed and reviewed by the divisional board. We saw evidence from board papers of analysis relating to progress towards “Our Big Plan” going to the board of directors in April 2023.

Most staff that we spoke to were aware of some of the trusts vision and strategy. They told us that it was made clear during meetings and appraisals.

We saw on the AAU the corporate strategy and next to that the goals that the ward had. These goals were aligned to the strategy and included reducing the amount of hospital acquired pressure sores, maintaining compliance in core skills training, and establishing fully integrated pathways with other clinical specialities.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most registered and unregistered staff, including AHP’s, said that they felt respected, supported, and valued and that there was a good culture throughout the medical division. However, there were some wards which had low morale. On 1 ward, staff told us that the lack of health care assistants was causing them stress, especially when they could not offer 1 to 1 nursing as required.

Senior doctors told us that there was a culture of ‘silo working’ on the MAU. They told us how the overcrowding and service demands does not make it conducive for junior doctors to learn and develop.

The trust had systems in place to monitor staff satisfaction and plans to improve it. Leaders for the division told us that the trust had an organisational development and leadership service, made up of chartered occupational psychologists, organisational development practitioners, knowledge and library experts, trained teachers in leadership development and qualified coaches who provided support to teams and specific wards to improve levels of team satisfaction and engagement which was measured through the staff survey. The respiratory ward, MAU and gastroenterology were highlighted as wards that had responded worse on the staff survey when compared to the wider trust average and therefore were either being supported by the Organisational Development (OD) Team or additional support was being sought following further discussion with divisions regarding their concerns.

The division offered incentives such as vouchers or gift cards for employee of the month. Some staff told us how they felt appreciated when they received recognition at the staffing award ceremony which was hosted by the trust. We also saw that a student had been nominated for an award by fellow students on ward 21.

Staff had access to mandatory training which included supporting patients and staff with learning disabilities and neurodivergence. Additional training offered to staff also included lesbian, gay, bisexual and transgender/transexual plus (LGBT+) training. We saw staff wearing LGBT+ badges as an indicator that they had completed the training.

Staff had access to health and wellbeing support located at the Preston site. The centre offered staff a confidential space to discuss their thoughts and feelings and attend classes including Yoga, arts, crafts, and mindfulness. The catering team provided a new health food choice menu for staff to encourage healthy eating and the trust had recently signed up to the Trade Union Congress 'Dying to Work Charter' which ensured that staff with terminal illnesses were supported with decisions regarding work during challenging times.

The medical division had an equality and diversity champion who promoted all aspects of equality and diversity both clinically and non-clinically. Equality and diversity champions worked closely with the Equality, Diversity and Inclusion subcommittee group who produced a report for the Chairperson, in line with the trust's equality, diversity and inclusion strategy (2021-2024) from a staff perspective and from a patient perspective. Staff completed mandatory training on equality, diversity, and human rights. The division had an overall completion rate of 98%.

Staff from the division were complimentary about the Freedom to Speak up Process. They told us that they felt confident escalating concerns to the Freedom to Speak up Guardian. Two members of staff told us how they had used the process and how they were both happy with how it was dealt with and the outcome. From the board papers from June 2023, we saw that 91% of staff that had used the Freedom to Speak up service would use it again.

In the yearly NHS staff survey for 2022, the trust was 1 of 3 trusts in the North West to have increased its overall staff satisfaction score. The trust scored above the national average in 71 out of the 96 questions that staff answered.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical division held monthly divisional board meetings which were attended by the triumvirate. Information was shared at the divisional board meetings from 3 sub committees which were divisional safety and quality, divisional finance and divisional performance and workforce.

A performance improvement forum, speciality governance meetings and committees for IPC, safeguarding, speciality governance and 'always safety first' were completed monthly and the main points from these minutes were escalated to the relevant safety, workforce, or finance subcommittee. Each speciality within the medical division, for example respiratory care, had their own governance structure.

If agenda items could not be resolved within those meetings, they would be escalated to a higher committee. We saw evidence of information from speciality governance meetings being shared at the divisional board committee and the escalation process was clear.

The triumvirate for the division held weekly meetings and told us they were in contact every day via email or text message.

Shift fill rates for nurses and non-registered nurses were monitored through the safety and quality committee. If fill rates were less than 80% this was discussed at the workforce committee and reviewed at matron meetings.

We saw evidence of a 6 monthly cycle of medicine assurance reports being reviewed in the Divisional Safety and Quality Meetings. Within the meetings from December 2022 medicine safety audits, controlled drug audits, prescription verification, medicine reconciliation, missed dose reports, among other areas were all reviewed.

The senior management team were responsible for patient flow on the medical division. The trust operational officer chaired daily capacity meetings and provided clinical leadership to the duty bed managers who liaised with the divisional management teams as required.

Staff had opportunities to meet and discuss issues regarding the division. Nurses, AHP's and corporate governance had an opportunity to meet with the chief of nursing on a weekly basis for any immediate learning from the meetings held. The 'raising concerns group' held meetings bi-monthly which reviewed and responded to concerns raised within the trust by staff. Once themes were identified, they were then fed back to the divisional leadership teams which had resulted in improvement opportunities.

Staff that we spoke to were clear about their roles and responsibilities.

Staff told us that governance structures were much improved, and that rapid incident reviews and investigations were robust.

Despite the governance processes being in place, the meetings were not always well attended. Between March and May 2023, 50% of invited staff attended the finance and performance committee, 33% the safety and quality committee, 19% attended the workforce committee and 52% attended for the divisional board meeting.

Matrons held monthly meetings with ward managers which reviewed the STAR assurance framework and ensured that all areas were being complied with. If some areas needed improvement, matrons and ward managers would collaboratively identify action plans. Matrons produced assurance reports for their wards which were reviewed at the clinical governance meetings. Ward managers would lead monthly ward or unit meetings and shared information regarding audits and targets. However, the division had not met the trust targets of 95% for monthly audits between February 2022 and February 2023 and in May 2023 58% had achieved silver or above for the comprehensive accreditation visits against a 75% trust target.

Management of risk, issues, and performance

Leaders and teams identified risks and issues and had plans to cope with unexpected events. However, some risks were not acted upon in a timely manner.

The trust had systems to record risks, issues, and performance. The risk register was held within the trust's incident and risk management system. The division had its own risk register which on the 1 June 2023 had 20 high risks, 66 significant risks, 12 medium risks and 1 low risk.

The risk register for the division clearly identified the risks and provided all the appropriate details, including the risk handler/owner, the controls and assurances and the risk levels which leaders then reviewed.

Medical care (including older people's care)

We reviewed meeting minutes from the renal clinical governance meetings between March and May 2023 and found that a review of the risk register was the 2nd agenda item. A review of the active risks was provided, and high risks, significant and moderate risks, controlled risks, and newly identified risks were reviewed. In the meeting for April 2023 a risk regarding no suitable ambulatory area for renal care for extremely vulnerable high-risk patients was reviewed and an update was provided on quotes from procurement regarding a tender which included plans to create more space on the unit.

The percentages of risks on the division with overdue actions between August 2022 and February 2023 was under 1% and risk reviews were above 90% within this time frame. The risk register from the division showed that high risks had been reviewed monthly and significant risks had been reviewed quarterly, in line with the trusts policy. However, the division had a target of 90% of active risks that would have an ongoing action plan. We received data from the trust from April 2022 to February 2023 which showed that they had not achieved this target 9 months out of 12. In February 2023 81% of active risks had an ongoing action plan.

The divisional leaders were well sighted on risks and issues in the service, could articulate these clearly, and had systems and processes in place to support good governance. They acknowledged the estate issues concerning the AAU and had an approved business case to increase the MAU's capacity, with plans to review the AAU space once this expansion was completed. In the short term, they had planned improvements for the AAU estate.

The division had pathways in place to support urgent and emergency care. The SDEC took 12% of patients whilst an average of 45% went to urgent care including the MAU and AFU. The division had introduced an AAU to reduce the waits in ED. They told us they needed to work on the right sizing of wards following the COVID-19 pandemic to improve access and flow. They had plans, which had been approved, to increase the size of the MAU from 30 beds to 42 and the AAU to 20 beds. The discharge lounge was being promoted at ward level to increase the number of daily transfers. Admissions to the discharge lounge had increased from a mean of 22.7 in May 2022 to 38.7 in May 2023 and admissions before 12 noon had increased from 4.9 to 11.9. The division had plans to increase admissions to the discharge lounge by the end of the year. To help with this, the division were participating in the development of a discharge whiteboard which identified all discharges within 24 to 48 hours. The division were working closely with the surgery division to capitalise on patients being discharged before 12pm to increase flow.

To address the shortage of HCA's and AHP's the division had ongoing recruitment and retention plans as part of the workforce plan. The medical workforce team were working closely with Clinical Directors and department managers to look to resolve the medical staffing vacancies. They were sourcing doctors through the medical training initiative in liaison with the Royal colleges, promoting vacancies through social media, relevant journals and websites and working with international placement agencies.

Regarding the thrombectomy service, the division was unable to offer it 7 days a week, leading to 8 severe harm incidents between March 2021 and December 2022. The trust acknowledged this as a risk and sought support from two local hospitals that provided the service. Unfortunately, due to their own capacity issues, this assistance was not feasible. However, the division made progress by recruiting a neurointerventional radiographer and expected the return of another staff member after parental leave. This enabled the 7-day service to be planned for availability from September 2023. Further expansion plans and recruitment discussions within the cross divisional thrombectomy mobilisation group were ongoing, with operationalisation expected by April 2024, aiming to offer the service from 8 am to 11 pm, 7 days a week.

Medical care (including older people's care)

The trusts SSNAP data had improved from an overall rating of a D to a B between January and March 2023 following successful initiatives including recruitment to services and the implementation of dashboards that allowed the team to monitor stroke patients in real time.

The division completed standard judgment reviews when deaths occurred. The audit and effectiveness department provided reports for the divisions and reported to the mortality and end of life committee which reported to the safety and quality committee. Between January and March 2023 there were 423 deaths reported for the division and 173 reviews completed.

The division had a lead sepsis nurse who completed a quarterly audit providing data on compliance with the trust sepsis policy. Following the most recent audit, risks were identified about the percentage of patients receiving antimicrobials within 1 hour of suspected sepsis diagnosis. An action plan was formulated which included refining the deteriorating patient dashboards to review the sepsis data within the divisional safety and quality forums and the 'Always Safety First' subcommittee.

The trust had a business continuity plan and an emergency planning, resilience, and response strategy.

However, leaders' ability to achieve sustainable progress and consistently mitigate risks was often compromised by the breadth and complexity of the services delivered, and further compounded by the impact of financial challenge in key parts of the service. The sustainable delivery of quality care was put at risk by the financial challenge. Leaders told us how a lack of finances had impacted on recruitment of medical staff which had delayed the Hyper – acute stroke unit (HASU) being opened sooner. Staff from the stroke unit told us they saw how financial restraints were impacting on the quality of services being offered to patients including the patient gymnasium for rehabilitation having to close.

We frequently heard that although issues were raised appropriately to senior levels of the trust, there was frequently a perceived lack of shared priority from senior leaders for focus on the immediate service issues.

The division had performance committees in place, but poor performance was not always dealt with in a timely manner. We saw trust targets for pressure ulcers, patient moves, falls, stranded patients (14 to 21 days) and super stranded patients (21 days and above) had not been achieved, regardless of actions taken. The trust had not yet delivered 6 of the 10 requirements set out by the NHS for cancer waiting lists and although they were making improvements with some of the cancer waiting targets, others were lengthy.

Risks were discussed within governance meetings, as outlined in the governance section. Given the low attendance rate of key staff, we were not assured they had a clear oversight of risk and within the division.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information systems were secure, well integrated, and reliable. The service used an electronic prescribing and medicines administration system.

The care organisation had access to electronic patient records.

Medical care (including older people's care)

Reviews of safe care, acuity, patient experience, incidents, and staffing were reviewed during workforce reviews. Following this the information was escalated to the trust quality committee and board and adjustments were made as required.

The division had access to safety surveillance dashboard which helped them to visualise the context on the ward. The tool provided a real time summary of information, including how many patients were on the ward, how many patients had a pressure ulcer, the number of outstanding risk assessments and the expected discharges for the day. The real time data fed into the safety surveillance dashboard.

We saw a dashboard for deteriorating patients with all electronic observations which all clinical members of staff had access to. The dashboard refreshed every 15 minutes and patients no longer appeared on it when their NEWS2 score reduced to 3 or under. The dashboard fed into a database which allowed the division to monitor how well they had responded to deteriorating patients.

The division submitted data to external organisations as required.

Staff did not always keep up to date with information governance training. Medical staff compliance was 89% whilst the trust target for information governance was 95%.

Staff said they did not have enough computers on the AAU which meant that uploading paper records was difficult.

There had been 4 externally reported data breaches between 2022 and 2023, 2 of which had been reported to the information commissioner's office (ICO) who are the United Kingdom's independent body for upholding information rights.

On some of the wards, including the AAU, patients' confidential details such as their names and where they were located on the ward were displayed on white boards in patient and visitor areas. Staff told us they were aware of this breaching confidentiality and were awaiting new boards that could close when staff did not require access to them.

Engagement

Leaders and staff openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division engaged with patient support groups such as the motor neurone disease steering group and the Lancashire and Fylde dystonia support group.

Experts by experience (people who have recent personal experience of using or caring for someone who uses heath care services) were utilised by the division. Leaders told us how they were used to support a recent recruitment process for matrons.

Patients thank you cards were displayed on most wards. Information about the family and friends test and for the patient advice and liaison service (PALS) were available on the wards. From May 2022 the trust had received 1437 more online responses, 3959 more paper responses, 737 more telephone responses and 942 more text messages than they had the previous year.

The wards that we visited had "you said, we did" notice boards on the wall near the entrance. These were not always completed but the ones that were showed what patients had fed back and how the ward had responded.

Leaders told us that ward managers and matrons had completed coaching and engagement training. An example of how this was used was through the 'love and nuts' exercise in which staff were encouraged to share what they loved about the ward and what annoyed them. This information was gathered and shared with the idea to resolve the issues identified. Coaches also held 'big rooms' (meetings available to all staff) for specific topics such as nutrition and mental health. The mental health 'big room' was well attended by colleagues from the trust and from the mental health liaison team with an ethos that improvement can be made by staff on the frontline.

The trust engaged with staff through staff survey presentations, staff survey drop – in sessions and junior doctors' engagement events.

We saw evidence of meeting minutes from the last 6 months for the equality and diversity strategy group, living with disabilities forum and LGBTQ plus forum. All these forums and groups were open for staff to attend.

The trust produced a weekly e-newsletter which staff could access on the trust's intranet, the newsletter covered organisation updates and changes.

Staff could access Schwartz rounds which were an opportunity for them to engage in conversations about the challenges they faced in their team and department.

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Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The trust had a continuous improvement strategy for 2021 to 2023 with priorities, as outlined in the 'Big Plan' at a system level, pathway level and local department and ward level. For the division of medicine some of the aims were risk assessment development, a pressure ulcer improvement cycle, patient flow, and discharge and improving stroke care.

Staff told us they were encouraged to participate within innovation projects, and they were committed to doing so.

The trust collaborated with the flow coaching academy programme across Lancashire and South Cumbria had led to 21 'Big Room' meetings being established for different areas including brain cancer, sepsis, DNACPR and frailty. These meetings allowed staff members on the frontline to collaborate and develop a shared purpose for improvement within the chosen areas. For example, the emergency mental health 'Big Room' had developed safety checklists to prompt staff on key areas of care processes.

We observed how staff had identified the vision and aims for the clinical pathway with a clear theory for change and measurement strategy. Staff told us how the deteriorating patient dashboard was developed as part of the flow coach academy continuous improvement work in the sepsis 'Big Room.' The 'Big Room' meetings provided quarterly submissions to the programme management team which reviewed whether the quality improvement work had been productive in achieving their goals.

The trust had implemented a new stroke triage tool which was powered by Artificial Intelligence (AI). The AI technology was able to analyse and categorise brain images following a CT (Computed Tomography) scan to detect signs of a stroke in 30 seconds, compared to the normal 30-minute scan to manual reporting timeline.

Staff across the services were involved in research, innovation, and clinical trials to improve patient care and treatment and routinely attended trust-wide research, development, and innovation committee meetings.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

Nursing staff received and mostly kept up-to-date with their mandatory training. During inspection, data we reviewed showed that not all nursing staff had completed their required mandatory training in all subjects. Subjects where there was lower compliance which was below trust training targets included Basic Life Support Skills (BLS), with overall compliance for all staff groups at 78.4%. For nursing staff there was 88.3% compliance for this training.

Of the total required number of band 6 and band 7 nursing staff, 70.3% of nurses had completed Advanced Life Support training. This data included staff who had recently joined the trust and who had been unable to access training modules to date.

For band 6 and 7 nursing staff required to complete Advanced Paediatric Life Support Skills training, there was 35.9% compliance, with only two staff still required to complete this. However, 100% of nurses in the Paediatric area were APLS trained and the service was meeting the minimal standard of one APLS trained doctor and nurse per shift. We saw that the practice educator continued to work to enable staff's access to complete their required life support skills training, including in engagement with external training providers to facilitate this

Managers confirmed they had completed a review of shift rotas and there was always a minimum of at least one ALS and APLS trained member of staff on each shift. .

Medical staff received but did not always keep up-to-date with their mandatory training. Compliance for completed BLS training by medical staff was 66%.

Training in infection prevention and control was 87.6% for all staff groups, just below the trust target for compliance.

The mandatory training was comprehensive and met the needs of patients and staff. At the time of inspection, trust data confirmed that in 10 of 13 mandatory training subject areas, all staff groups in the department were compliant. Subject areas where compliance was not met included Medicines Management for Clinical Staff (81%); Patient Safety for boards and senior leadership teams (86%); and Speak Up - Core Training for all Workers (37%). The trust advised that for Medicines Management, Speak Up - Core Training, and Oliver McGowan Learning Disability E-Learning had been newly mandated or updated modules which had only been added to the training needs analysis from 1 May 2023. There was a three-month grace period for staff to build the required compliance of 90% target, by 31st July 2023.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Urgent and emergency services

Managers monitored mandatory training and alerted staff when they needed to update their training.

The practice educator in the department monitored staff compliance for all training updates and provided regular face-to-face training sessions, as well as different opportunities for a range of contextual learning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although safeguarding training compliance for medical staff did not always meet trust targets.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding adults' level one and two training was above trust targets for nursing staff. For Safeguarding adults' level three training, there was 92% compliance for all qualified nursing staff. For Safeguarding children level two there was 99% compliance, and 91% compliance for safeguarding children level 3 for all qualified nursing staff.

Medical staff received training specific for their role on how to recognise and report abuse. However, medical staff were below the trust targets for completed safeguarding training in the following areas: Safeguarding Adults (Level 3) 74%, Safeguarding Children (Level 2) 88%, Safeguarding Children (Level 3) 71%.

The trust had an established safeguarding team, with named doctors and named nurses as safeguarding leads for children and adults. The trust's safeguarding team were described by staff as being accessible and responsive when requests were made for any safeguarding advice and concerns. there was a named consultant for safeguarding within the urgent and emergency service.

