Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

# Lancashire Teaching Hospitals NHS Foundation Trust

Excellent care with compassion

Always Safety First

@LancsHospitals

# Quality Account 2023-24

## Measuring success

Throughout the Quality Account 2023-24 the following key symbols will be used as an easy reference tool.

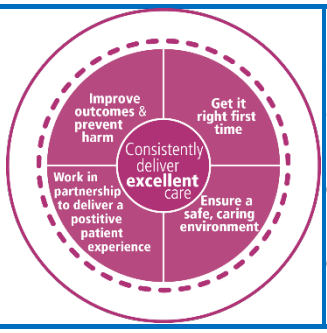
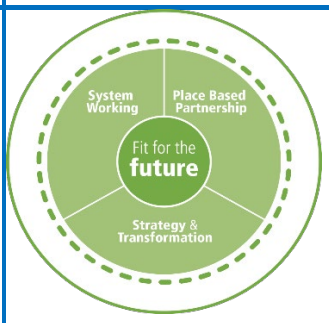
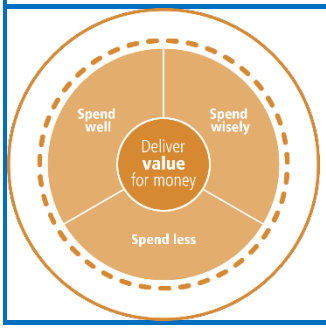
| Symbol | Meaning |
|---|---|
|  | The Trust continues to perform well and/or has improved |
|  | The Trust is achieving well in some areas, but further areas require development |
|  | The Trust is not achieving our target however are aware and have improvement projects in place |

### Key - Our Ambitions

*Our Big Plan* is our Strategy which aligns to our mission to provide "excellent care with compassion" and is founded on our four ambitions which are:

1. To 'Consistently deliver excellent care'
2. To 'Deliver value for money'
3. Be 'Fit for the future'
4. Be 'A great place to work'

Each ambition has a symbol which is presented in the key below. These are highlighted throughout our Quality Account to demonstrate how the content relates to *Our Big Plan* and Mission Statement.

| **Consistently deliver excellent care** | | **Fit for the future** | |
|---|---|---|---|
|  | Improve outcomes and reduce harm<br>Get it right first time<br>Positive patient experience delivered in partnership<br>Ensure a safe, caring environment |  | System working<br>Place Based Partnership<br>Strategy & Transformation |
| **Deliver value for money** | | **A great place to work** | |
|  | Spend well<br>Spend wisely<br>Spend less |  | Promote health and wellbeing<br>Inform, listen, and involve<br>Develop people<br>Value each other |

# PART 1

## Chief Executive's Statement

I am pleased to present the 2023-24 Quality Account for Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR). This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1st April 2023 to 31st March 2024.

We are hugely proud to provide healthcare services to both the people of Preston, Chorley and the surrounding Central Lancashire footprint and the wider population of Lancashire and South Cumbria and we aim to deliver high quality compassionate care to patients and their families through the services we offer.

Quality is key to everything we do at LTHTR, the clinical outcomes and experiences of our patients underpins every decision we make. We intend to build on the excellent work already underway by our clinical teams and strengthen the quality of services we provide; we know that this is a primary motivator of our teams and by remaining focused on this we are more likely to attract and retain the high quality colleagues that provide our services.

The Trust has operated under the 'Our Big Plan Strategy 2021–24' during 2023-24, this has ensured a balanced approach to safety, quality, experience, workforce, operational effectiveness, finance and strategy in local and specialist services.

Our teams have worked hard to deliver the best care possible during incredibly pressured times and I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients. It does not go unnoticed.

The operational performance of the organisation has improved in the way we deliver elective care, less patients are waiting longer this year compared to the year before. Urgent Care pathways continue to present some of the most significant challenges to the organisation and we know that this, alongside our finances are areas that requires improvement in this next year. We know how important it is to carefully balance this and our attention to the safety and quality of services remains our single largest priority.

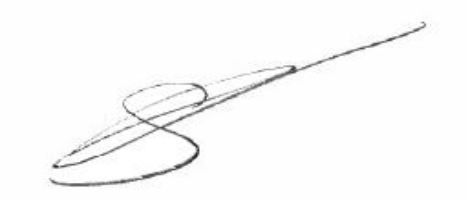
We also recognise that things do not always go to plan, this year we launched the national Patient Safety Incident Response Framework (PSIRF) and are focusing on building a culture that encourages learning and transparency, so, on the occasions when things do not go to plan, we can recognise this and respond in ways that means the people affected have their experiences really heard and we take

measures to prevent recurrence.

The Board of Directors are committed to ensuring the capability and capacity within the organisation to deliver high quality services, our Continuous Improvement Strategy has equipped colleagues with the skills required to lead improvement at each level of the organisation.

The Trust continues to work in partnership with local partners, to develop collaborative leadership at Place level within Central Lancashire and with the Integrated Care Board, Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, Health Scrutiny Committee and third sector partners including our local hospices; Derian House and St. Catherine's Hospice. We firmly believe that working with other organisations who are as committed to the quality agenda as we are can only be beneficial for all concerned and we work hard to make sure that organisational boundaries do not prevent the improvement of services for the benefit of our patients.

This report sets out our performance in detail and together with the support of the Trust's Executive Directors, I am pleased to confirm that, to the best of my knowledge, the following Quality Account 2023-24 complies with the necessary national requirements, the information it contains is an accurate and fair reflection of our performance and that the information in this document is accurate.



**Silas Nicholls**

**Chief Executive Officer**

# PART 2

## 2.1 Priorities for Improvement

Our Big Plan was developed in partnership with our divisions and aligns the organisation's mission to provide 'excellent care with compassion' with our ambitions.

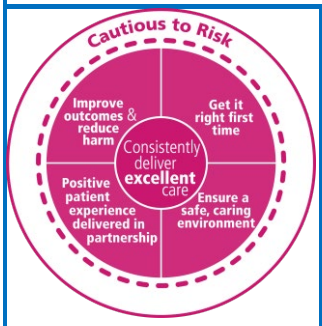
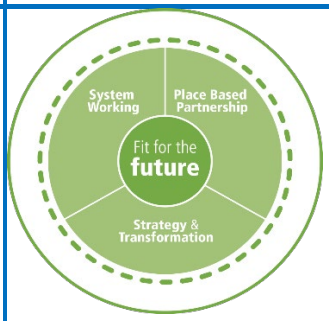
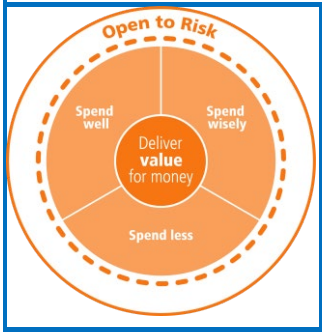
Our values underpin everything we do and support the delivery of our ambitions.

The plan also sets the priorities for improvement and annual performance standards aligned to each of the four ambitions below:

**Our values**

- Being caring and compassionate
- Recognising individuality
- Seeking to involve
- Building team spirit
- Taking personal responsibility

**Figure 1- Our Ambitions**

<table>
<tr><th colspan="2">Consistently Deliver Excellent Care</th><th colspan="2">Fit for the Future</th></tr>
<tr>
<td> 
</td>
<td>Improve outcomes and reduce harm<br><br>Get it right first time<br><br>Positive patient experience delivered in partnership<br><br>Ensure a safe, caring environment</td>
<td> 
</td>
<td>System working<br><br>Place Based Partnership<br><br>Strategy & Transformation</td>
</tr>
<tr><th colspan="2">Deliver Value for Money</th><th colspan="2">Great Place to Work</th></tr>
<tr>
<td> 
</td>
<td>Spend well<br><br>Spend wisely<br><br>Spend less</td>
<td> 
</td>
<td>Promote health and wellbeing<br><br>Inform, listen and involve<br><br>Develop people<br><br>Value each other</td>
</tr>
</table>

Our Big Plan is enabled through the commitments in our Clinical Strategy as well as those in our Patient Experience and Involvement Strategy using the methodology and approach outlined in the Continuous Improvement Strategy.

**Clinical Strategy commitments**

- Continuously strive to improve.
- Lead with care and compassion.
- Work as a team to improve as much as possible.
- Look for diversity and be inclusive.
- Nurture a workforce able to meet our local population demands.

**The Patient Experience and Involvement Strategy commitments**

- Deliver a positive experience.
- Improve outcomes and reduce harm.
- Create a good care environment.
- Improve capacity and patient flow.

**Patient Experience**

Our Big Plan and other strategies can be found on our Trust website.

## Big Plan key priorities achieved:

During 2023-24 there has been positive delivery of a number of *Our Big Plan metrics as follows:

*Data source for Our Big Plan metrics from Business Intelligence.

**Table 1 Big Plan Achievements**

| Improve outcomes and prevent harm | |
|---|---|
| *Achieve 62-day cancer target (target as per NHS England (NHSE) recovery plans) | |
| Mortality within the expected range for adults, children, and paediatrics | |
| 90% patients rating services as good or very good | |
| 75% clinical areas with Silver 'Safety Triangulation and Accreditation Review' (STAR) rating. Compliance was at 82% | |
| Reduction in 104-week waiters (target as per NHSE recovery plans) | |
| Reduce falls by 5% | |
| Reduction in complaints | |
| **Ensure a safe caring environment** | |
| Maintain staff engagement. | |
| Maintain 90% for appraisals | |

**Table 2 Big Plan indicators not achieved**

| Improve outcomes and prevent harm | |
|---|---|
| Reduce pressure ulcers by 5%. | |
| Deliver the *C. difficile* measure within nationally set trajectory. | |
| Reduce sickness absence to 4%. | |

| | |
|---|---|
| Reduce vacancies by a further 5%. | |
| Achieve 90% mandatory training. | |
| Core skills training | |

## Continuous Improvement

The Trust's Continuous Improvement (CI) Strategy been delivered throughout the year and has supported a number of key programmes as outlined below. A new CI strategy will be developed and launched through 2024.

The Lancashire and South Cumbria Flow Coaching Academy is now well established, delivering three cohorts and a fourth is currently in progress. 77 Flow Coaches have been trained and have applied the methodology in the following Big Rooms: Brain Tumour, Breast Reconstruction, Cauda Equina Syndrome, Chemotherapy, Colorectal, Deconditioning, Deteriorating Patients, Do Not Attempt Cardiopulmonary Resuscitation, Eating Disorders, Emergency Mental Health, Enhanced Care, End of Life, Endoscopy, Ears Nose and Throat, Entry to Emergency and Urgent Care Frailty, Falls Prevention, Gynaecology, Inflammatory Bowel Disease, Inpatient Avoidance, Inpatient Pre-operative Pain Management Lung Cancer, Kidney Care, Major Trauma, Neurology (Headache), Neonatal, Nutrition, Pain Management (Spine), Pneumonia, Pre-operative and Prehabilitation, Radiotherapy, Respiratory, Sepsis, Stroke, and Vascular Surgery.

The Lancashire Microsystem Coaching Academy programme has now delivered six cohorts and a seventh cohort is currently in training. With 65 areas trained in the Microsystem Coaching Academy methodology and 121 Coaches.

Over the last 12 months we have worked collaboratively with our Integrated Care System (ICS) and health care partners to test a new approach to deliver system-level improvement across our Lancashire and South Cumbria footprint. Working in partnership with the Engineering Design Centre at Cambridge University we have delivered a programme as an ICS system with a focus on Frailty. We used the Engineering Better Care model to develop and test new ways to deliver healthcare for this population group. More locally across central Lancashire the team participating in the programme have focusing their efforts on reducing conveyance from care homes to the Emergency Department by working with place and system partners to develop more joined-up support services and pathways to mitigate the need for Emergency Department attendance and support patients to live well and age well. The learning and outputs from this programme have been developed and integrated into the 2024 GP Quality Contract, supporting standardised identification, assessment, and care planning for our over 65 population living with Frailty.

There has been a continued focus throughout the year on building CI capability across the organisation through the delivery of the CI Building Capability Strategy in line with the NHSE report and dosing formula for provider organisations for year one of the strategy.

Improvement projects have included:

- Hands First Two (National Quality Improvement Collaborative with the Royal College of Surgeons).
- The Lancashire & South Cumbria Neck of Femurs (#NOF) Quality Improvement Collaborative.
- The Hospital Handover Collaborative (Regional Collaborative with North West Ambulance Service and the Advancing Quality Alliance).

- Core20Plus5 Reducing Health Inequalities (National collaborative with NHS and the Institute for Health Care Improvement).
- The Race & Health Observatory & Institute for Healthcare Improvement Learning Action Network (National collaborative with NHS and the Institute for Health Care Improvement).
- Patient experience, including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project.
- Always Safety First Strategy delivery and improvement programmes aimed at reducing avoidable harm through the development of highly reliable systems and processes.
- Improved compliance to prescribing oxygen and development of a prioritisation process.
- Waste reduction programme within a number of divisions.
- Organisational flow through the following initiatives utilising the Theory of Constraints.
- Co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures.
- Maternity triage assessment unit.
- Patient flow improvement programme.

## Always Safety First

The Trust's 3 year plan and organisational response to the national Patient Safety Strategy is entitled Always Safety First and was launched on World Patient Safety Day, 17th September 2022.

**Key actions achieved in this reporting period are:**

- Implementation of the Patients Safety Incident Response Framework (PSIRF), a comprehensive training plan, identification of local priorities and oversight of learning. PSIRF incorporates health inequalities into the terms of reference of learning responses.
- 3 Patient Safety Partners (PSP) have been recruited and commenced in post in Nov 2023 and patient safety volunteers are being recruited to. The PSPs are having a positive impact, and their role will be formally evaluated in terms of outcome measures.
- A new maternity neonatal voices partnership chair has been appointed to for maternity and neonatal services ensuring the voice of women and families is heard through the services.
- Successful delivery of the year 5, ten Clinical Negligence Scheme for Trusts (CNST) safety actions.
- Themed analysis to determine improvement priority workstreams in year 3 includes deteriorating patients, reducing violence and aggression, ED exit block and patient flow, rapid tranquilisation, Mental Health, *Clostridioides.difficile (C.difficile)* infection reduction and pressure ulcer reduction.
- The Emergency Department (ED) safety surveillance system has been completed and rolled out in Year 2 which enables the identification of real time organisational safety risks. This is being embedded in year 3.
- Safety surveillance systems are embedded within all adult inpatient acute and general wards.
- The national staff survey has demonstrated an improvement in safety scores.
- Circa 1500 colleagues across the Trust have undertaken some form of continuous improvement training.
- 41 clinical areas have been part of the Microsystem Coaching Academy focussing on safety improvement programmes and cohort 7 is in progress. This amounts to 121 individuals in total.
- Safety II toolkit with measurable outcomes is being rolled out across the organisation.

- The Learning Disability plan has been launched alongside mandatory level 1 Oliver McGowan training.
- There is a plan in place and a working group has commenced to establish the Trust approach to implementing Safety II. This is being led by the Continuous Improvement clinical fellows.
- Venous thromboembolism (VTE) risk assessment compliance has improved and sustains to above 90%. (Recent performance has dipped due to collecting the community health care hub data in the overall total however, this will be resolved).
- In year 3, the medicines safety improvement work has focussed on missed doses. As at end of March 2024, the data demonstrates consistent performance of 2% for missed doses of critical medicines. Pharmacy and nursing teams remain engaged with the continuous improvement work
- Safety metrics for medicines safety have been incorporated into the single improvement plan.
- The Deteriorating Patient Dashboard has been created which gives the Critical Care outreach team the ability to undertake proactive reviews of patients at risk of deterioration.
- Level 1 and Board and senior leaders' safety training remains compliant, level 2 safety training has been introduced and organisational compliance continues to improve.
- The Do Not Attempt Cardio Pulmonary Resuscitation Big Room (DNACPR) has led to a reduction of incidents from 10 in 2022 to 2 in 2023 for inappropriate resuscitation attempts where a valid DNACPR decision was in place.
- Development of a critical care delivery group focused on improving outcomes for patients in critical and enhanced care environments. The group is overseeing working towards compliance of the perioperative care standards in enhanced care settings.
- In year 3, the emphasis on reporting compliments and good practice is being developed so that learning from what goes well is incorporated into practice. The promotion of reporting compliments has resulted in a 45% increase during 2023-24 from the previous year.

**Areas not yet progressing in line with improvement plans**

- Pressure ulcer reduction
- Falls reduction
- C.difficile rate reduction

All have been subject to improvement plans this year and whilst pressure ulcers and falls have seen a reduction this has not achieved the target reduction.

## Risk Management and Risk Maturity 

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to internal and external reviews. The Trust's strategic intentions, policies, procedures, and supporting documentation are openly accessible via the intranet for all staff to reference. The existing organisational management structure and Risk Management Policy illustrates the Trust's commitment to effective governance and quality governance, including risk management processes. There is a central risk management team and a

centralised health and safety team, supported by divisional governance and risk teams, led by a Lead Clinical Governance and Risk Manager in each division.

Our Trust has adopted a strategic approach to the management of risk by integrating risk into 'Our Aims' and 'Our Ambitions' so that they link to the strategic objectives of Our Big Plan and support the well-led aspect of the Care Quality Commission (CQC) requirements.

**Risk Management Strategy**

In pursuit of excellence in its risk management arrangements, the Trust developed a new Risk Management Strategy 2024-27. The strategy sets out the approach to further enhancing Risk Management at Lancashire Teaching Hospitals over the next three years after consultation with key stakeholders.

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the policy. The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts: the Strategic Risk Register, those risks that threaten the delivery of the strategic objectives and are not likely to change over time, and the Operational Risk Register, those risks that sit on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation.

Responsibility for reviewing and updating the strategic risk and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director. The BAF is also presented in full to the Audit Committee at each meeting once approved by the Board.

All operational risks are categorised in line with the Trust aims or ambitions that they predominantly impact upon. Any higher scoring operational 15+ risks are also presented to Committees of the Board to which the strategic aims or ambitions are aligned.

At the end of 2023-24, the risk profile of the Trust remains similar to that at the end of 2023 with 489 overall risks in March 2024 compared to 488 in March 2023 and 85 high risks in March 2023 compared to 92 in March 2023. High risk themes continue to be reflective of the following:

- Financial challenges.
- Increasing demand.
- Use of escalation areas.
- Suboptimal capacity to meet targets/manage backlog following Covid-19.
- Staffing challenges.
- Physical environment/estate being suboptimal.
- Mental health care provision.

There is a continued focus on risk maturity, and this is being achieved through the continued embedding of risk management within the Trust.

**Risk Appetite**

The Trust's Risk Appetite Statement was reviewed and approved by the Board of Directors in June 2023.

**The Risk Appetite Statement set by the Board is as follows:**

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to Consistently Provide Excellent Care, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to create a Great Place to Work. By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our Trust values.

We also have an open appetite for risk in relation to our strategic ambition to Deliver Value for Money and our strategic aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria, maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the Trust's use of public funds.

We seek to be Fit for the Future through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in driving health innovation through world class Education, Training & Research by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

**Risk Tolerance**

In addition, the Trust's risk tolerance levels were also updated to outline the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives.

**Table 3 The Risk Tolerance levels as agreed by the Trust Board**

| Strategic Risks | | Risk Tolerance | Rationale |
|---|---|---|---|
| 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 | 1-6 | We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place. |
| | Risk to delivery of Strategic Ambition: A Great Place to Work | 4-8 | Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values. |
| | Risk to delivery of Strategic Ambition: Deliver Value for Money | 8-12 | Acute Trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk. |
| | Risk to delivery of Strategic Ambition: Fit for the Future | 8-12 | To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk. |
| Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research | | 9-12 | We recognise that investments in education, training and research can take time to generate the expected benefits for the Trust, and that new ways of working have a higher inherent risk than established methods. |
| Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria | | 6-9 | We are willing to take risks where there are clear opportunities to streamline and modernise services whilst maintaining and strengthening our position as the leading tertiary care provider in the local system. |

### Our principal risks and issues

The Trust continues to identify potential risks to achieving its strategic aims and ambitions as part of established organisational governance processes. The BAF is used to identify the strategic risks to the Trust alongside actions being taken to mitigate them. During 2023-24, there were six principal risks presented in figure 2 below:

**Figure 2 – Principal 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 due to:<br>a) Availability of staff<br>b) High Occupancy levels<br>c) Fluctuating ability to consistently meet the constitutional and specialty standards and<br>d) Availability of some services across the system<br>e) Existing health inequalities across the system<br>This may, result in adverse patient outcomes and experiences. |
| | 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. |

All principal risks were reported to the Board of Directors and to the relevant aligned Committees of the Board. Principal risks are reviewed to consider the effectiveness of controls, assurances and mitigation plans to support the achievement of the target risk score, as determined by the Trust's risk appetite statement which was set and approved by the Board. In addition to the principal risks identified, during 2023-24, there have been three operational high risks escalated to the Board within the BAF.

These are:

- Impact of exit block on patient safety
- Elective restoration following the Covid-19 pandemic
- The impact of strikes on patient safety following announcement of the national pay award and the probability of ongoing strikes

These are overseen by Board of Directors whilst additional input is required to address the risk and controls.

## 2.2 Statements of Assurance from the Board

This section of the Quality Account is presented with the narrative which is mandated in the Quality Account regulations which refers to Lancashire Teaching Hospitals NHS Foundation Trust or the Trust.

During 2023-24 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 46 relevant health services.

The Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 46 relevant health services.

The income generated by the relevant health services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2023-24.

## Participation in Clinical Audits 

During 2023-24, 56 national clinical audits including three national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 95% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust did not participate in 3 national audits: Improving Quality in Crohn's and Colitis (IQCC) and National Diabetes Footcare Audit due to pressures in the services and inability to find the relevant staff to support the audit and in the National Ophthalmology Database (NOD) Audit due to system requirements. The Trust will continue to review capacity and capability to participate in these three national audits.

The applicable national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2023-24 are listed below in Table 4.

**Table 4 National Audit and Confidential Enquiries – Eligible for Participation[1]**

| NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES | | |
|---|---|---|
| **National Programme Name** | **Audit Title** | **Trust Participation** |
| Adult Respiratory Support Audit | As per the national audit name | Yes |
| BAUS Urology Audits | BAUS Nephrostomy Audit | Yes |
| Breast and Cosmetic Implant Registry | As per the national audit name | Yes |
| Case Mix Programme (CMP) | Intensive Care National Audit a Research Centre (ICNARC) | Yes |
| Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme) | As per the national audit name | Yes |

| National Programme Name | Audit Title | Trust Participation |
|---|---|---|
| Emergency Medicine Quality Improvement Programmes (QIPs) | Mental Health Self Harm | Yes |
| Emergency Medicine QIPs | Care of Older People in Emergency Department | Yes |
| Emergency Medicine QIPs | Time Critical Medications | Yes |
| Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (CYP) | Epilepsy 12 – Cohort 5 | Yes |
| Falls and Fragility Fracture Audit Programme (FFFAP) | National Audit of Inpatient Falls | Yes |
| Falls and Fragility Fracture Audit Programme (FFFAP) | National Hip Fracture Database | Yes |
| Improving Quality in Crohn's and Colitis (IQICC) | As per the national audit name | No |
| Learning Disability Mortality Review Programme (LeDeR) | As per the national audit name | Yes |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | MBRRACE UK Saving Lives, Improving Mothers' Care Surveillance & Morbidity | Yes |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | MBRRACE-UK: Perinatal Mortality Births | Yes |
| Medical and Surgical Clinical Outcome Review Programme (NCEPOD) | End of Life Care Study | Yes |
| Medical and Surgical Clinical Outcome Review Programme (NCEPOD) | Juvenile Idiopathic Arthritis | Yes |
| Medical and Surgical Clinical Outcome Review Programme (NCEPOD) | Rehabilitation following Critical Illness | Yes |
| National Adult Diabetes Audit (NDA) | National Diabetes Foot Care Audit | No |
| National Adult Diabetes Audit (NDA) | National Diabetes Inpatient Safety Audit (NDISA) | Yes |
| National Adult Diabetes Audit (NDA) | National Core Diabetes Audit | Yes |
| National Adult Diabetes Audit (NDA) | National Pregnancy in Diabetes | Yes |
| National Asthma and COPD Audit Programme (NACAP) | Adult Asthma Secondary Care | Yes |
| National Asthma and COPD Audit Programme (NACAP) | Chronic Obstructive Pulmonary Disease (COPD) Secondary Ca | Yes |
| National Asthma and COPD Audit Programme (NACAP) | Paediatric Asthma Secondary Care | Yes |
| National Audit of Cardiac Rehabilitation | As per the national audit name | Yes |
| National Audit of Care at the End of Life (NACEL) | As per the national audit name | Yes |

| National Programme Name | Audit Title | Trust Participation |
|---|---|---|
| National Audit of Dementia | Care in General hospitals (Rou 6) | Yes |
| National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer | NAoMe- National Audit of Metastatic Breast Cancer | Yes |
| National Cancer Audit Collaborating Centre National Audit of Primary Breast Cancer | NAoPri - National Audit of Primary Breast Cancer | Yes |
| National Cardiac Arrest Audit (NCAA) | As per the national audit name | Yes |
| National Cardiac Audit Programme (NCAP) | Myocardial Ischaemia National Audit Project (MINAP) | Yes |
| National Cardiac Audit Programme (NCAP) | National Heart Failure Audit | Yes |
| National Child Mortality Database (NCMD) | As per the national audit name | Yes |
| National Comparative Audit of Blood Transfusion | National Comparative Audit of Bedside Transfusion Practice | Yes |
| National Comparative Audit of Blood Transfusion | Audit of Blood Transfusion against NICE Quality Standard 138 | Yes |
| National Emergency Laparotomy Audit (NELA) | As per the national audit name | Yes |
| Gastro-intestinal Cancer Audit Programme (GICAP) | National Bowel Cancer Audit | Yes |
| Gastro-intestinal Cancer Audit Programme (GICAP) | National Oesophago-Gastric Cancer Audit (NOGCA) | Yes |
| National Joint Registry | As per the national audit name | Yes |
| National Lung Cancer Audit (NLCA) | As per the national audit name | Yes |
| National Maternity and Perinatal Audit (NMPA) | As per the national audit name | Yes |
| National Neonatal Audit Programme (NNAP) | As per the national audit name | Yes |
| National Ophthalmology Database (NOD) Audit | National Cataract Audit | No |
| National Paediatric Diabetes Audit (NPDA) | As per the national audit name | Yes |
| National Perinatal Mortality Review Too (PMRT) | As per the national audit name | Yes |
| National Prostate Cancer Audit (NPCA) | As per the national audit name | Yes |
| National Vascular Registry (NVR) | As per the national audit name | Yes |
| Perioperative Quality Improvement Programme (PQIP) | As per the national audit name | Yes |

| National Programme Name | Audit Title | Trust Participation |
|---|---|---|
| Sentinel Stroke National Audit Programme (SSNAP) | As per the national audit name | Yes |
| Serious Hazards of Transfusion (SHOT UK National haemovigilance scheme | As per the national audit name | Yes |
| Society for Acute Medicine Benchmarki Audit (SAMBA) | As per the national audit name | Yes |
| Trauma Audit & Research Network (TARN) | As per the national audit name | Yes |
| UK Cystic Fibrosis Registry | As per the national audit name | Yes |
| UK Renal Registry Chronic Kidney Disease Audit | As per the national audit name | Yes |
| UK Renal Registry National Acute Kidn Injury Audit | As per the national audit name | Yes |

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website https://www.hqip.org.uk/wp-content/uploads/2023/02/NHSE-QA-List-2023-24-Version-2_February-23.pdf

There were 20 reports published for the national clinical audits in 2023-24. The reports were reviewed and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

**Table 5 National Audits and Confidential Enquiries – Intended Actions**

All Actions are monitored in the Trust's Audit Management and Tracking (AMaT) system:

| Title of Audit | Actions |
|---|---|
| MBRRACE-UK: Perinatal Mortality Surveillance (2021) Births | • MBRRACE real time monitoring tool to be added to the maternity and neonatal monthly clinical governance report to the respective safety and quality committees.<br>• Complete the annual MBRRACE quality assurance check when available on the MBBRACE platform. |
| National Audit of Inpatient Falls NAIF (2023) | • Falls Big Room meets regularly and is an ongoing improvement forum for the Trust.<br>• Post fall checklist to be updated to include the national recommendations. |
| National Bowel Cancer Audit (NBOCA) 2023 | • The Trust's case ascertainment rate was slightly below the national average and only ranked as "fair".<br>• This was discussed with the Corporate Cancer Team and changes to the dataflow have been made to enable the teams to see data in real time for any potential issues. |
| National Pregnancy in Diabetes 2022 | • Offer continuous glucose monitoring and other technologies such as insulin pumps and closed loop systems.<br>• Offer HbA1c at booking. Monitor women with type 2 diabetes or a HbA1c of 41 or above. Regular clinics reviews and access to a dietician.<br>• Offer a pre-conception clinic. Provide rapid referral to lead midwife and consultant within one week. Offer monthly checks. |

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| National Neonatal Audit Programme 2022 (NNAP) | • Real-time monitoring of NNAP measures and data quality with internal performance dashboard reviewed at monthly Neonatal Operational Directorate meetings.<br>• To undertake a quality improvement project focusing on early colostrum showing improvements in latest data from real-time monitoring. |
| National Paediatric Diabetes Audit 2022 (NPDA) | • Monthly review of patients with HbA1c >69mmol/mmol using NPDA Result online.<br>• Multi-Disciplinary Team (MDT) meetings to assess patients who have high HbA1c and tailor management accordingly.<br>• More intense psychology support for patients and embedding into their care from diagnosis. To offer either face to face or online appointments to all the patients. “Attend Anywhere” as a virtual clinic was provided throughout the pandemic and this continues to be provided for all the diabetes referrals.<br>• Blood Glucose Targets: new targets agreed to drive continued improvement in HbA1c. Robust Insulin Dose Adjustments with emphasis on self- management and increase use of technology and pumps based on NICE and patient need. |
| Perioperative Quality Improvement Programme (PQIP) | • Digital solution to collect data/compliance with Drinking, Eating, Mobilising (DrEAMing):<br>• Discussion with surgical team and IT regarding a DrEAMing bundle/order set requested by surgical team requiring mandatory completion by ward staff as an alternative to the above<br>• DrEAMing is a CQUIN target. |
| SAMBA 2023 (Society for Acute Medicine Benchmarking Audit) | • To ensure that the clerking team is fully staffed daily.<br>• To set up an audit to look at the reasons for readmission to hospital within 30 days. |
| Serious Hazards of Transfusion (SHOT) | • Every SHOT case is investigated, reviewed and presented at senior staff meetings, haematology managers' meeting, Hospital Transfusion Committee and divisional Datix meeting |
| The National Hip Fracture Database (NHFD) | • To improve time to surgery to meet the Key Performance Indicators: to introduce a Standard Operating Procedure for trauma theatres.<br>• To improve physiotherapy weekend cover: to use a Band 6 physio to cover the weekends.<br>• To improve the time from admission from Emergency Department to ward to be within 4 hours: to assess the feasibility of ring fenced beds for fractured femur patients |

The reports of 401 local clinical audits were reviewed by the provider in 2023-24 and some examples of the Lancashire Teaching Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are referenced in Table 6.