The trust had recently established a lead nursing role in the department to provide additional support for staff in a wide safeguarding context. The aim of this role was to strengthen existing systems and risk assessment processes, particularly for any patients who may be more vulnerable due to their needs. This included a wide range of patient needs, including for those patients with mental health needs and learning disabilities, patients who had experienced domestic violence, as well as patients who were at risk of falls.

A daily meeting had been established Monday to Friday morning, involving the unit manager, the trust's security team, mental health team and the lead nurse. This had improved communication between the different teams, enabling staff to respond to individual patient needs in a more effective way.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. PLACE assessments had been suspended during the pandemic. The trust's Monitoring Team and Domestic Services had conducted an internal PLACE audit in November/December 2022 across both hospital sites. The results of this were used within the department to identify any areas of concern. The trust was re-engaging with the full national PLACE programme this year 2023/2024.

The trust monitored a range of safety metrics through its Safety Triangulation Accreditation Review (STAR) programme, which included outcomes for infection prevention and control. The latest STAR report indicated that ED Royal Preston Hospital was one of the areas scoring red over the last three months. Performance boards for May 2023 in the children's ED showed 96.4% achievement in matrons STAR audit, however results for hand hygiene audits were not displayed.

Where we reviewed these during inspection, we saw that cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw in all department areas that equipment routinely displayed 'I am clean 'labels which were in date.

Environment and equipment

The design, of the department made it difficult to keep people safe; the maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Patients could reach call bells and staff usually responded quickly when called. We heard only isolated comments from some patients about having to wait before staff responded to calls.

The environment in ED was limited for space and the estate was ageing. This was a recognised and ongoing issue, where staff worked as well as they could within the limitations of the physical premises. We saw there were areas where equipment was stored on corridors and in general the department appeared cluttered in areas.

Following the COVID 19 pandemic, areas that had been reconfigured to manage the infection prevention and control needs of that time had now been returned to different clinical areas in daily use. Isolation rooms were still available in paediatric and adult areas in case of any patients with infectious diseases. There was paediatric resuscitation equipment available in a dedicated area of the emergency department". We saw that an issue regarding secure access to the paediatric department which was raised in the latest inspection report had now been addressed, with secure keypad access now in place.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation equipment and saw that all resuscitation trolleys were stocked correctly with in date equipment and medicines. However, in one of the resuscitation trolleys we saw that records of completed daily and weekly checks were not all kept up to date.

We saw that action had been taken in response to three never events, one which had occurred originally in January 2022, followed by 2 more in January 2023. These were repeated incidents, regarding the unintentional connection of a patient requiring oxygen to an air flowmeter. The original incident in 2022 was identified retrospectively after the two incidents which occurred in January 2023. Among the actions taken included the removal of all medical air flowmeters from resus, Covid resus and green areas, and majors; identification of clear signage visible above all medical air ports, and fitting of temporary caps to the 400kpa medical air ports.

The service had suitable facilities to meet the needs of patients' families. Work was continuing to improve the child friendly aspect of the children's ED, in accordance with the Royal College of Paediatrics and Child Health's Facing the Future Standards.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient. They mostly minimised risks for patients, although mental health risk assessments were not always completed and actions to reduce risks for patients with mental health needs were not always taken. Staff identified and quickly acted upon patients at risk of deterioration.

The trust had worked with the NHS regional ambulance service to reduce delays in ambulance handover times. At the time of inspection, the percentage of attendees who were treated within 60 minutes of arrival had improved and from February to April performance had been better than the England average. The percentage of attendees who spent less than 4 hours in A&E has remained in line with the England average, at around 70-75%. A member of nursing staff was allocated to monitor any patients waiting in ambulances and ambulance staff would escalate any concerns to staff where patients needed to be seen more quickly.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff had access to the National Early Warning Scores tool to assess patients who may deteriorate.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Two triage nurses were available in the rapid assessment treatment area for assessing patients' needs on their arrival. Any urgent patients, including those brought by ambulance, would transfer straight to the majors or resuscitation area for any immediate treatment and care.

Suitably trained staff with Advanced Life Support skills (ALS) and Paediatric Advanced Life Support (PALS) Skills included Consultants, Senior and Junior Clinical Fellows, Specialist trainee year 4 and above doctors and Band 6/ Band 7 nurses. The trust confirmed that there was sufficient resource to provide 24/7 emergency cover, and that review of rotas confirmed there had been no incidents reported arising from lack of available trained staff for patients in an emergency.

Staff in the service used a mental health risk identification tool when assessing patients who attended ED with mental health needs. The mental health risk tool is a paper document that should be completed within one hour of the patient's arrival and is intended to support the ED nurses to carry out an immediate simple risk assessment and identify measures to reduce risk while the patient is waiting for a specialist mental health assessment.

We saw during each day of inspection that there were high numbers of patients attending who presented with differing urgent needs in relation to their mental health. The department only had one mental health assessment room, and during inspection we saw this was being used continually for different patients. When the mental health assessment room was in use, other patients with mental health needs would need to be seen in the regular department cubicles. We saw there were ligature risks in the wider environment, and actions to reduce risks were not followed up, where for example patients may have been at risk of self-harm. We also saw in three patient records we reviewed that mental health risk assessments were absent or had not been fully completed. We escalated our concerns to trust leaders during the inspection and they provided an immediate response with follow up actions to mitigate the risks that had been

identified. These included a full incident review of the patient incidents where we had identified concerns; implementation of the ED safety surveillance system, with updates to electronic patient record to allow for real time monitoring of compliance with this; learning for staff and plans for future auditing. After the onsite visit we wrote a letter of concern to the trust regarding the issues found. Following the inspection, the trust continued to implement relevant actions to improve and achieve sustained high performance in the areas of concern that had been identified.

Staff knew about specific risk issues and there were systems and processes documenting and escalating patients where there were any concerns. However, we saw that documenting patient records from their observations was not always completed. For example, we saw one patient who had a NEWS score of seven and been diagnosed with sepsis, however there was no record of a completed sepsis screening tool.

The service had 24-hour access to mental health liaison and specialist mental health support when staff were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The children's emergency department had a mental health calm room for any children presenting with distress due to their mental health.

Staff shared key information to keep patients safe when handing over their care to others.

A new role had recently been introduced in the department to assist on oversight of patients who were waiting for assessment and treatment. A band 6 'helicopter' nurse supported staff safety huddles, assisting department managers in providing continuing updates of any changing immediate needs for response.

Shift changes and handovers included all necessary key information to keep patients safe. We observed nursing handovers in which full information about patient care needs was discussed, including any risks identified such as safeguarding, mental health, falls and any immediate clinical risks.

Managers in the service were continuing to develop the ED safety dashboard, with work also in progress to link this to the electronic patient system.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The development of emergency pathways throughout the pandemic had led to an increase in the department's service delivery options to meet national standards, within the available physical space.to manage COVID-19. The staffing establishment had been increased by 74.81WTE at RPH in response to the pandemic. An ED nurse staffing report was presented at Safety and Quality Committee in November 2022, with the footprint of the Emergency Department currently under review.

During 2022 the trust had implemented a programme of international nurse recruitment, with several nurses joining the emergency department through this route. The trust's annual staffing review 2022 to 2023 identified that in Model Hospital data from (September 2022), Lancashire Teaching Hospitals was placed in the highest quartile for Care Hours Per Patient Day (CHPPD) when compared with neighbouring and peer organisations in the north-west.

We saw and heard from staff that nurse staffing levels had improved since the last inspection. Although there had been an uplift in nurse staffing, managers observed there had needed to be focus for supporting skill mix, due to the different levels of nursing experience for staff in the department.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Healthcare assistants worked flexibly across teams to provide additional support for nursing staff in case of any shortfall in registered nurses. Data provided by the trust confirmed that between 1 December 2022 and 31 May 2023 there was one incident reported within the Emergency Department in relation to insufficient staffing levels.

The department manager could adjust staffing levels daily according to the needs of patients. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low turnover rates, although at particular grades, such as for band five nurses where there was regular turnover. During 2023 -2024 to date nursing staff turnover was 0.45%. There were plans in place to manage any shortfalls in staffing numbers. Staff could be redeployed across the two ED's dependent on need. Senior managers could support staff as necessary. Meetings were held throughout the day where staffing levels were discussed. Bank and agency staff could be utilised if needed.

In the children's ED, staffing was also supported in flexible working arrangements with the Paediatric Assessment Unit. This assisted the service towards meeting the staffing requirements of the Facing the Future Standards, the Royal College of Paediatrics and Child Health.

The average sickness absence for nursing staff over the last six months was 6.34 per cent.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience, although patients were kept safe from avoidable harm and provided with the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff in workforce planning numbers, however staff worked well to keep patients safe and prevent avoidable harm to patients. Staffing was planned across both hospital ED's. The services were funded for 106 medical staff; there were 23 vacancies.

The service always had a consultant on call to provide cover out of hours during evenings and weekends.

Senior leaders identified staffing as a key risk in the department. The potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies was included in the ED risk register.

The overall sickness rates for medical staff was 2%. During 2023 -2024 to date medical staff turnover was 1.65%.

Managers could access locums when they needed additional medical staff. Advanced clinical practitioners (ACP's) were also available in the department to support medical staff and support patients in accessing ongoing care pathways.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Doctors worked in the emergency departments across both the hospital's locations and said there was good support available from senior doctors in the service, also to ensure patients were in the right place and receiving appropriate care.

As part of the people strategy there were plans to increase the numbers of advanced practitioners and non- medical consultant positions across urgent and emergency care to support the service.

The department met the Royal College of Paediatrics and Child Health's Standard for access to a dedicated consultant trained in paediatric emergency medicine. There was good access to a consultant on call during evenings and weekends in the service and doctors highlighted no concerns in this area.

Records

The service used electronic and paper systems to detail and record patients' care and treatment. However, staff did not always complete documentation or record this in a timely way. Records were clear, were stored securely and easily available to all staff providing care.

Patient notes were available for all staff to access them easily. The service had electronic and paper systems for recording different care interventions.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in the department.

Each area had a whiteboard to assist staff with required tasks. We saw this displayed patient information, including their bed number, full name, presenting complaint, observation of vital signs, if an electrocardiogram (ECG) had been performed, any blood tests taken, pressure area care, if a do not attempt cardiopulmonary resuscitation (DNACPR) was in place, any tasks needed and any other additional information. This meant that information about patients was visible to anyone in the department including relatives of patients.

We had been informed the service used new documentation for recording sepsis screening in accordance with NEWS2 methodology, and that the old forms had been removed from the department. However, during inspection we saw the old forms for recording against sepsis 6 procedures were still in use. We also saw that although staff acted appropriately to initiate treatment when patients presented with possible sepsis, in two patient records we reviewed there were gaps in the related documentation.

In records we reviewed during inspection we saw there was inconsistent documentation of pain assessments and there was incomplete documentation in three of four records fluid balance charts we checked.

Urgent and emergency services

Medicines

Staff did not always complete medicines records accurately or kept them up-to-date , although the service used systems and processes to safely prescribe, administer, and store medicines

Staff followed national practice to check patients had the correct medicines when they were admitted.

Doctors had access to the local care record to view patient's current medicines when patients were clerked in. However, capacity within the pharmacy team meant there was limited proactive clinical pharmacist review in ED. We saw that both nursing and medical staff actively engaged with the pharmacy team to discuss more complex prescribing.

Staff followed systems and processes to prescribe and administer medicines safely.

Since our previous inspection the trust's electronic prescribing and medicine administration (ePMA) system had been rolled out to the adult emergency department. Paper records remained in use in the children's ED with copies sent to the children's ward should the patient be admitted. Changes made to the electronic systems had successfully brought about an improvement in oxygen prescribing.

Staff stored and managed all medicines and prescribing documents safely. The implementation of ePMA gave improved visibility of medicines optimisation information.

The recent roll out of automated fridge temperature monitoring supported improvements in compliance with the trust's medicines safety audit. We also saw that appropriate action was taken when medicine room storage temperatures were too high in the children's ED.

Staff did not always complete medicines records accurately or kept them up-to-date. Compliance with the trust standards for controlled drugs management was poor, largely linked to record keeping. This was included on the department risk register. Improvement actions were being reviewed and monitored by the pharmacy team.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were known and visible in the department. Staff knew how to contact them for advice or to obtain medicines outside the normal working day. Pharmacy staff were deployed flexibly across the ED and Medical Admissions Units. Pharmacy vacancies and priorities in the admissions units meant that there was only limited dedicated pharmacist support to ED. For example, prompt pharmacy review of prescribing for patients with mental health concerns was being piloted, but only two records had been reviewed in the first week of the pilot.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Urgent and emergency services

Following the inspection, the trust provided details of incident reports raised in trust systems within urgent and emergency care. This confirmed there had been a total of 3, 659 incidents which were reported to have occurred within the Emergency Department during the period 1st June 2022 – 30th May 2023. The highest number of incident reports in month was for August 2022 with 352 incidents reported, and the lowest number of incidents reported was for May 2023, with 237 incident reports.

The highest reported incident type for urgent and emergency care in National Reporting and Learning System reports was 'Infrastructure (including staffing, facilities, and environment). Over 96% of these incidents resulted in no or low harm. There were 16 incidents falling under the specialty type 1, Accident and Emergency, as well as two more incidents were reported without a specialty but fall under UEC, giving a total of 18 overall incidents linked to urgent and emergency care.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

There had been three never events which had occurred between January 2022 and January 2023 related to the unintentional connection of a patient requiring oxygen to an air flowmeter. All three incidents had originally been categorised as low harm incidents.

Two of the incidents occurred within a two-week period during January 2023, following which the trust had completed a full retrospective review of any incident reports raised since 2019. We saw during inspection that 11 actions out of the total 14 identified actions had been completed, following the trust investigation of these incidents.

The initial investigation identified that in 2016, Lancashire Teaching Hospitals NHS Trust (LTHTR) had received a National Patient Safety Alert (NPSA); Reducing the risk of oxygen tubing being connected to air flowmeters (2016). However, staff in the service had not implemented immediate actions in response to the original safety alert.

Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers reviewed incidents to identify any themes and trends and discuss these findings with staff. Managers described and we saw that there was a proactive approach to incident reporting.

Managers and staff had access to support from the trust's risk and governance departments for additional advice where needed. Managers held weekly meetings to review incidents and safety performance, also attending the monthly divisional quality and safety meeting.

We saw there had been learning following an incident of patient deterioration in the children's ED, where the child had not always been under the immediate view of staff. Measures had been introduced to increase active monitoring of waiting areas for non-urgent patients following this incident.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. We saw local governance boards following incidents in the department. These displayed information about any identified learning from these, helping staff to complete the identified improvement actions.

There was evidence that changes had been made as a result of feedback. Following incidents of patient falls in the department, we saw a new approach had been introduced in which patients were provided with yellow blankets where they had been identified as at risk of falling.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

The trust provided data on request following inspection to indicate there had been 70 incidents reported on the trust's incident reporting system regarding restraint by security staff for patients presenting with mental health concerns between 1st December 2022 and 31st May 2023. All the incidents resulted in no harm or low harm.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Evidence-based service guidelines were available on the trust's intranet and in the electronic patient record.

Any changes in national guidance, such as the National Institute for Health and Care Excellence (NICE), were discussed at monthly governance meetings that covered both ED locations.

The service had implemented an action plan to meet the Royal College of Paediatrics and Child Health Facing Future Standards, Children and Young People Urgent and Emergency Care. Local audits were completed to measure compliance with policy and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. We heard during handovers staff included discussions about any patients who were anxious or agitated, together with the best approach for managing any individual patient needs.

The trust's sepsis lead nurse had worked with staff in the department to support improvements in practice. A new deteriorating patient dashboard have been introduced and this was used in close working between the department and critical care outreach team.

The trust's sepsis policy had been updated in line with the Academy of Medical Royal Colleges sepsis guidance (May 2022), supporting the appropriate use of antimicrobials in sepsis. There were plans to roll out a Patient Group Direction (PGD) for antibiotic administration supporting prompt access to antibiotics, if sepsis was identified.

The service had policies to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. However, we saw one example where the use of rapid tranquilisation was not monitored in accordance with trust policy. We raised this immediately with the trust and appropriate actions were taken to help improve this compliance. The trust had a programme of local audit. Staff completed audits as part of the trust's safety triangulation accreditation review (STAR) process. This system was used to monitor performance in all areas of the trust and included monthly report of results and monthly reviews by peer review matrons. The trust's quality assurance team also completed accreditation visits as part of this process. Between January and April 2023, staff in the ED had scored between 66% and 71% in completed audits towards STAR accreditation and actions were being identified to improve this performance. Staff in the children's ED had achieved a silver rating in the trust's STAR process and was working towards a gold rating.

The service had access to a tissue viability nurse for any patients whose skin condition was more vulnerable due to their frailty or medical condition.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff mostly made sure patients had enough to eat and drink. However, several patients we spoke with during inspection who were in different areas of the department, including whilst awaiting triage, had not been asked if they needed anything to eat or drink. Of these, some had been waiting for more than several hours. Vending machines were available for public use in the waiting room. Dietary choices were available for patients' religious, cultural and other needs.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Staff in the ED completed monthly audits on completion of fluid balance documentation, with latest results from the trust indicating these were 65% achieved. We saw this performance had consistently improved since 1 December 2022, with results at 56%. An improvement action plan was identified to support staff in making improvements to scores.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust risk assessments included the calculation of a malnutrition universal screening tool (MUST) score.

The MUST Score was triggered once patients are admitted to the hospital and therefore compliance with MUST completion is not audited in the ED. However, to a system was in place to allow the nursing team in the ED to make electronic referrals for patients to see dieticians, where needed. The nutrition specialist nurses also provided support and in reach into the ED to manage any patients with nutritional needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

During the inspection patients told us they received pain relief soon after it was identified they needed it, or they requested it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. Managers used information from the audits to improve care and treatment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The sepsis audit had been updated to reflect changes in national guidance and the sepsis group was focussed on supporting improved compliance with this. Between October to December 2022, in a local audit of sepsis guidelines, of 50 patient records checked there was 66 % compliance in practice. Between January and March 2023, of 50 patient records checked there was 54% compliance.

From April 2022 to March 2023 there was overall compliance of 77% for NEWS 2 audits. The critical care outreach team also conducted quarterly audits of vital signs compliance; between April 2022 – March 2023 the lowest performance was 72.2% and the highest 86.10%. The lead nurse for sepsis was working in collaboration with the critical care outreach team to support staff in improving this performance.

As part of medicines management, we saw the department was now included in the trust's quarterly antimicrobial stewardship audit, showing good overall compliance. Additionally, there were plans to capture departmental performance data relating to medicines verification and medicines reconciliation for review.

The trust's Clinical Audit and Effectiveness Department monitored the performance of national and local clinical audits in relation to governance requirements, providing a regular report to the trust's Safety and Quality Committee. Among these included The Trauma Audit & Research Network (TARN) Audit and the Royal College of Emergency Medicine (RCEM) Audits.