**Table 6 Local Clinical Audits and Resulting Actions**

| Audit title | Actions intended/completed |
|---|---|
| Audit | Evaluation of investigative modalities for postmenopausal bleeding at the generic outpatient department. |
| Actions – all complete | • Update and finalise changes to local guideline and standard operating procedure on investigation of post-menopausal bleeding.<br>• Design and carry out a patient satisfaction survey within the post-menopausal bleeding service. |

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| | • Set up and establish patient initiated follow up for 6mths. |
| Audit | Audit of ultrasound scan outcomes on Gynae assessment unit |
| Action – in progress<br><br>Action – in progress<br><br>Action – in progress<br>Action – in progress<br><br>Action – in progress | • Make changes to current gynaecology & early pregnancy assessment unit criteria: Offer face to face assessment to anyone with concerning symptoms.<br>• Introduce M6 model for evaluation of pregnancies of unknown location.<br>• Standardised the ultrasound reporting.<br>• Use of systematised medical nomenclature for medicine–clinical terminology codes. Creation of gynaecology and early pregnancy assessment unit dashboard<br>• Develop gynaecology and early pregnancy assessment unit forms on Harris Flex. |
| Audit | Caesarean - Section Rates at Lancashire Teaching Hospitals |
| Actions – all complete | • Ensure vaginal birth after caesarean clinics are running and counselling addresses patients concerns and ensure provision of updated leaflets.<br>• Provide cardiotocography reviews/teaching to staff.<br>• Conduct induction of labour audit to see the gestation of babies at induction. |
| Audit | Appropriateness of referrals of dizziness to the Ear, Nose & Throat department |
| Action – complete | • Design dizziness referral pathway. |
| Audit | Use of cell salvage in obstetric cases |
| Action – in progress<br><br>Action – in progress | • Discuss if an electronic elective caesarean section booking form on Flex and a logbook on Flex is feasible/attainable.<br>• Review and update if indicated, the integrated care systems guideline. |
| Audit | Delayed Computed Tomography Scan (CT) Reports: Cancer Care Consequences |
| Actions – all complete | • Share the results of the audit with Radiology and Safety and Quality Committee.<br>• Add CT reporting to the risk register for Oncology. |
| Audit | Emergency Re-admissions to General Surgery |
| Action – complete | • Introduction of a telephone consultation follow up service for recently discharged patients to assess any ongoing symptoms. |
| Audit | Frailty scoring for Oncology Out-patients |
| Actions – all complete | • Contact Frailty team to assess which services are currently available to patients that could be used within Oncology.<br>• Feed figures from audit into existing business case between Radiotherapy and Dietetics to increase support for on-treatment patients and look into possibility of expanding to include all patients receiving active therapy, not just radiotherapy.<br>• Clarify what programmes the Cancer Alliance have planned around frailty in Oncology.<br>• Ensure frailty score is captured on system for all new patients attending Oncology outpatients.<br>• Educate outpatient staff on how to complete full frailty |

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| | assessment, emphasising the importance of completion of all domains. |
| Audit | Parental education in children with asthma |
| Actions – all complete | • Incorporate a discharge checklist within our electronic patient records to ensure personal asthma action plans are completed.<br>• Identify "champions" to help raise awareness of the importance of asthma care & personal asthma action plans.<br>• Consider and discuss the possibility of combing two leaflets into one personal asthma action plans and weaning. |
| Audit | Systemic steroid use in children aged 1 to 5yrs admitted with wheeze to Paediatric assessment unit & general paediatrics at Royal Preston |
| Actions – all complete | • Create a local guideline or standard operating procedure on the subject for education and continuity and cascade to emergency department staff and trainees. |
| Audit | An evaluation of the experiences of diagnosis and support for individuals with functional neurological disorder. |
| Action – in progress | • Group psychoeducation sessions to be rolled out to reduce waiting times and improve patient care. |
| Audit | Intra-Oral Radiographic Audit |
| Actions – all complete | • Step wedge to be carried out weekly to monitor image quality.<br>• Cassette to be fully opened and checked prior to dispensing exposed image receptor into cassette for processing.<br>• Aiming aid to be utilised when taking x-rays.<br>• Arrange a remedial training session on how to position the image receptor and x-ray head to produce a diagnostic x-ray.<br>• Introduce periodic competency checks of staff taking x-rays. |
| Audit | Investigating “did not attend” rates in hand therapy |
| Action – complete | • Create a new information booklet specific to fingertip injuries to help improve patient information and attendance rates. |
| Audit | Neonatal sepsis audit (Jan 2022 – Dec 2022) |
| Actions – all complete | • Input into the national Infection in critical care quality improvement programme website for external monitoring.<br>• Monitor antenatal/intrapartum antibiotics if the infant is less than 34 weeks.<br>• Maintain eLearning competency assessments for peripherally inserted central catheter inserting staff.<br>• Introduce measures to reduce colonisation of incubator environment such as: Environmental scrubbing and hand hygiene. |
| Audit | Re-audit Neonatal jaundice audit 2023 data |
| Action – in progress<br><br>Action – in progress<br>Action – in progress<br><br>Action – in progress | • Education and dissemination regarding Jaundice, treatments.<br>• Provide Badgernet training for relevant staff groups.<br>• Create new pro forma once Badgernet established.<br>• Improve rates in regard to when total serum or plasma bilirubin samples are to be taken, chasing blood samples & communicating results & potential treatment required.<br>• Utilise total serum or plasma bilirubin monitoring of patients on neonatal unit over 35 weeks. |

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| Action – in progress | |
| Audit | Management of Achalasia: Enhancing treatment outcomes and improving quality of life |
| Action – in progress | • Design and introduce a pre-op quality of life assessment and follow up questionnaire to assess longer term outcomes. |
| Audit | Re-audit of retrospective review of blood transfusion occurring in urgent/emergency cholecystectomy operations |
| Action - complete | • To improve compliance with the group and save policy by creating awareness posters/flyers and circulating them to junior doctors, senior house officers, registrars and consultants. |
| Audit | Syringe Driver Destination Audit |
| Action – complete<br><br>Action - complete | • The District Nurse referral form on HarrisFlex has been amended to include a question relating to whether the patient was being discharged on a syringe driver, and if the answer is yes, there will be a prompt to remind the District Nurses to return the syringe driver.<br>• Copy of return instructions are now included in the syringe driver envelope so that community teams know how to return the syringe driver. |
| Audit | Reasons for failed osteosynthesis in mandible fractures |
| Action – in progress<br><br>Action – complete<br><br>Action - complete | • Suggested 14-day course of antibiotics coverage to prevent the infection of the surgical site and consequently failure of the Open Reduction and Internal Fixation (ORIF).<br>• Highlight to colleagues the importance throughout the consenting process of a clear explanation to patients that infection is a high-risk complication that is most linked to failure.<br>• Highlight to colleagues the importance of a strict aseptic approach pre, intra, and post operatively. |
| Audit | Re-audit: Investigating the Did Not Attend (DNA) rates in Special Care Dentistry across Lancashire Teaching Hospitals |
| Action – in progress | • Continue department conversations with regards to recruitment of a Band 4 staff member to call patients and manage appointment reminders. |
| Audit | Re-audit: Assessment of Pre-Operative Instructions Compliance for Anaesthetist-led Intravenous Sedation Clinic within Special Care Dentistry Department |
| Action – in progress<br><br>Action – in progress | • Ensure all staff are using the same pre-operative instructions.<br>• Remind staff to continue going over pre-operative instruction with patients at pre-sedation appointment. |
| Audit | Referrals for paraproteinemia to haematology service |
| Actions – all complete | • Share the results at Lancashire Teaching Hospitals/Blackpool Teaching Hospitals Haematology job plan meeting and agree Trust guidance on choose & book Haematology referrals.<br>• Add the Trust guidance to the induction of new locum staff. |
| Audit | Compliance with Stop Before You Block (SBYB) |
| Action – complete<br><br>Action – in progress | • The simulation based training was delivered and teaching on SBYB was done at the audit meeting.<br>• To incorporate the Prep-Stop-Block into the new theatre checklist based on the National Safety Standards for Invasive Procedures (NatSSIPs): to be done across the theatres and to be added to the new team brief whiteboards and also in the theatre system (awaiting change board approval). |

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| Action – complete | • To extend the “8 step for safer surgery” with the Prep-Stop-Block: This will be a part of mandatory training for all theatre staff. |
| Audit | DrEaMing (Drinking, Eating, Mobilising) - Post Procedural Review |
| Action – in progress | • To set up a form which will highlight the patients to be reviewed 24hrs post-op which would help to pick up any deteriorations or complications and adjustments needed. |
| Audit | Adherence to British Orthopaedic Association Standards (BOAST) guidelines for medical photography of open fractures and availability of means to take, store and view photos. |
| Action – in progress<br><br>Action – in progress | • To introduce the Clinical Uploader app on the relevant wards and areas to take pictures of the open fractures.<br>• To introduce a Standard Operating Procedure (SOP) on managing/photographing of the open fractures. The SOP will be drafted after the Case Uploaded app is live in order to test how the process works and how reliable it is to work. ED and Plastics to be involved in this SOP development. |
| Audit | Lipid Profile Management in Acute Coronary Syndrome |
| Action – complete<br><br><br><br><br>Action - complete | • Create a poster for the cardiology team to remind them to request lipid profile for acute coronary syndrome patients and to consider Ezetimibe/PSCK9i for those already on large, tolerated dose of statin but still have high low-density lipoproteins (LDL).<br>• General Practitioner action request added to the discharge summary of all acute coronary syndrome patients to check lipid profile 3-4 weeks after discharge with consideration of either Ezetimibe/PSCK9i according to the LDL-C level. |
| Audit | Delirium - attaining the new equilibrium |
| Action – complete<br><br><br><br>Action - complete | • Introduction of a delirium working group - involving more staff at the shop floor, educational activities and awareness - e-learning to be updated.<br>• To update and agree delirium policy focussing on Intensive Care management of delirium. |
| Audit | Pre-Treatment Screening for Long-Term Steroid Therapy in Neuro-Muscular Disorders |
| Action - complete | • Create a checklist for pre-treatment tests and screening to remind doctors what pre-treatment screening is recommended for patients starting long-term steroid therapy for neuro-muscular disorders. |
| Audit | Adherence to Department of Vehicle Licensing Agency Guidelines in Acute Stroke Patients |
| Action - complete | • A field has been added to HarrisFlex, the Trust’s electronic patient record to prompt and improve the documentation of the driving advice that is given to stroke patients. The information is then also automatically included in the discharge summary for the patient. |
| Audit | Ward Round Documentation |
| Action – in progress | • The Neurosurgical Medical Handbook to be updated with the clear expectations of the clinical team with regards to documentation of the ward round/handover, VTE prophylaxis, referrals and communication with the patient or family. |

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| Audit | Documentation of antiplatelets or anticoagulants on neurosurgical wards |
| Action - complete | • The handover sheet has been updated to include the information on antiplatelets/anticoagulants. |
| Audit | Re-audit of lens exclusion in routine CT head examinations |
| Action - complete | • Flyers/posters disseminated within the radiology department to ensure radiographers are aware of lens exclusion measure and are reminded to use gantry tilt wherever possible to reduce lens radiation exposure in patients scanned. |

## Clinical Research

### Participation in Clinical Research

2023-24 has been a record year for the number of patients recruited during the period to participate in research, approved by a research ethics committee and completed at Lancashire Teaching Hospitals NHS Foundation Trust. The team in the Centre for Health Research & Innovation recruited 3,421 patients to National Institute for Health Research (NIHR) portfolio adopted studies in this period. The Trust recruited a further 483 participants to non-portfolio studies. In total, there are currently 190 open research studies recruiting patients at the Trust. The return to a more balanced, pre-pandemic style portfolio has stabilised with commercial trials at 13% of the case mix up from 9% at the end of the pandemic.

### Research Governance

The research department granted local confirmation of capacity and capability for and opened 51 new studies during the period April 2023 to March 2024.

### Trust Achievements in Research

### Infrastructure

- Ongoing funding for the NIHR Lancashire Clinical Research Facility (LCRF) with further NIHR Clinical Research Network strategic award for commercial trials.
- Implementation of the new NIHR Manchester Biomedical Research Centre. There are 6 embedded studies at the Trust and progression into year 2 of a joint PhD colorectal fellow working with The University of Manchester.
- Research and Innovation in the Trust has received the Gold STAR award for safety and quality four times running.
- All research projects have a ‘green’ rating in the NIHR Clinical Research Facilities (CRF) annual report feedback.

### Workforce

- The Senior Research Midwife has been accepted on to the NIHR Senior Leadership Programme which commenced in April 2024.

- The neurosciences clinical research practitioner was nominated for the 'Living the Values' Our People Award and was commended, also receiving a special recognition award at the end of the ceremony.
- Neurosciences Senior Research Nurse was part of the winning Menopause Advocates Team that won Our People Award for Colleague Health & Wellbeing.
- Consultant Oncologist has been awarded an honorary clinical chair at the University of Central Lancashire (UCLan) for his contribution in the development of the NIHR Clinical Research Facility (CRF) into a functioning centre for early phase studies as Medical Director for the CRF.
- Head of Data Science and Colorectal Surgeon has been awarded an Honorary Clinical Chair at Lancaster University, in recognition of his work on the Trust's Trusted Research Environment (TRE).
- Two successful candidates for the NIHR Early Career Researcher Development Pathway the Paediatric Research Physiotherapist and a Specialist Therapeutic Radiographer.
- In Neurosurgery three registrars are currently involved in the NIHR Associate Principal Investigator (PI) scheme.
- The Royal Preston Paediatric Neuromuscular Service received a prestigious Centre of Excellence award from leading national charity Muscular Dystrophy UK.

**Studies/Trials/Research**

- Refurbish of the clinical trial aseptic suite.
- A successful Research Council Impact Acceleration Account award further strengthens partnership working between Lancaster University and the Trust to further develop neurology data science work.
- Recruited the first UK patient to the HeredERA clinical trial, sponsored by F. Hoffmann-La Roche Ltd in advanced or metastatic breast cancer.
- Our motor neurone disease (MND) service is participating in the National MND studies group and TRICALS, the largest European research initiative to find a cure for MND.
- HARMONIE trial in children/neonates trialled Nirsevimab which was proven to protect infants against hospitalization for Respiratory Syncytial Virus (RSV)-associated lower respiratory tract infection and against very severe RSV-associated lower respiratory tract infection in conditions that approximated real-world settings. (Funded by Sanofi and AstraZeneca.
- A Phase 2, Multicentre, Open-Label, Umbrella Study of SCIB1 and iSCIB1+ in Patients with Advanced Unresectable Melanoma Receiving Either Nivolumab with Ipilimumab or SCIB1 with Pembrolizumab (The SCOPE Study). The Cancer Research Team and Lancashire Clinical Research Facility have recruited randomised and treated the first global patient into the Scope study. This is a first in human (FiH) treatment study.

## Registration with the Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the CQC, and it is currently registered and licensed to provide the following services:

- Diagnostic and/or screening services.
- Maternity and midwifery services.
- Surgical procedures.

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Termination of pregnancies.
- Treatment of disease, disorder, or injury.
- Management of supply of blood and blood derived products.

**CQC Finney House**

The Trust is also registered to provide services from Finney House Community Healthcare Hub. Finney House provides out-of-hospital community-based care through community services, clinics and support patients medically at satellite dialysis units and is registered with the CQC and licensed to provide:

- Accommodation for persons who require nursing or personal care.
- Treatment of disease, disorder or injury.

The Chief Nursing Officer is the Registered Manager with CQC for Lancashire Teaching Hospitals NHS Foundation Trust and Finney House Community Healthcare Hub. Both the Foundation Trust and Finney House Community Healthcare Hub are fully compliant with the registration requirements of the CQC.

**Trust Inspections**

The CQC undertook an unannounced inspection over the period May, June and July 2023 as part of its continual checks on the safety and quality of healthcare services at the Trust. The areas inspected were 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 and they also inspected the well-led key questions for the Trust overall. The report was published on the 24th November 2023 and the CQC ratings of our services stayed the same as "requires improvement". The CQC rated safe, effective, responsive and well led overall as requires improvement and caring as good. Surgery at Preston and urgent and emergency care and maternity at Chorley was rated good. With urgent and emergency care, medicine and maternity at Preston as requires improvement.

Please refer to figure 3 for the CQC Trust wide ratings for each of the domains inspected.

**Figure 3 CQC Trust wide ratings**

The CQC noted there was progress with performance but also highlighted areas where further work was needed to address bed pressures and flow and delivery of the financial plan. During the inspection of urgent and emergency care the Trust received a letter of concern regarding the management of mental health patients. The Trust responded to the concerns raised and since the inspection the CQC has been assured with the information provided and this area is no longer under active monitoring by the CQC. The Trust is responding to the must and should do's issued as part of the inspection through its quality improvement plan. this will be overseen through the new single improvement plan in 2024/25 and continue to be reported to the Board of Directors. At the end of March 2024, of the 54 'Must Do's' and 'Should Do's' included in the 2023-2024 CQC Quality Improvement Plan (QIP), there are 28 (52%) recommendations assessed as 'Green' i.e., delivered, 24 (44%) as 'Amber-Green' i.e. ongoing and progress made and 2 (4%) as 'Amber-Red' i.e. not currently delivered and risks with delivery. There are nil currently assessed as 'Red' i.e. not expected to deliver at any point in time.

The report highlighted several areas of good practice recognising improvements and positive changes the Trust has made to drive its safety and improvement culture as follows.

- The Trust had processes 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 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.
- Leaders operated effective governance processes, throughout the services 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.

## Quality of Data

### Information Governance

The Trust has a clear focus on data quality. Performance information is triangulated with other known information to identify any areas of weakness and where data requires further exploration, specific reviews are undertaken. A data quality management review was undertaken in 2022–23 and recommendations provided. In response, the Trust is taking forward a refreshed data quality group in relation to high priority performance metrics and a data quality audit was undertaken in 2023–24.

The Digital and Health Informatics Directorate continue to secure the Trust's data and services with monitoring through the NHSE Data Security and Protection Toolkit (DSPT) Regional Health Information and Management Systems Society Infrastructure Adoption Model assessments have also

been undertaken, with recommendations assessed and added to the Cyber Security action plan and monitored through the Cyber Security Committee.

The Trust has a high risk (scoring 15) related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved. All eligible Windows servers and workstations have been onboarded to enhanced national threat detection and monitoring systems Cyber recovery solutions have been procured to protect critical server backups and over 11,000 staff members have been onboarded to multi-factor authentication, thus protecting Trust email and applications.

## Data Quality 

It is generally accepted that good quality data is at the heart of identifying the need to improve. It also provides the evidence that there has been improvement in the quality of care delivered as a result of changes that the Trust has made.

Lancashire Teaching Hospitals NHS Foundation Trust reports on data quality through submission of a bi-annual Data Quality Assurance Report to the Trust Board providing a summary of Data Quality Team activities and an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the latest published data, which included the patient's valid NHS number, was:

- 99.9% for admitted patient care.
- 99.9% for outpatient care.
- 99.3% for accident and emergency care.

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 99.6% for admitted patient care.
- 99.6% for outpatient care.
- 99.4% for accident and emergency care.

All data set types are either consistent with or show an improvement compared to 2022-23, and all are above the national average for 2023-24.

As part of the Lancashire Teaching Hospitals NHS Foundation Trust annual assessment, the Data Security and Protection Toolkit (DSPT) is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2022-23 DSPT is 'standards met'. The Toolkit Audit for 2022-23 provided substantial assurance for the self-assessment and National Data Guardian standards. The 2023-24 submission is not due to be made until June 2024.

The Trust was subject to an internal Information Governance clinical coding quality assurance audit during 2023-24. Results indicate a high level of coding quality and completeness as follows with improvement across secondary diagnosis and procedures:

- Primary Diagnosis 92.5%.
- Secondary Diagnosis 92.65%.
- Primary Procedure 93.04%.
- Secondary Procedure 93.22%.

In terms of the NHS Digital Data Quality Maturity Index the Trust scored the following for the latest position available, above the national average in all datasets and overall showing an improvement compared to the 2022-23 position. Please see table below for NHS Digital Data Quality.

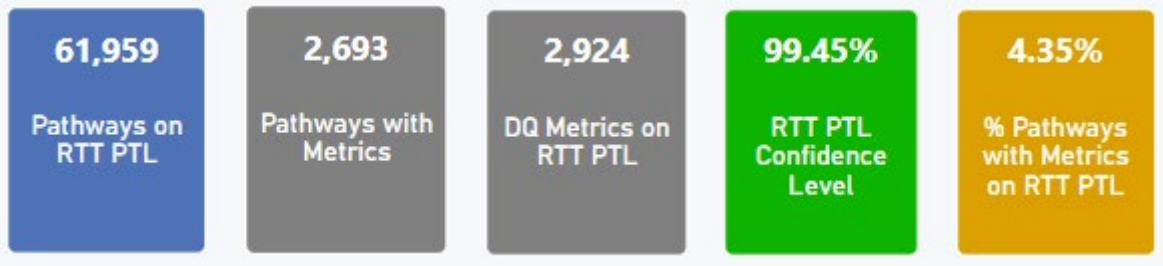
**Table 7 - NHS Digital Data Quality**

| | Overall | Emergency Care Dataset | Admitted Patient Care Dataset | Out-Patient Dataset |
|---|---|---|---|---|
| National Average | 88.9 | 82.6 | 92.6 | 93.5 |
| Lancashire Teaching | 92.4 | 86.4 | 99.5 | 98.2 |

***Data source NHS Data Quality Maturity Index***

The National Waiting List Minimum dataset data quality confidence level of 99.45% for the Trust is above the national threshold of 95%. Compliance is detailed below and shows a 2% improvement in the number of records with a data quality query:

**Figure 4 National Waiting List Data**




***LUNA National Data Quality Solution***

Whilst the figures for data quality are above the national average the Trust remains committed to continued improvements and supporting actions are referenced below.

- Extended suite of validation reports to increase validation and assurance of the quality of data on the main Patient Administration System (PAS).

- Interactive workshops to ensure engagement with clinical and support staff regarding the importance of good data quality and individual responsibility.
- Established a Data Quality Forum to support improvements to data quality in core systems.
- Engaged with external audit partners to improve the quality and depth of clinically coded data and overall data completeness.

## Information Governance 

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies, all of which support current legislation and are reviewed on a regular basis. Personal information is increasingly held electronically within secure Information Technology (IT) systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory, and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and the Information Commissioner's Office (ICO) where appropriate.

The Trust experienced two externally reportable serious incidents in the 2023-24 period, one of these incidents reached the reporting criteria and was sent to the ICO. For all incidents full internal processes were followed and both incidents were reported using the Data Security and Protection Toolkit (DSPT).

As part of our annual assessment, the DSPT is reviewed annually and updated to ensure Trust standards are aligned with statutory obligations. The status for the 2022-23 DSPT was 'standards met'. The Trust has submitted the baseline assessment for 2023-24 and is working towards the final submission which is due on 30th June 2024.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation. This is well embedded and identifies information asset owner responsibilities for ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This ensures compliance in line with the UK General Data Protection Regulations (UKGDPR) and the Data Protection Act 2018 (DPA18).

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Chief Medical Officer who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO) is the Finance Director.

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development

of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

## Adult Mortality Reviews

The Trust has robust governance arrangements in place to monitor, review, report and learn from patient deaths and implemented the nationally recommended approach to Mortality Review (MR) during 2017-18 which was based on the Royal College of Physicians Structure Judgement Review (SJR) model. This has been embedded in practice for the past six years. The SJR mortality model was developed for the review of adult deaths, the outcomes of which are presented below.

Neonatal and child deaths are managed through different nationally defined review and reporting processes which are presented separately in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section in this quality account. The deaths listed this section include inpatient and Emergency Department (ED) deaths which are reviewed using SJR methodology.

**Structured Judgement Reviews**

The Trust completed SJRs (Structured Judgement Reviews) for 52% of deaths.

During 2023-24, 1,908 of Lancashire Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 484 in the first quarter.
- 419 in the second quarter.
- 466 in the third quarter.
- 539 in the fourth quarter.

***Data source: Trust data warehouse***

By 31 March 2024, 964 case record reviews and 16* Serious Incident Investigations (either StEIS under Serious Incident Framework (SIF) or Patient Safety Incident Investigation (PSII) under Patient Safety Incident Response Framework (PSIRF) have been carried out or are ongoing in relation to the 1,908 of the deaths noted above. This is excluding any incident involving a child or neonate and only specifically relates to deaths.

** 12 StEIS investigations have been completed, of which 2 remain awaiting Coroner ruling, and 4 are ongoing investigations (ether StEIS or PSII under PSIRF).*

The number of deaths in each quarter for which a case record review of StEIS investigation was carried out was:

- 216 in the first quarter (plus 7 StEIS investigations).
- 267 in the second quarter (plus 4 StEIS investigation).
- 300 in the third quarter (plus 4 StEIS/PSII investigations).
- 233 in the fourth quarter (plus 1 StEIS/PSII Investigations).

***Data source: Trust MR Database & Datix***

3* representing 0.16 of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient in relation to each quarter, this consisted of:

- 2 representing 0.10% for the first quarter.
- 1 representing 0.05%for the second quarter.
- 0 representing 0% for the third quarter.
- 0 representing 0% for fourth quarter.

***Data source: Trust MR Database & Datix***

These numbers have been calculated using the SJR Mortality Review process, the StEIS/PSII process and the Coroner's Inquest process. There are 4 investigations ongoing and 2 StEIS investigations completed in 2023-24, which remain awaiting Coroner's Inquest hearing and so it is not possible to determine for all cases if deaths were on balance likely due to problems in care. It is noted that the new Patient Safety Incident Response Framework, which the Trust implemented from 6th November 2023, advises that avoidability of death should not form part of the terms of reference for PSII investigations, with that being the remit of HM Coroner.

**Learning from Structured Judgement Reviews**

During 2022-2023, the mortality review pro forma was updated to capture both positive and negative learning and learning from deaths is regularly shared in the divisional Safety and Quality meetings and speciality governance meetings. The learning outcomes from the SJR reviews are extracted from the electronic SJR tool in our clinical audit system; AMaT. This is collated and key themes are reported into our Divisional and Trust Safety and Quality Committees. Themes for learning are also reported into our Mortality and End of Life Care Committee which highlight excellent practice as well as areas for consideration and action.

Key positive themes arising from the outcomes of SJR Mortality Reviews 2023-24:

- Appropriate escalation of patients.
- Good Communication with the family and patient.
- Prompt investigations.
- Good documentation.
- Multi-disciplinary approach.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR 2023-24. These themes are being addressed through the continuous improvement and risk management process:

- Resuscitation decision making and delays in initiating a do not attempt cardio-pulmonary resuscitation (DNACPR).
- Missed escalation of patients.
- Emergency Department (ED) delays

## 2.3 Reporting Core Indicators

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS Improvement compliance framework and the acute services contract.

The NHS continued to face significant challenges and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has continued to experience pressures as a result of the COVID-19 pandemic. Performance across the board, both emergency and elective has been impacted with operational pressures and infection, prevention control measures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures in response to increased demand resulted in high bed

occupancy throughout the year with the need to focus both on non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside remained high throughout the year. This, together with both Influenza demand resulted in significant capacity and demand pressures. Workforce capacity to undertake elective activity was also impacted by sickness absence and industrial action throughout the latter part of the year.

A health economy system-wide action plan is in place to address the urgent care system and pressures; with identified primary, community and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2023-24 the Trust continued to take a lead role in bringing together operational delivery of the system-wide urgent and emergency care programme, including key transformational work streams identified and prioritised by all system partners: a Community Healthcare Hub at Finney House continues to provide health-led community bed capacity; the continued development of Virtual Wards; additional Home First capacity and crisis hours to support people to stay safe at home; and to expedite timely discharge from hospital.

The Trust has worked hard to deliver against the Core Indicator Performance and for the 2023-24 period a number of indicators are showing an improved position against the 2022-2023 submission. The indicator for Methicillin-resistant Staphylococcus aureus (MRSA) has been maintained with one case reported consistent with last year and there remain three indicators which have shown a deteriorating position.

- The C-difficile trajectory has not been achieved. Please refer to the Control of Infection section of this report for all actions in relation to reducing the incidence of c-difficile infections.
- The Trust 4-hour standard for Accident & Emergency (A&E) has deteriorated and a number of operational workstreams are directed towards achieving this target.
- Cancer - 31 Day Target - Subsequent treatment – Surgery – performance against the standard was not met in 2023-24 with actual performance showing a deteriorating position compared to the previous year.

Core Indicators: Summary position detailing performance for 2023-24 is shown in table 8 below.

**Table 8 Core Indicator Performance 2022-23 and 2023-24**

| Indicator | 2022-23 | 2023-24 | Current Period | Comparison |
|---|---|---|---|---|
| **A&E - 4 hour standard** | 75.3 | 70.4 | % - Cumulative to end Mar 2024 | Deteriorated |
| **Cancer - 2 week rule (All Referrals) - New method** | 58.6 | 83.5 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 2 week rule - Referrals with breast symptoms** | 82.2 | 91.0 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 31 day target** | 83.3 | 84.4 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 31 Day Target - Subsequent treatment – Surgery** | 59.3 | 58.2 | % - Cumulative to end Mar 2024 | Deteriorated |

| Indicator | 2022-23 | 2023-24 | Current Period | Comparison |
|---|---|---|---|---|
| **Cancer - 31 Day Target - Subsequent treatment – Drug** | 96.8 | 98.4 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 31 Day Target - Subsequent treatment -Radiotherapy** | 82.3 | 87.1 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 62 day Target** | 43.2 | 56.0 | % - Cumulative to end Mar 2024 | Improved |
| **Cancer - 62 Day Target - Referrals from NSS (Summary)** | 29.2 | 29.9 | % - Cumulative to end Mar 2024 | Improved |
| **28 day faster diagnosis standard – compliance** | 57.5 | 71.5 | % - Cumulative to end Mar 2024 | Improved |
| **MRSA** | 0 | 0 | % - Cumulative to end Mar 2024 | Maintained |
| **C.difficile Infections** | 196 | 203 | % - Cumulative to end Mar 2024 | Deteriorated |
| **18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks** | 50.5 | 55.0 | % - Cumulative to end Mar 2024 | Improved |
| **18 weeks - Referral to Treatment -Number of Incomplete Pathways > 104 Weeks** | 5 | 0.0 | End March 2024 census position | Improved |
| **18 weeks - Referral to Treatment -Number of Incomplete Pathways > 78 Weeks** | 130 | 11.0 | End March 2024 census position | Improved |
| **% of patients waiting over 6 weeks for a diagnostic test** | 50.44 | 45.6 | % - Cumulative to end Mar 2024 | Improved |

***Data source: NHS Digital/LTHTR Data Warehouse***

## Summary of Performance against Core Indicators

The source of all the data presented in the following tables is from NHS Digital as is the requirement for the Quality Account and is the most current data available for each Performance Indicator presented. All benchmarking data presented is related to Acute (non-specialist) NHS Trusts.

### NHS Digital Data availability

All data reflects the latest data period available on the NHS Digital Data platform.