The latest TARN results showed the trust were above the national average for both data accreditation and case ascertainment.

In 2022-2023, the trust signed up to the following RCEM audits 2022: Mental Health Self Harm Audit and RCEM 2022: Consultant Sign-Off Audit. For the reporting period 2022/23 the trust reported outcomes in RCEM audits for fractured neck of femur; pain in children; and infection prevention and control. In 3 of 4 overall metrics included in fractured neck of femur audits, the trust's performance was above average compared to nationally, with one metric additionally having no available national comparator.

For pain in children, the trust performed better than the national average in all three standards.

For infection prevention and control, the trust performed worse than the national average for the first two standards but better for the third standard of moving patients identified as potentially infectious to an appropriate area.

Staff in the paediatric service had undertaken a benchmarking exercise as part of the regional asthma network.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support in development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with said they were supernumerary for six weeks after starting work in the service and had good access to support from clinical educators. At the time we inspected, there had been four new starters in the department; newly qualified staff had a six-week induction, new to ED staff had a 4-week induction, and experienced in ED staff had a 2-week induction.

The clinical educators supported the learning and development needs of staff. Since the last inspection the service had introduced several roles particularly to support children's ED, including a neonatal champion and a new educator for children and young people (CYP) seconded to the service. Nursing staff were widely available as champions to support other staff, including for learning disability, dementia, and safeguarding.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. More experienced nurses were deployed to work alongside more recently qualified nurses and nurses who had been recruited from overseas, to support their day-to-day practice.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were some opportunities to access further training and funding was available for continuing professional development to support this. However, there was often difficulty in accessing external emergency care courses due to funding issues.

The trust was supporting a member of staff to complete a postgraduate qualification in paediatric advanced practice. Two staff were due to start training in September as paediatric advanced clinical practitioners. There were eight advanced clinical practitioners already established in the adult A&E services.

Managers made sure staff received any specialist training for their role. Staff completed different competencies related to their roles, including such as for non-invasive ventilation (NIV), thrombolysis, and tracheostomy. The clinical educator ran monthly update skills training within the service, including resuscitation skills and monthly simulation training for adult and paediatric emergencies. Clinical educators also supported healthcare assistants on study days, which included an introduction to equipment, blood tests from triage, pressure area care. Where available to do so, clinical educators frequently offered direct support to staff working alongside them in the department.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance rates for both medical staff and registered nurses was 89% across both hospital ED's, just below the trust's target of 90%.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. In particular, staff in the department worked with an independent 'high intensity user team' based in the trust. This team followed up contact with any patients who had more complex needs due to their social setting and ongoing health situations. This team engaged widely with different organisations including the police, local authority, and other community settings.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There was close day-to-day working with the mental health liaison team based in the trust. Information was available for patients and staff regarding local authority support for mental ill health or depression.

Staff in the children's ED worked well with other services, including community-based services such as health visiting.

Seven-day services

Key services were available seven days a week to support timely patient care.

The emergency department was open seven days a week 24 hours a day. Staff could call for support from doctors including mental health services, 24 hours a day, seven days a week. Support from other disciplines and diagnostic services was routinely available Monday to Friday weekdays, and on call arrangements out of hours.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the department.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Where appropriate, staff provided information and signposted patients to support services, such as hospital drug and alcohol liaison services.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff mostly supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. We saw there was some variation in the assessment of patients who may lack capacity. In particular, we had concerns about capacity assessments completed for patients who presented with urgent needs in regard to their mental health.

Otherwise, staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff routinely checking with patients before any treatment or care interventions.

Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest.

Staff made sure patients consented to treatment based on all the information available.

Staff recorded consent in the patients' records. However, when documenting capacity assessments, we noted that the trust's electronic patient record only indicated whether the patient had capacity or not. The system did not allow for recording any related specific decision, in accordance with the Mental Capacity Act 2005

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff in the children's A&E department had good awareness of the context for assessing children's competence, and how this applied for children & young people when making informed decisions about their treatment and care.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust confirmed that Mental Capacity Act training was included in Safeguarding Adults Level 1, Level 2, and Level 3, with compliance for this at 92%.

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance for medical staff who had completed this training was 74%, which was below trust targets.

Staff did not always appear to understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. There appeared to be some confusion regarding what legal frameworks were appropriate for applying in situations where patients may be at risk of harm.

Security staff employed by the trust completed mandatory training in Control and Restraint Techniques (Restrictive Interventions). However, data provided by the trust showed that at the time of inspection, that 100% of staff had completed this, but only 59% of staff were in date towards the trust target of 100%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

The trust completed audits for Do not attempt cardiopulmonary resuscitation (DNACPR) decision and reported 100% compliance across both hospital ED locations.

Is the service caring?

Good 

Urgent and emergency services

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We saw how staff provided reassurance and encouragement in an appropriate manner, when caring for patients, their family members, or carers.

Staff mostly followed policy to keep patient care and treatment confidential. However, we observed a whiteboard in the emergency department displaying patient names and details of their diagnosis, which could be viewed by other patients and the public.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our inspection there were several patients we spoke with who were attending the department due to their mental health needs. We saw how staff were consistently professional and caring for each patient, despite often challenging circumstances in the service.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

The trust participated in the NHS Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Between May 2022 and April 2023 there was an average of 73% positive response for patients attending the emergency department. There was no response rate provided and data was presented across both hospital locations. In the children's ED, there had been a 96.4% positive response, which represented the highest score across the women's and children's division at the trust.

In the CQC adult inpatient survey, of the 47 questions in the survey the trust scored "about the same when" compared with other trusts for 42 questions. There were decreased scores for the indicator 'How long do you feel you had to wait to get to a bed after you arrived at hospital?',

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. However, we observed and heard of isolated comments about clinical staff speaking to patients in more public areas about their planned treatment. We heard this was often due to the lack of available treatment rooms in the department.

Urgent and emergency services

Additional support was available for patients with diagnosis of dementia or mental health needs.

Multi faith chaplaincy services were available for patients who wished to access these. The service provided for dietary choices to meet patients' religious, cultural and personal needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Family rooms were available in the paediatric and adult emergency departments, for use when staff needed to share difficult news with patients' relatives.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Nurses in the paediatric emergency department were alert to children's emotional needs when providing care and were flexible in responding to these changing needs.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. With only isolated exceptions, most of the patients we spoke with during inspection said they had been told what was happening and were kept informed of any plans for their treatment and care. In the CQC adult inpatient survey there was a decreased score for the metric question 'To what extent did staff looking after you involve you in decisions about your care and treatment? '

However, we observed staff talked to patients in a way they could understand. Communication aids were available to support patients where necessary. We saw widespread use of pictorial symbols for communication, particularly in the children's ED. Noticeboards displayed information regarding interpreter services, including British sign language.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported most patients to make informed decisions about their care. However, they did not always know how to support patients who lacked capacity to make their own decisions when experiencing mental ill health.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Urgent and emergency services were available 24 hours a day, seven days a week. Between 1 April 2022 and 1 May 2023, the total number of patient attendances for the emergency department was 62,730. The overall number of patient attendances, including for the co-located urgent care centre was 124,775.

Urgent and emergency services

Facilities and premises were mostly appropriate for the services being delivered, although the trust and service leaders recognised the environment was increasingly limited by the age of the estate. We saw the designated mental health assessment room for patients with mental health needs was not fully appropriate or always used appropriately, with equipment sometimes blocking the exit and introducing being potential ligature risks in the environment.

There was continuing engagement between the hospital and ambulance trust aimed at reducing ambulance handover times and signposting patients to alternative routes for emergency care needs. There was also ongoing engagement with the local mental health trust to identify support for patients who needed to attend the department with urgent mental health needs.

The service was co-located with an urgent care service that was managed by an independent health provider that was available for all age groups 24 hours a day, 7 days a week. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The mental health liaison team was based in the emergency department and responsive to requests when these were made. A specialist lead nurse for learning disabilities, autism and dementia was available to support individual patients where needed.

Patients living with dementia were discreetly identified by a daisy cutout on their patient ID band. There was a range of individual support available for patients with dementia and a strong network of champions, led by a healthcare assistant who had a specialist interest in this area.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were no mixed sex breaches reported for the ED.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. A same day emergency care (SDEC) ward was available for patients to access, where this was appropriate. The service had also opened an acute assessment unit for patients to transfer to where they were anticipated to need a short hospital admission.

There was separate access and directions to the children's ED. Work to improve the child friendly aspects of the children's ED had been progressed, with a CALMS room now available in the department for children experiencing mental health illness.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, we saw that patient preferences documented in care plans were not always followed. However, we observed that on occasions, patients' wishes detailed in patient passports were not always fully taken into account when implementing urgent interventions for patients who were experiencing mental health illness.

There were some changes in the department designed to meet the needs of patients living with dementia, with the use of different signage and symbols.

Urgent and emergency services

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and the local community. These covered a wide range of conditions and health related issues including for example, advice for acute simple low back pain, scald injury, plasters and casts, sedatives. The service also provided QR codes for patients and relatives to access further specific information about care and other support organisations that were available.

There was continuing work to improve electronic systems to be able to add different alerts on the electronic patient record to identify individual patient needs.

There was a process to support patients deemed as high intensity users (HIU). The core principles of the HIU service were to identify, personalise, de-escalate, discharge, and manage relapse. The team worked with patients, their families, and other professionals to identify needs and implement a care plan to help reduce the need to attend the ED.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times, but patients could not always access emergency services when needed or receive treatment within agreed time frames and national targets.

National datasets reported by NHS England for Accident & Emergency attendances indicated the total number of type 1 attendees at the trust overall had increasedduring July 2022, with 6,664 type 1 attendances for Lancashire Teaching Hospitals NHS Foundation Trust. On August 2022, there was 11,460, a difference of 4,796. The trust went from the lowest number of attendees in the Integrated Care System to the highest. At the same time the percentage of attendees who were admitted, transferred, or discharged within four hours increased from 49% to 68%. However,data provided by the trust following inspection confirmed that the number of type 1 attendances locally for Royal Preston Hospital emergency department during this period had remained stable.

The trust has consistently seen more than 50% of patients waiting more than four hours from the decision to admit to admission. This metric had been higher than the England average for the last two years. The number of patients waiting more than 12 hours had remained consistent between 120-175 patients per month.

The percentage of attendees who were treated within 60 minutes of arrival was improving and from February to April performance has been better than the England average. The percentage of attendees who spent less than 4 hours in A&E has remained in line with the England average around 70-75%.

Urgent and emergency services

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers and staff started planning each patient's discharge as early as possible.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

The service moved patients only when there was a clear medical reason or in their best interest.

In February 2023 the COVID Majors area of the ED had been re-allocated to acute medicine reducing the ED footprint and the number of patients the ED nursing and medical teams needed to oversee.

Acute medicine and respiratory had been working together to create an Acute Assessment Unit in this space using an innovative Advanced Clinical Practitioner led model to proactively pull patients with an expected length of stay of 72 hours or less from the ED, either at triage assessment or just after. The trust noted that early data was not yet indicating a significant reduction in length of stay in ED for medical patients, however the data did demonstrate that on average an additional 5 patients per day were being discharged home due to these changes.

During April a Rapid Improvement Event had taken place with the Same Day Emergency Care (SDEC) Unit, with the aim of increasing the number of patients who arrived by ambulance going directly to the SDEC and avoiding the ED. The event was successful and increased the number of patients going to SDEC and avoiding ED by an average of 5 per day from less than 1 per day. A weekly improvement group was now established with the acute medicine team to further develop both the Acute Assessment Unit and the SDEC to continue to avoid patients needing to attend the ED and reduce length of stay.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Between December 2022 and May 2023, a total of 20 complaints regarding the service had been reviewed and completed. Of these, 10 were not upheld and 9 partially upheld. One complaint regarding children's ED was upheld. Common themes of complaints included waiting times; communication issues and missed diagnosis; communication support and assistance provided for elderly or vulnerable patients.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Urgent and emergency services

Managers shared feedback from complaints with staff and learning was used to improve the service. Clinical and non-clinical staff described some of the support that had been provided for assisting staff's awareness when responding to patients with communication needs. There were also plans to provide reclining chairs in waiting rooms, to improve experience for patients who may need to wait for lengthy periods.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Service leaders had the skills and abilities to run the service. The divisional leadership team managed the urgent and emergency services at both of the trust's main hospital sites. Since the last inspection, there had been strengthening of the local leadership team, which now included a senior nurse leader whose responsibilities spanned across the urgent and emergency care and medical services at the hospital. This had particularly helped support initiatives to improve access and flow through the emergency department, which was a key focus for service leaders.

There had also been development of the children's A&E leadership structure, with establishment of more direct relationships and communications with inpatient children's wards. Although some of these roles were more recently established, we saw that leaders already had a holistic view of all aspects of the service and had shared priorities for the service overall.

There was regular contact between leaders in their day-to-day oversight of services, as well as routine planned weekly meetings.

Staff had confidence in their local leaders and told us leaders were accessible and responsive when needed. We saw during inspection how leaders were visibly present in the department as a routine, and they had good knowledge of the operational challenges in the service. Otherwise, staff we spoke with told us that senior leaders of the trust were not really visible and visited the department only occasionally.

Service leaders described some of their challenges as working in a busy department with an old infrastructure, and many of the service priorities were related to this. Work to increase staffing levels over the past 18 months had seen an increase in numbers of nursing staff, particularly supported by a programme of overseas nurse recruitment. However, staffing remained one of the key challenges for the service. There was a focus on building and establishing the skills within the workforce, with an ambition to grow future leaders from within the service.

Work was already beginning in this way, with a Practice Nurse Associate now also available in the service and offering monthly supervision and one-to-one support for teams. Leaders of the children's ED had been working with services across different divisions, including community paediatrics and paediatric assessment unit to assist with staffing issues,

Leaders also acknowledged the increasing challenges of patients attending the department with acute mental health needs. Leaders were continuing to work with the local mental health trust and other services to review this situation and plan future actions.

We heard from doctors during inspection saying there was good support for the medical workforce, with senior doctors approachable and readily available.

Staff worked well as a multidisciplinary team and supported each other. Local clinical leads were available and accessible in the emergency department and provided support to junior team members.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had an overall vision for what it wanted to achieve in the service as a whole.

The ED's the vision was "… for patients to receive the right pathway first time, from pre-hospital to in hospital. For the Emergency Department to resuscitate, treat the trauma and acutely unwell, save lives through outstanding timely patient-centred care that is driven by educational innovation, high performing teams, and practice-changing research. This will be supported by system care delivery closer to home."

Urgent and emergency care was one of the trust and divisions strategic priorities that included:

- Providing the right pathway.
- Delivering high quality safe and effective care.
- Reducing mental health delays.
- Obtaining a right sizing of estate to improve patient flow.
- Being responsive to surges in demand.
- The development of a workforce that enabled front end assessments, with a clear roadmap of development opportunity for nursing, medics, and allied health professionals.
- Providing a well-defined wellbeing strategy

The service had a divisional service strategy and an action plan detailing key timelines for achieving this. Metrics were linked to the trust's strategic ambitions and actions towards achieving this progress was reviewed regularly in the divisional improvement forum.

Urgent and emergency services

Leaders could clearly articulate the priorities for the service strategy and action plan and shared this effectively with staff at all levels in the service. The vision and strategy were well aligned to the trust's strategic ambitions and the local health needs of the community served. Staff we spoke with had relevant understanding of the service aims and the key areas of current focus.

During inspection we saw notice boards displaying information for the public, patients, and staff regarding the department's strategic aims. We saw these were aligned to the trusts 'Big Plan, strategic goals, with clear identification of specific targets at local level within the urgent and emergency service. Amongst these aims included to maintain triage time within 15 minutes, and to reduce the time for patients waiting to be seen; to aspire to silver STAR accreditation; to achieve 90% appraisal rate; and to recruit to vacancies across the department.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during inspection said they felt well supported by their managers. Leaders described staff in the service as keen and enthusiastic, acknowledging the work of each individual as part of the team Across the service we saw how staff worked together to provide best care for patients. There was a positive culture evident in the service which was focused on the needs of patients using services. Staff were proud to work in the service and were positive about their achievements. There were good opportunities for development, and during inspection we heard of several examples where staff were being supported to progress in their careers.

Staff promoted equality and diversity in daily work, recognising the individual needs of patients regarding their different cultural backgrounds. Over the previous 12 months there had been a programme of international nurse recruitment in the trust, with a number of international nurses now working in the emergency department. We saw how staff at all levels worked well to support each other in different ways.

Medical staff told us there was good support from consultants and their peers. We saw there was effective team working in the department, despite the service pressures. As reflected in previous inspection reports, we frequently heard about frustrations with the limited accommodation in the emergency department, and the challenges of access and flow through the hospital. Doctors felt this had impact on their ability to provide best care for patients.

There was an open culture in the service and staff we spoke with said they felt confident to raise concerns if they had any. Managers provided opportunities for staff to give feedback and responded to any issues as needed. Staff had access to a network of freedom to speak up champions and staff were aware of how to follow trust processes in case they needed to raise any concerns.

Patients we spoke with said they would be comfortable to raise any concerns.

Health and well-being support was available for staff to access, with information boards prominently displaying leaflets and contact details for these organisations. Staff we spoke with said they had received good support when they have needed to access this and were supported by managers to be able to do this.

Urgent and emergency services

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had effective structures, processes, and systems of accountability to support the delivery of the strategy and quality in the services being delivered. Leaders attended a monthly directorate governance meeting within the service, with key reports from this feeding into the trust's overarching governance committees.

The ED governance framework included representation from different disciplines working across both emergency departments, to allow for full oversight across the service. Governance meeting minutes we reviewed showed there was effective communication and mechanisms for escalation of any issues that were identified.

The standard agenda included different topics including a review of highest risks on the risk register; progress in local and national audits; implementation of NICE guidance; medicines updates; and review of patient experience reports. The meeting also included review of an action log, for monitoring any key items needing to be progressed. We saw from meeting minutes that there were appropriate actions and monitoring systems in place for continued effective governance.

The ED lead pharmacists provided assurance and exception reporting to ED governance to promote discussion and capture the improvement actions where standards were not being met. Specialist pharmacists in ED have started to do Directorate Medicines reports. The Medicines Safety Officer provided divisional safety reports every month for discussion at divisional always safety first. In additional there were rapid improvement cycles. The divisional lead pharmacist for medicines provided Medicines Assurance Reports shared at Divisional Safety and Quality meetings.

Staff at all levels were clear about their roles and accountabilities and were given opportunity to learn about the performance of the service. In different areas of the department, we saw governance boards displaying key service information, indicating service goals and performance towards achieving this. In the children's ED, some of the goals included on board displays were to triage all patients within 15 minutes; to hold a monthly well-being meeting; and to reduce agency cost.

The service worked closely with the co-located urgent care centre that was manged by an independent provider. They collaborated to ensure the most appropriate pathways for patients.

We saw during inspections a 'Green ED – sustainability board', related to early project work led by one of the doctors.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were clear arrangements in the service for managers to be able to have oversight of risks and performance. Staff and managers followed systems and processes to identify and escalate any risks when these emerged.

Service leaders recorded departmental risks in a local risk register document, with the highest-level risks also escalated to a trust wide risk register for continuing monitoring at trust board level. Service risks were reviewed and discussed at monthly governance meetings, with review of continuing action plans to remove and mitigate any risks identified.

Urgent and emergency services

During inspection we saw there were five risks scored as 'high risk' which included: falls in the emergency department; impact of exit block on patient safety who are referred to inpatient areas; potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies; delays in mental health pathway for patients with mental health needs; patients being cared for in the waiting room due to impact of exit block; and medication errors.

In the case of the risk identified as 'Impact of exit block on patient safety', this had been escalated to Trust Board, with the Safety and Quality Committee noting the risks and the continued work to review this long-standing risk. In March 2023 the trust had appointed an executive lead as Senior Responsible Officer for Urgent and Emergency Care Improvements. An Urgent and Emergency Care Board had been established in the trust to oversee delivery of 3 main transformation programmes aimed at reducing length of stay and crowding in the ED.

Service leaders were able to clearly describe the local risks that were recorded, and we saw there were relevant action plans related to each of the risks. As a general observation, service leaders also told us that financial restrictions were an everyday challenge, particularly regarding equipment issues. Leaders had routine day-to-day contact with senior managers in order to raise any immediate concerns if this was needed. During inspection we also noted that the local risk registers were an accurate reflection of the service challenges and were a good representation of the areas of concern frequently raised in discussions with staff. Action plans identified relevant leads for continuing monitoring and review of progress towards achieving these.

Service leaders implemented a systematic programme of clinical and internal audit to monitor quality and operational processes, and there were systems to identify where action should be taken.

Staff at all levels frequently stated that one of the departments main risks was a lack of space. The ageing estate and limitations of the physical environment in the department were clearly acknowledged and recorded as a trust wide issue.

We saw that staff worked flexibly and as best they could to meet this challenge, and used opportunities where they could, to influence any change. The trust's safety and quality committee notes recorded that work was continuing to improve the environment in the ED at Royal Preston Hospital, with plans to increase the isolation capacity in the ED to 12 isolation cubicles. This would improve infection control standards and reduce the risks of hospital acquired infections in the ED, with work beginning in May 2023.

Following the last inspection, staff in the children's ED had followed up an action regarding secure access through an internal entrance to the department. In their reconfiguration of the department although this issue had been rectified, there was still a shared corridor where staff in the adult A&E service continued to access the route. The service met the standards set out by the Royal College of Paediatrics and Child Health Standards for children in emergency care settings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers and staff had access to a range of information and data to monitor service activities and performance, both in daily reports and review reports of service performance over time. Staff had access to computer terminals in the department for accessing the information they needed.

The trust used dashboards to monitor performance, including live dashboards which indicated patient waiting times, ambulance handover times, and any delays in patients being transferred to other wards and departments.

Staff completed training in information governance and were aware of the confidentiality requirements of record keeping.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders engaged with patients and the public. A revised patient experience and involvement strategy was launched in 2022 with contributions from patients, relatives, and carers as well as staff, governors, and partner organisations.

Engagement with public groups, with the exception of the NHS Friends and Families Test, had been stopped prior to the COVID pandemic, although this was starting to be progressed again. Examples we heard about during the inspection included the 'red rose and recovery group'. This was a community engagement for patients who had attended with mental health needs, and which offered support looking at support for patients with drug and alcohol addiction. The sepsis lead nurse was also developing plans for a 'sepsis survivor' group.

We also heard how there had been active engagement with the youth forum in the development of the CALMS room in the children's ED.

Governance boards in different areas of the department also provided information including 'you said we did' updates, and general notices.

Staff at all levels received information and feedback from the trust through different communications, including newsletters from the chief executive and intranet bulletins. Staff had the opportunity to meet together in weekly team meetings, with different social media groups for staff to share updates. These included a 'WhatsApp' group for managers group and a patient flow.

Managers engaged with staff in different ways, also taking opportunities for staff recognition. In one example we saw there was a "team paediatric staff praise board", and "team ED be kind appreciation board". We saw messages acknowledging staff for "being so supportive and caring" and" thank you for all your hard work".

There was an extensive range of employee wellbeing support available for staff to be able to access. In addition, one of the trust's volunteers who was passionate in acknowledging the commitment and work of staff in the department, looked after the trust's wellbeing dog. We heard how staff in different areas around the hospital positively appreciated the support provided in this wellbeing initiative.

Included in the 4440 responses in the 2022 staff survey, there were 240 responses from the ED and acute medicine division. The responses were RAG rated in comparison to the whole organisation. There were six responses rated green, 42 that were amber and 49 that were red. There were 80% of staff who thought there were opportunities to show initiative frequently in their role. There were 65% who said that team members often meet to discuss the team's effectiveness. There were 62% of staff who responded that said the organisation acts fairly with career progression and

57% said they were involved in deciding changes that affected their work. However, of the responses that were worse than the average for the organisation, there were 14% who said that they are never or rarely worn out at the end of work, 20% who said they were satisfied with their pay and there was 32% who said their appraisal left them feeling that the organisation valued their work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff in the service had participated in mental health awareness week during May 2023, identifying various resources and activities for staff learning. These included a mental health bulletin, and the findings identified as good practice from the mental health risk assessment tool.

The service had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. In early results, data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

The children's ED had been continuing work to raise awareness of promoting safer sleep for babies, with information provided for every parent or carer of an under 2-year-old attending the department. The service had been nominated for the trust's 'our people award' for this work.

One of the middle grade doctors in ED had begun work with focus on the 'green footprint' of the department. This involved improvement actions such as being 'paper lite' and monitoring the use of nitrous oxide. The department had been recognised with a Royal College of Emergency Medicine award for the work focussing on sustainability in the department.

Maternity

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Training compliance for the trust was 90% and included training such as, conflict resolution, fire safety, infection prevention and control, maternity antenatal screening, maternity post op, patient safety, newborn feeding and human factors.

The service was not able to split mandatory training compliance data by location, therefore we could ascertain if areas of lower compliance related to maternity services at Royal Preston Hospital.

The service had a training needs analysis for maternity skills and drills training; it was in date, version controlled and next due for review in June 2026. There was an additional spreadsheet which outlined other mandatory training required for each role. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards. It covered all members of the multidisciplinary team and the management of non-attendance at skills training.

There was a blended approach to training sessions and sessions were either classroom based, e-learning, simulation training and workshops.

All maternity staff completed the maternity specific essential training, which included several key topics in managing maternity obstetric emergencies, such as, management of obstetric emergencies, sepsis training, maternal AIMS course which provided midwives tools on how to deal with obstetric emergencies and care of the critical ill pregnant or postpartum woman.

Specialist midwives completed additional training dependent on their specialty and role. For example, the infant leading attended additional training for advanced clinical tongue tie, breastfeeding and relationship building and the fetal monitoring lead midwife attended additional training on baby's lifeline and the national fetal monitoring lead network meetings.

Maternity care assistants attended a two-week health care assistant course prior to commencing in clinical areas and completed the care certificate.

Most midwifery staff completed mandatory training and compliance was good across all modules except resuscitation training. For level 2 immediate life support, only 66% of midwives had completed the training and only 64% of midwives had completed paediatric immediate life support training. However, newborn life support was included in obstetric emergency training. This meant that staff did not have the appropriate level of training to provide lifesaving treatment to women and birthing people and babies in their care.

Medical staff overall compliance with training targets was 83%, which was below the trust target of 90%. Only 61% of medical staff had completed required growth assessment protocol/gestational related optimal growth (GAP/GROW) training.

The service provided training and competency-based assessments on the use of Cardiotocography (CTG). Midwifery staff compliance with CTG update was 99%, CTG and fetal monitoring competency was 99% and CTG equipment competency was 99%. For medical staff the compliance was 94% with CTG update, 91% for CTG and fetal monitoring competency and 94% with CTG equipment competency. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

Staff completed regular skills and drills training. Ninety-nine percent of midwifery staff and 89% of medical staff had completed obstetric emergency training.

Staff told us they completed skills and drills in pool evacuation. However, the service did not provide information to show that staff completed pool evacuation training or compliance rates. Therefore, we could not be assured there would be enough staff trained to evacuate women, birthing people and babies from the birthing pool in an emergency.

The service had a practice development midwife who supported staff to access training and facilitated face to face fetal monitoring, obstetric emergency and public health training days.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training.

At the time of the inspection the service had not yet fully implemented the Oliver McGowan or equivalent learning disability eLearning. This was required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The service provided information that showed the training had been agreed by the trust. Following the inspection, the service provided information which showed staff had met the trust target in learning disabilities, autism and neurodiversity training.

Safeguarding maternity e-learning was part of all maternity staff induction and included perinatal mental health, alcohol and pregnancy, domestic abuse, female genital mutilation (FGM) and ICON training. ICON training is interventions on abusive head trauma. Following the e-learning, staff completed a competency assessment.

Following initial safeguarding induction training, staff completed a yearly 4-hour mandatory safeguarding training as part of their public health study day.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Medical staff overall compliance with safeguarding training was 83% for level 3 safeguarding adults and 73% for safeguarding children level 3. This did not meet the trust target of 90%

Maternity

Nursing and midwifery staff compliance with training targets was 95% for safeguarding adults and children level 3. This met the trust target.

Support staff/unregistered nursing staff completed level 2 safeguarding adults and level 3 safeguarding children training. The compliance with training targets was 100% and 94% respectively. This met the trust target.

The safeguarding team consisted of a named safeguarding midwife, specialist midwife for perinatal mental health and specialist midwife for enhanced support. The enhanced support midwife supports teenage pregnancy and women experiencing domestic abuse and women using drugs and alcohol. This team is also supported by band 6 midwives.

The team worked closely with the perinatal mental health midwife and supported staff. The safeguarding team were visible and attended the daily safety huddles.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

The safeguarding team and maternity services had developed and piloted “HOPE” boxes for those women who were separated from their babies either permanently or temporarily. This was being used across local maternity and neonatal systems (LMNS) and nationally to support loss and grief for mother and the child if a long-term separation is the final outcome.

The lead midwife for safeguarding represented the trust at the ICON babies cry, you can cope task and finish group within the local area, which then fed into the national ICON steering group. ICON provided key messages and awareness to women, birthing people and their families to show babies crying is normal and there are methods which could be taken to help parent and families’ cope. To educate parents and to reduce head trauma in babies.

The service worked with local partnerships to provide community-based simulation training to support midwives to recognise areas of risk and safeguarding concerns during home visits. For example, post-natal follow up care.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Maternity

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The service-controlled infection risk well. Staff used equipment and control measures to protect woman and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. During our inspection we saw cleaners, cleaning all areas throughout the day. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Staff cleaned equipment after contact with women and we could see 'I am clean' stickers to identify when equipment was cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service.

Data provided by the trust showed both medical and midwifery staff were trust compliant in infection, prevention, and control (IPC) training.

The service had effective processes to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and saw action plans developed to improve compliance with infection prevention and control standards. Actions were monitored through the divisional infection prevention and control meetings. The service generally performed well for cleanliness, and we saw evidence of the unannounced accreditation visits, with each area displaying a STAR certificate. We were told that the maternity service was consistently good in their STAR ratings with the birth centre and delivery suite scoring gold. Antenatal clinic, maternity A antenatal ward and maternity day case scoring silver and maternity B postnatal ward scoring bronze.

The service audited infection control standards every month. We looked at audits for March to May 2023 and saw overall compliance across all areas was 95.3%. Compliance had declined in May 2023 on maternity A and B ward from 100% to 94.4% and on delivery suite from 100% to 88.9%.

The service had effective processes to monitor hand hygiene. We looked at the most recent audit for March to May 2023 which showed 100% compliance in all areas.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The design of the environment followed national guidance. The maternity unit was situated in a purposed built part of the hospital with a separate entrance into maternity. The maternity assessment unit was on the ground floor and included maternity triage and antenatal clinics. Situated upstairs was the delivery suite, maternity ward A (antenatal), maternity ward B (postnatal) and the midwifery led birthing centre. Out of hours the maternity triage was based within Maternity ward A.

Maternity

Inductions of labour took place on the antenatal ward and there was a separate transitional care area within the postnatal ward. The transitional care bay had 4 beds with an additional bay used if required. There was one neonatal nurse allocated to 4 babies.

All equipment and store cupboards were visibly clean, tidy, and uncluttered. A fridge specifically for infant milk storage was kept in a locked room which stored medicines and dressings. The name, hospital number, date and time expressed were written clearly on all labels. The milk-fridge was checked daily to ensure it was always locked, maintained at the correct temperature for safe storage.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. Equipment such as birthing balls, aromatherapy and knee pads were also available on request.

The service had a system to monitor equipment safety checks completed and due. All new equipment underwent acceptance testing and was placed on an asset database which generated a schedule for preventative maintenance.

We reviewed records of planned and reactive equipment maintenance and saw 121 out 124 planned maintenance jobs and 251 out of 257 reactive equipment maintenance jobs had been completed.

Ligature point risk assessments had been completed for maternity services in each area. Each item of risk was identified, a risk score agreed, and control measures put in place.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

Staff identified and quickly acted upon woman and birthing people at risk of deterioration. Staff used a nationally recognised tool to identify woman and birthing people at risk of deterioration and escalated them appropriately.

During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators, and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

Maternity

The dashboard showed several areas which had been given a red flag as performance was lower than expected. These included 3rd/4th degree tears following assisted birth, postpartum haemorrhage (PPH) over 1500ml and the still birth rate. We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measures to ensure all patient safety incidents were reported to NRLS. The service took immediate action to ensure all staff reported incidents of 3rd and 4th degree tears and PPH over 1500ml to the online reporting system in accordance with guidance.

The service provided information that showed declining performance in relation to the time taken from making the decision to carry out a category 1 (urgent) caesarean section to delivery in line with clinical guidance. The number of category 1 caesarean sections had increased each month since November 2022. The service reported the number of category 1 caesarean sections where the time from decision to delivery was less than or equal to 30 minutes was 68% in May 2023, this had declined from 100% in November 2022. In May 2023 the number of category 1 caesarean sections was 25 compared to 18 in November 2022. However, there were 21 cases in March 2023 and the trust was still at 90.5% compliance.

The service had 5 postnatal readmissions within 14 days of discharge between September 2022 and May 2023.

One to one care on labour was achieved on the delivery suite for 98% of births between June 2022 and May 2023, this was 100% for Preston Birth Centre.

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Staff used a situation, background, assessment and recommendation (SBAR) tool when handing over the care of women, birthing people and babies to others.

We reviewed audits of SBAR completion carried out in May 2023 which showed low compliance with documentation of the SBAR in women's and birthing people's notes. SBAR was recorded when transferring care between shifts in 40% of the time on maternity ward A, 60% of the time in intrapartum care and 55% of the time in postnatal care. When transferring from the antenatal ward to intrapartum care the SBAR was completed 90% of the time and 80% of the time on transfer between intrapartum care to the postnatal ward. However, the audit stated that a verbal SBAR had been completed in 100% of cases. The service had an action plan to address low compliance, a poster was developed to educate staff and actions were on track for completion by the end of September 2023.

The service completed monthly Cardiotocography (CTG) and fresh eyes audits. CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audit for October 2022 to April 2023.

We saw compliance with hourly CTG reviews had declined at 80% in April 2023 and compliance with hourly 'fresh eyes' reviews had increased to 83%. However, this was below the target of 85% compliance. The service had an action plan to address low compliance and planned to continue quarterly audits to check improvement.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists every month. We reviewed audits for January to June 2023 and saw some areas of low compliance in relation to sign in, time out and sign out. The service explained this was related to audit questions which were no longer required as part of the WHO checklist and had an action plan to address areas of non-compliance. Compliance with these areas had improved in the audit completed in June 2023, with 4 out of the 6 areas within the audit being 100% completed. The two areas with compliance of less than 100% were the WHO signing in checklist which scored 93.9% and WHO surgery checklist timeout. WHO checklist compliance was monitored via the divisional risk register.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn observations using track and trigger system (NOTTS) is designed to be used by healthcare professionals working in areas caring for newborns in the early postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NOTTS completion. We looked at the audit for the April to June 2023 and found 29% of observations were not performed on time. Most delays were for observations due to be performed within the first hour of life and at 12 hours. The audit identified 100% compliance with appropriate escalation to the neonatal team.

The service used a nationally recognised tool called Maternal Early Warning Scores (MEWS) in detecting the seriously ill and deteriorating. The MEWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016).

Audit results for April to June 2023 showed the overall compliance for the completion and escalation of MEWS scores for delivery suite was 98% and for maternity ward B (postnatal) was 84.2%.

The maternity assessment suite (MAS) had partially introduced a nationally recognised safety tool for use within maternity triage to prioritise care for pregnant women and birthing people. There were a core team of midwives working within the MAS. The service had not adopted all the principles of the nationally recognised safety tool due to the MAS environment and medical and maternity staffing pressures.

The partial implementation of the triage safety tool had been risk assessed and was a current active risk on the divisional risk register.

The telephone triage line was not within a dedicated space and was not always staffed by a qualified midwife at night. The telephone line was not dedicated to maternity assessment triage. During the inspection, staff told us there was no system to monitor missed calls or drop off rates. However, following the inspection the service put in place a telephone system to monitor missed calls or drop off rates.

Maternity

From January 2023 to June 2023, there were 51 incidents reported which showed women and birthing people frequently waited over 15 minutes for an initial triage by a midwife, which was not in line with trust policy. However, the trust provided information that from January 2023 to June 2023 the average compliance rate for women and birthing people to be seen within 15 minutes was 90%. From April 2023 to June 2023 97.8% of women were seen by a doctor within the triage tools timeframes.

Women and birthing people who were not fully triaged within 15 minutes were risked assessed by midwives to maintain safety. The MAS midwives used their clinical judgement to prioritise the order in which women and birthing people were seen and an incident report was completed so that the case was reviewed to identify if there was any harm.

Following, the inspection a review of further information of data and from staff, we issued a Letter of Intent under section 31 of the Health and Social Care Act 2008. We requested further assurances from the trust that risks to women, birthing people and babies across the maternity pathway were assessed and risks were mitigated. The trust responded to the letter of intent confirming they had sourced a telecommunication software package. The software could be customised to the service and allowed a filter for calls not intended for maternity triage, allow a hold-the line message and queue option as well as a call back option, to allow for monitoring of any missed calls.

There were delays in the induction of labour pathway, both to the start of induction of labour and once induction of labour had been started. The audit for induction of labour showed between April to May 2023 there were 52% of cases experiencing a delay in starting induction of labour with the main cause being 'unit activity'. There were 14 out of 23 women and birthing people who experienced an additional delay in the induction of labour process following start of induction of labour, 7 cases where the induction of labour process from first induction cycle to birth was over 56 hours with the longest being 90 hours 30 minutes. The audit also found over half the cases did not have an explanation for delay documented in the woman or birthing person's notes and there was decreasing compliance with maternal observations in induction of labour from the previous audit.