- Summary Hospital-Level Mortality Indicator (SMHI) - Table 9 relates to 2022-23.
- Readmissions within 30 days of Discharge - Table 10 relates to 2022-23.
- Venous Thromboembolism – Table 11 relates to 2020-21 (remains paused since COVID-19).
- Clostridioides Difficile Infection - Table 12 relates to 2022-23.
- Patient Safety Incidents - Table 13 relates to 2023-24.

| Table 9 Summary Hospital-Level Mortality Indicator (SMHI) * most current data | | | | | |
|---|---|---|---|---|---|
| **Summary Hospital-Level Mortality Indicator (SMHI)** | **December 2018-<br>Nov-19** | **December 2019-<br>Nov-20** | **December 2020-<br>Nov-21** | **December 2021-<br>Nov-22** | **December 2022-<br>Nov-23 *** |
| | **Trust = 0.9702** | **Trust = 0.9671** | **Trust = 0.9593** | **Trust = 0.9641** | **Trust = 0.9169** |
| **(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period** | England average = 1.0 | England average = 1.0 | England average = 1.0 | England average = 1.0 | England average = 1.0 |
| | Low = 0.69 | Low = 0.69 | Low = 0.71 | Low = 0.71 | Low = 0.71 |
| | High = 1.19 | High = 1.18 | High = 1.19 | High = 1.22 | High = 1.25 |
| | Banding = 2 | Banding = 2 | Banding = 2 | Banding = 2 | Banding = 2 |
| **(b) the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period** | **Trust = 53%** | **Trust = 52%** | **Trust = 51%** | **Trust = 55%** | **Trust = 55%** |
| | England = 36% | England = 36% | England = 39% | England = 40% | England = 42% |
| | High = 59% | High = 59% | High = 64% | High = 66% | High = 66% |
| | Low = 11% | Low = 8% | Low = 11% | Low = 13% | Low = 16% |

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- NHS Digital categorises NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). The Trust remains in band 2 which is within the expected range. The SHMI for the most current data available (Dec 2021 – Nov 2022) is 0.91 which is lower than the previous 12-month period but still below the 1.0 average.
- The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.

| Table 10 Readmissions within 30 days of Discharge * most current data | | | | | | |
|---|---|---|---|---|---|---|
| **The percentage of patients aged: 0 to 15 and 16 or over Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from the Trust during the reporting period** | **April 2017-Mar 18** | **April 2018-Mar-19** | **April 2019-Mar-20** | **April 2020-Mar-21** | **April 2021-Mar-22** | **April 2022- Mar-23*** |
| **0-15 years** | **Trust = 15.2 (A1)** | **Trust = 15.8 (A1)** | **Trust = 13.5 (A5)** | **Trust = 12.0 (W)** | **Trust = 12.5 (W)** | **Trust = 13.7 (A5)** |
| | England = 11.9 | England = 12.5 | England = 12.5 | England = 11.9 | England = 12.5 | England = 12.8 |
| | High = 17.0 | High = 19.3 | High = 18.5 | High = 12.1 | High = 12.6 | High = 12.9 |
| | Low = 1.7 | Low = 2.0 | Low = 2.4 | Low = 11.9 | Low = 12.5 | Low = 12.8 |
| **16 years – 74 years** | **Trust = 10.9 (B1)** | **Trust = 12.0 (B1)** | **Trust = 11.8 (B1)** | **Trust = 12.4 (B1)** | **Trust = 10.4 (B1)** | **Trust = 12.7 (B1)** |
| | England = 12.4 | England = 13.0 | England = 13.1 | England = 14.5 | England = 13.4 | England = 13.3 |
| | High = 21.0 | High = 21.8 | High = 19.5 | High = 14.5 | High = 13.4 | High = 13.3 |
| | Low = 2.2 | Low = 1.2 | Low = 3.2 | Low = 14.4 | Low = 13.4 | Low = 13.3 |
| **75 years +** | **Trust = 16.9 (B1)** | **Trust = 17.8 (W)** | **Trust = 17.6 (B5)** | **Trust = 19.5 (W)** | **Trust = 16.6 (B1)** | **Trust = 17.0 (W)** |
| | England = 18.4 | England = 18.7 | England = 18.6 | England = 19.6 | England = 18.0 | England = 17.2 |
| | High = 22.5 | High = 29.4 | High = 31.9 | High = 19.7 | High = 18.0 | High = 17.3 |
| | Low = 6.7 | Low = 6.1 | Low = 8.6 | Low = 19.4 | Low = 17.9 | Low = 17.1 |

2022 -2023 not yet released by NHS Digital. As such data is presented 12 months in arrears.

Banding key:

B1 = Significantly lower than the national average at the 99.8% level

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)

A5 = Significantly higher than the national average at the 95% level but not at the 99.8% level

A1 = Significantly higher than the national average at the 99.8% level.

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years, and 75+ years.
- The banding has been presented to indicate the Trust performance.
- The 0-15 year's readmissions are higher than the England average and shows a deterioration from the last reported figure.
- The Trust re-admissions rate for patients 16-74 & 75+ is either as expected or lower than the average.

| Table 11 Venous Thromboembolism (VTE) Risk Assessment * most current data | | | |
|---|---|---|---|
| | **Q4 2018 -2019** | **Q3 2019 -2020 *** | **Q4 2020-2021** |
| **Percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period** | **Trust = 95.7%** | **Trust = 97.0%** | NHS Digital VTE data collection and publication paused in March 2020. |
| | England = 95.7%<br>High = 100%<br>Low = 74% | England = 95.3%<br>High = 100%<br>Low = 71% | **No data for 2021-22 & 2022-23** |

NHS Digital VTE data collection and publication was paused to release NHS capacity to support the response to COVID-19. The Trust's VTE risk assessment compliance data continues in 2023 -24 to be collated and reported to Safety and Quality Committee in an assurance report.

| Table 12 Clostridioides *Difficile (C. difficile)* Infection * most current data available nationally | | | |
|---|---|---|---|
| | **2020-21** | **2021-22*** | **2022-23** |
| **The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.** | **Trust = 74.5** | **Trust = 71.4** | **Trust 68.7** |
| | High = 140.5 | High = 138.4 | High=76 |
| | Low = 0 | Low = 0 | Low=0 |

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023-24, the national objective set by NHSE for the Trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023-24 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022/2023 which had a total of 196 hospital associated cases.

Please refer to the Infection prevention and control section of this Quality Account for comprehensive data on Clostridioides Difficile (C. difficile) Infection.

**Table 13 Patient Safety Incidents * most current data**

**The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death. * Comparative data for England all Trusts has not been available nationally since April 2021 to date.**

| | Oct 2017-Mar 2018 | Oct 2018-Mar 2019 | Oct 2019-Mar 2020 | April 2020 - Mar 2021 | April 2021 - Mar 2022 | April 2022 – Mar 2023* | April 2023 – Mar 2024 |
|---|---|---|---|---|---|---|---|
| **(i) Rate of Patient Safety Incidents per 1000 Bed days** | **Trust Number = 6506 Trust Rate = 43.6** | **Trust Number = 7250 Trust Rate = 52.4** | **Trust Number = 7766 Trust Rate = 51.8** | **Trust Number = 14428 Trust Rate = 68.9** | **Trust Number = 19773 Trust Rate = 67.8** | **Trust Number = 20626 Trust Rate = 66.1** | **Trust Number = 26920 Trust Rate = 81.3** |
| | England – 42.1 All * Trusts Rate High = 69.0 All * Trusts Rate Low = 23.1 | England – 45.2 All *Trusts Rate High= 95.9 All *Trust Rate Low = 16.9 | England – 49.6 All *Trusts Rate High = 110.2 All *Trusts Low = 15.7 | England – 57.3 All *Trusts Rate High = 118.7 All *Trusts Low = 27.2 | No longer produced in the same way to compare. | | |

**The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death. * Comparative data for England all Trusts has not been available nationally since April 2021 to date.**

| | Severe harm or death | Severe harm or death | Severe harm or death | Severe harm or death | Severe harm or death | Severe harm or death | Severe harm or death |
|---|---|---|---|---|---|---|---|
| **(ii) % of Above Patient Safety Incidents = Severe/Death** | **Trust Number = 62 Trust Rate = 0.42 % of all incidents = 0.95%** | **Trust Number = 60 Trust Rate = 0.43 % of all incidents = 0.83%** | **Trust Number = 49 Trust Rate = 0.33 % of all incidents = 0.63%** | **Trust Number = 88 Trust Rate = 0.42 % of all incidents = 0.61%** | **Trust Number = 80 Trust Rate = 0.27 % of all incidents = 0.40%** | **Trust Number = 110 Trust Rate = 0.35 % of all incidents = 0.53%** | **Trust Number = 107 Trust Rate = 0.32 % of all incidents = 0.39%** |
| **Rate = per 1000 Bed Days** | England – 0.35% All *Trusts Highest % = 1.54% All *Trusts Lowest % = 0% | England – 0.32% All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0% | England – 0.30% All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0% | England – 0.44% All *Trusts Highest % = 2.80% All *Trusts Lowest % = 0.03% | No longer produced in the same way to compare. | | |

The Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to improve education regarding the reporting of incidents and near misses,

the importance of doing so and the outcome of the learning gleaned from incident reporting. The Trust has also seen a rise in incident reporting with regards to service delivery and the management of waiting times for example, reporting of incidents where a patient is placed into a non-designated or boarded bed space, there has also been an increase in incidents linked to gaps in Thrombectomy service provision, treatment target breaches and prolonged waiting times. Trust staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. Incident dashboards and an automated interactive Governance Dashboard are now in use across the Trust for embedded incident analysis. The Trust continues to use the Always Safety First Learning and Improvement forum to respond to learning from incidents.

**Patient experience performance indicator**

Table 14 Responsiveness to Personal Needs

| Q 48. The Trust's overall experience of patient's personal needs during the reporting period | 2019-2020 | 2020-21* | 2021-22 |
|---|---|---|---|
| | **Trust = 66.8** | **Trust = 8** | **Trust = 6.6** |
| | England = 67.1<br>High = 84.2<br>Low = 59.5 | England = 8.1<br>High = 9.4<br>Low = 7.4 | Please refer to narrative at ** |

This indicator value is based on the average score from the National Inpatient Survey, which measure the experiences of people admitted to NHS Hospitals. Please note that the data methodology changed in 2020 and the scores are presented as those in the latest published report 2021/22.

* Due to methodology changes in 2020, we do not do historical comparisons any earlier than 2020. The historical comparisons include the England average for 2020-21. The national average for 2021-22 is calculated from the average score for all Trusts that exist in the data set for that year. (Source CQC: https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey)

**Following the merger of NHS Digital and NHS England on 1st February 2023 the presentation of the NHS Outcomes Framework indicators is being reviewed. As part of this review, the annual publication which was due to be released in March 2023 was delayed. Further announcements about this dataset will be made on in due course.

**Where patient experience is best**

- ✓ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Expectations after the operation or procedure: patients being given an explanation from staff, before their operation or procedure, of how they might feel afterwards
- ✓ Cleanliness: patients feeling that the hospital room or ward they were in was clean
- ✓ Answers to questions: hospital staff answering patients' questions before the operation or procedure

## Where patient experience could improve

- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- Enough nurses: patients feeling there were enough nurses on duty to care for them in hospital
- Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- Quality of food: patients describing the hospital food as good
- Taking medication: patients being able to take medication they brought to hospital when needed

The Trust is continually aiming to improve being responsive to the personal needs of patients and undertakes the following actions to improve the quality of its services, by

- Continuing to implement all of our patient experience and professional strategies in pursuit of 'consistently deliver excellent care'.
- By responding to feedback from patients and families through the Friends & Family test as well as national and local surveys.
- The Safety Triangulation Accreditation Review (STAR) accreditation system drives continuous improvement in our services being responsive to the personal needs of patients.
- Strengthening the connection between patient experience plans and equality, inclusion and diversity to support responding to patients' individual needs.

**Staff experience performance indicator**

Table 15 Staff Recommendation as a Provider of Care

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| **Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (%)**<br>**NHS Digital Data**<br>**21/22 NHS Staff Survey Data** | **Trust = 62** | **Trust = 60** | **Trust = 58.3** |
| | Best = 89.5<br>Average = 67<br>Worst = 43.5 | Best = 86.4<br>Average = 61.8<br>Worst = 39.3 | Best = 88.8<br>Average = 63.3<br>Worst = 44.3 |

Data is presented from the National Staff Survey with the latest survey for 2023. The Trust figure for Q25d referenced above is 58.3 which is a decrease of 1.7% from the 2022 figure. There is work to be done to improve how colleagues feel in regard to recommending the organisation if a friend or relative needing treatment, as our results are 5% below the national average for this question and this is coupled with a downward trend from 2021 to 2023.

Lancashire Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by

1. Launching the new Workforce and Organisational Development People Strategy
2. Implementing continuous improvement programmes
3. Sustaining and improving our listening channels
4. Driving awareness to support Advocacy

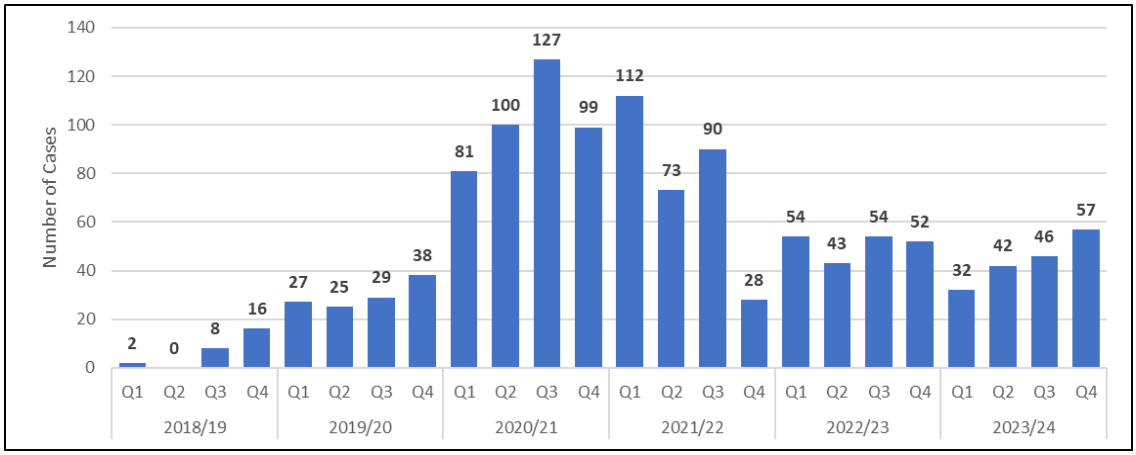
## Freedom to Speak Up

In response to the principles and actions described in the review into Mid-Staffordshire Hospitals[1] (2013) and the later review of whistleblowing in the NHS[2] (2015), undertaken by Sir Robert Francis Queens Counsel (QC), the Trust reviewed its processes and systems for inviting, listening, and responding to concerns raised by staff. The Board of Directors oversaw implementation of a range of measures to strengthen systems and processes to enable staff across the Trust to raise concerns and speak up with confidence. These included:

- The appointment of a Freedom to Speak Up (FTSU) Guardian.
- Establishment of Board level representation (Executive and Non-Executive Directors) for staff raising concerns.
- Establishment of Trust policy.
- Quarterly reporting of concerns and learning that comes from them.
- Inclusion of importance of raising concerns in new staff induction for all staff including Board members and inclusion in mandatory training.

The ability to raise concerns in a safe way is essential as a contribution to the delivery of safe, effective care. The Trust recognises that this ability is also a key element towards a positive staff experience, affecting our ability to retain our staff. Trust staff are encouraged to raise any concerns, including those about: patient safety and quality of care; bullying and harassment; or financial impropriety, to immediate line managers or their line manager's superior as they feel able. Where there are immediate safety concerns, staff are encouraged to report to their line manager and to record this as a patient safety incident in Datix. Where staff feel that their concern has not been addressed, they can raise their concern with our FTSU Guardian, either directly or via the Datix Freedom to Speak Up function; a FTSU Champion; or their union representative.

**Figure 5 Quarterly FTSU activity since 2018**




***Source: FTSU activity data/Datix***

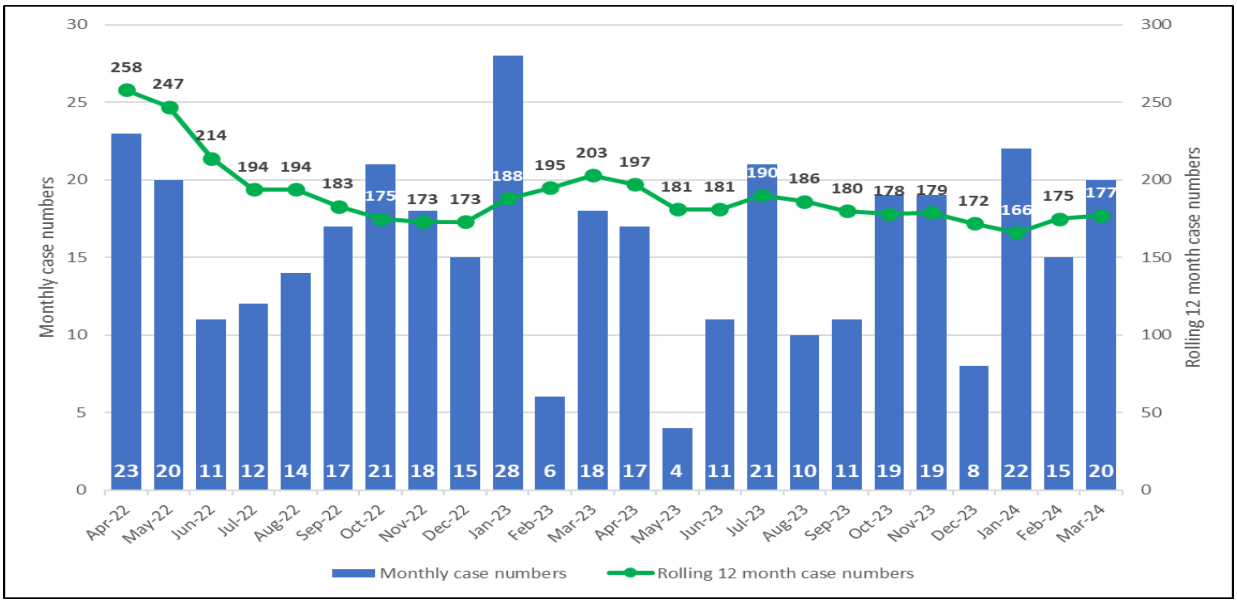
During 2023-24 there were 177 contacts with the FTSU service compared with 204 in 2022-23 and 303 in 2021-22, representing a 13% reduction in activity in the previous year and a 42% reduction against 2020-21 activity. It should be noted that the Freedom to Speak Up service passed the enquiries function on the Trust intranet, held since 2020, to the Communications team during Q3 in

[1] Francis Enquiry 2013
[2] Freedom to Speak Up Report 2015

2022. This undoubtedly impacted on the level of activity during this period and the comparability of year-on-year performance. Since 2022-23 data suggested a more consistent level of activity.

Of the concerns raised during 2023-24, 36 (33.5%) involved concerns about patient and/or worker safety. However, this figure rises to 121 (68%) when including staff who reported an adverse impact on their health and wellbeing. 24% of staff raising concerns reported that they had experienced bullying and/or harassment (an increase of 2% compared to last year) with 14% reportedly by managers (down 1%) and 10% (up 3%) by peers. The latest staff survey results demonstrated that a higher proportion of staff experienced bullying and harassment from colleagues than managers with over 50% of staff who experienced bullying from any source, reported it.

**Figure 6 Monthly and Rolling 12-month FTSU case numbers.**




***Source: FTSU activity data/Datix***

Whilst activity is again reduced compared to last year, the rate of reduction has levelled off during 2023-24 as forecast in the previous Quality Account for 2022-23. No member of staff should suffer detriment as a direct result of raising concerns with the FTSU service. Trust policy reinforces a commitment to protect staff who raise concerns from unacceptable behaviour, detriment, or harm. The Freedom to Speak Up Guardian and the Deputy Director of Workforce are identified as sources of support if such harm is suspected. The Guardian records and reports all instances of perceived/actual detriment.

During 2023-24 one staff member reported detriment that they believed to be because of raising a concern/complaint formally (though not necessarily through involvement of the Guardian). Seven others expressed a fear of detriment for speaking up, but no evidence was forthcoming that this was the case but nevertheless their anonymity was protected.

In the 2022-23 Quality Account key priorities were identified to strengthen and embed Speak Up Listen Up Follow Up across the Trust. These included:

- A review of Trust Freedom to Speak Up policies and procedures will be undertaken to ensure that Trust guidance is consistent with national guidance. This review was completed but work continues to ensure that procedures and systems to provide effective support and identify important learning are further strengthened.

- Access to support is sustained through the recruitment of Freedom to Speak Up Champions.

- A network of champions is in place with representation from a range of services and staff groups. However, there is a further identified need to include staff from under-represented groups and service areas where evidence of raising concerns is weak. This work will continue as a priority in 2024-25.

- The importance of speaking up, listening, and responding to concerns continues to be promoted across the Trust and informs the provision of safe, high-quality care and treatment along with a positive staff experience. Our FTSU Guardian provides assurance to the Board that the Trust is responsive to concerns and meets with our Chief Executive and Chair to share any concerns, emerging themes, and trends. The Trust values the benefits of rich data and intelligence in accurately identifying and responding to concerns raised by staff. The Trust's Raising Concerns Group now meets more frequently, at least six times a year and reviews data and intelligence from sources including workforce and organisational development data, safety incidents, complaints, staff surveys, and safeguarding information. Areas of concern and good practice, along with themes, trends, and actions taken are reported to the Workforce Committee and to the Board of Directors.

- During 2023-24, the group has strengthened its contribution to the Divisional Improvement Forums where areas of concern can be explored, and assurance of learning and improvement can be obtained. The Executive Freedom to Speak Up Lead and other group members are active participants in this process. Divisional management teams are now in receipt of monthly dashboards and reports providing valuable information about any area of concern within their respective teams. This information has made a valuable contribution to awareness at a more local level and improved opportunity to learn and improve.

- The Freedom to Speak Up Guardian attended the National Guardian's Office Freedom to Speak Up annual conference in 2024 and has actively attended and participated in regional network meetings.

- All new staff receive information about speaking up as part of their Trust induction and information about speaking up is available in the dedicated webpages on the Trust intranet. The Guardian has met with teams and individuals on occasions both virtually and in person to raise awareness of the importance of speaking up and to managers and others in supervisory positions on the importance of listening and responding. Allowing staff the option of anonymity is a means of creating a safe environment for colleagues. Anyone raising concerns through the Datix Freedom to Speak Module has the choice of remaining anonymous or not. During 2023-24, 18 colleagues (10%) chose to remain anonymous, a reduction of 2% compared to 2022-23.

During 2024-25, the Trust will build on previous successes and ensure that:

- The visibility of the Guardian is increased through attendance in team meeting and the availability of revised publicity resources, ensuring that staff have ready access to information on how to contact the service.

- Further developing relationships between the Guardian and the Board and Divisional management teams though the flow of information about concerns and learning and improvement arising in response to those concerns.

- Increased contribution of the Guardian to training resources, particularly those relating to leadership development, influencing the development of safe environments in which to raise concerns and encouraging a culture of business as usual for speaking up, listening, and responding.

# PART 3

## Review of Quality Performance – Patient Safety

The Trust considers the safety of patients to be our principal priority. To ensure the organisation is a safe place to receive care and treatment, the Trust monitors performance against certain factors and continually aims to reduce and eliminate patient harm where possible. In 2023-24 the Trust responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals' Always Safety First programme. During 2023-24 this has continued to be led by the Chief Nursing Officer and Chief Medical Officer and supported by the Governance, Nursing and Continuous Improvement teams. The programme promotes staff to always consider safety across the organisation and has involved lay representatives from the community to support the programme to provide opportunities to share their ideas. This section of the Quality Account presents indicators relating to patient safety, clinical effectiveness and patient experience as outlined below.

**Patient Safety**

- The Patient Safety Incident Response Framework.
- The Trust STAR programme.
- Falls Prevention.
- Safeguarding Adults.
- Safeguarding Children.
- Maternity Safeguarding & Safety.
- Incidents and Never Events.
- Duty of Candour.
- A Learning Organisation

**Clinical Effectiveness**

- The Getting it Right First Time (GIRFT) programme.
- Tissue Viability – Pressure Ulcer Incidence and Prevention.
- Nutrition for Effective Patient Care.
- Medication Incident Monitoring.
- Infection Prevention and Control.
- C Difficile
- Methicillin-resistant Staphylococcus Aureus (MRSA).
- Influenza and SARS coronavirus-2 (SARS-CoV-2) – COVID-19.
- Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths
- Medical Examiner Service.

**Patient Experience**

- Complaints and Concerns & Compliments.
- The Parliamentary Health Service Ombudsman (PHSO)
- Friends and Family Test (FFT) & Care Opinion
- National Survey Results

## The Patient Safety Incident Response Framework (PSIRF)

The PSIRF sets out significant changes to the approach taken by the NHS in response to patient safety incidents. PSIRF provides guidance for organisations on how to respond to patient safety incidents, defined as *"unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare."* The opportunity for learning is a key area of focus in the new approach advocated by PSIRF and some incidents will qualify for a Patient Safety Incident Investigation (PSII) based on national and local priorities (more information on these included below), but it is recognised that there may be other alternative proportionate responses (e.g., 'being open' conversations; after action review; and audit) as well as some incidents where 'local management will be appropriate. The selection of incidents to be investigated as PSIIs will be based on the opportunity for system-based learning. However, there are incident categories for which a PSII is nationally mandated, known as National Priorities (such as Never Events).

In line with the requirements of the National Patient Safety Strategy, the Trust commenced the transition from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) on 6th November 2023. In advance of the transition to PSIRF, the Trust sought to identify local priorities as part of the development of a patient safety incident response plan (PSIRP). The Trust reviewed a range of information held within the organisation including:


The Trust also engaged with a range of stakeholders including staff, governors, patient representatives and the Integrated Care Board (ICB). As a result of the analysis and engagement undertaken, the Trust identified and agreed five local PSIRF priorities:

1. Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).
2. Delayed, missed or incorrect cancer diagnosis.
3. Prescribing or administration error or near miss of anticoagulation medication.
4. Adverse Discharge due to gaps in communication or misinformation.
5. Delay in responding to a critical pathology finding.

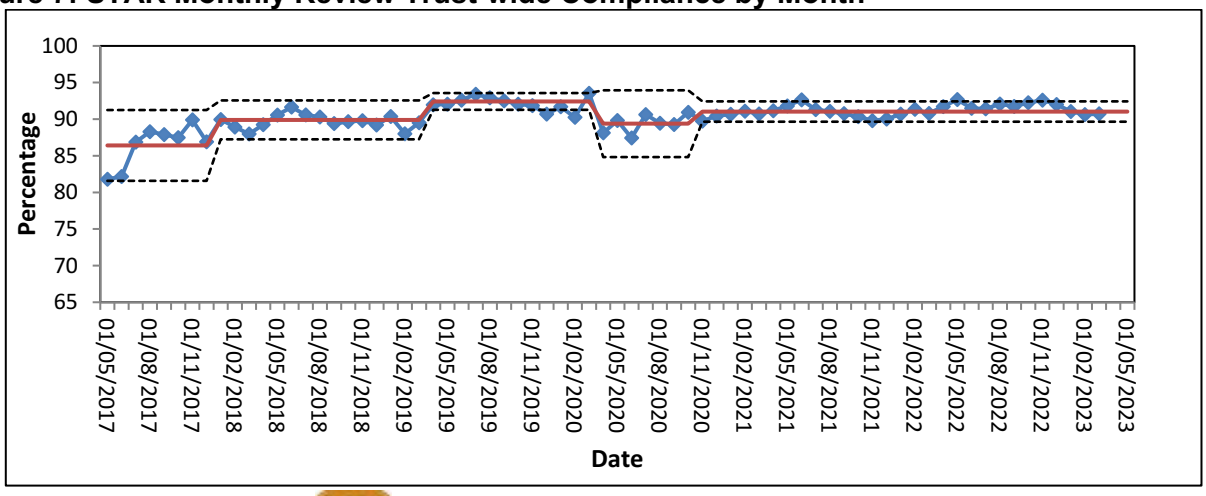
A PSIRF policy and the Trust's Patient Safety Incident Response plan was developed and approved at the Board of Directors meeting in October 2023. The Trust plans and polices were also endorsed by the ICB Quality Committee on 18th October 2023. Implementation of PSIRF was undertaken in two phases:

- Phase 1 was implemented on 6th November 2023 and included implementation of patient safety incident investigations (PSIIs) for any patient safety events that met National and Local priorities.
- Phase 2 was implemented on 25th March 2024, which included implementation of all learning responses.

## Safety Triangulation Accreditation Review (STAR)

The STAR Quality Assurance Framework is the audit, assurance and accreditation system for the organisation. STAR is reported as part of the accountability framework into Divisional Improvement Forums, in Safety and Quality Committee and as part of the Big Plan to Board. Of the 126 clinical areas registered, there has been an increase in silver ratings from 76% to 82% in the reporting period, which has exceeded the Big Plan aim of 75%. Despite the challenges of the past two years of the COVID-19 pandemic, a further 25 areas have achieved gold awards, 54 in total, which demonstrates consistency in standards and evidence the clinical teams have shared learning with peers. The monthly audit of fundamentals of safety provides insight into activity at department level on a monthly basis. The focus moving into the next year is on raising standards within the inpatient and Emergency department settings.

**Figure 7: STAR Monthly Review Trust-wide Compliance by Month**

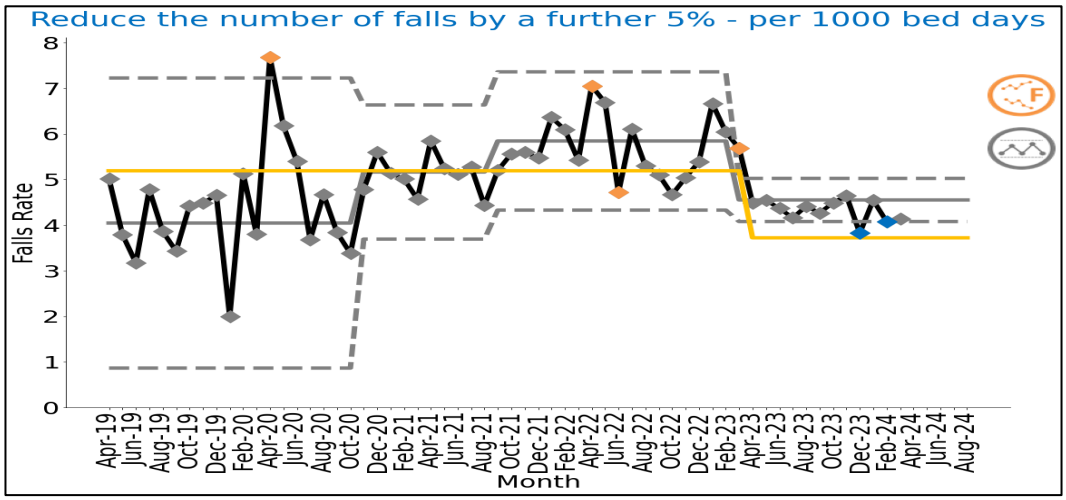



## Falls Prevention

Falls prevention continues to be one of our key priorities for improvement and Our Big Plan target is to achieve a year on year 5% reduction in falls. Falls prevention will be included within the Single Improvement Plan from 2024 onwards. In this reporting period improvements have included commencement of a Falls Prevention Big Room using continuous improvement methodology, developed through the Flow Coaching Academy and Falls Prevention Champion role for teams to drive improvements in falls prevention within the Divisions.