Following, the inspection a review of further information of data and from staff, we issued a Letter of Intent under section 31 of the Health and Social Care Act 2008. We requested further assurances from the trust that they would take action to address delays in induction of labour. The service had now introduced a new booking process to support the reduction of delays in the induction of labour process and an audit would be completed in August 2023 to review this progress. The delays to induction of labour were also placed as high risk on the maternity risk register, there were specific maternity red rated options on the electronic incident reporting system for staff to use. Delays were also reported within the monthly maternity and safety quality committee reports and the number which were due to unit acuity.

Elective caesarean section lists over running was placed as high risk on the maternity risk register.

Following the completion of The BirthRate plus assessment in 2022 it was identified there was an increase in complexity of cases and emergency caesarean sections had increased by 11.9% and elective caesarean sections by 19.6%.

This meant it had put additional pressures such as staffing and a lack of capacity for emergency caesarean sections. To support the pressures the service scheduled additional theatre lists if increased capacity was anticipated. There was a daily review of cases and a weekly scheduling meeting to confirm the appropriateness and times of surgery.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Women and birthing people who had severe or complex mental health were supported by the perinatal mental health midwife throughout their pregnancy.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service last completed a staffing and acuity review in December 2022 and reported this to board in July 2023. It said the service did not have enough staff to meet the planned needs of women. There were plans in place to address this and to provide safe care to women who used the service. Actions to address the shortfall included rolling recruitment, department specific roles and recruiting internationally trained midwives.

From June 2023, there was a registered midwifery vacancy rate of 10.6 whole time equivalent (WTE), with a further 18.8 WTE of staff leaving or on maternity leave from June 2023, totalling 29.47WTE staffing gap by August 2023. A recurrent advert to fill all vacancies was ongoing with 8 prospective midwives recruited on condition of qualification. The service had a predicted maternity support worker vacancy of 4.41 WTE by August 2023.

The service introduced department specific roles to retain existing staff and attract new staff to the trust. There was an international recruitment process with 3 midwives joining the service. There was a plan to recruit a further 13 international midwives throughout the year.

All unfilled shifts were offered as bank and then were converted into agency if they had not been filled within 2 weeks.

There was not always enough appropriately skilled and trained staff to provide safe care and treatment to women and birthing people presenting to triage and the maternity assessment centre at night. The service had completed an audit activity to confirm safer staffing levels within the triage area at night, this was 1 whole time equivalent trained midwife. However, we to staff who felt midwifery staffing within the triage area at night was not sufficient to both assess women and birthing people coming into triage and to answer the triage telephone line. The service followed up our concerns quickly and introduced a maternity support worker (MSW) into the MSU day and night to support within triage and were actively recruiting more staff into the unit. From August 2023, a speciality doctor was dedicated to the MAS, Monday to Friday from 1pm to 5pm. Outside of the hours were covered by the medical on-call team.

Maternity

The service operated within the Northwest Maternity Escalation Policy and Operational Pressures Escalation Levels Framework. This was supported by a local policy which covered out of hours consultant role, anaesthetic cover and duties, clinical escalation, maternity staffing levels and escalation to on call manager support.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Ninety-one per cent of midwifery staff and 93% of medical staff had received an appraisal. However, the service did not break down compliance rates by location, so it was not possible to ascertain appraisal compliance for this location.

Managers made sure staff received any specialist training for their role. Midwives had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course. The maternity service had a team of practice development midwives, which included lead midwives for practice development for staff and for students, clinical skills facilitator, lead fetal monitoring midwife.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In May 2023 the service reported 72 red flag incidents. The highest reported delays included a delay in review for more than 30 minutes for obstetric review in triage and delay in time critical activity.

Staff working within the maternity assessment suite, maternity ward A and maternity ward B told us they were regularly moved staff from areas they were working in to cover staff shortages within the delivery suite. This meant there were extra pressures within other areas of the maternity departments.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Supernumerary compliance was monitored within the service monthly and reported to the trust safety and quality committee. The service had 100% compliance.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had worked with other local trusts to create and implement a new preceptorship package for newly qualified midwives. The package included a two-week induction to complete skills and training. A 5-week supernumerary rotational period through intrapartum care, antenatal clinics and community midwifery services. The preceptorship team introduced social media groups for newly qualified midwives and coffee mornings and a monthly preceptorship drop in.

The service was continuing to work to improve recruitment and retention and had introduced specialist midwives to support this agenda. Leaders worked with local maternity and neonatal systems partnerships (LMNS) to develop a support package for midwives who had been recruited from other countries and to evaluate the experiences of international recruitment.

Maternity

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep women and birthing people and babies safe and medical staff did not always match the planned number.

There were 21.31 funded whole time equivalent (WTE) consultant posts with 3.09 vacancies. The 3 vacant consultant posts were currently filled by long term locums. Two of the vacant posts had been recruited and were due to start in August and September 2023.

The service had 15 WTE of middle grade and specialty trainee doctors, with 2.23 WTE vacancy.

The service also had in place 12 foundation doctor's speciality level doctors. All posts were recruited to and there were 3 trainee clinical fellows to train to become middle grade doctors within 12 months.

Obstetric consultants were allocated duties via the consultant rota. Consultants allocated to the delivery suite did not cover alongside other duties due to the delivery suite taking priority. The obstetric consultant was allocated to be resident from 8.30am to 9pm on weekdays and for 7.5 hours on public holidays and weekends.

The on-call consultant attended morning handover 7 days per week. The handover was multidisciplinary and took place on the delivery suite. Following handover, the medical team completed a ward round on the delivery suite with the on-call team. The team completed a ward round on maternity ward A antenatal as well as any postnatal readmissions.

Managers made sure locums had a full induction to the service before they started work. There was a local induction checklist for locum staff. The checklist included an introduction to the department, working practices and procedures, clinical and ward-based protocols.

There was a clear process for the admitting consultant or consultant of the week to follow to make sure the locum doctor was supported and had a clear understanding of their role.

The service met the 90% compliance for appraisal rates, with 93% having had an appraisal in May 2023.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used an electronic notes system and staff were confident and competent to use them.

We reviewed 7 records and found they were clear and complete. We saw good examples of information regarding communication and mobility for women attending the service with a disability. Safeguarding alerts were visible on the electronic records along with management plans. The service audited records every 3 months. Following, the inspection we reviewed record keeping audits and found lower compliance related to documentation of postnatal care at Royal Preston Hospital.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. The trust used electronic records which had a 'break glass' system to view electronic records held by other trusts. This system meant if a women or birthing person transferred to another team, even if that team was part of a different provider, the records were available to anyone providing maternity care.

Records were stored securely. Staff locked computers when not in use and had individual computer tablets to use in the birthing rooms.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had systems to check staff competency when using medicines was in line with trust policy and national guidelines. A management training and competency package was launched in May 2023. The service told us they aimed for 90% of staff to complete this by the end of July 2023 and by the end of May 2023 71% of midwifery staff had completed it. Following the inspection, the service told us that in September 2023 training compliance was 84%.

The service had systems to check staff competency when using medicines was in line with trust policy and national guidelines. We saw 100% of midwives had completed intravenous drug administration training and were signed off as competent.

Staff reviewed each woman's medicines regularly and provided advice to woman and birthing people and carers about their medicines.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medication was kept secure, neat, and tidy in medication cupboards. Staff completed medicine records accurately and kept them up to date. Woman and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly.

Staff could explain how to report serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Ward managers attended the perinatal mortality reviews to ensure learning from incidents across the trust maternity services was shared. They shared learning from incidents at regular team meetings.

Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff described learning from trust wide cardiotocography (CTG) monthly review meetings where any incidents which featured CTG were discussed and learning from those. Staff received a monthly safety briefing which included lessons learnt form incidents and investigations.

From January 2023 to March 2023 there were 7 perinatal deaths, 1 death did not meet the criteria for the Perinatal Mortality Reviews Summary Report (PMRT) tool. All 6 eligible cases were notified to MBRRACE within 7 working days, with the review of information in each case completed within 1 month. MBRRACE is a national audit programme to collect information on late fetal losses, stillbirths, neonatal and maternal deaths. For all 6 cases the service informed parents for the PMRT review and gave them the opportunity to ask any questions or to provide any information for the review.

Quarterly reports submitted by the Director of Midwifery to the trust board included details of all deaths reviewed and action plans. The quarterly reports formed part of the agenda for the maternity safety champion meetings.

The Corporate Governance Team had a rolling programme of submission to the National Reporting and Learning System (NRLS). Incidents were uploaded once an incident was closed on the trust incident reporting system, to allow for update on the national database of any changes to the categorisation of harm. They re-uploaded following investigation which they told us accounted for any other delays.

However, the service did not consistently report incidents to the National Learning and Reporting System (NRLS), nor did they report all incidents in a timely manner. We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measure to ensure all patient safety incidents were reported to NRLS. In the response, the service provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust took immediate action to ensure all patient safety incidents were reported to NRLS accurately and in a timely manner in accordance with guidance.

The maternity dashboard showed the service reported a rate of 3rd and 4th degree tears of 2.7%, from January 2023 to May 2023. However, we reviewed NRLS for January to June 2023 and found only 4, 3rd or 4th degree tears had been reported.

The dashboard showed 39 post-partum haemorrhages (PPH) over 1500ml between January and May 2023. However, we reviewed NRLS from January to June 2023 and found only 5 reports of PPH over 1500ml. We asked for further information from the trust within the letter of intent issued.

Maternity

Information received highlighted that the service did not report all 3rd and 4th degree tears and PPH's as incidents. These cases were reported to the regional maternity dashboard and all cases were reviewed. If there was a gap in the care given or an opportunity for learning, then the service would report these cases as an incident and report to the NRLS.

Following the inspection feedback, the service gave assurance that all 3rd and 4th degree tears and cases of PPH over 1500ml would be reported as an incident.

Following a never event in January 2023 in a theatre that wasn't used by maternity services, the service introduced additional peer review audits in April 2023. These highlighted areas of low compliance with WHO checklists, which improved from May to June 2023.

In the last 6 months, 3 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation. We reviewed the rapid reviews of these incidents and found they were comprehensive with clear action plans to address immediate learning.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders understood and managed the priorities and issues the service faced. There was a clear triumvirate leadership structure in place.

The service was within the women's and children's division. This was led by a divisional director, divisional midwifery and nursing director, divisional medical director and divisional nursing lead for children and young people, also known as the 'quad'. The quad was supported through clear professional arrangements and had professional reporting lines to the medical director and chief nurse.

There was a maternity leadership team which consisted of a clinical director, associate medical director, divisional midwifery and nursing director, deputy divisional midwifery and nursing director, consultant midwife, clinical business manager and clinical governance lead. The maternity department and birthing centres cross site were managed by the divisional midwifery and nursing director.

The leadership team also included the safety and quality matron, lead midwife for safeguarding, midwifery led care matron, complex care matron and specialty business manager. There were clear lines of reporting from the maternity leadership team to the quad. The maternity leadership team managed a team of band 7 specialist midwives, managers and coordinators.

Maternity

Leaders were visible and approachable in the service, for woman and birthing people. Leaders were respected, and most staff told us they found the matrons would listen to them, were supportive, approachable, and keen to drive improvement. However, not all staff we spoke to felt they were listened to when raising concerns around staffing.

Each area of the service had a designated ward manager, who worked clinically when required. Staff told us they were well supported and listened to by ward managers.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The service was supported by maternity safety champions and non-executive directors. Maternity safety champions carried out regular visits and walk rounds at Royal Preston Hospital. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Leaders recognised the importance to support staff in developing their skills and to take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy covered 2021 to 2024 and was called 'Our Big Plan'. It was developed in consultation with key stakeholders and staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

The vision had 4 key objectives. These were to provide outstanding personalised care for women and families, to provide safe and high-quality evidence-based services, to provide opportunities for research, innovation and continuous improvement and to care for our workforce providing a supportive workplace where compassionate leadership is a priority. The 4 key objectives were aligned to national strategic drivers and clinical priorities, with clear actions attached.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The maternity service aimed to support and empower women and birthing people to make informed choices about their care, with plans in place to be able to support the continuity of carer pathway to women and birthing people from socially deprived backgrounds and from a Black, Asian or other Minority Ethnic group (BAME).

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity service strategy linked to the overarching trust strategy.

Culture

Staff mostly felt respected, supported, and valued. Staff were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families could raise concerns without fear.

Maternity

During the inspection we spoke to some staff who were not positive about the culture within the maternity department or its leadership team, and concerns around safety and staffing had not been addressed and they were not always listened to. We found there was a clear difference in opinion in regard to support from the inpatient midwives working compared to the community and continuity teams.

This was also reflected in the overview the service provided around the main themes identified from the most recent staff survey in 2022. They identified the lowest and highest scoring teams and analysed the reasons for those scores. The survey showed staff on delivery suite and maternity wards A and B scored low on how they felt about their team, the people in the organisation, their managers and their personal development. In contrast, the maternity continuity team and specialist midwives were highest scoring teams in the division with high scores for working with colleagues and support from managers.

The service had undertaken a number of actions to address burnout and fatigue, including funding higher education course for midwives, holding a local maternity conference, awarding 'shining star' recognition awards monthly, relocating senior midwives to the wards and refurbishing a new staff breakout room. They also were taking steps to address staffing short falls which impacted on morale and resilience. However, some staff continued to tell us the areas they were working within felt unsafe and staffing had not improved.

The May 2023 Maternity Service bi-annual safer staffing review identified sickness levels within the service had been significantly above the trust target for over 12 months. The report highlighted that the staff survey indicated there was work to do to improve the way that some staff felt about work. Following the identification of sustained high sickness rates, the division had requested further follow up and support to ascertain how sickness could be improved.

Staff were fully focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Women and families, we spoke to during our inspection spoke highly of the staff and told us they were treated with dignity and respect.

The trust measured against other NHS organisations to compare against workforce race equality standards (WRES). These standards are a set of measurements to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The results for staff from all other ethnic groups were lower or similar to results for white staff at the trust.

The trust scored positively compared to the national averages for staff, with a lower proportion of staff from all other ethnic groups having experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months and a similar proportion of staff from all other ethnic groups who had experienced harassment, bullying or abuse from staff in the last 12 months. The trust did not score as positively for the measurements against the workforce disability equality standards (WDES). Results showed staff with a long-term condition or illness had poorer experiences compared with staff without a long-term condition or illness. The trust's results were similar to the average for comparable NHS organisations.

Midwives had additional training to become professional midwifery advocates (PMAs) to support the practice and development of midwives. PMA's supported restorative supervision, provide leadership to midwives, supported local governance, risk management and staff development.

Maternity

The maternity and neonatal safety champions met every 2 months. We looked at meeting minutes for the last 6 months and saw they were comprehensive, with a set agenda aligned to the key lines of enquiry. They covered all key safety elements such as incidents, staffing, mortality reviews and equality and diversity. Clear actions were recorded in minutes and the dates for future safety champion walk rounds.

Oversight of safety in maternity services was reported to the board every month. We reviewed the last 3 reports and found they covered key safety and staffing data, risks and challenges. These were reflected in other reports we reviewed and what we found during our inspection.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. For example, they had used this data in the annual review of still births to identify any themes or trends for women, birthing people and babies from ethnic minority and disadvantaged groups.

The service recently carried out a mapping exercise with the local maternity and neonatal system to look at how they could provide enhanced continuity of carer teams in geographical areas of greater deprivation or greater numbers of women and birthing people from ethnic minority and disadvantaged groups.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement.

The service had an open culture where women and birthing people and their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There had been six complaints about the care received at Royal Preston Hospital between April and June 2023.

All complaints and concerns were handled fairly, and the service used the approach ,most applicable to deal with complaints and progressed complaints through formal processes where appropriate.. The service gave information about how to raise a concern in welcome packs in each birthing room. Staff understood the policy on complaints and knew how to handle them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a strong governance structure that supported the flow of information from frontline staff to senior managers.

There was a divisional governance group which consisted of a divisional governance lead, 2 divisional governance facilitators and 2 band 7 governance risk managers. Relevant information was escalated to the Trust quality and safety committee.

Maternity

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings which outlined how key information and risks flowed from maternity speciality level through to divisional committees, boards and improvement forums to the executives, board committees and board of directors. The divisional governance structure reflected the requirements of the Ockenden report. There was a clear structure for escalating higher scoring risks from divisional board to the trust board through the senior leadership team and board committees.

Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months and saw they comprehensively covered expected areas of safety and quality. This included clinical effectiveness, audits and performance dashboards, key risk including risk register review and safeguarding, incidents and lessons learnt, staffing and feedback from women, birthing people and their families. The meeting was attended by relevant managers, midwives and stakeholders.

Managers and staff carried out a programme of repeated audits to check improvement over time. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

The service did not provide the last 3 meeting minutes for the divisional quad meetings, therefore we could not review the contents of the meetings, themes, actions or learning.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

The service had a meeting structure which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

There were opportunities for managers to meet with the senior management team on a monthly basis, and key areas including performance, staffing and incidents were discussed in these meetings.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

There were plans to cope with unexpected events. The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. All diverts were incident reported and women and birthing who were affected were contacted to check on their wellbeing and an apology letter was sent to them. Leaders in the service monitored diverts through their dashboard. Between March and October 2022, the unit had been closed 4 times with 17 women and birthing people affected. The unit had not been on divert since the end of October 2022.

Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

The service had an adverse incident reporting, management and investigation policy and procedure. This outlined key principles for incident reporting and the roles and responsibilities of staff in relation to internal and external reporting of incidents. It gave clear guidance to staff on the management and investigation of incidents and included guidance on reporting incidents to HSIB.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 safety initiatives. Within 2 safety initiatives there was an exception, 1 relating to one-to-one care in labour and the other to antenatal corticosteroids. The service had submitted action plans to board to address these areas an ensure they met required compliance levels. This meant they declared fully compliant with the scheme. We saw they provided sufficient evidence of their compliance to the trust board in February 2023.

The service used a quality assurance framework called STAR designed to provide an evidence-based assessment to show how maternity areas demonstrated the required standards of care delivery, what is working well and where further improvements were required. There were two elements to the framework. The first element was monthly reviews of maternity areas completed by the matrons and professional leads for the division. The second element was accreditation visits undertaken by the quality assurance team with support from staff, governors and volunteers across the trust.

The outcomes from the STAR monthly audit formed part of the monthly assurance report. This was monitored by the divisional and committee of the board as part of the safety and quality dashboard, to provide ward to board assurance monthly. Outcomes from the monthly audits were also included in the divisional improvement forums and within in divisional meetings.

Maternity

The maternity assessment service (MAS) introduced a nationally recognised maternity triage tool in February 2021 following the introduction, the service identified that MAS was unable to deliver a full implementation due the estates of where MAS is currently situated and medical and midwifery staffing. The service continued with a partial implementation of the tool and in March 2023 an external review of the use of the tool was completed. The findings of the review identified there was not a designated telephone triage line, or triage space, midwives were working at an unsustainable level to manage current flow and workload. This was also identified during our inspection and during discussions with staff from MAS.

The partial implementation of the triage safety tool and the actions found following the independent review were assigned to an active risk on the risk register and compliance was monitored. Key performance monitoring was ongoing, with waiting times audited monthly.

Following the inspection, we issued a letter of intent around the concerns raised regarding staffing and triage. The service provided the required further assurance around extra staffing and the implementation of a new dedicated telephone triage line that would monitor waiting times for calls and call drop off rates.

The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Mortality Reviews Summary Report (PMRT) tool and produced a quarterly report. This data was provided to the national MBRRACE survey.

The service was an outlier for still birth, neonatal mortality and perinatal mortality rates, for data submitted for 2021 and was more than 5% higher than the average for a similar trust in all 3 measures. The stabilised and adjusted still birth rate was 4.5 per 1,000 births, the stabilised and adjusted neonatal mortality rate was 2.09 per 1,000 births and the stabilised and adjuster perinatal mortality rate was 6.57 per 1,000 births. The neonatal mortality rate had worsened over the last 3 years of the MBRRACE report.

We reviewed board papers related to the MBRRACE survey. We saw the service had identified the increased still birth rate prior to the survey publication and carried out a review and identified no themes or trends. They identified the need to make improvements to triage and an action plan was in place for this. The service had a still birth outlier action plan which was monitored and updated regularly. The action plan showed all 8 key actions had been completed with evidence provided. All still births were reviewed through the perinatal mortality review process.

The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

There was a system for local manager's audits which were recorded on the AMaT system. Managers gave examples of actions taken to improve audit results, for example refresher training with midwives to improve compliance with carbon monoxide monitoring at booking.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register in place. We reviewed the risk register and saw it identified 6 high risk, 9 moderate risk and 1 low risk items across both maternity locations.

Each risk was clearly defined with controls and assurances and any gaps in these identified. The risks aligned with challenges we found during our inspection and mitigating actions described by staff. Senior managers reviewed risks regularly and each risk had a clear set of actions taken to reduce it, with clear action owners and target dates. The risk register clearly outlined where action had been taken to address identified risks.

Levels of inhalational nitrous oxide (Entonox, or gas and air: for pain relief in labour) was listed as high risk on the maternity risk register. There was no data available regarding the current exposure to staff across intrapartum care. However, the service mitigated these risks by completing an estates inspection of Entonox seals within the intrapartum areas to ensure compliance, staff provided women and birthing people with instructions on the correct use of Entonox equipment and housekeeping audits of the piping for Entonox was implemented.

We saw through clinical governance meeting minutes that risk was discussed at the monthly meetings.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

The information systems were integrated and secure**.** The service had a digital midwife to support staff accessing electronic information systems and they visited the birth centre regularly.

Data was collected to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women’s care. Managers also used this information to inform decisions around service delivery such as continuity of care teams and community caseloads.

Data or notifications were consistently submitted to external organisations as required. The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that required local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Maternity

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity and Neonatal Voice Partnership (MNVP) to contribute to decisions about care in maternity services. The chair of the MNVP had left but the service was involved in the recruitment of a new chair and had engaged with the chair of a neighbouring MNVP to ensure women and birthing people's voices were still heard in the interim.

The MNVP had completed a 15 Steps visit and report. Staff from the continuity of carer team had developed an infographic about latent labour for women and birthing people in collaboration with the MNVP and service users.

Maternity voices partnership engagement meetings were scheduled quarterly and included all key partners from health and the third sector. The service had a Maternity and Neonatal Voice Partnership (MNVP) work plan based on the principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trusts. We reviewed the plan and saw all actions had deadlines set, were monitored and were fully or partly achieved. The service told us that once the new MNVP lead was appointed that actions would be adjusted to ensure that the plan was co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

Senior leaders told us they were proud to work with the local community to improve services and had recently organised and set up a maternity stall at a local festival.

The lead midwife for bereavement worked with service users to develop bereavement services for families and were developing an antenatal and peer support offer for families who are experiencing a pregnancy following a miscarriage, infant loss, stillbirth or neonatal death.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Leaders understood the needs of the local population. They took opportunities to engage with the local population and promote the centre as a birth option. Staff from the service had taken part in the Leyland festival, to promote birth options and key health promotion messages such as infant feeding. Staff had taken part in the pregnancy circles research project where midwives combined clinical care with antenatal education and peer support. This was done in partnership with local family centres and has shown group antenatal care has a positive impact on women's experiences of antenatal services

In the Antenatal Clinic, Ultrasound and Maternity Assessment Suite there were pregnancy schedule visual displays, and the pregnancy journey and the postnatal ward there were information boards on recovery pathways for caesarean sections.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

Quality improvement was routinely discussed at team meetings. We saw that what was not working well was discussed at team meetings for midwifery led services and staff engaged in conversation about their ideas and innovations. For example, during the Maternity Summit held in June 2023 the service held a 'Flashes of Brilliance' competition. This was to encourage staff to suggest service improvements or changes to way of working and encouraged staff to submit any ideas no matter how big or small.

Leaders encouraged innovation and participation in research. The service was part of the Health Foundation Flow Coaching Academy Big Rooms & Microsystem Coaching Academy and meetings were held weekly. The purpose of the weekly meetings was to coach improvement and design tests of change, review results and plan next steps and action notes were taken to record improvement.

Staff received training and coaching to lead and facilitate improvement at ward and department level through the microsystem coaching academy. This trained staff to be coaches trained to internal quality expert level (as defined in the NHSI national guidance). One example of an improvement project being led by delivery suite staff was a project to reduce the time taken for women and birthing people from the delivery suite to the postnatal ward.

The service took part in continuous improvement programmes and activities aligned to the trust-wide continuous improvement strategy for 2021 to 2023.

The service took part in wave 1 of the national MatNeo programme on the optimisation and stabilisation of the pre-term infant and shared learning regionally and nationally.

There were hearing loop signs around the maternity service to help support hearing aid reception for women and families using hearing aids.

There was a 52% gestational diabetes increase in women and birthing people in 2021/2022. Due to the increase diabetic service provision had been adapted and the service held a joint obstetric and diabetic clinic. The clinic consisted of 2 diabetic consultants, diabetic registrar, diabetic specialist nurse, diabetic specialist midwife and a dietician.

Tulip team was a continuity of care team for all women and birthing people with diabetes. Designated midwives completed all care for women within the team and supported women and birthing people with advice, clinic appointments and birth plans.

The maternity service had developed and displayed a number of infographic information for women, birthing people and their families. This information was displayed throughout the maternity unit. Information displayed showed information learning posters on neonatal seizures, extreme prematurity, as well as sharing learning with families that had been developed from incidents. For example, aspirin in pregnancy and the importance of routine urine testing.

Following a response from women, birthing people and their families the maternity service developed the maternity pregnancy schedule. The schedule provided information on the named midwife and consultant for women and birthing people. There were two pathways, one for a standard pregnancy schedule and the other was for women and birthing people who required multiple scans during pregnancy. The schedule provided information as to the pregnancy journey, including routine scans and antenatal checks.

Surgery

Good

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

The trust set a target of 90% for completion of mandatory training courses.

Training compliance rates for staff in the surgical division were above the 90% target rate for conflict resolution; equality, diversity and human rights; fire safety; fraud and bribery in the NHS; health, safety and welfare; infection prevention and control levels 1 and 2; moving and handling; patient safety for all staff and patient safety for boards and senior leadership teams.

Three further mandatory training courses had been introduced with effect from 1 May 2023 and the relevant committee had authorised a 3-month grace period to build compliance to over 90%. These were medicines management for clinical staff with an overall compliance rate of 87% at the time of our inspection; speak-up core training for all workers with a compliance rate of 49% and staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia, the Oliver McGowan learning disability e-learning. Compliance data for this training was not available at the time of our inspection.

Resuscitation training was undertaken by medical and nursing staff with a compliance rate of 90%. Most levels of resuscitation training had met the trust target with the exception of level 2, adult basic life support and paediatric basic life support for medical staff with a compliance rate of 79%, level 3, immediate life support for nursing staff with a compliance rate of 83% and level 3 paediatric immediate life support for nursing staff with a compliance rate of 70%.

Sepsis training undertaken by staff had compliance rates of 70% for medical staff and 95% for nursing staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a monthly report of staff who needed to complete training and staff were informed in safety huddles. There was capacity to allow 2 staff members each month to concentrate on bringing mandatory training up to date.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Medical and nursing staff undertook safeguarding adults training, levels 2 and 3 and safeguarding children, level 2. These courses were aligned with the Core Skills Training Framework England version 1.1 (the latest iteration). The training provided also adhered to the inter collegiate guidelines for roles and competencies for health care staff.

The trust had an overall compliance target of 90% for safeguarding courses. Data provided showed that medical staff in the division of surgery had 100% compliance for safeguarding adults level 2; 93% for safeguarding adults level 3 and 94% for safeguarding children level 2.

Data showed that nursing staff had achieved 98% compliance for safeguarding adults level 2; 94% for safeguarding adults level 3 and 98% for safeguarding children level 2.

Non-clinical staff undertook safeguarding adults levels 1 and 2 and safeguarding children levels 1 and 2. Data provided showed that compliance was 95% or above for all of these courses.

Staff also received training in the prevent (anti-radicalisation) strategy, child sexual exploitation and female genital mutilation as part of their safeguarding training and staff we spoke with had a good understating of how to identify these.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

The trust had safeguarding policies available to support staff and these could be accessed on the trust intranet. Staff were aware of how they could seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff disposed of clinical waste safely. Waste management audits showed 100% compliance from December 2022 to April 2023 for the division.

There were enough hand wash sinks and hand gels. Staff we observed followed hand hygiene and 'bare below the elbow' guidance. Staff and visitors were encouraged to wash their hands.

We reviewed hand hygiene audits from December 2022 to May 2023 and saw there was an average compliance of 98.5% in the division.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we observed wore suitable personal protective equipment, such as gloves and aprons while delivering care. Gowning procedures were adhered to in the theatre areas.

PPE compliance audits from December 2022 to May 2023 showed an average of 91.5% compliance for the division.

Patients identified with an infection could be isolated in side-rooms. We saw that appropriate signage was used to protect staff and patients. Staff told us they could seek advice and support from the trust-wide infection prevention and control team if required.

We looked at the organisational and site scores for the Patient-led Assessment of the Care Environment (PLACE) scores for 2022, part of which measures cleanliness in hospitals, however, there was no data available for the trust or Royal Preston Hospital. We were therefore unable to make a comparison with the national average for cleanliness.

Staff used records to identify how well the service prevented infections.

Staff worked effectively to prevent, identify and treat surgical site infections. Patients receiving elective surgery were screened for infections such as C.difficile, MRSA and MSSA at a pre-operative assessment clinic. Emergency admissions were screened for infections on the ward.

Cases of C.difficile versus the trajectory were tracked and reported to the safety and quality committee within the monthly safety and quality dashboard. From April 2022 to March 2023, the division had 39 cases of hospital onset hospital associated C.difficile cases. The objective total for the trust was 122 cases.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The design of the environment followed national guidance. The ward and theatre areas were well maintained and free from clutter. The equipment in the theatre areas was also well maintained, fit for purpose and checked in line with professional guidelines.

Access to the surgical wards was secure and the ward and theatre areas required key code access for entry. Patients could reach call bells and staff responded quickly when called.

All the ward areas had sufficient shower and bathing facilities. The ward areas were free from clutter, and we saw that equipment and consumable items were stored appropriately and were not stored on the floor.

Staff told us equipment was routinely checked and cleaned in between use. Equipment (such as hoists and blood pressure monitoring machines) we saw were visibly clean. Single-use, sterile instruments and consumable items were within their expiry dates.

The service had enough suitable equipment to help them to safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Ward staff also told us they did not have any difficulty obtaining any equipment. Equipment was serviced by the trust's medical engineering team under a planned preventive maintenance schedule. Staff told us they received good and timely support if a fault was reported.

Emergency resuscitation equipment was available in all the areas we inspected, and this was checked daily by staff. We saw that daily and weekly equipment check logs were complete and up to date in the areas we inspected. There were 5 cardiac resuscitation trolleys in the main theatre area plus 3 difficult intubation trolleys that were all checked daily. There was also a major haemorrhage cupboard that contained emergency equipment to deal with a major bleed. Staff could access this quickly in case of an emergency.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The division had a live safety surveillance dashboard in place that gave an indication of the likely reliability of safety on the ward at any time based on number of patients on the ward Vs actual staffing numbers; patients requiring risk assessments; number of patients requiring discharge; patients with NEWS scores of 3,5 or 7 or above; patients requiring hourly or less observations; patients with acute kidney injuries and patients with sepsis. It also included missed doses of medication.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks.

Managers told us the pre-operative checklist for patients was checked and the patient was unable to leave the ward for surgery unless the checklist had been validated as correct.

All patients over 65 years of age, or if they met the criteria, were given a falls risk assessment. Staff had access to specialist falls nurses who could provide support.

Patients identified as high risk were placed on care pathways and care plans were put in place, so they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours so any changes to the patient's medical condition could be promptly identified. Patient records we looked at showed that patients were reviewed regularly and escalated appropriately when required.

Staff knew about and dealt with any specific risk issues. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

Surgery

Staff were aware of the NEWS score escalation process so that patients with a NEWS score over five were seen and assessed by medical staff as soon as possible. Staff were encouraged to use clinical judgement so that if a patient's observations were not triggering an escalation, but the patient did not look well they could still escalate and make a medical emergency team call.

Staff followed appropriate guidelines, pathways and screening tools, based on national guidelines for the management of patients with sepsis. Staff we spoke with understood how to identify the signs of sepsis and management of sepsis in line with national guidelines. Nursing staff had received training and used a sepsis kit on the ward for those patient's displaying signs of sepsis, this included antibiotics and fluids. At April 2023 89.2% of relevant staff in the division had received sepsis training.

If the sepsis pathway was triggered, patients were usually treated within the hour. The trust had carried out audits to ensure that the treatment being delivered with presumed sepsis was within the recommended pathway timeline. The sepsis audit data for April 2022 to March 2023 showed that there had been 85 patients screened. Of these, 69 (81%) had been treated within the recommended pathway timeline and 16 (19%) had not. There was a working group in place to identify actions to improve compliance.

The service carried out audits and produced an annual report on Local Safety Standards for Invasive Procedures (LocSSIPs). There were different LocSSIPs for different surgical invasive procedures and each had a clinical audit or checklist assigned, how often this should be conducted and how it should be recorded.

The annual report for LocSSIPS confirmed that the trust was compliant with national requirements and that there were robust governance arrangements in place to effectively manage and audit them. The report confirmed that there had been no identified themes and trends relating to the procedures and no single incidents that had necessitated escalation.

The theatre teams followed the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. There was a monthly audit to check staff compliance against the safer surgery checklist across the theatre areas. This included observational audits to observe staff practice and a review of completed checklist records. Each part of the WHO checklist was audited separately so there was close monitoring of the "team brief"; "sign in"; "time out"; "prosthetic pause"; "sign out" and "de-brief" phases of the WHO checklist. Monthly audits showed high levels of compliance and follow-up actions where anything had been observed to be missed.

During our inspection, we observed 4 WHO checklists in theatres and found that these were all performed as required.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Surgery

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

The senior nurses and ward managers carried out daily staff monitoring and escalated staffing shortfalls to the matrons due to unplanned sickness or leave. Managers told us that if the ward was not staffed safely, they would escalate this by using the red flag system so that additional staff could be found.

Staff participated in huddles at the start of each day and nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues.

The trust carried out an annual safe staffing review and this was regularly reviewed and monitored throughout the year at the safety and quality committee.

The number of nurses and healthcare assistants matched the planned numbers. The division of surgery had an overall planned nursing establishment of 266.44 full time equivalent (FTE) and an actual establishment of 296.56 full time equivalent staff. There was an over-establishment of 35.88 FTE staff which, when staff on maternity leave was accounted for, was an over-establishment of 23.24 FTE nursing staff at the time of our inspection.

The service had minimal vacancy rates. There were only 3 wards within the surgical division that had any nursing vacancies. These were the major trauma ward with 3.64 FTE vacancies; ward 16 (orthopaedics) with 1.96 FTE vacancies and ward 11 (upper GI) with 0.16 FTE vacancies.

The service had low turnover rates. From November 2022 to April 2023, the division of surgery had a staff turnover rate of less than 1% each month for nursing staff. Staff turnover for allied health professional during the same period was an average of 0.95%.

From May 2022 to April 2023 (12 months), there was an average sickness absence rate for nursing staff of 7.45%. From May 2022 to April 2023 (12 months), there was an average sickness absence rate for allied health professionals of 6.49%.

The service had low and reducing rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

In the six months from December 2022 to May 2023, data showed that the percentage of duties requested (to cover substantive staff absence) were filled an average of 67.2% of the time by bank staff and an average of 10.4% of the time by agency staff.

Over the same period, an average of 22.3% of duties requested were unfilled.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The numbers of medical staff did not match the planned number across the division of surgery, but shortfalls were met using bank, locum and agency medical staff, for example, the worked versus funded variance for April 2023 showed a shortfall of only 0.33 WTE.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

April 2023, data showed the division of surgery had overall funding for 413.47 medical staff and there were 378.13 WTE contracted staff in post, a shortfall of 35.34 WTE medical staff. This equated to an 8.55% vacancy rate. This vacancy rate had remained steady throughout the previous 6 months. The trust were recruiting for vacant posts though speciality surgeons (for example neurosurgeons) could not always be recruited in a timely way.

The three specialities with the highest number of medical staff vacancies were neurosurgery with 9.52 WTE vacancies (22.9%); anaesthetics with 7 WTE vacancies (5.7%) and Upper GI/colorectal with 4.6 WTE vacancies (9.6%).

The service had low and reducing turnover rates for medical staff. From November 2022 to April 2023, the division of surgery had an average staff turnover rate of 0.98% for medical staff.

Sickness rates for medical staff were low. From May 2022 to April 2023 (12 months), there was an average sickness absence rate of 2.82%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. All specialities in the division of surgery had junior doctors on shift 24 hours a day, 7 days a week.

The service always had a consultant on call during evenings, overnight and weekends. They were supported by an on call middle grade doctor.

Medical staff undertook twice daily ward rounds.

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. Staff used electronic patient records for recording risk assessments, care plans and for medical and nursing notes, care plans and patient assessments. When patients transferred to a new team, there were no delays in staff accessing their records.

Staff used electronic records for standardised nursing activities, such as daily observations and nutritional care. We saw that observations were well recorded, and the observation times were dependent on the level of care needed by the patient.

We looked at the records for 5 patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.

Patient risk assessments were reviewed and updated on a regular basis. We found that patient's care plans were person-centred and were completed to a good standard. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

Patient records were checked for accuracy and completeness as part of routine audits, such as the routine weekly and monthly quality audits undertaken by ward managers.

Medicines

The service used systems and processes to safely prescribe, record and store medicines but monitoring times between doses were not managed well on some wards and the division was not always compliant with guidelines for the prescribing of antimicrobials.

Staff followed systems and processes to prescribe medicines safely.

The trust used an electronic prescribing and medicines administration (ePMA) system on the wards, paper prescribing was used in theatres this was on the trust risk register, with plans to roll out ePMA later in 2023.