The end of year falls data demonstrates a reduction in the overall number of inpatient falls; there were 1443 inpatient falls (Inpatients, not including Community Healthcare Hub or Finney House Residential, assisted/faints/collapses/seizures removed) during 2023-24, in comparison to 1590 inpatient falls the previous year, which is a 9.26% reduction. The total number of falls with major and above harm (severe, death) was increased; there were 17 inpatient falls resulting in major or above harm, compared to 12 the previous year. It is noteworthy that there has been an increase in the number of patients using our services and overall occupancy levels in the hospital, therefore the approach to measurement is to assess this per 1000 bed days. The falls per 1000 bed days is demonstrated below in figure 8 and demonstrates a more stable position than crude numbers only.

**Figure 8 - Total Inpatient Falls/1,000 bed days – April 2019 to March 2024 (excluding Finney House Community Healthcare Hub and Finney House Residential)**




***Source: LTHTR data***

The Trust's Our Big Plan falls prevention target for 2023-24 was to achieve a year on year 5% reduction in inpatient falls. This was achieved during 2023-24.

There were 177 falls reported within the Community Healthcare Hub and Finney House residential for 2023-34 (assisted falls/faints/collapses/seizures removed), of which 3 resulted in severe or above harm.

These were reported as:

- Buttercup - 72 falls (includes 1 with severe harm)
- Meadow - 71 falls (includes 1 with severe harm)
- Orchard (residential) - 34 falls (includes 1 with severe harm)

The Community Healthcare Hub has a relatively high proportion of patients with frailty who medically optimised but need further support and assessment or rehabilitation prior to discharge. It is expected that the rehabilitation process involves a balance of risks for the patients preparing for independence following discharge. A thematic review has been undertaken and a falls prevention action plan has been developed for Finney House.

We continue to prioritise falls prevention as part of our Always Safety First Strategy.

# Safeguarding

## Lancashire Safeguarding Adult Board and Children's Safeguarding Assurance Partnership

As per statutory requirements the Trust holds positions for a Head of Safeguarding, Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children, Named Nurses for both adults and children and a Named Midwife. The Trust employs a Matron for Mental Health, Learning Disabilities, Autism and Dementia within the safeguarding team, ensuring the safeguarding/vulnerable people agenda has nursing/midwifery senior leadership and strategic direction across all portfolio areas.

### Maternity Annual Safeguarding Activity

During the past 12 months there has been a significant increase in the overall safeguarding activity within Maternity in comparison to the previous year. There has been a 10% increase in the number of referrals to the Enhanced Support Midwifery Team (ESMT) with the number of out of area referrals being consistent with the previous year. There has been a 54% increase in the number of cases referred to Children Social Care (CSC) from 106 in 2022-23 to 194 in 2023-24. The number of Female Genital Mutilation (FGM) referrals have increased by 45% in comparison to the previous year. The referrals to the Specialist Perinatal Mental Health team have increased by 39% from 154 to 252 in comparison to the previous year. The team have completed 69 mental health and wellbeing plans over the past 12 months which is consistent with the previous year.

The ESMT have made 29 referrals to the Reproductive Trauma service over the past 12 months in comparison to 19 from the previous year. The ESMT have had 207 domestic abuse notifications over the past 12 months in comparison to 176 from the previous year, 99 of these cases were heard at the Multi-Agency Risk Assessment Conference (MARAC). The Trust have now appointed a hospital independent domestic violence advisors (IDVA) and a hospital Independent Sexual Violence Advisor (ISVA) who have supported the ESMT in caring for these women to ensure their safety and ensure they receive the support they require at the right time.

### Safer Sleep

A safer sleep risk assessment tool has also been introduced within Maternity, Neonatal Intensive Care Unit (NICU) and NICU outreach, paediatrics, urgent care, and the Emergency Department. Safer sleep guidelines have been developed to support staff to undertake safer sleep discussions with parents/carers and ensure consistent advice is being provided by professionals across Pan-Lancashire. Audits have been completed in Maternity and NICU which have provided significant assurance of compliance and the quality of assessments being undertaken. A briefing and Standard Operating Procedure (SOP) has been produced regarding mothers being admitted to adult wards for treatment accompanied by their babies following several women being admitted for treatment with their well-baby. These mothers are usually breast feeding or have no one else to care for their baby. The briefing outlines what actions should be taken to support these women and provide safe care including advice regarding safer sleep. The ESMT and the wider Trust promoted Safer Sleep week on the 11th – 17th March 2024 across all social media channels and displays were created in each relevant area across the Trust. The Safer Sleep Project team were selected in the final three for the Best Safety Initiative award from the Trust's Our People Awards.

**ICON Programme**


The ICON programme (Babies Cry, You Can Cope) is a Child Death Overview Panel (CDOP) campaign which aims to help parents and carers to cope with a crying baby. The recommendation for resources came from several infant deaths and serious case reviews where a baby has died or been seriously injured because of Abusive Head Trauma (AHT). The Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership, and the Pan-Lancashire CDOP have raised awareness of key messages and resources to let parents and carers know that infant crying is normal and there are methods which can be taken to cope.

Messages were shared as part of ICON week 25th – 29th September 2023 across the Trust and Pan-Lancashire, which included lighting up the Maternity Unit, Preston Market, the Trust's Emergency Department, and Blackpool Tower in the ICON colour to raise awareness. The Trust engaged North West Ambulance Service, Enterprise, Midwifery, the wider Trust, footballers from Preston North End, Burnley, Blackburn Rovers, and University of Central Lancashire (UCLAN) to record videos and messages to raise the ICON message on all social media channels.

Articles were also published in the local press to raise awareness of ICON. The Named Midwife was also interviewed on 'That's TV' to raise the importance of the ICON messages. The Named Midwife for Safeguarding has worked in conjunction with UCLAN to ensure that the ICON learning package is now part of the Midwifery core training.

## Safeguarding Audit Activity

**Adults**

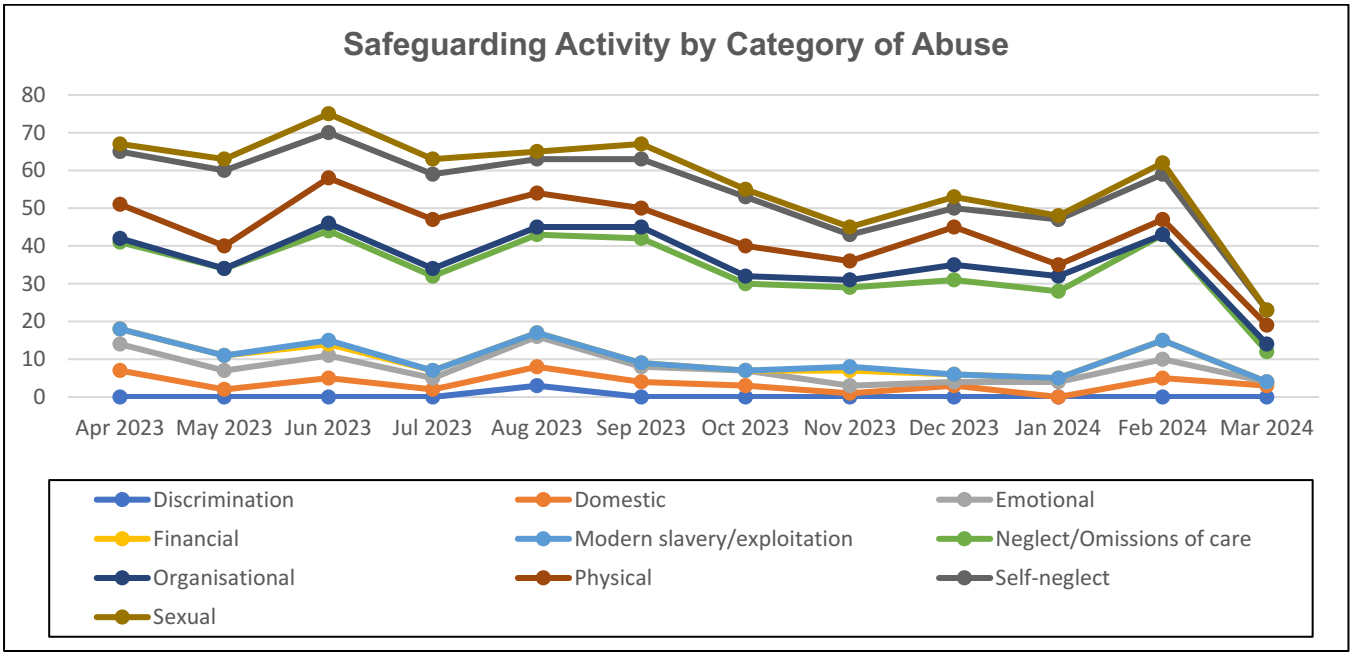
The adult pathway of the Trust Safeguarding Team has expanded over the last year due to specialist commissioning from the Police and Crime Commissioner and the Violence Reduction Network. As a

result, three new posts have been commissioned through the Police crime Commissioner: a Health Independent Domestic Violence Advisor (HIDVA), a Health Independent Sexual Violence Advisor (HISVA), and an Emergency Department (ED) Navigator. The team work as part of the Lancashire Violence Reduction Network whose aim is to facilitate a system-wide trauma-informed approach to making Lancashire a safer place to live, work and visit.

**Safeguarding Activity**

The Figure 9 below shows a summary of the safeguarding activity reported via Datix in the last 12 months, broken down by categories of abuse.

**Figure 9 Annual Total Adult Safeguarding Activity**



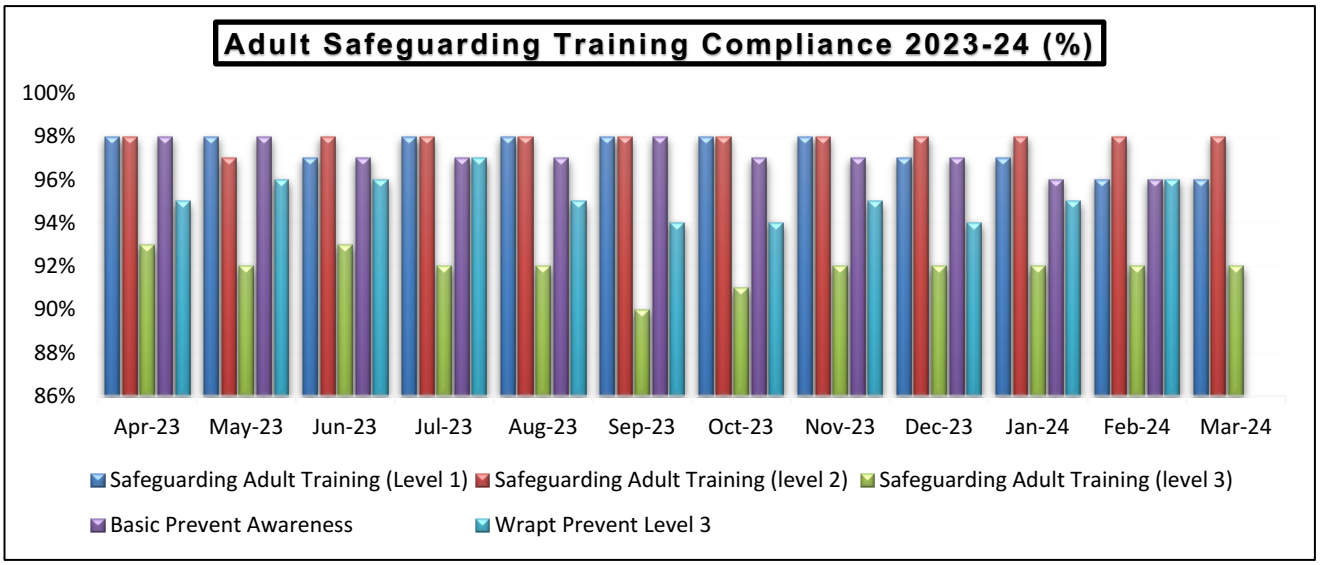

**Managing Allegations Persons in Position of Trust (PiPoT)**

The Deputy Chief Nursing officer is the named PiPOT for the organisation. The Safeguarding Team support workforce and the Divisional Teams in managing allegations against staff when there is a risk of harm to patients, staff, or organisational reputation.

**Safeguarding Adults and PREVENT Training**

Figure 10 below shows the figures for safeguarding adults and PREVENT training compliance over the previous 12 months.

**Figure 10 Adult Safeguarding Training**




## Safeguarding Supervision

Twenty members of staff across the Trust attended the Bond Solon Bespoke safeguarding supervision training and are now supporting safeguarding supervision across the Trust.

## Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

### Trust wide MCA and DoLS Activity

The MCA/DoLS - Always Safety First project has successfully achieved an electronic MCA/DoLS pathway throughout the patient's journey during admission/attendance as per the requirements of the Mental Capacity Act (2005). The system design implemented captures cognitive assessment, best interest decision making, least restrictive practice and deprivation of liberty.

**Figure 11 RPH Number of DoLS Applications**

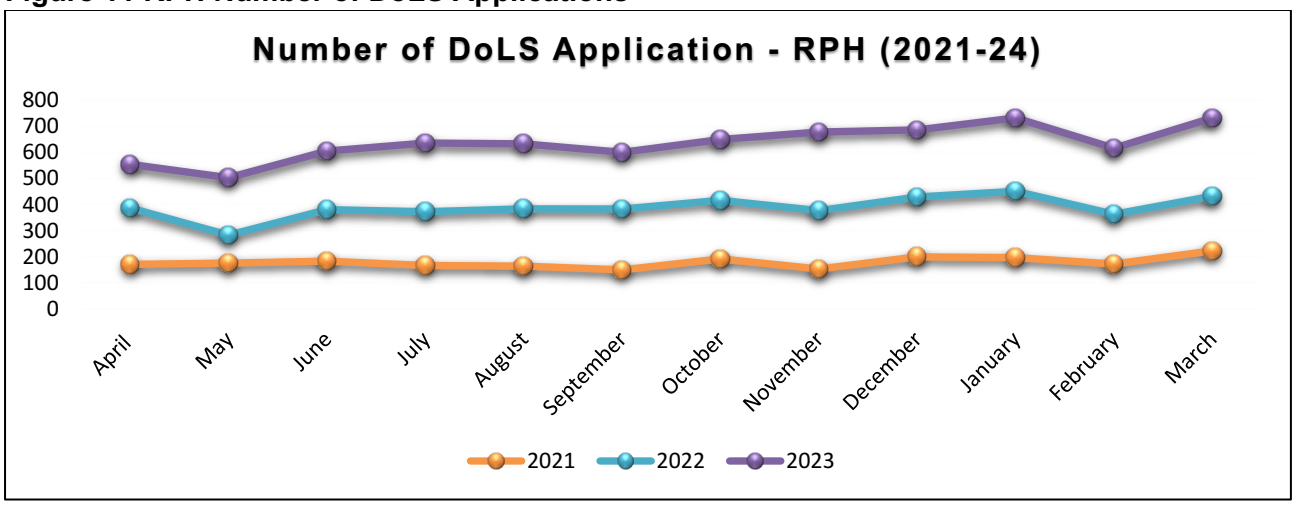
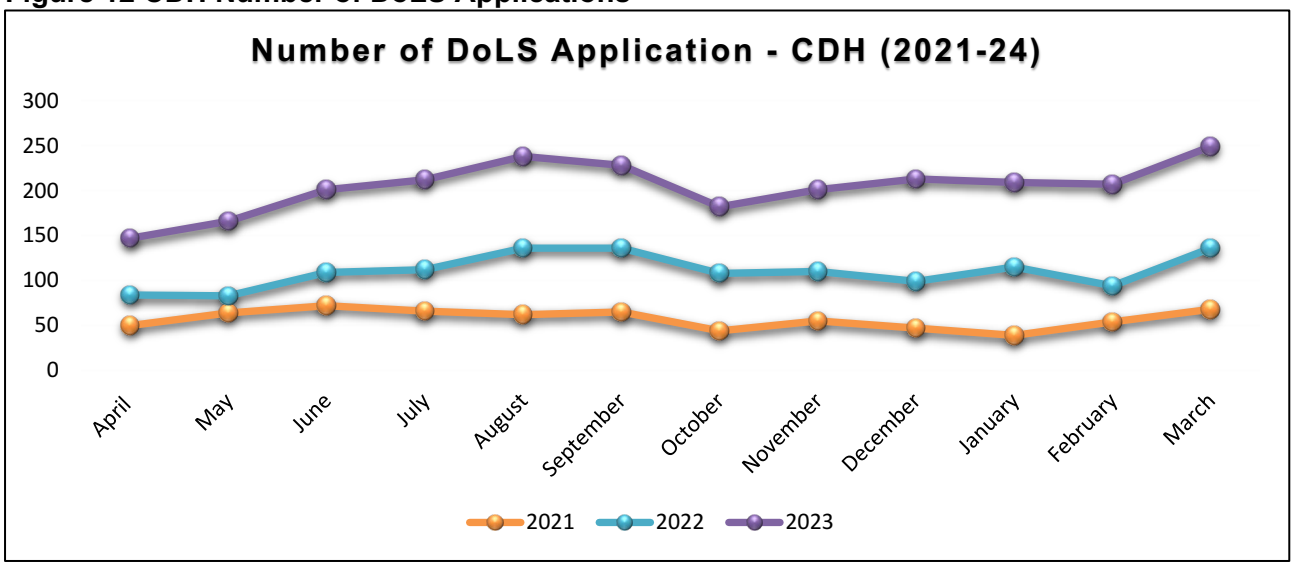


**Figure 12 CDH Number of DoLS Applications**




The data in Figures 11 and 12 demonstrate a year-on-year improved position in relation to the Trust upholding the principles of the Mental Capacity Act (2005). Both graphs demonstrate a continued increase in DoLS applications over a 3-year period. The 49.5% increase in activity is a positive reflection in the growth of the staff's ability to recognise additional vulnerabilities and act in accordance with the principles determined through the legislation.

**Mental Health, Learning Disabilities, Autism and Dementia**

The mental health, learning disability, autism, and dementia team works with some of our most vulnerable patients accessing healthcare within the Trust. The team drives continuous improvement initiatives, works to increase staff knowledge and skills, ensures compliance with the Mental Health Act (MHA) and the triangulation of other statutory requirements (such as the Mental Capacity Act and Children's Act), sits within the safeguarding team, and drives positive patient experience. The team has a High Intensity User Lead within the service and holds the role of Special Education Needs and Disabilities (SEND) champion within the Trust.
The team have focused on the following areas as part of their work this year.

- Special Education Needs and Disabilities (SEND)
- Learning Disability and Autism
- Learning Disability and Neurodiversity Training
- The Learning Disability Plan was launched June 2023
- The Autism plan has been completed and is due to be launched
- Mental Health Risk Tool (MHRT) Audit compliance
- Dementia assessment and treatment
- Delivery of the dementia strategy
- Development and pilot of a Dementia Toolkit for acute hospitals
- The High Intensity User service
- Trauma Informed development
- Rapid Tranquilisation policy and assurance
- Review of Tier 2 face to face Dementia training

## Children and Young People

### Summary of Safeguarding Activities

- Safeguarding supervision has continued to be embedded across paediatric areas with a focus on priority topics this year.
- Monthly audits continue of the safeguarding checklist across ED (0-15 years old, and 16-17 years old) and paediatric and adult assessment units.
- A new guideline, 'Safeguarding Guidance for assessing the risks to patients (adult and child) from dogs and dog bites' was compiled in recognition of the number of patients attending with bites, particularly to the Surgical Assessment Unit (SAU).
- A new guideline was completed, 'Admission of babies or children to adult wards when a parent or carer is admitted'.
- Focus on the 'Was Not Brought' Pathway.
- The Paediatric Liaison Form has been updated to include the voice of the child, additional demographics, and information important for the 0-19 team to follow-up the child adequately.
- 7 Minute Briefings formulated by the Children's Safeguarding team include 'Bruising in Non-Mobile Babies/Children', 'Professional Curiosity' and 'Risks to Children from Drowning at Home – Water Safety'. These have been formulated in relation to serious incidents that have occurred.
- Leaflets for bathtime safety are now available as push notifications on BadgerNet when a child is discharged from post-natal ward.
- Work has commenced in relation to obtaining demographics and awareness of the 'Hidden Male' with the Children's Community Nursing Team updating their assessment documentation to reflect all those present in the child's home when visiting.
- A bespoke training session has been facilitated by the Children's Safeguarding Team with the Local Authority Designated Officer (LADO) for all staff across the Trust, including Workforce, Security, and all Divisions. There is an upcoming session planned for May 2024.

**Figure 13 Child Safeguarding Training Data (Trust wide)**

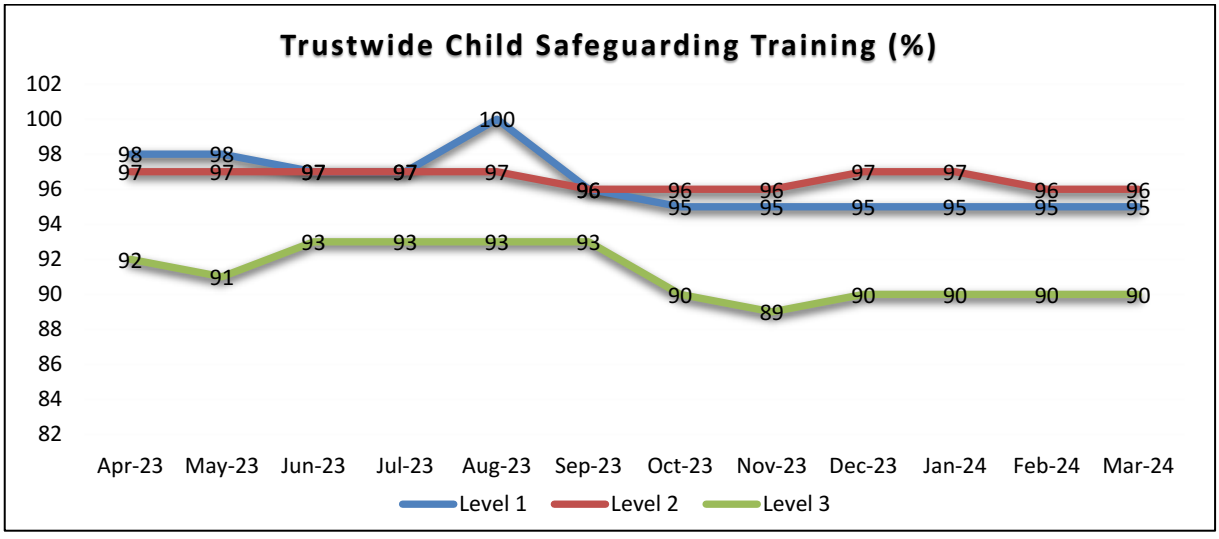



Figure 13 above shows Trust wide annual child safeguarding training levels 1 to 3. The training packages and training needs analysis are in accordance with the requirements of the Royal College

of Nursing (RCN) *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019). Child safeguarding training across Levels 1 and 2 has remained 95% and above, with Level 3 remaining compliant at above 90% overall.

### Children's Social Care Referrals

Referrals to Children's Social Care have increased in comparison to the previous year, with a third of the year showing over 20 referrals per month as opposed to less than 20 the previous year. In comparison to the previous year (183 referrals in 2022-23 and 242 in 2023-24) there has been a 32% (n=59) increase in referrals to Children's Social Care. This increase potentially reflects staff awareness and professional curiosity when a child may be at risk or in need of support.

### Child Deaths

There has been a total of 28 deaths between April 2023 and April 2024, and 61% (n=17) of these deaths were unexpected and 39 % (n=11) were expected, of these expected deaths, 64% (n=7) were neonatal deaths and the additional deaths were in other departments. There has been a 26% (n=6) decrease in unexpected deaths in comparison to the previous year, with expected deaths remaining the same as the previous year. Unexpected deaths have included Sudden Unexplained Death in Childhood (SUDC) and sadly, several children who have completed suicide or been the victim of significant trauma (accidental and non-accidental). A Trust '7 Minute Briefing' was shared in response to the National Child Mortality Database (NCMD) Report (2023) into traumatic deaths of children and young people.

## Incidents

Trust staff are proactively encouraged to report all incidents including near misses and no harm to enable increased opportunity to identify themes and trends before harm occurs to patients. Our incident data with associated levels of harm from incidents in 2023-24 are presented in table 16 below. Whilst the percentage of incidents with a harm level of moderate and above is 3% of all incidents reported the Trust continues to respond with actions and learning in order to reduce incidents across all levels of harm.

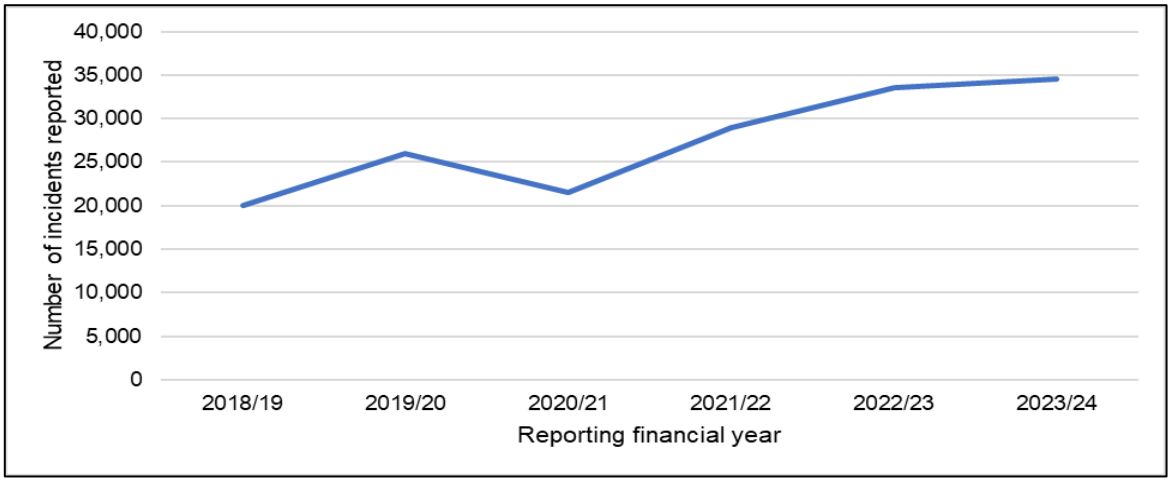
**Table 16 Level of Harm Related to Incidents 2023-24**

| Level of Harm | Number of Incidents Reported |
|---|---|
| No Harm | 24,406 |
| Low Harm | 9,072 |
| Moderate Harm | 929 |
| Severe Harm | 78 |
| Death | 33 |
| Total | 34,518 |

***Source: LTHTR Datix data***

The Trust's incident reporting has over successive years continued to improve which is demonstrated in figure 14 below.

**Figure 14 Incidents Reported 2018-19 to 2023-2024**




***Source: LTHTR Datix data***

## Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes and can damage patients' confidence and Trust. All Never Events are subject to either a serious incident review (under the previous Serious Incident Framework) or considered for a Patient Safety Incident Investigation (under the new PSIRF framework that was implemented within the Trust from 6th November 2023) and reported to the local ICB as well as nationally to incident reporting systems where learning can be shared across the country. Of the three never events in the reporting period April 2023 to March 2024, two of the incident investigations have been completed and the third has a patient safety incident investigation (PSII) in progress.

The Trust has an Always Safety First work stream to review actions from all Never Events both for compliance with initial target completion dates and for quality of evidence. Never Events have been added to our 'Learning to Improve' programme to ensure that actions and learning are embedded over time and participation in a regional learning event has taken place to share learning across organisations.

**Table 17 Never events incidence April 2023 to March 2024**

| StEIS ref | Datix ID | Incident Date | Division | Category | Level of Harm | Status |
|---|---|---|---|---|---|---|
| 2023/11484 | 123788 | 07/06/2023 | Surgery | Wrong site surgery | Moderate | Investigation completed |
| 2024/2222 | 149449 | 31/01/2024 | Surgery | Wrong site surgery | Low | PSII ongoing |
| 2024/2223 | 149503 | 01/02/2024 | Surgery | Incorrect Naso-gastro tube placement | No Harm | After Action Review completed |

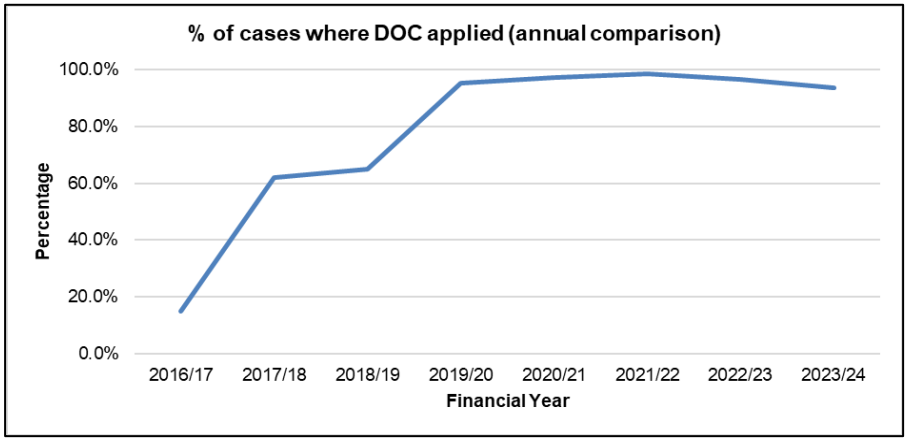
## Duty of Candour

Duty of Candour is a regulation that has been applicable to health service organisations since November 2014 in response to the Francis report (2013) which stated that *"any patient harmed by the provision of health care service is informed of the fact and an appropriate remedy offered regardless of whether a complaint has been made or a question asked"* (Francis 2013).

In the year 2023-24 the Trust identified 937 cases where Duty of Candour was applicable. This is a decrease (23.1%) in cases since the previous financial year. The financial year of 2022-23 was much higher than historic financial years due to hospital-acquired COVID-19 cases which have required Duty of Candour.

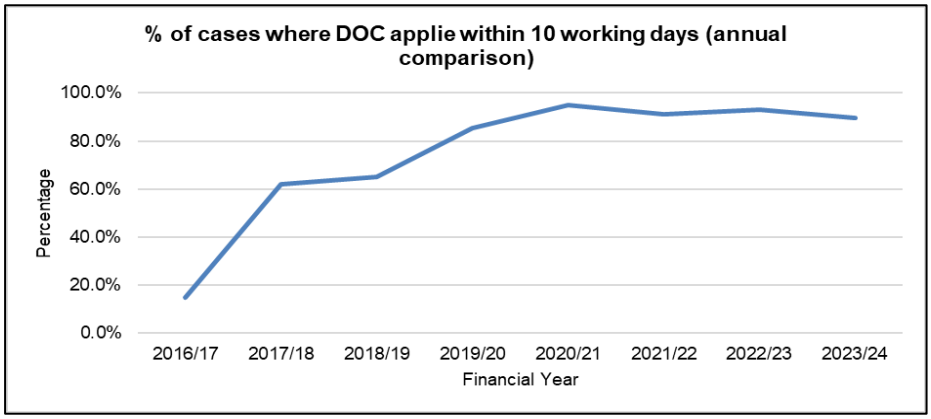
Of those 937 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 877 occasions (93.6%). Of the remaining 60 (6.4%) all have documented validated reasons as to why Duty of Candour has not been carried out.