We found people's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine they had previously reacted to. The trusts medicine safety improvement work had resulted in a reduction in the number of missed doses of critical medicines. Audit results showed the missed doses had reduced from 4.20% December 2022 to 2% in April 2023.

We found medicines were not always administered as prescribed. We found that when people were prescribed medicines with a minimum time interval between doses, for example paracetamol, doses were sometimes given too closely together placing the people at risk of side effects. This was raised with staff during the inspection to increase awareness and review systems to address the issue.

We found that antimicrobials that required additional monitoring were safely prescribed and monitored. The trust's antimicrobial stewardship audit showed good overall compliance, but the surgery division was not always compliant with guidelines for the prescribing of antimicrobials with an increase in use of broad spectrum antimicrobial use.

The period January -March 2023 showed it was below the target at 84% 'compliance with guidelines', however they did meet the target for documented indication on the prescription at 92% for the same quarter.

The service reported medicine related incidents and near misses for investigation and lessons learnt to be shared to reduce the risk of recurrence.

Staff stored and managed all medicines and prescribing documents safely.

Surgery

We found medicines were stored safely and securely. Staff knew the process to access medicines out of hours and an on-call rota for pharmacy staff was in place to provide pharmacy support. The pharmacy team attended the wards at regular intervals to ensure stock was appropriately managed and checked medicine expiry dates.

We randomly checked expiry dates of medicines and found no concerns. Medicine safety audits were completed monthly by the trust's pharmacy governance team. The audits showed compliance was repeatedly below target with a number of recurring themes. The audits also highlighted non-compliance against the trusts standards regarding controlled drugs due to recording issues. The concerns had been added to the risk register and new actions were being devised to drive forward improvement.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The pharmacy team were present on several wards to support the clinical staff and complete medicines reconciliation to ensure people were prescribed the correct medicines when they were admitted to the wards.

However, information provided by the trust showed between September 2022 to March 2023 less than 50% of reconciliations were completed within 24 hours of admission to the hospital. There was a risk people may not be prescribed all of their medicines as they had not had a medicines reconciliation within 24 hours of admission (National Institute for Health and Care Excellence (NICE) NG5).

This was linked to pressures within the pharmacy department, with the trust confirming they had an approximate 40% vacancy rate of some pharmacist roles and approximately 30% of pharmacy technician roles in the year to March 2023, a number of the vacant roles have been recruited to in quarters 2 and 3 in 2023. The trust had identified the need to review the lack of pharmacy provision at the surgical assessment unit and pathways for elective surgery.

The trust had introduced a clinical prioritisation tool to identify and focus medicines reconciliation for people who were taking high risk medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

The division of surgery had reported 1 never event during 2022/23. This was in relation to wrong site surgery (wrong side anaesthetic block) and occurred in October 2022. An investigation found that parts of the WHO checklist had not been followed which would likely have prevented the incident from occurring if they had.

We saw that actions from the investigation included a series of observational audits for regional block cases across theatres to ensure that the "stop before you block" process was being followed.

Surgery

Managers shared learning about never events with their staff and across the trust.

Staff reported serious incidents clearly and in line with trust policy.

The trust produced an annual thematic review report for serious incidents and never events. This report provided a high-level overview of level 3/STEIS serious incidents reported between 1 April 2022 and 31 March 2023. The report identified any emerging incidents or themes of concern. No themes of concern were identified in the division of surgery.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Duty of candour was monitored in all cases requiring this and the thematic review found that duty of candour had been applied in a timely way for all cases unless a justifiable exclusion had been identified. Compliance with duty of candour was reported to the Safety and Learning Group on a weekly basis.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made because of feedback. The trust had Always Safety First (ASF) working safety groups which were part of the incident management maturity programme of work to better manage long term improvements and wider organisational learning. The working safety groups involved point of care staff and senior clinicians and decision makers. There were frequent meetings to ensure pace and continuity of the work. There were current working groups, for example, reduction in pressure ulcers, falls and hospital acquired infections.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Data showed that, in the division of surgery in 2022/23 there had been 22 level 3 STEIS reported incidents. These were made up of 8 pressure ulcer incidents; 4 relating to suboptimal care of the deteriorating patient; 2 relating to slips trips and falls; 2 relating to treatment delay and 1 for each of diagnostic incident inducing delay; medication incident; accident and treatment not available or not completed.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards.

We reviewed care pathways for a number of surgical procedures and found these were based on best practice guidance. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

The surgical directorate leads had oversight of policies and procedures relating to surgery and were responsible for their ratification. Speciality leads were assigned to updating speciality specific policies and procedures. The governance team tracked policy updates to ensure that they were updated in a timely way.

Policies were stored electronically and were easily accessible to staff. Review dates for policies and procedures were monitored monthly.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced one to one monitoring and supervision. Staff could also seek support and advice from the trust-wide safeguarding team and mental health liaison teams from another trust when providing care for these patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used the Malnutrition Universal Screening Tool (MUST), which was a nationally recognised screening tool to monitor patients at risk of malnutrition. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for patients who needed it. The patient records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff. Patients with difficulties eating and drinking were placed on special diets.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Optional menus were available for patients with specific requirements. We saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Patients waiting to have surgery were not left nil by mouth for long periods.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an appropriate pain scale for patients that were unable to communicate effectively, such as those living with dementia or a learning disability. Acute pain symptoms were managed by the surgical consultants.

Pain scores were recorded electronically. Staff prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.

Patients received pain relief soon after requesting it. The majority of patients we spoke with told us staff gave them pain relief medicines when needed and their pain symptoms were managed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. There was a clinical lead for audit for the division of surgery.

National mandatory audits were recorded on a clinical audit assurance system. A monthly report showed where audits were up to, action plans and audits or actions that were outstanding. At speciality level there was a named consultant who kept oversight of clinical audits. When audits were complete and results evaluated, leads had 3 months to put an action plan in place. Action plans were monitored by speciality leads.

There was a clinical audit team who assisted in facilitating clinical audits.

Managers and staff used the results to improve patients' outcomes. The trust produced an annual clinical audit and effectiveness plan.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

The trust had a Safety Triangulation Accreditation System (STAR) quality assurance framework that was developed to standardise and reduce duplication and the number of audits undertaken each month and ensure a consistency of approach. Ward managers and matrons undertook monthly audits feeding into the framework. In addition, independent, unannounced accreditation visits were also made to clinical areas to test standards of care alongside experience for patients and staff. These were undertaken by the quality assurance team, governors, volunteers and colleagues from across the trust.

In the division of surgery, all inpatient wards and theatres undertook the monthly STAR audits. These looked at 17 specific areas, including environment; performance data; medicine management; infection prevention and control; well led; acutely unwell; harm free care; documentation; staff health and wellbeing; safeguarding; end of life care; patient feedback; discharge and communication and safety.

Accreditation visits resulted in the ward of a bronze, silver or gold star rating. A bronze star was awarded where an area received a red or amber rating; a silver star was awarded where an area received a green rating and gold stars were awarded to those areas receiving three consecutive green ratings and had supported a peer ward or department to achieve an improved rating.

Surgery

In the division of surgery a total of 45 areas were registered for STAR though this included Chorley Hospital. Data showed that at 31 March 2023, 42 areas had a green rating, 2 areas had an amber rating and 1 had a red rating. Following accreditation visits, 3 areas had a bronze star, 20 had silver stars and 22 had achieved gold star status.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Managers made sure staff received any specialist training for their role. The staff we spoke with told us they routinely received competency-based training in their specialty area and felt confident to do their role. Staff received role-specific training in areas such as venepuncture, cannulation, acute kidney injury, aseptic non-touch technique, dementia, falls prevention, nasogastric awareness, pain management, palliative care, safe use of insulin, sepsis awareness and NEWS2.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Competency-based assessments and training support was provided by the managers and practice-based educators based in the ward and theatre areas. Staff told us that they were well supported by their line managers to undertake development opportunities and additional learning.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided showed that, at the time of our inspection 95% of medical staff had received an annual appraisal and 94% of nursing staff.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Surgery

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical, nursing and allied health professional staff as well as staff from other hospitals within the trust or external hospitals where patients received care and treatment from more than one healthcare organisation. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Seven-day services

Key services were available seven days a week to support timely patient care.

Records showed nursing and medical staff levels were sufficiently maintained outside normal working hours and at weekends across most of ward and theatre areas based at this hospital.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds taking place seven days per week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The ward and theatre staff we spoke with told us they received good support outside normal working hours and at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information leaflets were readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addiction to alcohol and drugs could be offered treatment and provided with support from specialist trust-wide liaison teams.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records we looked at showed that patient consent had been obtained and that planned care was delivered with their agreement.

Staff made sure patients consented to treatment based on all the information available. Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient.

Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act and Deprivation of Liberty training was incorporated into the adult safeguarding training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. A range of multidisciplinary staff were trained to carry mental capacity assessments (such as nurses and medical staff) and capacity assessments were documented in the electronic patient records.

We did not identify patients with Deprivation of Liberty Safeguards (DoLS) in place within the surgical wards we visited. However, ward staff were able to demonstrate a good understanding of DoLS processes.

If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that had lasting power of attorney and could legally make decisions on the patient's behalf. Where this was not possible, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff could seek support from the trust-wide mental health liaison team and the safeguarding team for advice and guidance on mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

The trust audited do not attempt cardio-pulmonary resuscitation (DNACPR) decisions and documentation. From December 2022 to April 2023 93.4% of the documentation and decisions made were compliant with relevant policies.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy.

Surgery

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Patients calling for assistance and call bells were answered in a timely manner across the wards we visited.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness. We spoke with 9 patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.

The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between March 2022 and April 2023 showed that the monthly satisfaction scores across surgical wards at Royal Preston Hospital was consistently above 90%. This indicated the majority of patients were positive about recommending the hospital's surgical wards to friends and family.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions.

Surgery

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the needs of the local population. There were daily meetings with the bed management team so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints and there was daily involvement by the matrons and ward managers to address these risks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines: we observed that male patients were cared for in separate areas to female patients.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, gastroenterology and colorectal surgery, ophthalmology, urology and vascular surgery.

Facilities and premises were appropriate for the services being delivered although the hospital estate was tired and buildings were often in need of repair. The trust was in the early stages of a new hospital building programme to future proof services for the local population.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had information leaflets available in the areas we inspected. These could be provided in different formats or in languages spoken by the patients and local community if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Surgery

Staff completed training in dementia awareness. Staff used specific care plans when providing care and treatment for patients with a learning disability or those living with dementia. We saw evidence of these care plans in use in the records we looked at and they included reasonable adjustments and additional support and advice for patients and their carers.

We observed during our inspection some surgical wards and theatre areas were not fully implementing the dementia strategy. However, there were measures in place, for example the forget-me-not symbol was in use at patient beds to identify patients living with dementia. Carers of patients living with dementia or other needs were identified with a specific lanyard. Clocks on some wards were dementia friendly along with toilet signage. There were red rails in bathrooms. The neurosurgical wards had a memory box for patients living with dementia and another for visually impaired patients. Patients who were mobile and living with dementia were identified by purple socks.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. Staff could contact dementia or learning disability specialist nurses for advice and support in relation to caring for patients living with dementia or a learning disability.

The trust was shortly to introduce the "Think yellow" campaign for patients at high risk of falls who would be identified by yellow blankets on the bed and yellow socks.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Because the hospital was also a specialist surgery and major trauma centre, patients were also admitted from other hospitals for specialist surgery and brought directly there following a major trauma, either by ambulance or air ambulance.

Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The England average length of stay for patients having elective surgery was 5.1 days in 2022. The England average length of stay for patients having emergency admissions was 9.1 days in 2022.

The trust as a whole had an average length of stay of 4.9 days which was better than the England average.

Because of the nature of the hospital as a specialist regional surgical centre, there was a wide range of average length of stay, dependent on the surgical speciality, on the complexity of the surgery and expected post-surgical recovery. The lowest average length of stay was for ophthalmology and plastic surgery at 1.7 days.

Surgery

The highest average length of stay was for spinal surgery at 17.4 days. Patients undergoing spinal surgery often had to wait for a place in a specialist spinal unit to continue their recovery and this increased the average length of stay. Similarly, repatriation of patients who had received specialist surgery, back to the referring trust for further recovery sometimes impacted on the length of stay as it was dependent on a bed being available in the receiving trust.

Since our last inspection and the Covid-19 pandemic, the trust had re-planned surgical services to reduce waiting lists whilst still maintaining their specialist and major trauma surgical status. Most general surgery elective services had transferred to Chorley and South Ribble Hospital so that specialist surgeries referred from other trusts and emergency surgeries could take place at the Royal Preston Hospital site.

The trust was performing well in the percentage change in waiting list and was in the top 25% of trusts when compared to other trusts nationally and overall waiting lists were falling steeply.

However, when all metrics were taken into account, at February 2023, the trust ranked 133rd out of 135 trusts nationally.

The trust was in the bottom 25% of trusts when compared to other trusts nationally for the new pathways as a percentage of completed pathways; for referral to treatment within 18 weeks and referral to treatment within 52 weeks but patients waiting more than 52 weeks for treatment had dropped very sharply from October 2022 to February 2023.

The trust had addressed their 104 week waits and 78 week waits and was tackling 52 week waiting lists at the time of our inspection. From April 2022 to February 2023 the 52 week waiting list had been reduced from 5363 to 2987 (44.3%).

The surgical specialities with the highest waiting lists at February 2023 were other surgical services, general surgery and oral surgery.

The specialities with the lowest performing 18-week referral to treatment at February 2023 were oral surgery and neurosurgical services.

The specialities with the highest 52-week waits for treatment at February 2023 were oral surgery, general surgery and other surgical services.

The trust told us that, following reconfiguration of where elective surgery was being delivered, they had concentrated on improving cancer waiting times. At February 2023, the trust remained in the bottom 25% of all trusts for their 2-week performance and third lowest in the North West. However, performance had increased from a low of 40% of patients seen within 2 weeks in June 2022 to 79% in February 2023. This was below the England average of 86%.

For cancer patients agreeing their treatment plan within 31 days of referral, the trust was in the bottom 25% of all trusts at February 2023 and the fourth lowest in the North West. However, there was an increase from 80% to 88% from January to February 2023. The England average at February 2023 was 92%.

The trust was in the bottom 25% of all trusts for cancer patients beginning their treatment within 62 days of referral and the fourth lowest in the North West at February 2023. Performance had improved from the previous month from 37% to 46% and this was against an England average of 58% at that time.

The trust had an elective recovery plan in place. However, because of the nature of the service, taking major trauma patients that took precedence in theatres and referrals from other trusts, the service acknowledged it was a challenge for them to be one of the best performing trusts in terms of waiting times.

Surgery

The service was not meeting targets for review of patients by a senior clinician within target timescales. There was a target of 90% for patients receiving a clinical assessment by a consultant within 14 hours from the time of admission. Data provided showed that from April 2022 February 2023 only 48% of patients received this.

There was a target of 90% for patients to be reviewed by a senior decision maker every 24 hours. Data provided showed that from April 2022 to February 2023 only 49% of patients received this on average.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards although managers told us that this was not a regular occurrence.

Managers worked to keep the number of cancelled operations to a minimum. The trust had an elective care transformation board which focussed on theatre utilisation improvement. There was a workstream on cancellations and processes to improve this. Theatre utilisation had improved from 68% at the start of the recovery programme at Royal Preston Hospital to 78%. The main elective hub had been moved to Chorley District Hospital and this had aided improvement. The trust told us that, over the last 4 years, cancellations had decreased, especially on the day by more than 50%.

Data provided showed that from December 2022 to May 2023, there were 320 (2.34%) cancellations on the day of surgery for clinical reasons. The highest instances by reason were patient deterioration, emergency cases clinically prioritised and an inadequate pre-operative assessment.

Data provided showed that from December 2022 to May 2023 there were 198 cancellations on the day of surgery for non-clinical reasons. The highest instances by reason were previous surgery overrun, an unrealistic number of patients on the list and no bed available. The trust had a target to reduce the number of operations cancelled for non-clinical reasons to 1%. From April 2022 to February 2023, they had achieved a figure of 1.45% of surgeries cancelled for non-clinical reasons.

Managers monitored that patient moves between wards were kept to a minimum.

Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust had a target of 50% of surgical patients to be discharged on their expected date of discharge but had only achieved 21% from April 2022 to February 2023. As described above, this was often because patients were repatriated to their referring trust and had to wait for a bed to become available.

There was a target of 33% of patients being discharged for this to happen by midday. From April 2022 to February 2023 14% of patients were discharged by midday.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. The ward and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

Staff understood the policy on complaints and knew how to handle them. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning.

Staff could give examples of how they used patient feedback to improve daily practice.

From April 2022 to March 2023, the division of surgery received 172 complaints which equated to 35% of the overall complaints received by the trust during this period. The trust told us that key themes of complaints about surgery were around consent, confidentiality and communication, particularly around communication of plans in relation to care, treatment and discharge.

Of the 172 complaints received about the division of surgery 10 were upheld.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The division of surgery was led by a triumvirate leadership team comprising a divisional director of nursing, divisional medical director and divisional director of operations. They were supported by service leads and deputies that had responsibility at surgical speciality level.

The surgical wards were managed by matrons who had responsibility for surgical wards within a speciality and each ward had a ward manager. The theatre manager was responsible for overseeing theatre services.

The trust offered a number of leadership courses that managers were encouraged to go on. There was a systems leadership course available via the leadership academy. The courses covered a variety of topics around culture and development of leaders. Band 7 managers received a specific away day to develop their leadership skills. There were also external leadership courses available, such as the Nye Bevan NHS programme and a masters degree.

There were medical leadership programmes available, such as new consultant programme and a consultant leadership stretch programme with clinical director topics also available.

Senior leaders we spoke with had undertaken relevant courses and had the skills and abilities to run the service. They understood the challenges to quality and sustainability and could identify actions needed to address them.

Staff spoke positively about the leadership team and organisational structure. The theatres and ward based staff told us that they understood their departmental reporting structures clearly and described leaders as approachable, visible and who provided them with good support. Staff said they felt well supported by the leadership team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trusts clinical strategy, which was developed in collaboration with staff, people who use services and external partners was called “Our Big Plan.” The mission was to provide excellent healthcare to local communities, to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria and to drive innovation through world class education, training, and research.

The vision and strategy for the division was to enable staff to exceed local and national targets with care and compassion. The vision and strategy had 6 objectives/priorities which were to provide safe care and offer a good patient experience, to respond to COVID-19 concerns, to deliver more elective care and reduce the backlog, to support the patient pathways and ensure the right sizing so that the patient is in the right place at the right time, to provide a 24/7 workforce and retain staff and recruit staff accordingly and to support education and innovation. The priorities outlined within the divisional strategy aligned to the trust strategy.

Metrics were used to compare the measure progress against the division and trust strategy. Progress against the delivery of the strategy and the objectives was reviewed yearly. A yearly report on each strategy was completed and reviewed by the divisional board. We saw evidence from board papers of analysis relating to progress towards “Our Big Plan” going to the board of directors in April 2023.

Staff that we spoke with were aware of some of the trust’s vision and strategy and confirmed that strategic objectives were discussed in team meetings.

Wards had goals displayed on notice boards. These goals were aligned to the strategy and included reducing the amount of hospital acquired pressure sores, maintaining compliance in core skills training, and establishing fully integrated pathways with other clinical specialities.

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The divisional staff survey results for 2022 showed that there were 9 themes that scored better than other comparable trusts. Thes included colleagues feeling their role made a difference to patients and service users, colleagues feeling that they are encouraged to report incidents and that the organisation will act upon this and colleagues feeling that they have development opportunities to improve and grow in their career.

The staff survey for 2022 showed 11 areas that scored lower than other comparable trusts. These included colleagues not feeling they have realistic time pressures, colleagues feeling that relationships at work are strained, colleagues feeling worn out, tired and frustrated and colleagues feeling they regularly work extra unpaid hours.

Staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that matrons and clinical leads were visible and approachable.

The medical and nursing staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and nurses told us they received good training and learning opportunities. Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared.

The majority of staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed and who they were. All staff had undertaken the freedom to speak up training.

The low staff turnover rates and high staffing levels reflected a positive culture in the division.

The service promoted equality and diversity in daily work. There was an equality, diversity and inclusion strategy in place and an annual report. There were divisional level equality, diversity and inclusion actions to increase representation of colleagues with specific protected characteristics in the workforce and to improve experience of work and to seek to remove discrimination. There were inclusion ambassador forums in place for ethnicity, living with a disability and LGBTQ+. There were also recently established menopause and carers groups.

However, only 52.8% of all staff in the trust with a disability believed that there was equal opportunity for career progression or promotion. This was compared to 60% of staff without a disability. More ethnic minority staff (45.5%) than white staff (44.6%) believed the organisation provided equal opportunities for career progression and promotion. Leaders were sighted on actions to improve these outcomes.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The division of surgery had clear governance structures in place that provided assurance of oversight and performance against safety measures.

The nursing and medical staff participated in routine local team meetings to monitor governance, risks and performance and share learning from divisional and care group meetings. Information was also shared through daily staff huddles and newsletters.

Ward level meetings took place monthly and included some standard agenda items, such as actions from previous meetings, the matron's report and audits. Meeting also included staff feedback, medicines safety and culture as well as other items of importance.

Ward level meetings fed into speciality quality and safety meetings. These were held monthly and included matrons, ward managers, consultant nurses, clinical governance leads, consultants and clinical directors. The agenda covered governance updates, documentation reviews, issues of concern and actions from previous meetings.

There were clinical business unit meetings attended by all heads of specialities and high level risks and information from these meetings fed into the overall divisional quality and safety meeting and from there to the divisional board and divisional improvement forum, attended by trust executives. High level risks or matters of importance would then be fed to the trust board.

There was a divisional "Always safety first" group that examined safeguarding and audits with high level results feeding into the quality and safety meetings for the division along with matters of importance from the infection prevention and control meetings and clinical investigation meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A risk manager was responsible for speciality local risk registers. Oversight of all the local speciality risk registers was performed by a governance lead who ensured that they were regularly updated.

A monthly risk report gave a breakdown of risks in the division, when they were last reviewed and highlighted risks that were due to be reviewed and actions required.

Quarterly risk management reports gave a summary of the risks, new risks, closed risks and any themes and trends.

Local risk owners tended to be matrons, clinical directors or governance leads within specialities. They were supported by clinical business managers within the governance team.

The trust used an electronic risk register system to record and manage key risks. The division of surgery risk register documented key risks to the surgical care services and the divisional register incorporated the individual departmental / ward risks. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Each risk had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to divisional and trust level.

Surgery

We reviewed the risk register for the division of surgery and noted that the trust was clearly sighted on the key risks to the division. These were the non-compliance with national cancer wait targets; theatre capacity; theatre overruns; deteriorating vascular patients (who were at greater risk of deteriorating than other patient groups); nurse staffing and the use of bank and agency staff, especially where strike action had impacted on staff numbers, and pressure ulcers developing in patients.

The results of STAR audits were triangulated with CQC findings in order to produce a reasonable indicator of areas that required additional support and focus.

Individual specialities reviewed and discussed morbidity and mortality in monthly audit or directorate meetings. Structured Judgement Review meetings had replaced mortality meetings. Data provided showed that there had been 341 deaths in the division from April 2022 to March 2023 and 259 (76%) had undergone a structured judgement review.

The service had a comprehensive performance dashboard to manage performance effectively. It was red, amber and green (RAG) rated giving a visual picture of areas of the service where improvement was required.

The service held a surgery division improvement forum that was attended by the executive team, divisional team, business partners and other support staff. The performance dashboard, staffing, financial use of resources and transformation projects were discussed at the forum with action plans arising from the meetings.

The service had a comprehensive audit programme to aid the monitoring of performance. In 2022-2023 the service carried out 18 national audits and 185 local audits. Oversight of audits was by the clinical audit team and audit leads within the specialities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were electronic. We saw that paper-based patient records were kept securely.

There were 2 incidents reported to the Information Commissioners Office in the 2022-2023 period, neither of which related to the division of surgery,

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke did not identify any concerns relating to accessing IT systems or any connectivity issues.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Staff also undertook information governance training that had a compliance target of 95%. Compliance figures supplied showed a compliance rate of 87% for medical staff and 98% for nurses.

Surgery

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The majority of staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Staff were provided with emotional support. For example, clinical supervision and debrief support was put in place to support staff.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

Staff told us that they were actively engaged in making improvements to their work areas and managers sought feedback from staff on how things could be done better and acted upon suggestions where they could.

The trust had patient engagement groups which provided opportunities to share their views. There was a cancer patient and carer forum for the surgery division that met monthly. They focussed on improving the experience for future patients,

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had established “The Big Room” methodology to make drive improvements and innovations. Where a need for improvement was perceived in a speciality, staff were brought together from multidisciplinary teams to establish a joint approach to improvement and co-designing new pathways or other improvements, with the patient at the heart of the work.

The multidisciplinary teams did not just include clinical staff but also staff such as IT colleagues and administrative staff who were brought on board at the earliest opportunity to provide input into how pathways could reduce wait times for appointments and results, for example.

The trust was consistently the lowest performing trust in England for cancer backlogs following the Covid-19 pandemic. The colorectal cancer backlog was the highest cancer patient tracking list with over 900 patients awaiting diagnosis. The trust pioneered an enhanced recovery ops support transformation programme with a one-stop approach and the colorectal backlog was cleared within 8 weeks. The overall patient tracking lists had been halved overall for cancer patients and there was faster diagnosis, early diagnosis, the quality, experience and outcomes for patients had improved and teams were being helped to reduce health inequalities.

Appendix 1 – Summary of Must and Should Do's by Core Service

Core Service	Location	Must/Should Do	Recommendation
Trustwide	Trustwide	Must Do	1. ***The trust must ensure staff complete mandatory training in accordance with the relevant schedule and receive sufficient training, supervision, and appraisal to perform their duties competently. (Regulation 18 (2)(a)).
		Should Do	2. ***The trust should ensure that it continues to monitor pharmacy staffing to support continued improvement in medicines optimisation (Regulation 18).
			3. The trust should monitor the administration of files for the fit and proper persons checks

Core Service	Location	Must/Should Do	Recommendation
Urgent and Emergency Care	Royal Preston Hospital Hospital	Must Do	4. ***The trust must ensure that medical staff complete all required mandatory training. (Regulation 18 (1)(2)(a).
			5. The trust must ensure that risk assessments are fully completed for patients attending with mental health needs and mitigating actions to limit identified risks are implemented. (Regulation 12 (1)(2)(a).
			6. The service must ensure that staff complete patient records accurately and in a timely manner. (Regulation 17(2)(b)).
			7. ***The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a))
	Chorley & South Ribble Hospital		8. ***The trust must ensure that all staff, including medical staff, complete mandatory training requirements. (Regulation 18(1)(2)(a)).
			9. The trust must ensure that checks of consumables are completed including integrity of packaging and within expiry dates. (Regulation 12(1)(2)(e)).
			10. ***The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a)).
			11. The trust must ensure patients with a mental health concern are cared for in a room that is free from objects that could be used to self-harm (Regulation 12(1)(2)(d))
	Royal Preston Hospital	Should Do	12. ***The service should ensure that patient identifiable details are not displayed on public boards. (Regulation 17).
			13. The service should continue its focus on establishing sufficient numbers of medical staff and managing any risks occurring as a result of staffing lack in medical workforce. (Regulation 18(1)).
			14. The service should continue its focus on improving local audit (STAR accreditation) outcomes.
			15. The service should ensure that patients' nutrition and hydration needs continue to be regularly monitored whilst they are waiting for treatment and care.
	Chorley & South Ribble Hospital		16. The trust should ensure that all conversations with patients, and their families take place in an environment where they are not overheard (Regulation 10)
			17. The trust should ensure that all noticeboards include current information such as safeguarding. (Regulation 13).
			18. The trust should ensure that all patients with protected characteristics are supported such as availability of information in formats that patients understand. (Regulation 9).

			19. ***The trust should ensure that complaints are managed in a timely manner (Regulation 16).
			20. The trust should consider including checks of the transfer bag with other daily checks
			21. The trust should consider locating paediatric emergency information where children would be treated.
			22. The trust should consider reviewing the environment where paediatrics are treated to be more child friendly
			23. The trust should consider sourcing comfortable chairs appropriate for patients with additional needs such as mobility or bariatric.

Core Service	Location	Must/Should Do	Recommendation
Medical Care	Royal Preston Hospital	Must Do	24. The service must ensure patients receive antimicrobials in line with the national guidelines. (Regulation 12)
			25. The service must improve compliance for resuscitation training for medical and nursing staff and compliance for sepsis training for medical staff. (Regulation 12)
			26. The service must ensure that patient records are kept secure.
			27. The service must ensure they have enough medical staff to keep patients safe. (Regulation 18).
		Should Do	28. The trust should ensure patients receive daily, timely review when not being provided care and treatment on the correct medical speciality ward. (Regulation 12).
			29. The service should ensure that staff follow infection prevention control principles. (Regulation 12)
			30. The service should ensure that premises are safe to use for patients. (Regulation 12)
			31. The service should ensure risk assessments, care plans and intentional rounding is completed regularly for all patients. (Regulation 12)
			32. The service should continue to monitor the correct recording of NEWS2 observations. (Regulation 12).
			33. The service should ensure that equipment is properly maintained, including the patient call bells and showering facilities. (Regulation 15).
			34. ***The service should ensure that complaints are managed in a timely manner. (Regulation 16).
			35. The service should continue to improve waiting times for patients accessing neurology cancer treatment.
			36. The service should improve staff attendance at governance meetings.
			37. The trust should continue to improve the provision of single sex washing facilities for patients.
			38. The Trust should continue to recruit allied health professions within medical care.
			39. ***The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed
			40. ***The trust should continue to use medicines data to support improvement in medicines safety.

Core Service	Location	Must/Should Do	Recommendation

Surgery	Royal Preston Hospital	Must Do	41. The trust must continue to take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12(1)).
			42. The trust must continue to take actions to improve the number of patients receiving a clinical assessment and daily review by a senior decision maker within target timescales. (Regulation 12(1)).
		Should Do	43. ***The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed
			44. ***The trust should continue to use medicines data and keep pharmacy staffing under review to support continued improvement in medicines safety, including medicines reconciliation
			45. The service should consider how wards and theatre areas can be made more dementia friendly

Core Service	Location	Must/Should Do	Recommendation
Maternity	Royal Preston Hospital	Must Do	46. ***The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training. (Regulation 18(2)(a)).
	Chorley & South Ribble Hospital		47. ***The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training.(Regulation 18(2)(a)).
			48. The service must ensure equipment is secure, suitable for the purpose for which it is being used and properly maintained. This includes but is not limited to emergency equipment and firefighting equipment. (Regulation 15(1)(b)(c)(e))
	Royal Preston Hospital	Should Do	49. The service should ensure the maternity assessment service has the right number of qualified staff and the triage telephone line is answered and monitored by a trained midwife.
			50. The service should improve the culture where staff feel listened to.
			51. The service should ensure they monitor delays in the induction of labour process and all reasons for the delays are documented.
			52. The service should ensure there is an accurate overview of risks faced, including the monitoring of delays in induction of labour, monitoring of missed telephone calls and telephone call drop off rates within triage and to rate all 3rd and 4th degree tears and post-partum haemorrhages as incidents.
	Chorley & South Ribble Hospital		53. The service should review use of patient group directions and storage of aromatherapy oils to assure themselves medicines management is in line with best practice.
			54. The service should ensure staff carry out newborn observations using track and trigger system in a timely way in line with local guidance.

*** Duplicated recommendations across different core services and sites.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

New Hospitals Programme Quarter 2 Board Report			
Report to:	Board of Directors	**Date:**	7 December 2023
Report of:	Finance Director/Deputy Chief Executive (LTHTr NHP SRO)	**Prepared by:**	R Malin, Programme Director
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide an update on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 2 period: July to September 2023.

This quarterly report is presented to the following Boards:

- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

The report includes the progress against plan for July to September 2023, in particular providing an update on the enabling work business cases, further work on potential new site locations and the emerging new governance model.

It is recommended the Board:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

N/a

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 2 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP).

2 Background

2.1 University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) are working with local NHS partners to progress the case for investment in new hospital facilities.

2.2 The L&SC NHP is part of cohort 4 of the Government's national New Hospital Programme (NHP).

2.3 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the current ageing hospital buildings. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.4 On 25 May 2023 the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer. Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital.

3 National New Hospital Programme

3.1 **Enabling works business case** – the Trusts were delighted to have been successful in obtaining funding to commence due diligence on the potential new sites e.g. technical ground surveys and supporting professional expertise. These works will continue for some time and will bring a greater level of certainty as to the deliverability of these sites ahead of public consultations.

3.2 National guidance – as part of cohort 4 of the national New Hospital Programme, L&SC NHP will be a full adopter of national guidance e.g. Hospital 2.0, an integrated systems approach built on best practice standards and delivery solutions, enabling best-value procurement and Modern Methods of Construction

(MMC). The aim of this is to drive an accelerated programme, creating transformative environments that will benefit patients and the public as a whole. A critical part of this system will be the ability to create prototypes to enable quick learning, collaboration and validation of hospital design, including new greener and safer ways of building.

3.3 During Quarter 2, the L&SC NHP team have supported the national New Hospital Programme team with several data exercises including Hospital 2.0 assessment, costing approach and model and articulating benefits. These have been undertaken to support the national programme team in understanding the L&SC schemes in a greater level of detail and also to ensure a consistent approach across all new hospital schemes. The L&SC NHP team have welcomed their continued involvement in a number of workshops focused on the development of national ambitions around Hospital 2.0.

4 Progress against plan (for the period July to September 2023)

4.1 **Potential new sites** –the L&SC NHP team has commenced significant preparatory work to appoint advisors to determine the viability of potential new sites for the new hospital builds for each of Royal Lancaster Infirmary and Royal Preston Hospital. In parallel, the Programme team will also continue to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – L&SC NHP is working with NHS England and the national New Hospital Programme team regarding the approach to future public consultations and will continue to work with local Health Overview and Scrutiny Committees, who are instrumental in determining the requirement to consult and the approach to be taken. The Strategic Oversight Group (SOG) has reviewed the milestones and dependencies to deliver the public consultations and the Decision-Making Business Cases (DMBC).

4.3 **Governance** – the enabling works (due diligence on the potential new sites) have shifted the programme into a delivery mode and the governance is now evolving to deliver these outcomes. It is anticipated new arrangements will be implemented during Q3 following presentation and discussion of the proposed terms of reference with the Trust's Board of Directors. The SOG has also reviewed and approved a revised risk management strategy and register focusing on the delivery of the programme objectives.

5 Public, patient and workforce communications and engagement

5.1 A summer series of national New Hospital Programme roadshow events visited Preston on 16 August 2023, as Government representatives arrived to discuss the next steps for building two new hospitals in the region. The roadshow event held at Royal Preston Hospital was an opportunity for Health Minister Lord Markham CBE to hear first-hand from staff and patients of University Hospitals of Morecambe Bay NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust, as well as local NHS

leaders, members of parliament and local councils, health and social care colleagues. Lord Markham saw first-hand the challenges of working in and being cared for in some of the current buildings. Conversations also explored what the rebuilds of Royal Lancaster Infirmary and Royal Preston Hospital could mean for those who access these facilities, including improving the working lives of staff and enabling patients to access outstanding care in new state-of-the-art hospital facilities, as well as the benefits of investing in improvements to Furness General Hospital. 94 people attended across the various sessions during the day.

5.2 Interaction with L&SC NHP digital communication channels continues to grow, with focus on driving traffic to the New Hospitals Programme website and providing information via Facebook and Twitter, with a new LinkedIn channel launched in August 2023. Social media toolkits continue to be shared with Lancashire and South Cumbria NHS Communications teams on a regular basis, with ongoing sharing of NHP content through partner channels.

5.3 The following new website content was published in Quarter 2:

- Where to build two new hospitals? (6 July 2023)
- Lancashire and South Cumbria NHS welcomes national New Hospital Programme roadshow (16 August 2023)
- Join the National New Hospital Programme patient involvement event (13 September 2023)
- The New Hospital Programme roadshow – what happened? (14 September 2023)
- Kevin McGee on the New Hospitals Programme (28 September 2023)

5.4 **Stakeholder management** – All Lancashire and South Cumbria and neighbouring MPs, Council Leaders and Chief Executives, and Health Overview and Scrutiny Committee Chairs and Members were invited to attend a roundtable discussion led by Lord Markham CBE as part of the national NHP roadshow on 16.08.23. The MP for South Ribble attended, along with Council representatives from across Lancashire and South Cumbria (with Leaders and CEOs or their deputies from Blackburn with Darwen Council, Chorley Council and South Ribble Council, Lancashire County Council, Preston City Council and Westmorland and Furness Council and Health Overview and Scrutiny Committee Members from Burnley, Chorley, Lancaster, Lancashire South East, Lancashire, Preston, South Ribble, Ribble Valley and Westmorland and Furness Council.

5.5 Members of the Programme team updated the Lancashire Health and Adult Services Scrutiny Committee on 12 July 23 and an update on the L&SC NHP was provided to Westmorland and Furness Health and Adults Scrutiny Committee on 15 September 2023 by the UHMBT Executive Lead.

6 Next period – Q3 2023/24

6.1 **Enabling works business case** - the Programme will focus on the delivering the technical assessments required for the due diligence on potential new sites. In parallel, the NHP team will progress a detailed business case regarding the potential new sites.

6.2 **Governance model** - the team will commence the implementation of the new model, delegated authorities and embed a revised decision-making matrix.

6.3 **Consultation approach** – the team will scope the tasks and resource required for future public consultations and pre-consultation engagement. This includes the overarching approach to consultation, a communications and engagement strategy and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies.

7 Conclusion

7.1 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 2 of 2023/24.

8 Recommendations

8.1 The Board is requested to:

- Note the progress undertaken in Quarter 2.
- Note the activities planned for the next period.

Rebecca Malin
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October 2023