**Figure 15 Percentage of Cases with Duty of Candour Applied (Annual Comparison)**




***Source: LTHTR Datix data***

**Figure 16 Percentage of Cases with Duty of Candour Applied in 10 Working Days**




***Source: LTHTR Datix data***

Whilst Figure 16 demonstrates a trend of improvement between 2016/17 and 2020/21 regarding timely application of Duty of Candour, there was a slight decrease in compliance with application of Duty of Candour within 10 working days.

In 2023-24 there has been a further decrease in compliance with application of Duty of Candour within 10 working days and work is underway to improve this through enhanced education, improvements in documentation facilities and enhanced monitoring in line with the implementation of PSIRF.

## Review of Quality Performance - Effective Care

The Trust aims to continually provide effective care and treatment by ensuring clinical practice is evidence-based against national standards and clinical research. Being involved with national quality and benchmarking programmes including GIRFT gives us opportunities to benchmark our services and improve our outcomes. Tissue viability and pressure ulcer prevention, nutritional support, management of medications and infection prevention and control are critical to the effective care and treatment of our patients.

We monitor our mortality benchmarking data to ensure there are no emerging risks and we also learn from the deaths of patients to inform change and improve practice where required. The Medical Examiner service provides an independent review of the care and treatment of patients who have died in our Trust. Requests from the Medical Examiner to undertake a SJR Mortality Review or Serious Incident Investigation (or consider for a PSII under the PSIRF model) are responded to and learning shared.

The following sections provide details on a number of areas that support the Review of Quality Performance.

## Getting it Right First Time

The GIRFT programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

The Trust recognises the opportunities that the national GIRFT programme provides and the benefits it will bring to the services provided. This quality improvement programme encompasses a wide range of clinical pathways, and it enables us to benchmark with other similar hospital services and share the learning.

The GIRFT visits to the Trust commenced in 2016, completing 48 visits across 32 specialties, 12 of which were revisits. Learning from the pandemic, GIRFT has now transitioned to a Regional Gateway Review, to facilitate a systems approach to improving patient care and experience, providing opportunities to develop pathways. To enhance this approach, in January 2023, a Lancashire and South Cumbria GIRFT Oversight Group was set up to enable access to a wider network of support and shared learning.

## Tissue Viability – Pressure Ulcer Incidence and Prevention

Pressure ulcer incidence is recognised worldwide as an indicator of safety and quality and reducing pressure ulcers has been and continues to be a priority for improvement in the care of our patients.

**Pressure Ulcers**

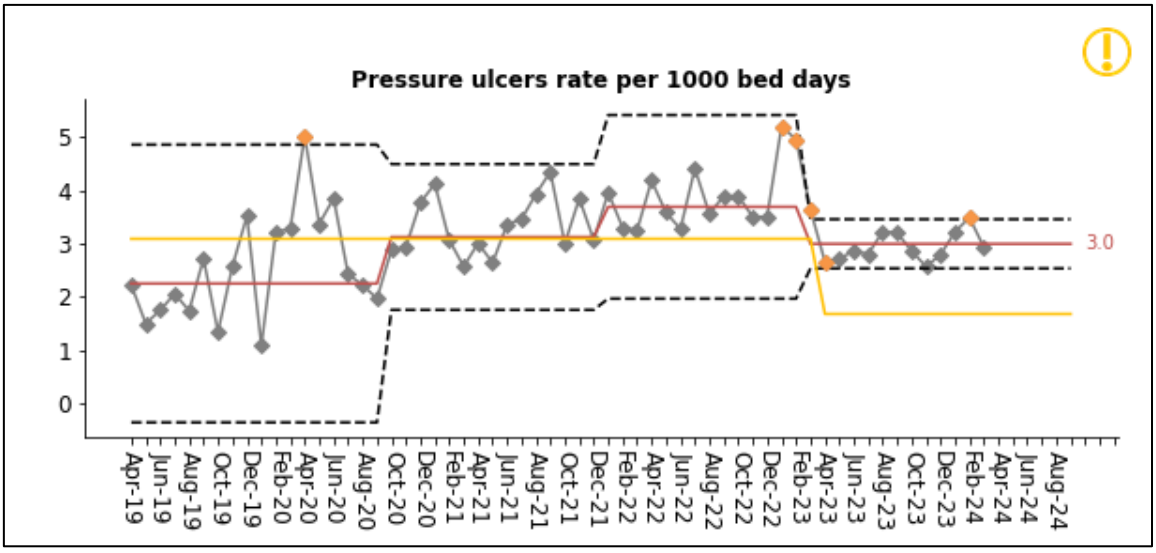
The Trust acknowledges that there has been an increase in the overall number of patients with pressure ulcers since 2018. The reason for this is multifaceted which includes the complexity and frailty of patients admitted to the Trust, increased number of patients admitted to hospital, increase in length of stay within the Emergency Department (ED) and increased bed capacity of the Trust. Consequently, pressure ulcer incidence is an area of improvement incorporating the new national wound care strategy programme recommendations. The improvement programme is focused on the delivery of:

Pressure ulcer improvement strategies also include:

- E-learning will now be completed once every 2 years to keep staff up to date on pressure ulcers, assessment and prevention. There will be two e-learning packages – one for staff who complete a risk assessment, and one for staff who do not.
- Continuous improvement program around the testing of a repositioning application on a smart device.
- The Datix system is inclusive of patients in the pressure ulcer review process to improve patient involvement in the review and learning process.
- Tissue Viability Nurse (TVN) attendance at nutritional and decondition Big Rooms, looking at malnutrition universal screening tool (MUST) and weight compliance to identify patients requiring additional nutritional support.
- Working with the ED reviewing equipment, training for staff, developing professional links within the department.
- Review of any incident that raise concerns with divisional governance and senior leadership team.
- Weekly in-depth divisional review of all Trust acquired pressure ulcers.
- Monthly Divisional Always Safety-First meetings focusing on shared learning.
- TVN link practitioner days (twice yearly).
- Pressure ulcer prevention training for healthcare assistance on induction.
- Pressure ulcer prevention champions training each.
- Student spoke days with the TVN's once a week.
- Student training sessions for each year of their training, 1st, 2nd and 3rd year on pressure ulcer prevention and complex wound management.
- Introduction of teaching in the preceptorship programme.
- Ward specific training and attending ward away days.
- Work around PSIRF and the pressure ulcer review process.
- The continue use of clinical areas taking photographs of pressure ulcers at the time identified.

When monitoring pressure ulcers within the Trust it is important to correlate the numbers of incidents that have occurred with the Trust activity in bed days. This is done by analysing pressure ulcer incidents per 1,000 bed days allowing for that comparison of incidents and Trust activity. Please see Figure 17 for Pressure ulcer rate per 1,000 bed days.

Figure 17




## Nutrition for Effective Patient Care

The provision of high-quality nutritional support is complemented by our 7-day Integrated Nutrition and Communication Service (INCS) who have led and supported a number of key initiatives in previous years, many of which are now well embedded in daily practice. INCS comprises of the Nutrition Nursing Team, Dietetics, Speech and Language Therapy, Central Venous Access team and the Tobacco and Alcohol Care team, previously known as the Hospital Alcohol Liaison Service.

One of our aims continues to be to ensure that patients admitted to the Trust who remain for more than 48 hours (excluding maternity and day-case patients) have a nutritional screening assessment on admission. The assessment is carried out using the Malnutrition Universal Screening Tool (MUST) developed by the British Association for Parenteral and Enteral Nutrition. The screening tool highlights patients who are already malnourished or at risk of malnourishment and determines the need for referral for a more detailed nutrition assessment by a dietician or an alternative nutritional care plan. This is monitored as part of the STAR quality assurance system.

## Medication and Incident Monitoring

### Medicines Safety

Medication errors are a major concern for patient safety in the UK healthcare system, with a report from the Care Quality Commission (CQC) indicating that medication safety incidents are the most commonly reported safety incidents in healthcare settings. In 2019-20, medication errors were a factor in 29% of patient safety incidents reported to the CQC. To address this issue, the Medicines and Healthcare Products Regulatory Agency (MHRA) launched a campaign to raise awareness of medication safety risks.

At Lancashire Teaching Hospitals Pharmacy Department, medication safety is a major focus, with ongoing efforts to enhance systems and processes to minimise the occurrence of medication errors and their impact on patient safety. The Pharmacy Medication Safety team is actively involved in fostering a culture that encourages incident reporting, in line with the principles of the Patient Safety

Incident Response Framework. The Trust's incident reporting system enables prompt reporting, thorough investigation and recording of medication errors and learning actions which have been taken.

From April 2023 to March 2024, medication incidents represented an average of 8.83% of all reported Trust incidents, with an average of 258 incidents reported per month. This reflects an 8.4% increase compared to the previous year's monthly average of 238 incidents, which demonstrates a positive reporting culture.

Data from the Model Hospital dashboard reveals that the national average for reported medication incidents causing harm stands at 11%. However, throughout the 2023-24 period, the Trust has consistently achieved a considerably lower rate, with reported medicine incidents causing harm at just 4.37%.

**Figure 18 Number of Medication Incidents Reported**

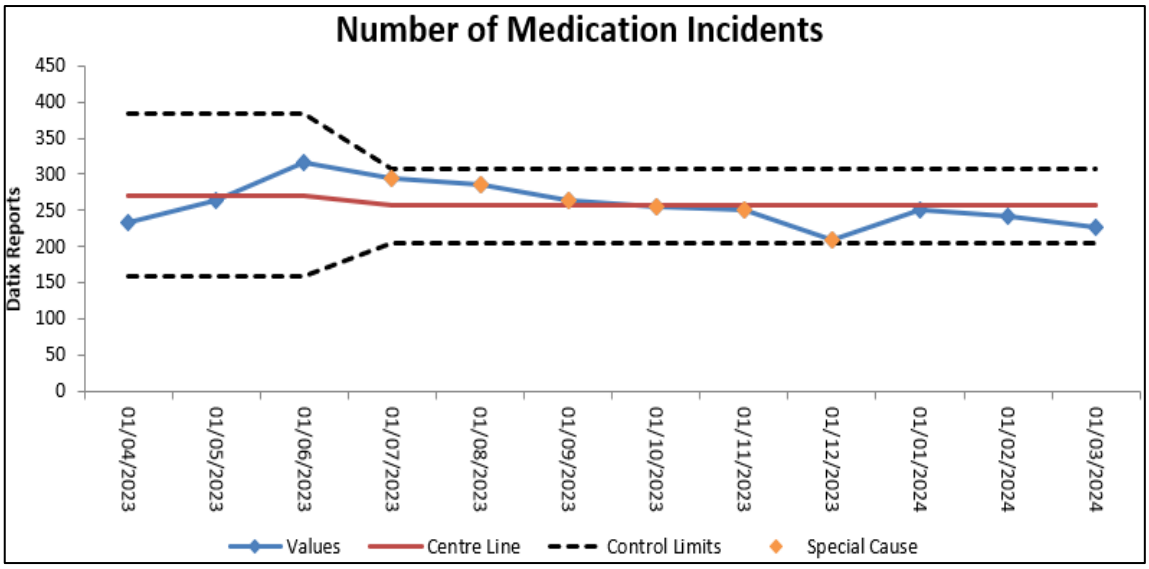
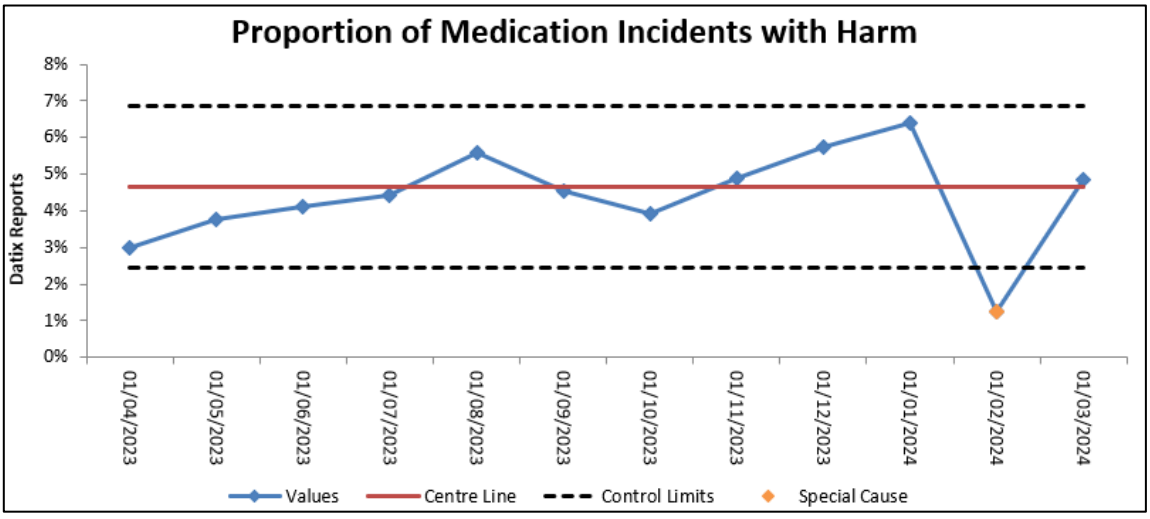



**Figure 19 Proportion of Medication Incidents Leading to Harm**




***Source: LTHTR data***

We have implemented a robust system for swiftly reviewing incidents of moderate harm or higher. This process is led by our Corporate Governance team through weekly meetings, with assistance from our Medication Safety Team and Divisional Governance Leads. We prioritise early interventions to make an immediate impact, identifying and disseminating important information even before formal investigations are concluded.

To proactively address medication safety, we actively share incident themes with relevant divisions, present Medication Safety reports during Always Safety First meetings, and maintain a network of Medication Safety Champions who convene monthly to exchange knowledge and serve as an educational platform. Our Medication Safety Team provides support to these champions.

On a monthly basis, we monitor our performance and report on harm and near miss patterns and trends to the Medicines Governance Committee. This committee follows a risk assurance reporting cycle aligned with our Trust's Risk agenda. This proactive approach to monitoring and sharing medication safety information enables us to continuously enhance our processes, mitigate harm, and ensure optimal outcomes for our patients.

**Medicines Reconciliation**

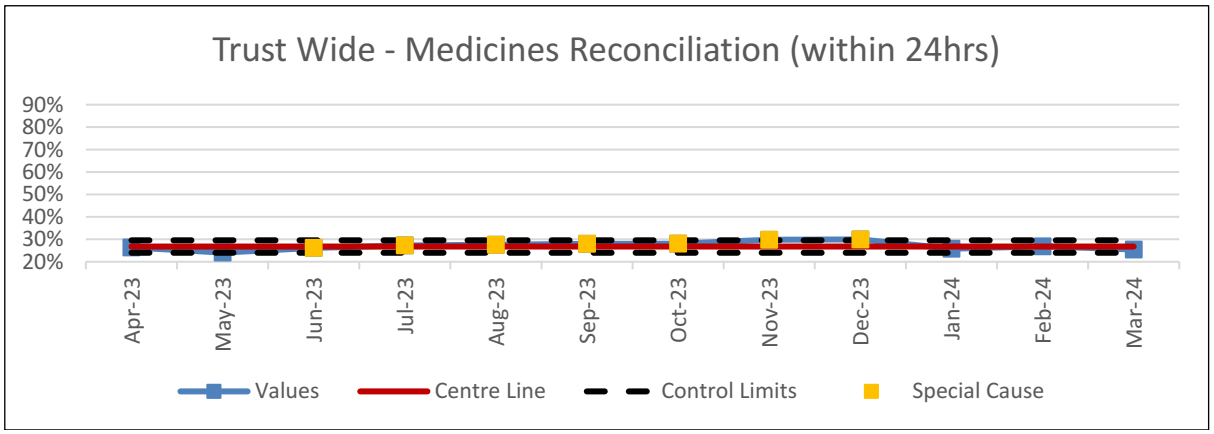
Medicines reconciliation is a critical process for ensuring patient safety during hospital admissions. It involves collecting and verifying information on a patient's medication history, including any changes made to their medication during on admission. The National Patient Safety Agency (NPSA) and National Institute for Health and Care Excellence (NICE) recommend that medicines reconciliation should be completed within 24 hours of admission.

Following the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system across the Trust, a pharmacy dashboard was developed within the Trust's Business Intelligence (BI) portal application. The dashboard uses data from the live EPMA system, which is updated every 15 minutes, to provide real-time information on medication-related processes.

In 2023-24, medicines reconciliation was completed within 24 hours of admission for 27% of patients, the significant decrease from 52% in 2022-23 is as described above due to the timestamp used. Factors impacting on performance relating to medicines reconciliation include pharmacy staffing challenges, such as vacancies (20% at junior pharmacist level), as well as additional unfunded beds due to patient flow issues across the system.

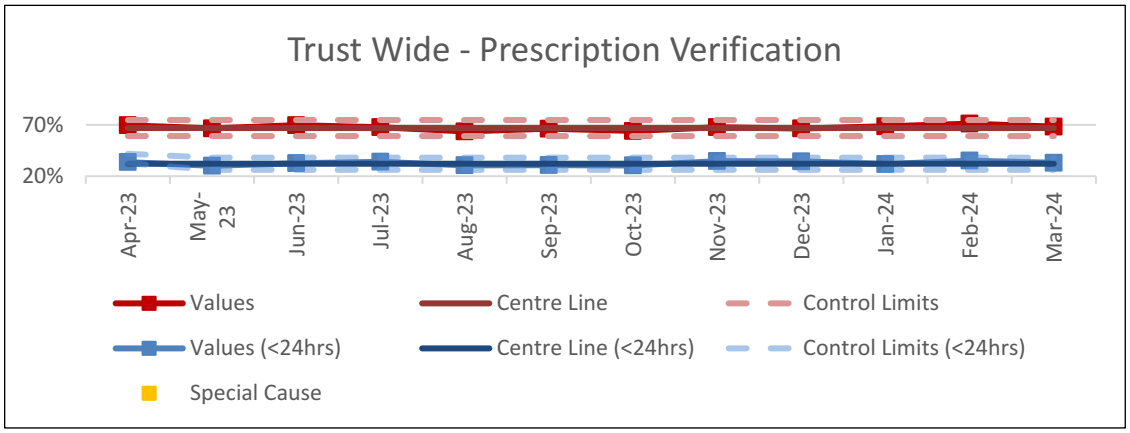
The variation in the 2023-24 data has led to a benchmarking survey within the ICB to check what other organisations use as the time point medicines reconciliation is completed. Three Trusts use the drug history documented and discrepancies communicated and one Trust the drug history documented. The former of these completion points aligns with the Royal Pharmaceutical Society hospital expert advisory group definition. Going forward into 2024-25, this definition will be adopted by the Trust. This is particularly important as we look to the best way to utilise staff. The medicines management technicians undertake a significant proportion of drug history documentation, enabling them to record the factual discrepancies will enable medicines reconciliation to be completed by this staff group and improve performance. To support patient safety a prioritisation whiteboard identifies patients prescribed any of the four high risk categories of medicines (antibiotics, anticoagulants, insulin and antiepileptics). Patients prescribed these medicines are prioritised for medicines reconciliation.

**Figure 20 Medicines Reconciliation (within 24 hrs)**




***Source: LTHTR data***

**Figure 21 Prescription Verification**




***Source: LTHTR data***

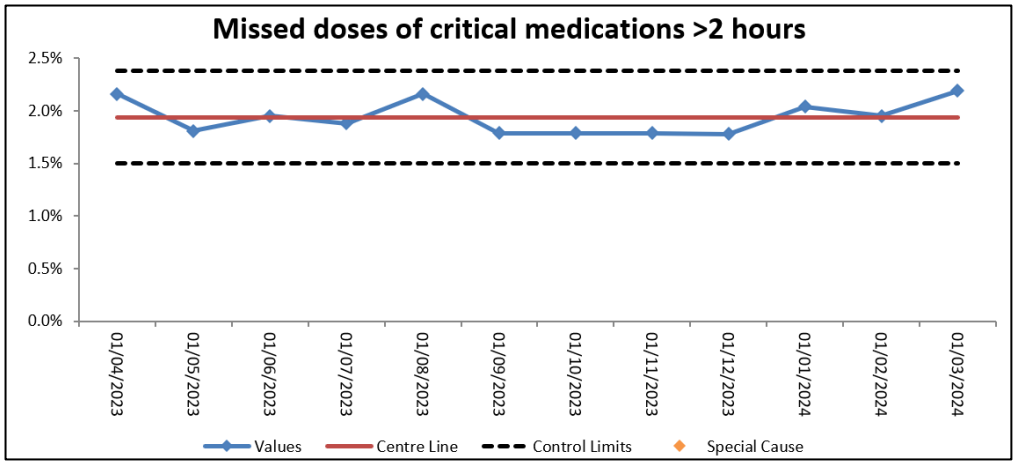
Our pharmacists play a vital role in assessing prescriptions for dose, legibility, interactions, appropriateness of therapy, formulary compliance, and legal requirements. However, we recognise that compliance with prescription verification within 24 hours has been a challenge, with the average compliance rate currently standing at 32%, down from 38% in 2022-23. On average, 67% of all live prescriptions are verified, down from 75% in 2022-23. Contributing factors include the ongoing increase of live prescriptions up by over 200 from the average in 2022-23. To mitigate patient risk the pharmacy teams, target high risk medicines with anti-epileptics and anticoagulants having verification sooner than the average medicine. Due to the frequent change of doses or formulation the other two high risk groups of insulin and antimicrobials remain a challenge.

**Administering medicines**

Ensuring the proper administration of prescribed medications is a crucial aspect of patient care within hospitals. However, we acknowledge that instances of missed doses have occurred in the UK, with some organisations reporting a rate exceeding 20%. Such occurrences can lead to suboptimal treatment outcomes and potential harm to patients. To address this, our Trust utilises data from an electronic prescribing and medication administration (EPMA) system to identify any missed doses. This information is then utilised by our pharmacy and nursing teams to take necessary action,

including administering the missed doses or documenting valid clinical reasons for their omission. Our Trust remains dedicated to continuously improving our medication administration procedures. Over a 28-month period since the start of the continuous improvement project we have seen a considerable reduction in missed doses with further reduction from 4% to 1.94% in the last year. This ongoing improvement project has resulted in better management of patient's medication and increased confidence in the safety and effectiveness of our medication administration processes.

**Figure 22 Critical Missed Doses**




***Source: LTHTR data***

## Antimicrobial Stewardship

Our Antimicrobial Stewardship team conducts audits across all in-patient areas, with an automated data collection process facilitated by EPMA. All patients prescribed antimicrobials in every inpatient ward are included. The audit assesses compliance with documentation of antibiotic indications, compliance with the Trust's antimicrobial guidelines or Microbiology recommendations, and documented reviews within 72 hours.

**Table 18: Antimicrobial Stewardship Point Prevalence Audit Results**

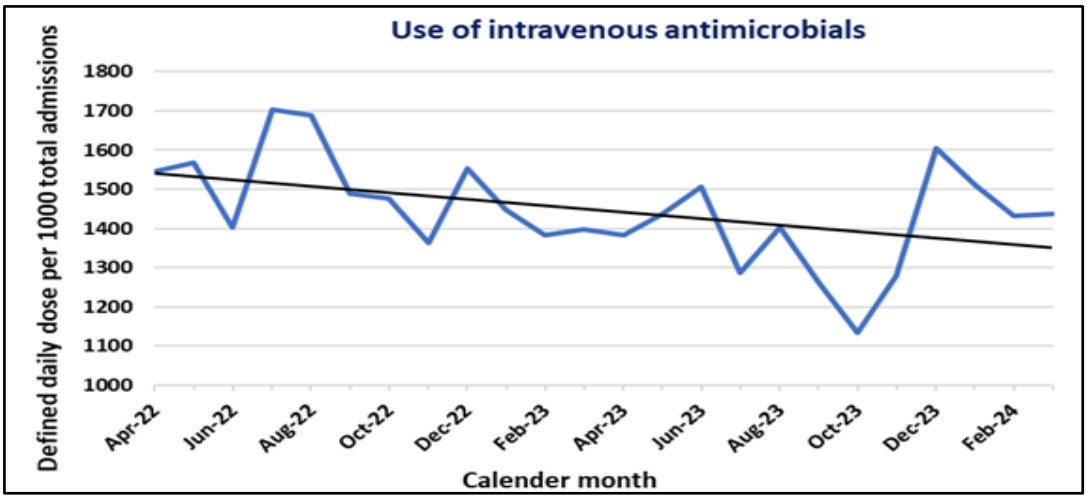
| | Nº of patients on antibiotics | Nº of antibiotic prescriptions audited | % Documented Indication on the Prescription | % Compliance with Guidelines | % Compliance with guidelines or Recommended by Microbiology | % Compliance with documented review within 72hrs |
|---|---|---|---|---|---|---|
| Trust Wide Q4 2023-24 | 396 | 512 | 96%↑ | 89%↑ | 91%↑ | 97%↑ |
| Trust Wide Q3 2023-24 | 341 | 437 | 95%↓ | 88%↓ | 90%↓ | 96%↑ |
| Trust Wide Q2 2023-24 | 311 | 425 | 98%↑ | 91%↑ | 93%↑ | 86%↓ |
| Trust Wide Q1 2023-24 | 351 | 465 | 95%↔ | 85%↓ | 88%↓ | 91%↑ |

***Source: LTHTR data***

Antimicrobial audit results are reported Trust-wide quarterly and specialities that achieve a red result in any of the three compliance areas are required to complete an action plan. The Antimicrobial Stewardship team offers support in the form of education/teaching or highlighting areas where good practice is not being followed.

A national focus for the past year has been timely intravenous to oral switch (IVOS) of antimicrobials. Our Trust has exceeded the IVOS Commissioning for Quality and Innovation (CQUIN) target of less than 40% of patients remaining on intravenous (IV) antimicrobials after meeting switch criteria, with results of 17%, 9%, 9% and 14% respectively for each consecutive quarter. We have seen a downward trend in use of IV antimicrobials as illustrated by the graph in figure 23 below and the focus on timely IVOS will continue.

**Figure 23 Use of intravenous antimicrobials**




***Source: LTHTR data***

## Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals. The IPC team continues to work closely with other providers across the health economy. a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Matron for Infection Prevention and Control, is the senior nursing lead. The DIPC is supported by the Deputy Chief Nursing Officer, the IPC specialist nurses, and Microbiologists.

**Overview of positive IPC outcomes**

In 2023-24 the Infection Prevention and Control speciality has delivered a number of positive improvements including a stable leadership and a full complement of IPC nurses providing a 7-day service.

There has been one case of hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. The Trust has met the national CQUIN target prompting a switch of intravenous to oral antibiotics for 2023-24 seeing a reduction in the 12-month trend for proportion of intravenous (IV) antibiotic use versus oral. The significant benefits of this have been shared widely across the Trust including reduction in patient length of stay and financial savings. The antimicrobial stewardship team work closely with the sepsis lead and a change in Trust guidance for first line antimicrobial options for sepsis of unknown source has supported a

reduction in cefuroxime usage which is linked to Clostridioides difficile infection (CDI) incidence. There is increased assurance of IPC and cleaning processes via the STAR accreditation process.

**Figure 24 STAR accreditation compliance for Infection Prevention and Control**

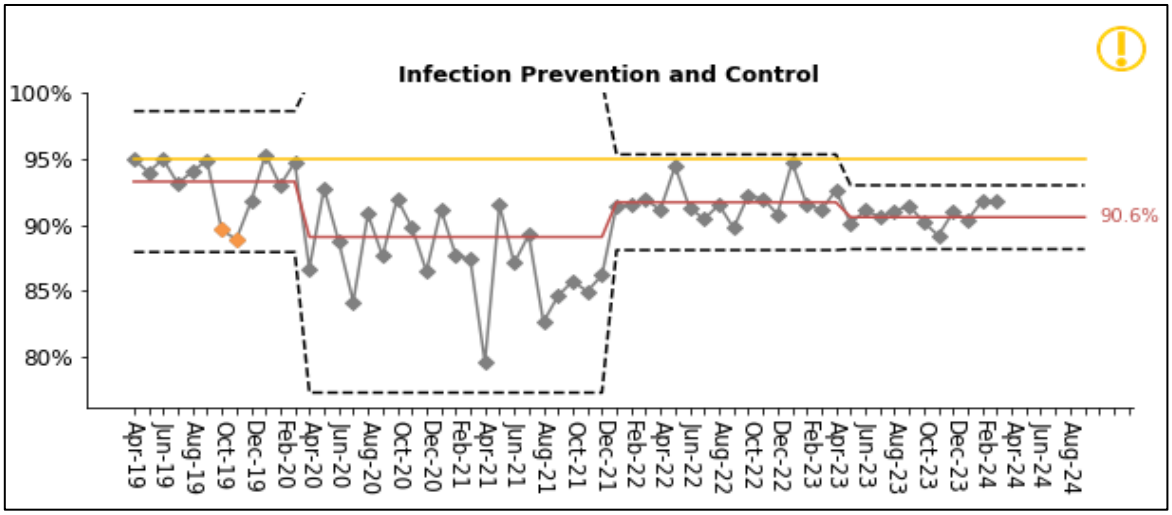
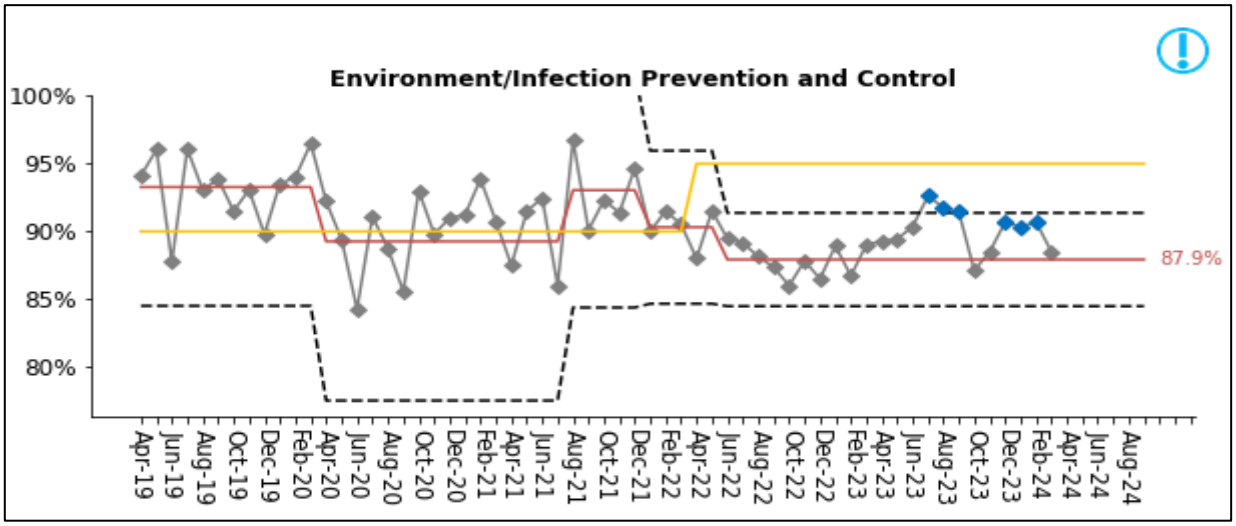



**Figure 25 STAR accreditation compliance for Environment/Infection Prevention and Control**




The infection prevention and control leads have ensured there are plans in place in response to the national measles outbreak with a measles policy formulated, Trust wide communications and scenario simulations to support staff with the actions required. The Trust target for IPC mandatory training is compliant and the Trust remains compliant with decontamination standards for decontamination of medical devices.

**Overview of negative IPC outcomes**

Challenges remain and during the year 2023-24 there has been an increase in Norovirus, Measles, extensively Drug Resistant Pseudomonas, and Influenza with the Trust and wider NHS operating under significant pressure as a result of the recovery following the COVID-19 pandemic.

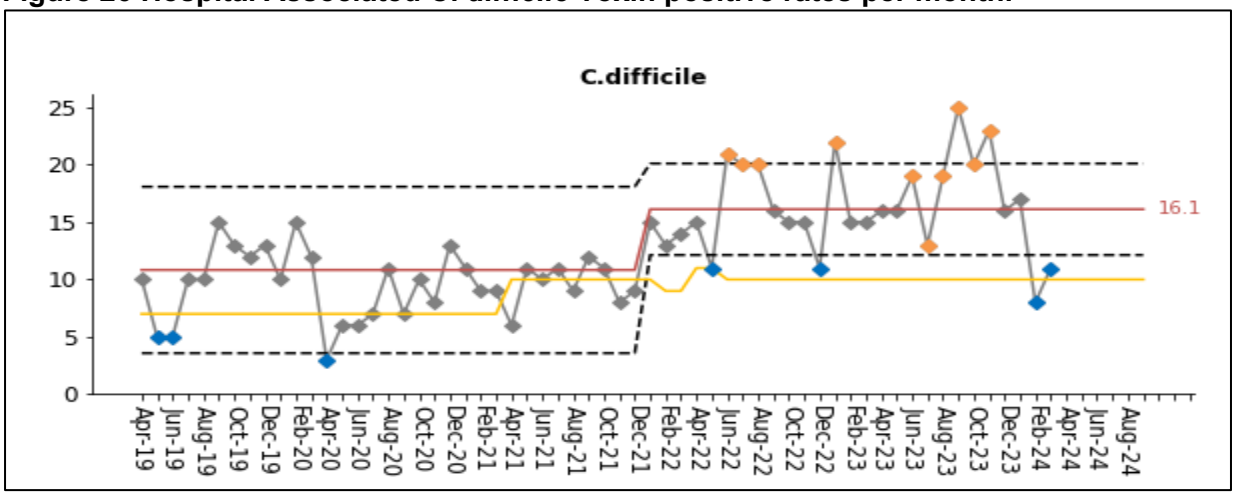
**Clostridium *difficile***

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023-24, the national objective set by NHS England for the Trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023-24 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022-23 which had a total of 196 hospital associated cases.

Although the year 2023-24 saw an overall higher number of hospital associated cases, the number of Hospital Onset Hospital Acquired cases decreased compared to 2022-23 with a reduction of 12 cases. Improvement work remains focused on faecal testing, mitigating the risk associated with the low percentage of side rooms within the hospital through accurate and early identification and isolation of C. *difficile* in the patient's journey.

There has been a national increase in C. *difficile* infection and a significant proportion of Trusts nationally are above trajectory. In the North West 12/24 Trusts (50%) were over their objectives. However, it is to disappointing to report that the Trust ranks highest of major Trusts in terms of C. difficile rate per 100,000 bed days.

**Figure 26 Hospital Associated C. *difficile* Toxin positive rates per month.**




The improvement work to address the increase in cases includes;

1) Removal of cefuroxime for treatment of unexplained sepsis since July 2023 as this is a high-risk antibiotic.
2) Introduction of Tristel jet (sporicidal) for general cleaning on wards since September 2023
3) Introduction of ward staff cleaning checklist for items that require daily and weekly cleaning by ward staff since August 2023. Assurance of this is built into the STAR process.
4) Gradual roll out of national cleaning standards by domestic services (15 wards currently) with a proposal to continue with all inpatient wards, subject to investment.
5) Improvement in fogging compliance where *C. difficile* cases were detected. This is now tracked via the daily bed capacity meetings and escalation actions recorded where fogging has not been completed within timescale.
6) Alternative ultraviolet (UV) light option being explored to mitigate delay in fogging.
7) Reduction in patient transfers on beds to enable beds to remain the property of wards, hence greater assurance of cleaning and mattress checks.
8) Trust wide mattress audit and replacement programme
9) Improved assurance of IPC/cleaning standards through the "STAR" assurance framework where wards get inspected and given a STAR rating.

10) New flag for estates remedial work requests from wards, if they have an IPC impact, so that they can be managed quickly from August 2023
11) Weekly communication of IPC-flagged estates requests and the time-period to resolution from August 2023
12) 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. To allow more efficient use of side-room capacity. Improvements sustained since July 2023
13) Expansion in the definition of diarrhoea to include type 5 stools (June 2022) – this resulted in a 50% increase in testing and earlier diagnosis of cases in 2022/23.
14) Introduction of rapid test for *C. difficile* (and 21 other gastro-intestinal (GI) pathogens) for use if side-room capacity is limited. If the test is negative, the patient with diarrhoea can remain in a bay.
15) Introduction of a ward "Whiteboard," which is checked 1-2 times per day by ward co-ordinators and flags patients who have diarrhoea from their electronic stool charts.
16) Introduction of a new electronic nursing Kardex which alerts nurses to recent diarrhoea and prompts them to perform a risk assessment for testing and isolation.
17) A dashboard that is available to IPC nurses which compiles a list of everyone in hospital with diarrhoea and includes details including – laxative use, recent CDI testing and whether or not they are in a side-room.
18) Implementation of a *C. difficile* Qlikview page which displays all the *C. difficile* cases in hospital, where they were detected and the wards that they passed through in graphical form to allow for pro-active fogging.

However, the following issues continue to impact on the delivery of IPC standards:

- Lack of capacity in domestic services to fully implement 2021 national cleaning standards in most areas.
- High reports of blockages, in the sewage system – estate survey commissioned to understand further action options.
- Insufficient decant facilities for more timely decontamination of the environment ("Fogging") in response to cases of infection.
- Sub-standard estate due to reduced funding for repairs and insufficient decant to perform repairs.
- Surfaces that are difficult to clean due to their deterioration.
- Insufficient side-room capacity leading to delays in isolation of *C. difficile* diagnosed patients.
- Understaffing within the Domestic Services and Estates, maintenance and service team and its impact on IPC practice.
- Overcrowding of patients on hospital sites because of increased demand.

**Other organisms of concern**

**MRSA Bacteraemia**

*Staphylococcus aureus* (S. aureus) is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the Trust, and the incidence of MRSA is outlined below:

- In 2021-22 there has been 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2022-23 there has been 1 incident of hospital onset MRSA bacteraemia and 5 cases of community onset MRSA.
- In 2023-24 there has been 1 incident of hospital onset MRSA bacteraemia and 7 cases of community onset MRSA.

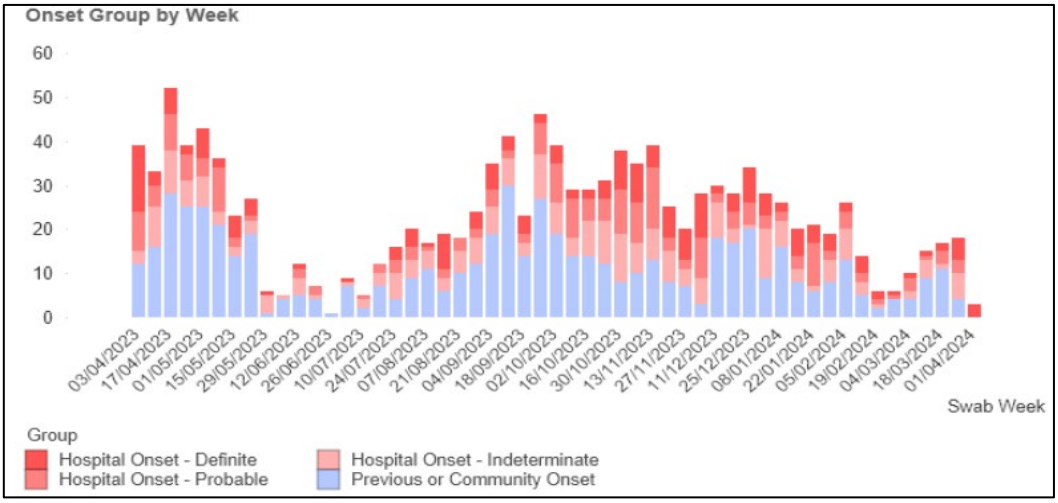
Despite an increase in MRSA bacteraemia cases in the community over the past year, the numbers reported as hospital onset have remained consistent with 1 case per annum.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention. The Hospital associated case identified in September 2023 was reviewed and was determined to be a contaminant. The key contributory factors were a lack of re-screening and further decolonisation after treatment.

**Covid-19**

On 31 December 2019, World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. Changes in policy in 2023-24 mirrored changes in national guidance. The impact of the operating environment during 2023-24 decreased however, there remained a significant impact as a result of Covid-19.

**Figure 27 Hospital Onset versus Community Onset COVID-19 infections**




*Source: LTHTR data*

**Gram-negative bacteraemia**

NHS England published objectives for Trusts to reduce Escherichia coli (E. coli), Klebsiella species, and Pseudomonas aeruginosa in 2022-23.

**E. coli bloodstream hospital associated infections**

The 2023-24 objective for E. coli bloodstream hospital associated infections was 95. The Trust ended the year with a total of 101 hospital associated with E. coli cases which was 6 cases above objective. However, this was a reduction of 7 cases from the previous financial year 2022-23.

**Pseudomonas aeruginosa bacteraemia**

The 2023-24 objective for *Pseudomonas aeruginosa* bacteraemia bloodstream hospital associated infections was 12. The Trust ended the year with a total of 17 hospital associated *Pseudomonas aeruginosa* bacteraemia bloodstream cases for 2023-24, this was 5 cases above objective.

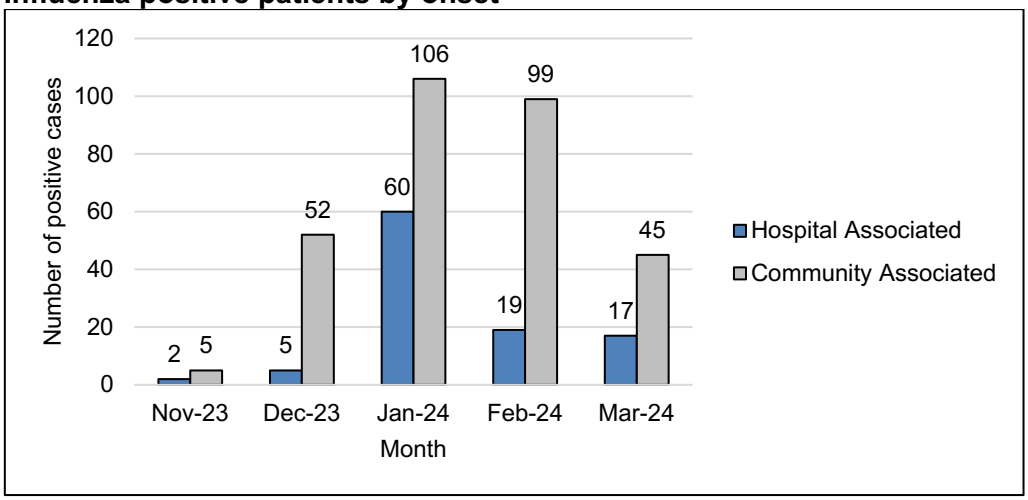
**Klebsiella species infections**

The 2023-24 objective for *Klebsiella* species bloodstream hospital associated infections was 25. The Trust ended the year with a total of 30 hospital associated Klebsiella species cases for the year 2023-24, this is 5 cases above objective.

**Influenza season 2023-24**

The Influenza season in the Trust for 2023-24 started in December 2023 in line with the national pattern and peaked in January and February 2024. The year 2022-23 saw a noticeable high-volume peak in December 2022. This year, 2023-24 did not have this significant peak however the Trust saw a sustained increase in cases across a 4-month period which reflected the national pattern. The sustained nature of this Influenza season posed significant challenges for Infection Prevention and Control, and there were a larger proportion of Nosocomial cases. Influenza A was the most predominant strain with a small number of cases of Influenza B.

**Figure 28 Influenza positive patients by onset**




***Source: LTHTR data***

## Mortality Surveillance and Learning from Adult, Child & Neonatal Deaths

Our ambition to Consistently Deliver Excellent Care is also supported through monitoring our mortality rates and importantly what we learn from the deaths of patients. This section presents how we monitor and improve through learning from Neonatal, child and adult deaths.

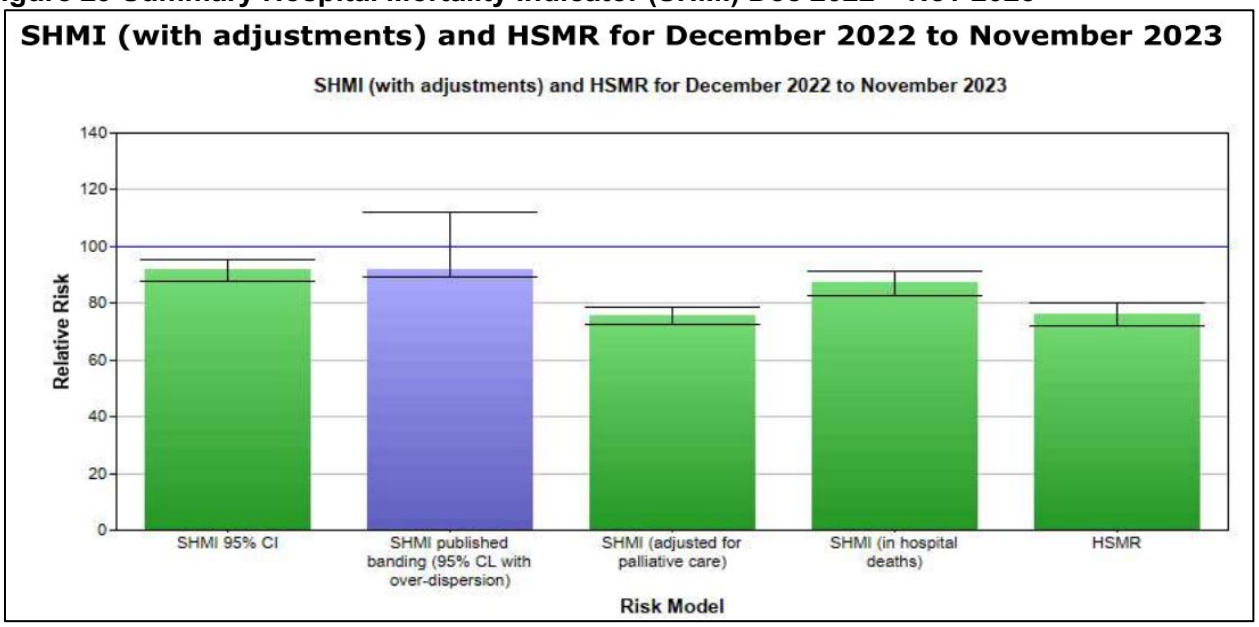
## Mortality Surveillance

The Trust recognises the importance of mortality rates as a key indicator in promoting confidence in the quality of the care and treatment provided through our services. The mortality data used relates to both the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR).

The SHMI measures mortality in patients who die in hospital or within 30 days of discharge from hospital. The SHMI does not take account of palliative care coding, social deprivation, but includes zero length of stay emergency patients and maternal and baby deaths. The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were included it would affect the accuracy.

The SHMI for the most current period available at the time of report writing is for the 12-month period from December 2022 to November 2023, is 91.69 and is statistically significantly lower than expected. When the SHMI is adjusted for palliative care, it is 75.66 and for in hospital deaths 87.03, both of which are lower than expected.

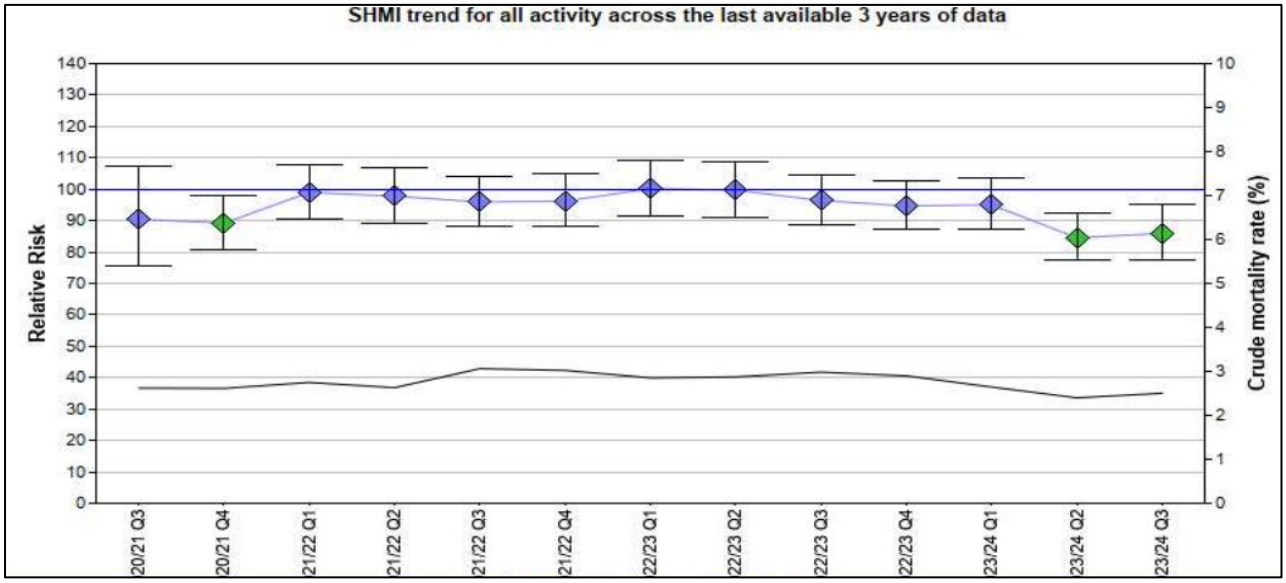
**Figure 29 Summary Hospital Mortality Indicator (SHMI) Dec 2022 – Nov 2023**




Source|: Telstra Health

The SHMI trend for the last 3 years is presented below, it demonstrates a within expected position for most quarters, however the 2 most recent quarters (23/24 Q2 and 23/24 Q3) report as statistically significantly lower than expected.

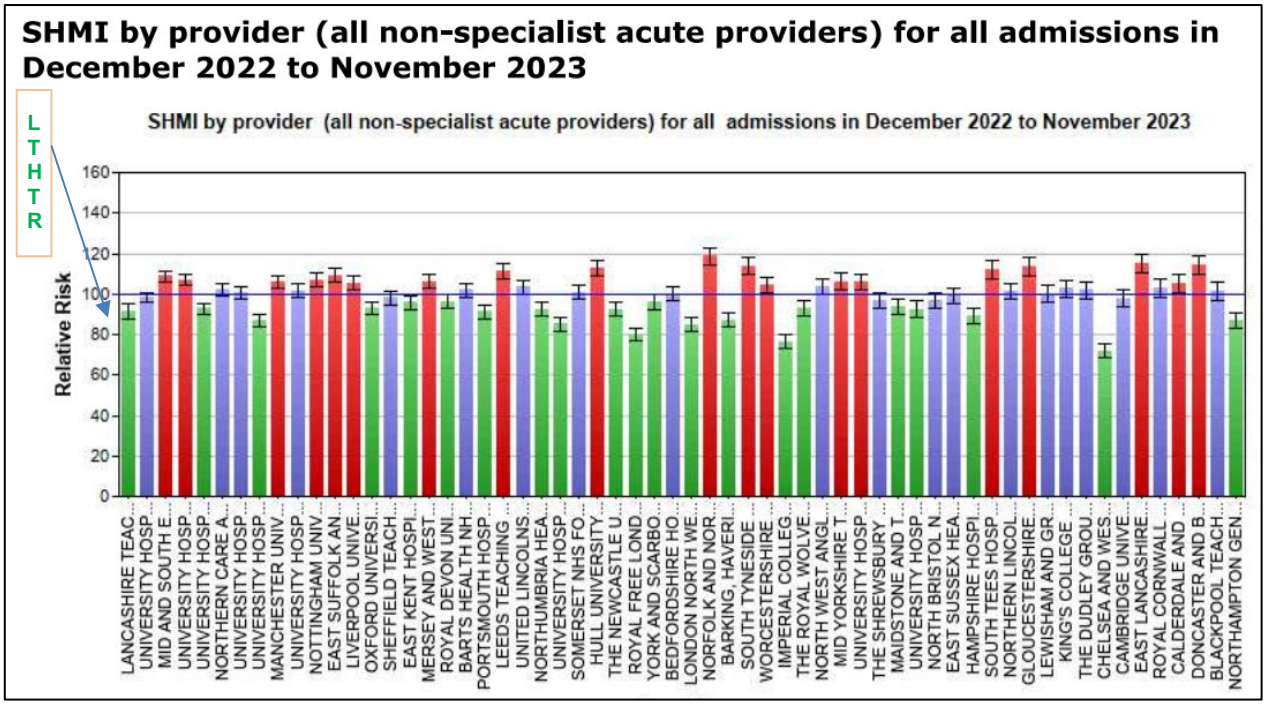
**Figure 30 Summary Hospital Mortality Indicator 3 Year Trend**




**Source|: Telstra Health**

The Trust can compare our SHMI with national peers and this is presented in Figure 31 below, the Trust is the first organisation in the bar chart. Trust's featuring in blue are those within the expected range, green bars are lower than expected and those in red are higher than expected.

**Figure 31 Summary Hospital Mortality Indicator Peer Comparison**




*Source|: Telstra Health*

## Hospital Standardised Mortality Rate (HSMR)

In addition to the SHMI the Trust monitors mortality rates using the HSMR which is derived from data based on 56 diagnostic groups, which account for approximately 80% of all hospital deaths. The data is adjusted to include a range of factors that can affect survival rates but that may be outside of our

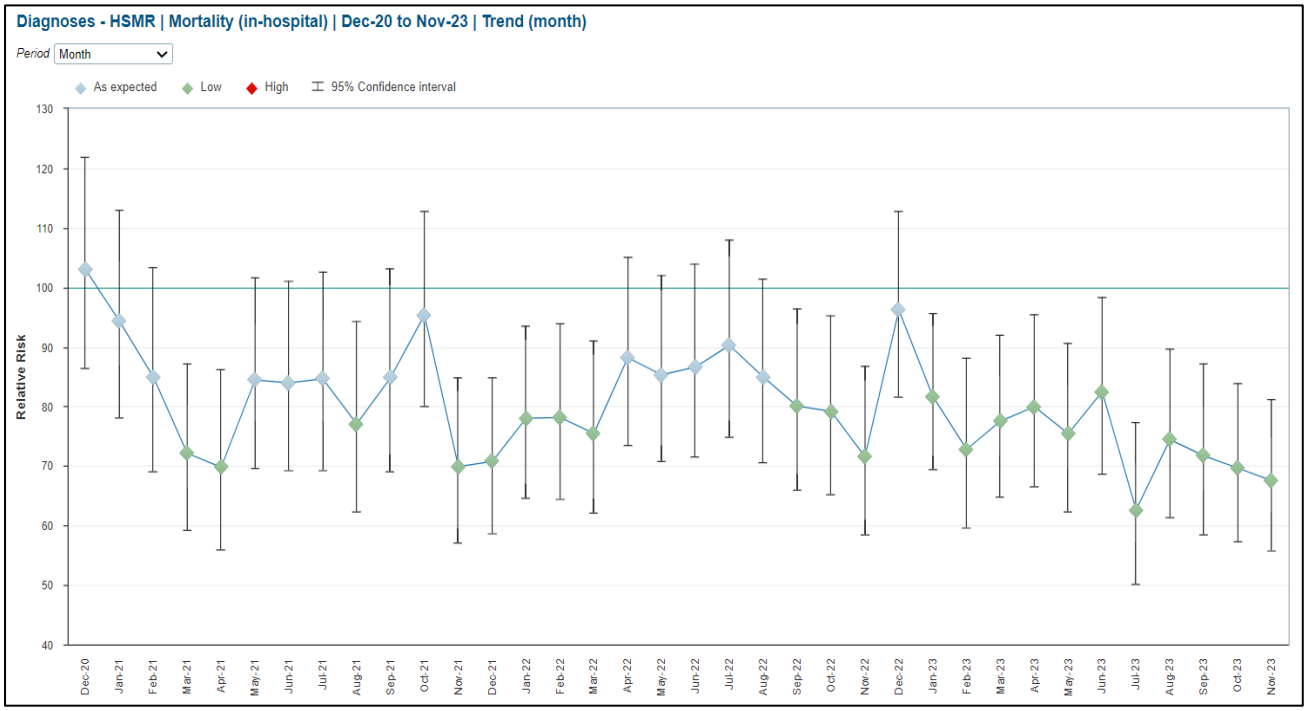
direct control such as age, gender, associated medical conditions and social deprivation. The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. A rate greater than 100 indicates a higher-than-expected mortality rate, whilst a rate less than 100 indicates either as expected or lower than expected.

The HSMR does not include patients who presented with a primary diagnosis of COVID-19; these are mapped to the viral infections group and included in the Standardised Mortality Ratio, which includes all diagnoses. However, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop COVID-19, are included in the HSMR figure.

The most current 12-month HSMR data relates to the period from December 2022 to November 2023, the figure is 76.2 and remains lower than expected. The HSMR for the same period between February 2022 and January 2023 was 82.0 and significantly lower than expected.

Our HSMR trend over the past three years is presented in Figure 32 below and demonstrates the continued HSMR trend of mortality being either within expected or lower than expected range. Most notably, 11 of the 12 most recent months report as statistically lower than expected.

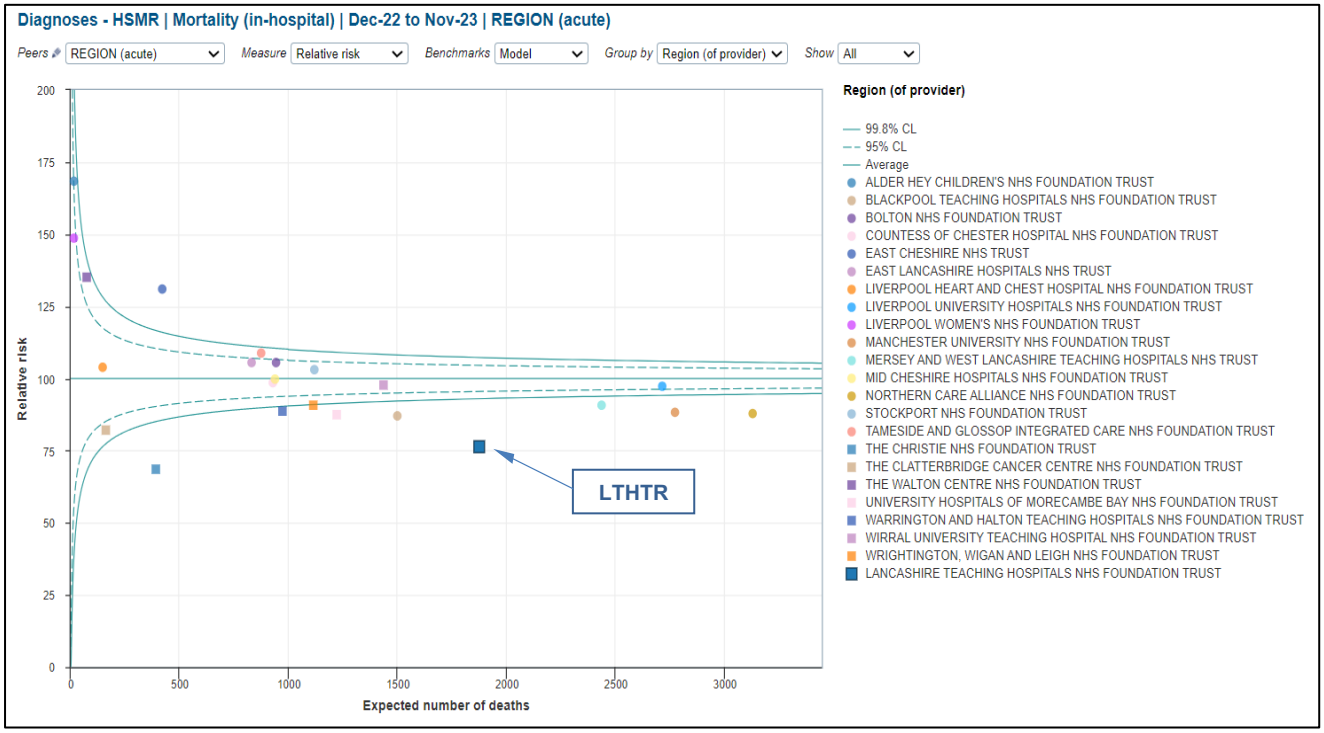
**Figure 32 Hospital Standardised Mortality Rate Dec 2020 – Nov 2023**




Source|: Telstra Health

A comparison with other regional acute peers is also presented below in the funnel plot in Figure 33 which shows the Trust has one of the lowest HSMRs in relation to our regional acute peers for the most recent data available.

## Figure 33 HSMR Regional Acute Peers Benchmark Dec 2022 – Nov 2023

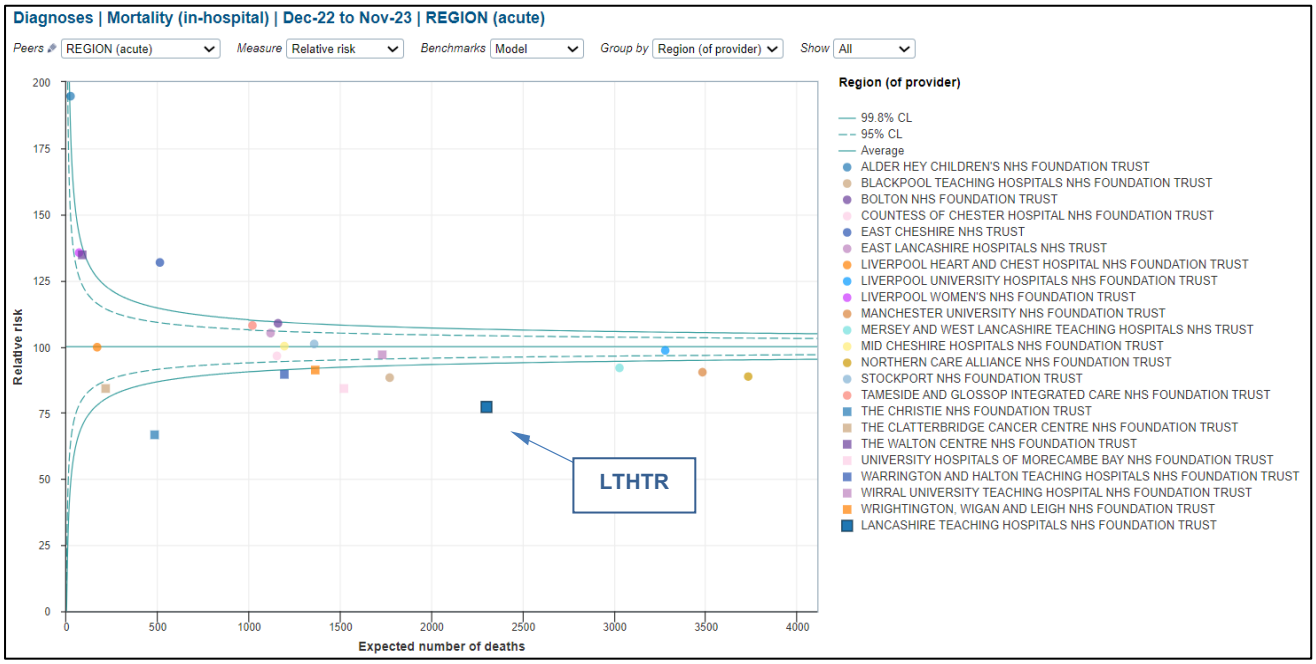



Source|: Telstra Health

### Standardised Mortality Ratio – Relative Risk for All Diagnoses

The Trust also monitors the Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' and for the period December 2022 to November 2023 this was 77.4, which is lower than expected. The funnel plot in figure 34 below, demonstrates that again the Trust has one of the lowest relative risks compared to our regional acute peers.

## Figure 34 SMR Regional Acute Trust Benchmark Dec 2022 – November 2023




Source|: Telstra Health

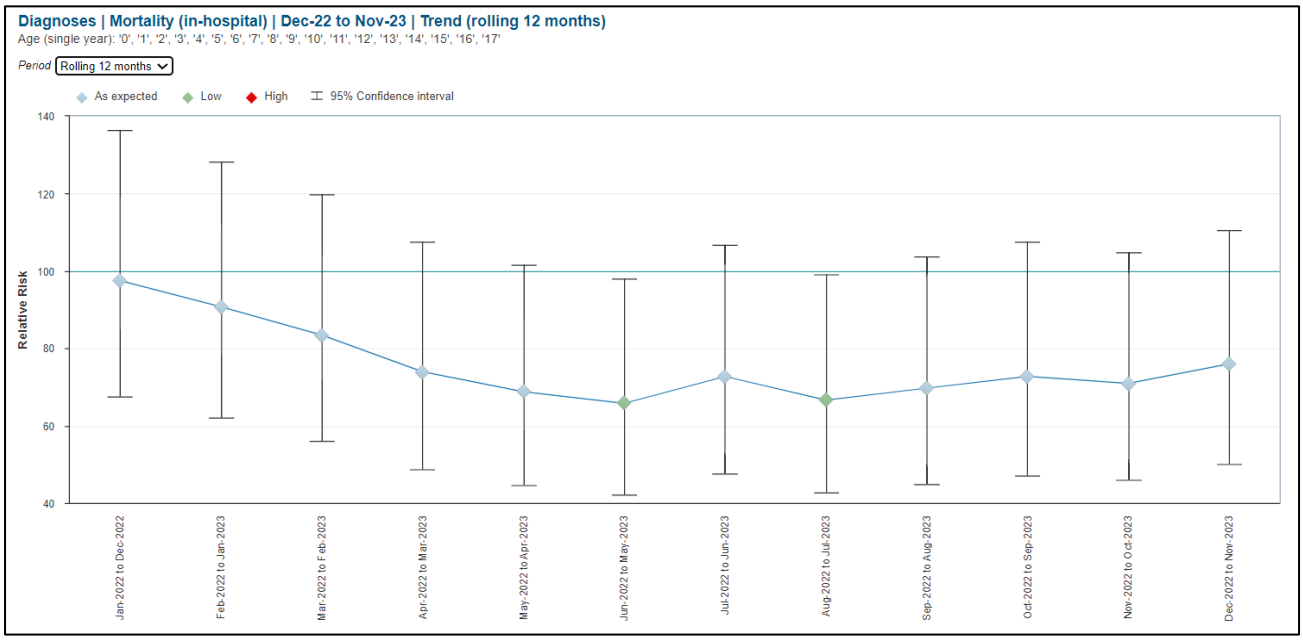
Learning from Mortality Reviews is shared at speciality level Morbidity and Mortality, and Safety and Quality meetings. The learning outcomes from the SJR reviews are extracted from the electronic SJR tool in our clinical audit system; AMaT. This is collated and key themes are reported into our Divisional, and Trust Safety and Quality Committees. Themes for learning are also reported into our Mortality and End of Life Care Committee which highlight excellent practice as well as areas for consideration and action.

### Child Deaths

Reporting of child deaths is managed in line with local and national guidance. The Trust offers immediate support to parents and families and the Trust has a bereavement midwife available to support the parents of newborn infants.

All child deaths are reported to HM Coroner unless the death is expected, and this has previously been agreed with HM Coroner. The statutory requirements for reporting child deaths to the child death overview panel (CDOP) are followed with this panel providing an independent multi-disciplinary review with the purpose of identifying lessons and preventing future deaths. In addition to reviewing children who have died in the Trust, a case review is undertaken for any children known to the children's services at the Trust for example those transferred to Paediatric Critical Care or children who have died unexpectedly at home.
The SMR for children for the 12-month period December 2022 to November 2023 (the most recent period available) is 76.0, which is within expected range as demonstrated in figure 35 below.

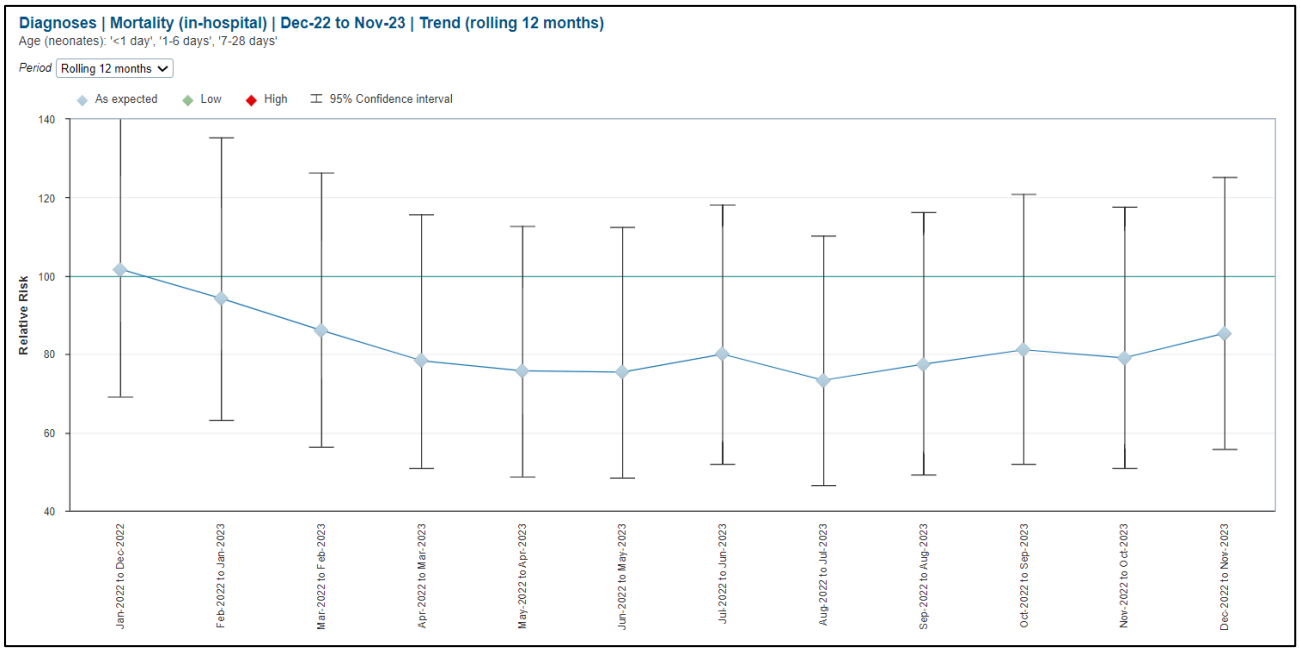
**Figure 35 SMR for Children (<1 - 17 years)**




### Neonatal Deaths

The SMR for Neonatal deaths for the 12-month period December 2022 to November 2023 (the most recent period available) is 85.3 which is within expected range and is demonstrated in figure 36 below.

**Figure 36 SMR for Neonatal Deaths (<1 - 28 days)**




All neonatal deaths under 28 days are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths, and infant deaths, including the Confidential Enquiry in Maternal Deaths (CEMD).

In addition, local reviews are undertaken by the neonatal lead Consultant for neonatal death or the Named Doctor for Safeguarding Children. All reviews are shared locally at departmental level and neonatal reviews have been shared at the Lancashire and South Cumbria Neonatal Operational Delivery Network Clinical Effectiveness Group. A summary is also presented to the Trust Mortality and End of Life Committee on a quarterly basis.

### Perinatal Mortality & Perinatal Mortality Review Tool

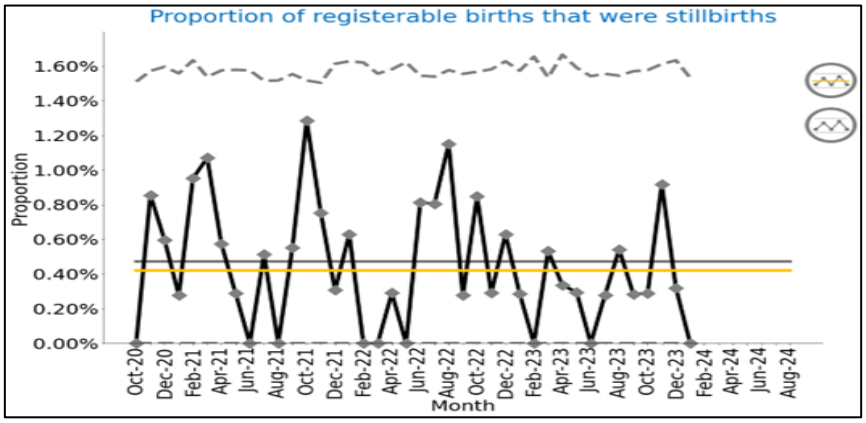
The Trust uses the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. This includes a comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth, excluding termination of pregnancy and those with a birth weight less than 200g. The tool is used to review the care collaboratively with a multi-disciplinary panel and includes an opportunity to consider the views and any concerns parents have about the care they received. The review results in a written report which is shared with the family within 6 months. When learning is identified from the reviews, action plans are formulated and tracked through Safety and Quality Committee for oversight and assurance.

The Trust also shares a summary report of all cases at the Maternity Safety Champions meetings held bi-monthly. Formal reporting is provided to the Trust Board bi monthly as part of the Maternity Service Update Report. Between March 2023 and April 2024, we reported 22 cases to MBBRACE that met the criteria for PMRT review, there were 11 cases of stillbirth and 11 cases of neonatal death.

**Stillbirths**

The stillbirth rate is monitored monthly by maternity Safety and Quality Committee. The SPC analysis, as shown in figure 37 shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. Currently the mean stillbirth rate is below the national average of 4.9 per 1000 births.

**Figure 37 Maternity SPC analysis - Incidence of Stillbirths (per 1000 births)**




## Medical Examiner Service

The Medical Examiner (ME) service was introduced nationally to establish a system which provides independent scrutiny of deaths, improved accuracy of death certification, more consistent and appropriate referrals to HM Coroner, reduced rejections of medical certificates by the Registrar and improved focus on the bereaved by responding to and reducing concerns. The MEs are supported by Medical Examiner Officers (MEOs).

The MEO under delegated authority scrutinises every death that occurs at the Trust, discusses any areas of concern the bereaved may raise and ensures that the correct medical certificate of cause of death (MCCD) is issued. Any concerns that require additional support are raised to either the attending doctor or the ME.

**Table 19 Medical Examiner Service Performance 2023-24 data**

| | Number | Percentage |
|---|---|---|
| Inpatient & ED Deaths | 2032 | |
| ME Reviews of all Deaths | 1422 | 70% |
| MEO Reviews of all Deaths | 2032 | 100% |
| ME/MEO Reviews of all Deaths | 2032 | 100% |
| ME/MEO Conversations with Bereaved | 1900 | 94% |
| Referrals to Coroner | 419 | 21% |

***Source: LTHTR Data***

The Coroner's Officers hold conversations with the bereaved when the death is referred to HM Coroner and out-of-hours the families are supported by the General Office team and bereavement service. The Registration Service has reported a reduction in the number of certificates rejected due to inaccurate or inappropriate causes of death, improving the experience of families.

# Review of Quality Performance – Experience of Care

## Patient Experience Performance Report 2022-23

### Patient care

Improving patient experience is a key ambition for the Trust underpinned by the mission to provide 'Excellent care with compassion'. Acquiring and acting upon the feedback provided by our patients, families and carers on their experience is an important component to achieving that ambition.

The strategy is divided into 3 sections.

- **Insight –** improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
- **Involvement –** to equip our patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
- **Improvement -** to design and support improvement programmes that deliver effective and sustainable change.

### Insight

- Patient Experience is a key part of the MCA (Microsystem Coaching Academy) with projects using the voice of the patient to help develop changes.
- Expanded participation in the patient experience research led by Imperial College Healthcare NHS Foundation Trust.
- Quarterly deep dive reports allowing for emerging themes to be identified.
- Friends and family feedback increased by 22.19%.
- Complaints reduced by 27.1%.
- National surveys demonstrate sustained positive performance in Maternity Services and cancer surveys, improvement in the Emergency Departments and a maintained position that requires improvement in adult inpatients.
- Governors and Integrated Care Board teams involved with STAR visits with an increase in compliance on patient feedback.
- Established links with under-represented group the '*Sahara Centre'.*

### Involvement

- The recruitment of 3 Patient Safety Partners and a new maternity neonatal voices partnership chair.
- Over 170 patient champions established across wards and areas.
- Volunteers supporting patient experience and hospital guide roles.
- 16 forums or groups for patients, advocacy services, charities, 3rd Sector and staff working collaboratively.
- All wards with 2 ward managers have demonstrated an improved STAR position.
- The development of an eLearning training package regarding Patient Advice and Liaison Service (PALS) concerns and local resolution.
- Increased number of Flow Coach Academy (FCA) big rooms and MCA projects.
- Increased training for staff in basic British sign language (BSL).

- Development of the Trust proud awards using MAGNET principles.
- Personalised Stratified Follow-Up (PSFU) and health and wellbeing workshops and initiatives have started across various specialities.

**Improvement**

- Person-Led Assessment of the Care Environment (PLACE) visits recommenced.
- Digitised food ordered with increased diverse options i.e. Vegan.
- Redesigned Gynae and women's assessment unit.
- Recruitment to a full time bereavement lead for Gynaecology services.
- Emergency department redesign and creation of Acute Assessment Unit.
- Day case surgery for children on CDH site.
- Multi-disciplinary CARING rounds focused on end of life.
- 7-day bereavement services.
- Refurbishment of ward 8 parent room.
- New Garden of Remembrance to honour organ donors and those who lost their life during pandemic.
- Increased satisfaction of patients attending radiotherapy.

## Complaints and Concerns

During 2023-24 the Trust received 355 formal complaints, a decrease of 132 from 2022-2023 and during this period the backlog of complaints from the COVID-19 pandemic was addressed with all now closed. The complaint performance has been monitored through the year and patients receiving response with 35 or 60 days has risen from 50% in April through to 79% in March and an average for the year at 75% compliance. It is the intention of the team to return and maintain the Trust target of 90% in 2024-25.

**Figure 38**

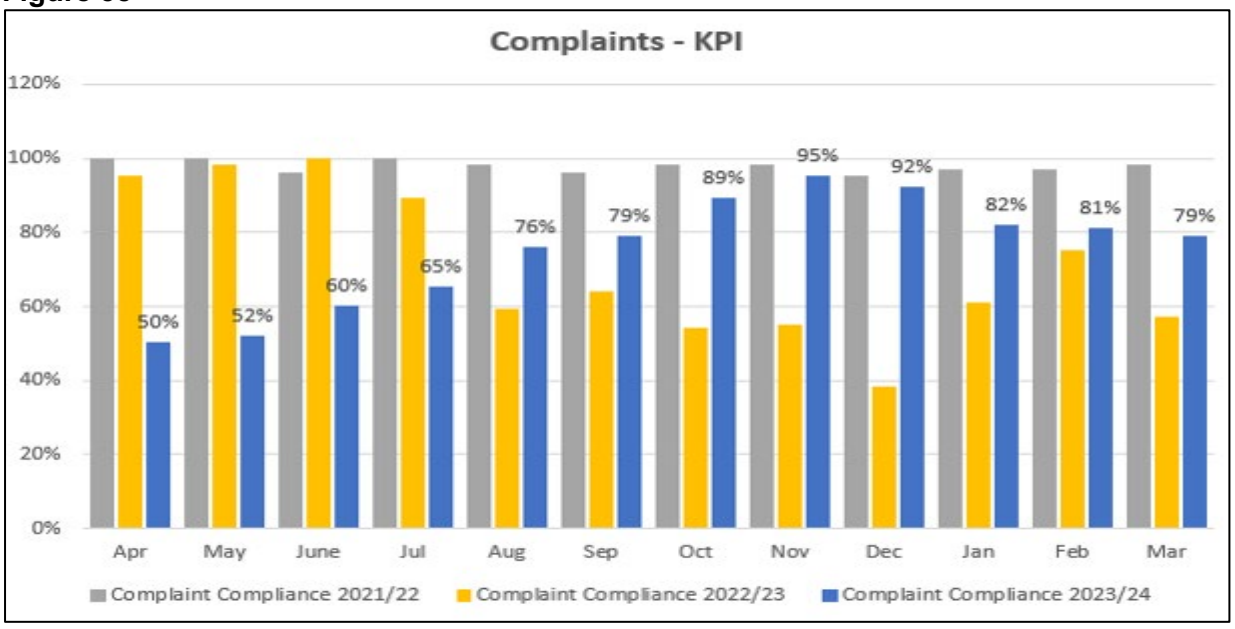


**Table 20 Comparator data for Complaints 2021/22 to 2023/4 inclusive**

| Year | Complaints received | Increase/reduction |
|---|---|---|
| 2021-22 | 580 | +219 |
| 2022-23 | 487 | -93 |
| 2023-24 | 355 | -132 |

***Source: LTHTR Datix***

During 2023-24 the Trust received 355 formal complaints, a decrease of 132 from 2022-2023. The decrease represents a percentage of 27.1%. This continues to follow the trend from the previous year where there was also a reduction. The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below:

**Table 21 Trend of ratio of complaints per patient contact 2021/22 to 2023-24 inclusive**

| Year | No of complaints | Total episodes (inpatient/outpatient) | Ratio of complaints topatient contacts |
|---|---|---|---|
| 2021-22 | 580 | 821,526 | 1:1,416 |
| 2022-23 | 487 | 849,328 | 1:1,744 |
| 2023-24 | 355 | 871,231 | 1:2,454 |

***Source: LTHTR Datix***

Of the 355 complaints received between April 2023 to March 2024, 285 (80%) related to care or services provided at the Royal Preston Hospital (RPH), 65 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (0.2%) to care or services provided by Preston Business Centre, and 4 (1.8%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were outside of the 12 months' timescale set out under the NHS Complaints Procedure.

**Table 22 Number of Complaints by Division – April 2023 to March 2024**

| Division | Number (%) | Division | Number (%) |
|---|---|---|---|
| Medicine | 150 (42%) | Women and Children's Services | 43 (12%) |
| Surgery | 129 (36%) | Diagnostics and Clinical Support | 27 (8%) |
| Estates and Facilities | 1 (0.5%) | Corporate Services | 5 (1.5%) |

***Source: LTHTR Datix***

During this financial year there were 334 cases due to be closed. The outcome of these can be broken down into the following outcomes 17 (5.9%) of the complaints had been upheld. 180 (53.89%) were partly upheld and 127 (38.02%) were not upheld. 10 cases currently remain open at the end of the year.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 87% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team. Whilst 100% of patients receive an acknowledgement via email or verbally on the telephone.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2023 and March 2024

we received 19 second letters.

During the period 1st April 2023 to 31st March 2024 249 complaints were closed. 75% of complaints received in 2023-24 were closed within the 35-day or 60-day timescale. Of note the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses to provide a better patient experience. The Patient Experience and PALS Team have dealt with a total of 2,325 concerns and 2,741 enquiries.

**Top Themes Complaints and Concerns by Division**

The following table provides detail of the top three themes based on the number of complaints made in each area for each division for the period April 2023 to March 2024.

**Table 23 Top Themes of Complaints and Concerns by Division**

| Division | Themes |
|---|---|
| Diagnostic and Clinical Support | 1. Confidentiality or communication<br>2. Treatment/Procedure<br>3. Nursing care |
| Women's and Children's | 1. Confidentiality or communication<br>2. Treatment/procedure<br>3. Staff Behavior or Attitude |
| Medicine | 1. Confidentiality or communication<br>2. Treatment/procedure<br>3. Nursing care |
| Surgery | 1. Treatment/Procedure<br>2. Confidentiality or communication<br>3. Nursing care |

The patient experience and involvement strategy will continue to focus on strategic plans to reduce the number of patient complaints through listening and taking action on the issues raised by patients.

**Compliments**

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2023-24 a total of 3,871 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 45% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. A new Trust campaign has been implemented to encourage recording of compliments recognising value our teams place on the recognition they receive from patients and families. From April 2024 league tables will be published to enable teams to benchmark against one another.

**The Parliamentary Health Service Ombudsman**

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2023 to 31st March 2024 there were 10 cases referred to the PHSO; 3 were partly upheld and 7 are ongoing. During this period, the PHSO sent final reports for 3 cases which were opened prior to April 2023 and the outcome of these were that 2 were not upheld and 1 was partly upheld. There is one further case referred to the PHSO prior to April

2022, which is still under investigation by the PHSO, and a final decision is yet to be reached.

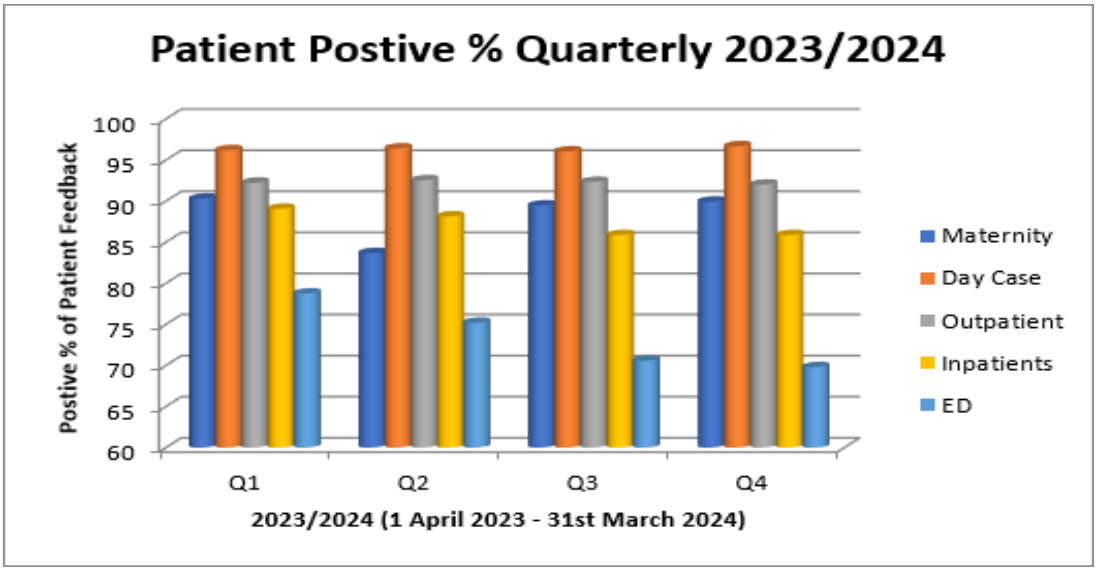
## Patient experience feedback

### Friends and Family Feedback

The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

**Figure 39 Quarterly percentage of positive responses Friends and Family by Division**




***Source: FFT data CIVICA***

A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day Case and Outpatients have consistently achieved more than 90% in all four quarters, Inpatients and the Emergency Department are under the target percentage in all four quarters.

The Trust undertakes surveys in Children and Young People's Services to ensure an equitable approach to measurement of experience. Children and Young People using the Urgent and Emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%.

**Figure 40 Children and Young People (CYP) Quarterly percentage of positive responses**

***Source: FFT data CIVICA***

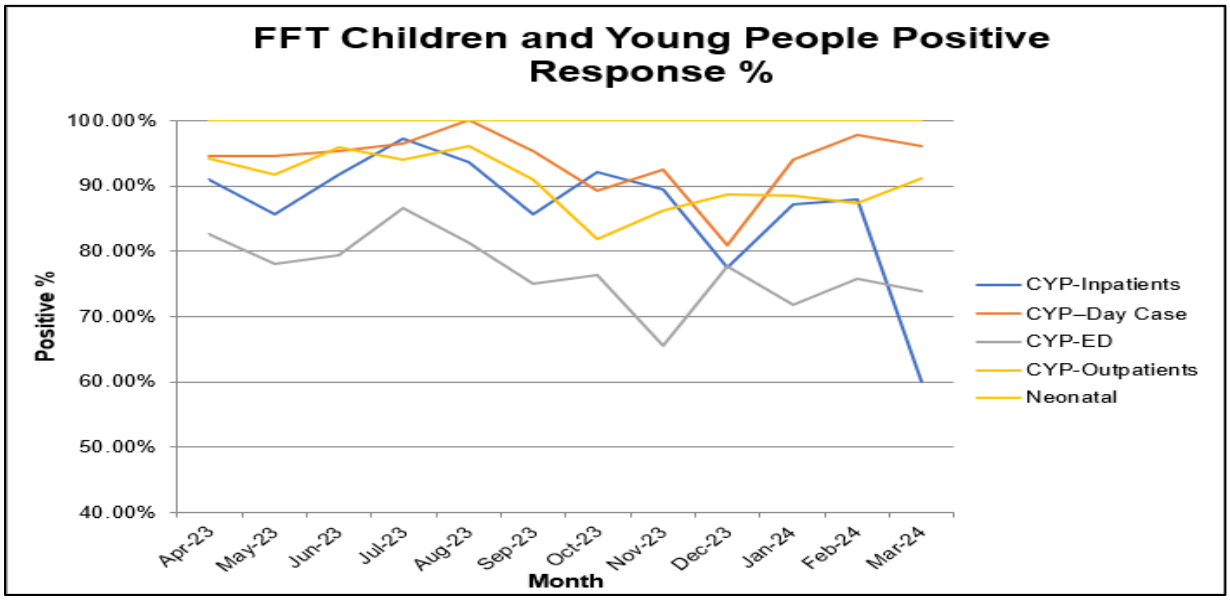
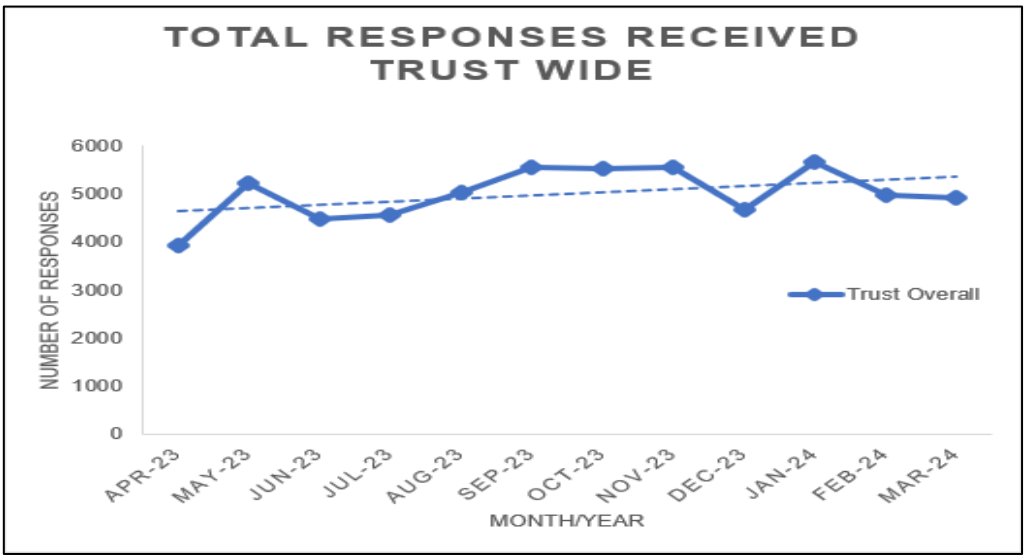



**Figure 41 Friends and Family % Response**




***Source: FFT data CIVICA***

The data above demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

**Friends and Family response rate**

Expanding the methods used to collect feedback is important if the Trust is to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 11,359 more valuable pieces of feedback than what was collected in 2022-23.

It is not yet possible to view this feedback through the lens of protected characteristics and deprivation, however work is underway to capture this.

**Table 24 Friends and Family response rate**

| Year | QR codes/online surveys | Paper surveys | Telephone surveys | SMS text surveys | Total |
|---|---|---|---|---|---|
| 2021-2022 | 1,468 | 2,829 | 3,684 | 36,128 | 44,109 |
| 2022-2023 | 2,905 | 6,788 | 4,421 | 37,070 | 51,184 |
| 2023-2024 | 3,016 | 10,944 | 2,112 | 46,471 | 62,543 |

In the year 2023-2024 there has been a positive increase in the response rates overall of 22.19% on the previous year. Increases have been realised due to the use of Quick Response (QR) codes, online surveys, paper surveys and Short Message Service (SMS) test surveys. There has been a reduction in the telephone surveys which in part may be due to an increase in online and mobile preferences for service users.

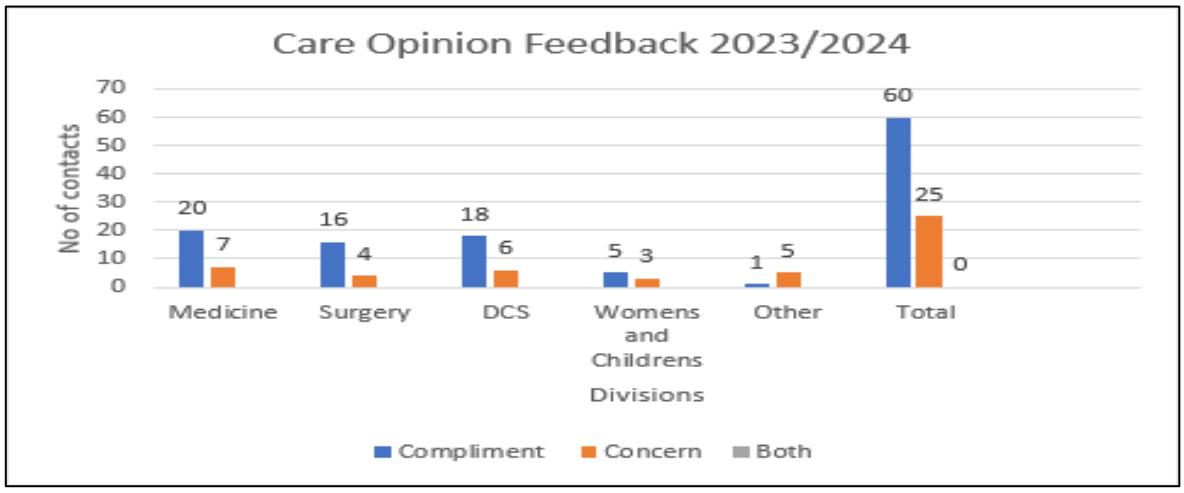
The Trust is continually training staff to use the system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded.

Managers and Leaders are actively seeking to make improvements with the Friends and Family test and this is measured through the Safety and Quality Committee.

**Care Opinion Website**

During the past financial year there have been a total of 85 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 60 compliments and 25 concerns.

**Figure 42 Care Opinion feedback**




## National Survey Results

### National Maternity Survey

The National Maternity survey is based on a sample of maternity service users who had a live birth between 1st March 2023 and 31st March 2023. In the 2023 survey the Trust was ranked 18th out of the 61 participating Trusts. Compared to the 2022 survey results, the Trust ranked 19th out of 65 Trusts surveyed by Picker. The response rate for the 2023 survey was 39% compared to the 2022 survey response rate of 44%.

Analysis identified two areas where the Trust scored significantly better when compared to the 2022

survey. There were no areas identified where the Trust score was significantly worse than the 2022 survey.

Overall, women reported that they were treated with kindness and compassion during labour and birth (98%), they had confidence and trust in staff during labour and birth (97%) and felt midwives and doctors were aware of their medical history during labour and birth (84%).

Within the bottom five scores, issues were identified in relation to information regarding infant feeding choices, review of health records by midwives and doctors, and induction of labour. The survey results triangulate with safety intelligence and patient feedback data already known to the maternity service. Action plans are in place to respond to this feedback with the aim of improving experience for women, birthing people and families.

**National Inpatient Survey**

Compared to the National Inpatient Survey in 2021, Lancashire Teaching Hospitals remains in the same position, with no areas identified as significantly better or significantly worse for 2022. Lancashire Teaching Hospitals is now ranked 50th out of the 70 Trusts surveyed by Picker. This compared to the 2021 survey where the Trust was ranked 55th out of 73 Trusts surveyed. This shows a slightly improved position in the overall positive score of 2 points, however, does not represent the improvement ambition the organisation is aspiring to. Adult inpatient experience is a priority area of action for the Patient Experience and Involvement strategy and progress against the strategies deployment will continue to be overseen by the Safety and Quality committee.

**Emergency And Urgent Care Survey**

The National Picker Adult and Urgent & Emergency Care Survey 2022 for patients attending the Royal Preston Hospital Emergency Department and Chorley District General Hospital. The Urgent and Emergency Care Survey is carried out every 2 years. The previous survey was undertaken in 2020. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 Emergency department. The results demonstrated an improved position for the Emergency Department compared to the last National Picker survey in 2022. The Trust is ranked 18th out of 62 Trusts nationally. This is compared to the 2020 survey, where the Trust was ranked 34th out of 66 Trusts surveyed.

**Children's and Young Peoples Survey**

There have not been any Picker survey results in this reporting period for Children and Young People. The survey will be undertaken between March and May 2024.

**Cancer Survey**

The survey results were published in July 2023. The overall score for care at our Trust was 9 out of 10, which is higher than previous years. There were 61 questions in total and 14 questions were in the higher-than-expected range with no responses in the lower-than-expected range which is a significant improvement on the previous years.

Common themes that require improvement across the range of cancer services include:

- Hospital care confidence in staff particularly within Head & Neck (H&N) Gynae and Upper gastro-intestinal (GI).
- Discussions with patients about research.
- Support and communication from primary care and cancer care reviews in primary care.
- Emotional support from voluntary services in the community.
- Information regarding immunotherapy.

Areas where the Trust has scored positively are:

- Head and Neck team scored highest with an overall rating of 9.5.
- Teams scoring above an overall rating of 9 were Lung 9.4, Prostate 9.3, Sarcoma 9.3, Upper GI 9.2, Colorectal 9.2.
- All teams scored highly for privacy when receiving results. H&N, lung, prostate and sarcoma all scored 100%.
- All teams scored highly regarding support from main contact, UGI, Skin and Colorectal teams scored 100%.
- All teams scored highly for review of care plans with patients, Upper GI, skin, colorectal and H&N scored 100%.
- All teams scored highly in the Treatment section.

## Major Service Developments and Improvements

Despite significant challenges across the Lancashire and South Cumbria healthcare system due to winter pressures, sustained demand for our services and the effects of industrial action, we continued to implement a number of major service developments during 2023–24. The developments have benefitted both patients and colleagues, helping to alleviate pressure on our emergency care pathways, reduce elective waits and improve flow across our sites.

These developments are testament to the resilience of our hard-working and dedicated colleagues and key partners who have remained committed to improving our services for the communities we serve. The major service developments during the past year are outlined below:

### Sir Lindsay Hoyle officially launches expansion of Clinical Health Psychology Services


The expansion of the Clinical Health Psychology Service was launched in May 2023 with a ribbon-cutting event attended by Sir Lindsay Hoyle, Member of Parliament for Chorley and Speaker of the House of Commons.

Sir Lindsay was invited to formally launch the expansion, with the Clinical Health Psychology Service (CHPS) opening a new department at Royal Preston Hospital, making psychological services more accessible to patients across Lancashire, when they need it most.

The aim of the service is to offer help and support to adult patients with psychological distress that they may experience as a result of chronic and life-changing physical health conditions or injuries, such as cancer or severe spinal injury.

### UK-first for cutting-edge LungVision Bronchoscopic Navigation System

In June 2023, Lancashire Teaching Hospitals NHS Foundation Trust became the first Trust in the UK to implement Lung Vision - the latest navigation bronchoscopy technology to locate and diagnose challenging peripheral lung tumours in a minimally invasive, safe fashion through an advanced tracking and navigation system.

Lung Vision enables doctors using a bronchoscope to examine inside a patient's lungs in real time, penetrating deeper and reaching areas they were previously unable to reach to take

biopsy samples. This procedure represents an incredible advancement which will identify lung cancer more quickly and enable patients to receive personalised treatment and enhanced care.

Lung cancer is responsible for 1.6 million deaths worldwide and 75% of patients have advanced disease at the time of diagnosis. Identification of patients with lung cancer at the earliest stage is vital if outcomes are to be improved. Patients often need to undergo multiple biopsies due the limited diagnostic yield ranges of existing equipment, which can lead to more than double the length of time a patient waits for their diagnosis. This creates additional stress for patients and even a few days or weeks delay can affect lung cancer outcome rates.

This system uses artificial intelligence to create 3D intraoperative images, improving accurate navigation and increasing biopsy success rates from 60% to above 85%. This helps to give timely and accurate diagnosis and therefore shortening the pathway for patients. It also helps in reducing the number of procedures to get to diagnosis thereby benefitting patients and healthcare systems.

The Trust engaged widely with partners, colleagues and the Rosemere Cancer Foundation Charity, who funded the equipment, to manage the process of bringing the system to the UK.

**New Regional Hyper-Acute Stroke Unit (HASU) is 'big step forward'**

A new Regional Hyper-Acute Stroke Unit (HASU) was opened in June 2023, bringing experts and equipment under one roof to help reduce death rates in stroke patients.

The unit, based at Royal Preston Hospital, is led by stroke specialist consultants, supported by a multidisciplinary team including specialist nurses, occupational therapists, physiotherapists and speech and language therapists, who are able to closely monitor and stabilise patients newly diagnosed with a stroke with world-class treatment for the first 72-hours following their diagnosis.

This project began planning in 2017, and the Trust is now the comprehensive stroke centre in the area. Patients will be monitored in a high care area, which will enable the staff to identify any deterioration and manage or escalate appropriately to prevent further deterioration.

**Waiting lists for children on the decrease thanks to new surgery offer**

July 2023 saw the opening of a new low complexity day surgery service for children based at Chorley and South Ribble Hospital.

The pop-up service, which operates once every two weeks from Rawcliffe Ward, was created to improve efficiency, experience and the number of children waiting for elective treatment.

The service brings together paediatric, anaesthetic and surgical teams to perform a range of procedures including dental, maxillofacial, ophthalmology, plastic surgery and ear, nose and throat (ENT)

**Finney House celebrates its first anniversary**

Finney House celebrated its first birthday in November 2023, marking one year since the Trust took over the facility to run a Community Healthcare Hub designed to accommodate patients who no longer need specialist hospital care.

In its first year the Community Healthcare Hub saw over 1,500 admissions and helped 70% of patients return home with support – in turn helping the local healthcare system to support discharge, patient flow and ease pressure on ambulance crews.

The site was formally opened on 14 November 2022, when the Trust took on the lease of the building and became the CQC-registered provider of services. Since opening, all 64 Hub beds within the facility are in use with a further 32 beds providing care for Local Authority and private residents.

Since opening, additional equipment has been purchased to enhance the therapy provision and outcomes at the Hub, which includes five specialist chairs, enabling all patients to spend time out of bed, various moving and handling adjuncts, gym equipment and functional assessment aids.

**New breast pain clinic launches in Central Lancashire**

The NHS in Lancashire and South Cumbria launched a new breast pain clinic to support people in Central Lancashire in November 2023.

The clinic provides examinations and advice to patients suffering from breast pain in Preston, Chorley and other parts of Central Lancashire and aims to reduce anxiety and worry for many patients who might otherwise have been unnecessarily referred for hospital tests on a cancer pathway.

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.

There are many causes of breast pain, including pregnancy, breastfeeding and other hormone-related issues, muscle-related pain or nerve problems and back pain. 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.

**Trust upgrade robotic system to speed up prescription processing**

A replacement robotic system has been installed in the Trust Pharmacy departments, to help both Royal Preston Hospital and Chorley and South Ribble Hospital speed up prescription processing to get medication to patients, faster.

The update to the Royal Preston Hospital's Pharmacy department comes on the back of upgrading the system at Chorley and South Ribble Hospital, and now complete, it will save valuable time for the Pharmacy team and bring greater efficiency to pharmacy processes.

The previous system was 16 years old, and is replaced by a more modern, more efficient robot. Once Pharmacy staff process the label for the medicine or input an order for stock, the robot selects the box from the shelves, scans it to ensure it is the right medication and transports it along a conveyer belt to a collection point.

The robot at Chorley will hold 12,000 packs of medicines, and 30,000 at Preston, and can supply the same number of packs in an hour that can be manually picked in a day.

There are other benefits such as accuracy, with the robot using barcode technology to identify the correct medicine, form, strength required and improved stock management.

**Trust unveils newly refurbished Gynaecology and Early Pregnancy Assessment Unit (GEPAU)**

In January 2024, the Trust opened its newly refurbished Gynaecology and Early Pregnancy Assessment Unit at Royal Preston Hospital, helping to enhance and improve care for women and families experiencing early pregnancy or complications.

The £90,000 scheme to redesign the Gynaecology Assessment Unit (GAU), received significant support from Baby Beat – part of Lancashire Teaching Hospitals Charity – who contributed £30,000.

This initiative is part of the broader women's health improvement programme to enhance the care for women and families experiencing early pregnancy or acute gynaecological complications including miscarriage and baby loss. Thanks to charitable funding, the refurbishment has relocated and rebuilt the scanning facility, provided a dedicated ambulatory care suite for women who experience hyperemesis gravidarum and created a welcoming space for women and families attending the department. The redesign has been co-produced with feedback from service users, ensuring women's voices were heard and asking families to share deeply personal accounts of their experiences has ensured that the new design is reflective of the needs of the people using our service.

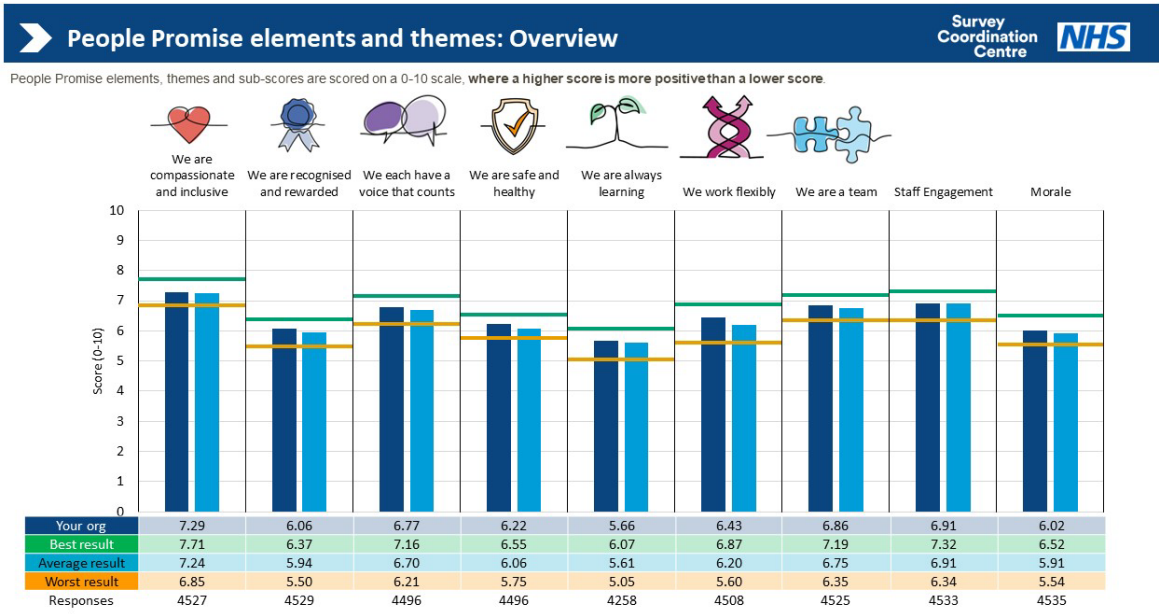
## Staff Survey and Recommendation of Our Care

### Annual National Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The Trust's response rate to the 2023 survey was 45%. This is 2% lower than the 2022 survey (47%) however we have met the national average (45%) in our benchmarking group (Acute and Acute and Community Trusts).

Scores for each indicator together with that of the survey benchmarking group are presented in figure 43 below.

**Figure 43 Annual National Staff Survey**




***Source: National Staff Survey***

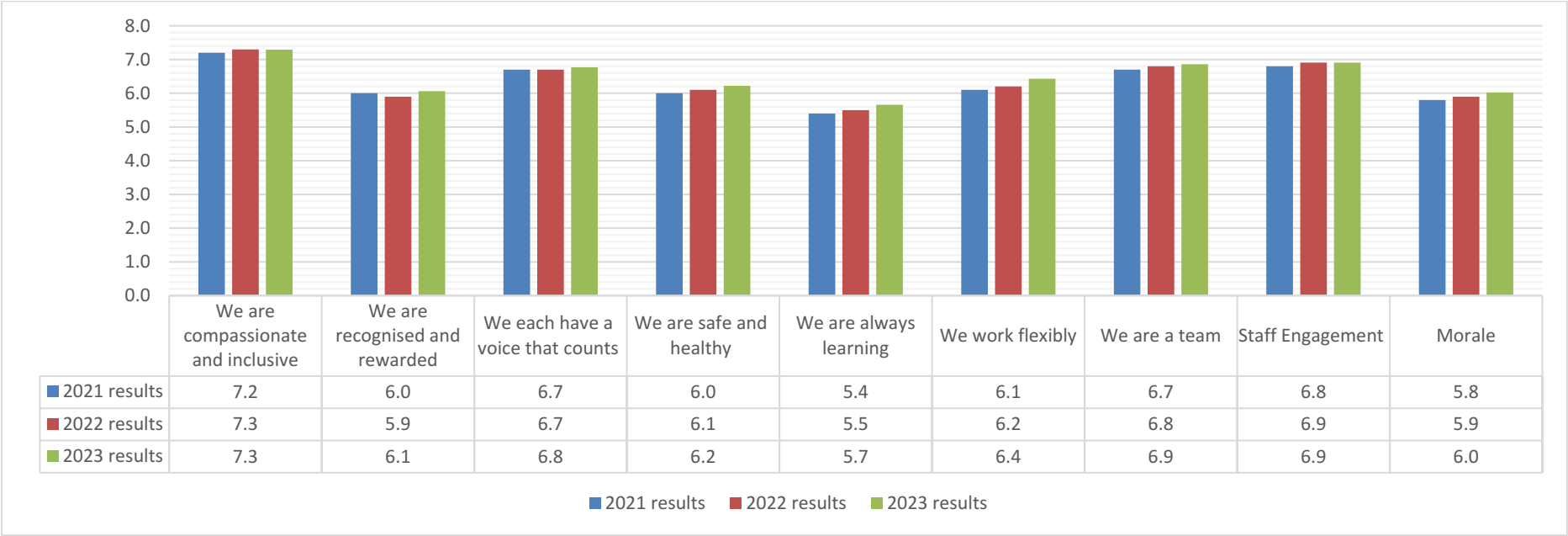
As indicated in figure 43 above, the benchmarking against the People Promise elements displays our position (navy blue bar) shows that we are **above** the national average for **all elements** except one (Staff Engagement measure) for which we have met the national average.

Within the context of pressure facing the organisation, teams and managers, these results are very positive. We have been able to sustain our levels of engagement whilst demonstrating improvements across the majority of the People Promise measures. Whilst the results still show us where are areas for improvement are, we can see we are continuing to make progress towards our aspiration of being the 'best' in the NHS.

**Table 25 People Promise Results Comparison 2022 – 2023**

| People Promise Measures | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| 2022 results | 7.3 | 5.9 | 6.7 | 6.1 | 5.5 | 6.2 | 6.8 | 6.9 | 5.9 |
| 2023 results | 7.3 | 6.1 | 6.8 | 6.2 | 5.7 | 6.4 | 6.9 | 6.9 | 6.0 |
| Differences | 0 | +0.2 | +0.1 | +0.1 | +0.2 | +0.2 | +0.1 | 0.0 | +0.1 |

**Figure 44 People Promise Measure Results - 2021-2023**



In table 25 above it shows that across four of the national measures we have seen an increase of 0.1 points, ('We each have a voice that counts', 'We are safe and healthy', 'We are a team' and 'Morale'). Across 3 of the elements, we have seen an increase of 0.2 points ('We are rewarded and recognised', 'We are always learning' and 'We work flexibly') and we have remained the same for the measures 'We are compassionate and inclusive' and overall Staff Engagement.

We have overall sustained the gap between our average and the 'Best' score for each of the People Promise Elements with the difference between our average and the best ranges remaining between 0.3 – 0.5 points. We can see good progress in the theme 'We are recognised and rewarded' closing the gap between ourselves and the best by 0.2 points and we can see an increase in the gap for overall Staff Engagement between ourselves and the best by 0.1 points.

It is pleasing to see that some of the corporate level action taken following last year's results appear to be demonstrating impact in this year's results. Examples include an increased focus on recognition, further work to embed our flexible working policy and toolkit, the new focus on zero tolerance training and toolkit and increased promotion of our learning and development offer across the Trust and Divisional workforce committees.

Looking at the data over the last three years (since the People Promise was launched) figure 44 demonstrates that we are showing a positive trend across all the People Promise measures, Staff Engagement and Morale.

Figure 44 indicates that 'We are always learning', and 'We work flexibly' are the areas we are showing the most overall progress (+0.3 points) followed by 'We are safe and healthy', 'We are a team' and over Morale which have all improved by 0.2 points.

**Staff Engagement**

When looking at the Trust level data, out of the 97 comparable questions, 83 have shown improvements, 2 remained the same and 12 declined.

Table 26 below details the overall staff engagement score for 2023 and the breakdown of scores for questions which measure the 3 facets of team engagement, namely motivation, involvement and advocacy. The results compare our scores against our 2022, identifies the changes and compares to the benchmark average for this year.

Table 26 below shows that for staff engagement we have seen improvements in all except two questions which have slightly deteriorated and both are linked to colleagues perceptions of the quality of care across the Trust. This was further seen through the free text comments analysis were colleagues felt patient care and services was being impacted by lack of staffing and resources.

**Table 26 2023 Staff Engagement Results and Comparisons**

| | Organisational Results and comparison (2022 to 2023) | | | Picker Average 2023 Comparison | |
|---|---|---|---|---|---|
| **Question** | **Organisation 2023** | **Organisation 2022** | **Changes** | **Picker Average 2023** | **LTH comparison to Picker average** |
| **Motivation** | | | | | |
| Often/always look forward to going to work | **57.00%** | 55.19% | 1.81% | 55.00% | 2.00% |
| Often/always enthusiastic about my job | **71.25%** | 70.20% | 1.05% | 69.39% | 1.86% |
| Time often/always passes quickly when I am working | **75.55%** | 74.50% | 1.05% | 72.33% | 3.22% |
| **Involvement** | | | | | |
| Opportunities to show initiative frequently in my role | **76.49%** | 75.73% | 0.76% | 73.66% | 2.83% |
| Able to make suggestions to improve the work of my team/dept | **74.96%** | 74.68% | 0.28% | 71.43% | 3.53% |
| Able to make improvements happen in my area of work | **57.16%** | 56.54% | 0.62% | 56.35% | 0.81% |
| **Advocacy** | | | | | |
| Care of patients/service users is organisation's top priority | **72.52%** | 72.84% | -0.32% | 74.83% | -2.31% |
| Would recommend organisation as place to work | **59.44%** | 57.18% | 2.26% | 60.52% | -1.08% |
| If friend/relative needed treatment would be happy with standard of care provided by organisation | **58.33%** | 59.89% | -1.56% | 63.32% | -4.99% |

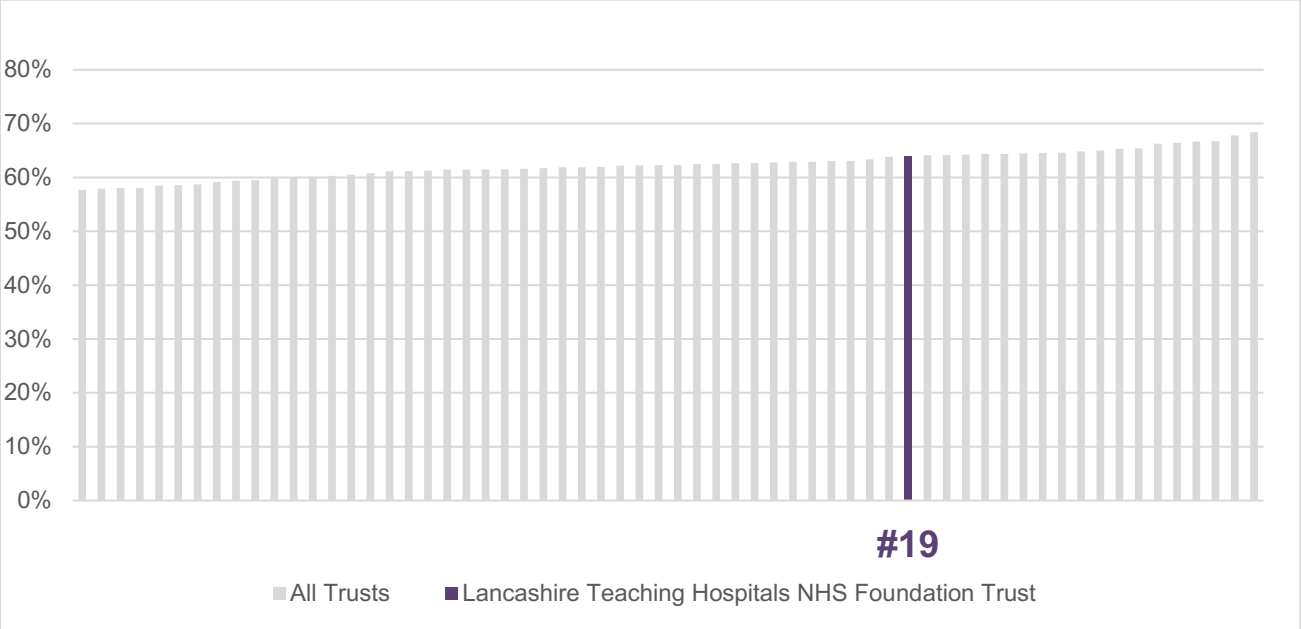
To summarise the staff engagement findings:

- In table 26 we can see our 2023 results are broadly in line with the benchmark average and we can see yearly improvements in our motivation and involvement sub-score which are both above the national average and shows all the questions in these themes have increased and are all scoring more positively than our comparative Trusts.
- Our overall staff engagement score has remained largely stable and whilst we are yet to see improvements in our advocacy score, we have not seen a decline either. When we look at the national picture, the average advocacy score has declined every year since 2020.
- Whilst our overall advocacy score has remained the same, when we look at the question breakdown, it shows an increase in colleagues agreeing they would recommend the organisation as a place to work. This is the first increase since 2020 and is a positive improvement towards our Big Plan goal to 'to be a great place to work'.
- However, it appears the score continues to be driven by a deteriorating perception in our colleagues with regards to if the care of patients/service users is organisation's top priority and if a friend or relative needed treatment they would be happy with the standard of care.

Figure 45 below shows our position in the league table when compared against 62 other Acute and Acute

Community Trusts who used Picker as their annual staff survey provider, this indicates, we ranked positively at position 19, which is a decline from last year's position of 13 but it is important to remember that each year the number of Trusts using Picker changes so this is not a direct comparison to previous years.

**Figure 45 NHS Staff Survey 2023: Overall Positive Score**




**Future priorities and targets**

The 2023 results show us where we are making progress to improve our overall staff experience and they help us to understand our priorities and key areas we need to pay attention to over the next 12 months. Many actions will continue to be delivered by the Workforce and Organisational Development team as outlined in Our People Plan 2023-26 which identifies our key strategic aims and deliverables.

Based on the findings reported in the free text comments and the question data the follow areas have been identified as priority areas for improvements to continue our work to enhance levels of staff satisfaction, morale and overall engagement:

- **Health, Safety & Wellbeing**
    - Address the different perceptions of the quality of care and find ways to increase feelings of advocacy across teams for provision of high-quality care.
    - Address the level of burn out and wellbeing concerns reported and explore how our corporate offer can further support improvements for colleagues experiencing this.
- **Staff Engagement/Morale/Hygiene Factors**
    - Continue to embed our new recognition offers at a corporate level and increase local level recognition to support all colleagues to feel rewarded, recognised and valued despite internal resourcing/financial challenges.
    - Explore and scope options there may be to improve key hygiene factors such as access to kitchen, break areas, car parking solutions, catering, dilapidated estate etc.

- **Culture/Leadership/Inclusion**

    - Support key manager practices such as 1:1s, appraisals and involving teams in decision making and continue to invest in leadership and management development.
    - Continue work to support more positive team cultures, calling out behaviours and incivility that does not support this and further embed 'Our Best Version of Us' to help address behavioural challenges.
    - Address experiences of personal safety i.e. discrimination, bullying, harassment, aggression by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.
    - Implement the NHS' Sexual Safety Charter which will support addressing experiences seen through the new question set which focus on unwanted sexual behaviour.

- **Teamworking**

    - Continuing to utilise TED, to support team members to feel involved in changes, manage team dynamics, integrate colleagues as well as to empower and upskill team leaders to be able to facilitate team improvements.
    - Promoting ways in which we can support teams and colleagues to overcome relationship challenges.

We know we can do better to improve our overall colleague experience and our corporate level action plan will detail the actions we will be taking to make improvements to these areas. Progress against our priorities and measurement of impact will be reported to the Workforce Committee through the regular cycle of business.

## Medical and Dental Workforce Rota Gaps

Our Workforce Department monitor vacant posts and as part of the 'Guardian of Safe Working' requirements are required to provide a quarterly vacancy gap analysis as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b. The Trust is required to include a plan for improvement to reduce the gaps for NHS Doctors and Dentists only in the Trust's Quality Account. There is no such requirement for Registered Nurses or Allied Health Professionals (AHP's).

An overview of Trust wide vacancies per grade are presented in Table 27 below.

### Table 27 Medical and Dental Vacancies

*Data is for each post as a whole time equivalent. It does not reflect gaps as a result of long-term sickness, maternity/adoption leave and working part time.*

| Grade | Vacant | Filled | Total | Vacancy Rate |
|---|---|---|---|---|
| **Deanery** | | | | |
| FY1 | 1 | 56 | 57 | 1.75 % |
| FY2 | 2 | 54 | 56 | 3.57 % |
| ST1-2 | 3 | 113 | 116 | 2.59 % |
| ST3+ | 11 | 144 | 155 | 7.10 % |
| **Trust** | | | | |
| Junior Clinical Fellow | 25 | 60 | 85 | 29.41 % |
| Senior Clinical Fellow | 33 | 92 | 125 | 26.40 % |
| SAS | 16 | 82 | 98 | 16.33 % |
| Consultant | 73 | 456 | 529 | 13.80 % |

***Source: LTHTR data***

Our Workforce Business Partners provide monthly reports to the Divisional Workforce Committees which includes the detailed status of each vacant post. The team use this information to work closely with Clinical Directors and departmental managers to source vacancies and agree recruitment strategies for new and hard to fill posts at speciality. This year this will feature as part of the single improvement plan under the medical workforce project.

## Core Skills Training

Core skills training is an area of focus identified by the CQC that requires improvement. Focused improvement work is underway to address the areas where compliance is not being achieved and maintained at professional group level. This analysis is monitored and managed through the Trust's Education, Training and Research (ETR) Report which is presented to the ETR Committee.

Please see table 28 below for detail of the Trust's Core Skill straining metrics.

Table 28 Core Skills training metrics

| Staff Group | Mar-24 |
|---|---|
| Conflict Resolution | 98.59% |
| Equality, Diversity and Human Rights | 94.82% |
| Fire Safety | 95.16% |
| Health, Safety and Welfare | 94.79% |
| Infection Prevention and Control - Level 1 | 93.88% |
| Infection Prevention and Control - Level 2 | 93.14% |
| Info Gov: All Staff | 94.02% |
| Moving & Handling L1 (Non-Clinical) | 83.52% |
| Moving & Handling L2 (Clinical) | 84.50% |
| Preventing Radicalisation - Awareness | 94.92% |
| Preventing Radicalisation - Basic Awareness | 95.55% |
| Resus - Level 1, Non-Clinical | 91.62% |
| Resus - Level 2, ABLS&PBLS | 83.75% |
| Resus - Level 3, ILS | 56.33% |
| Resus - Level 3, NILS | 83.94% |
| Resus - Level 3, PILS | 49.52% |
| Safeguarding Adults (Level 1) | 95.93% |
| Safeguarding Adults (Level 2) | 97.88% |
| Safeguarding Adults (Level 3) | 92.37% |
| Safeguarding Children (Level 1) | 94.67% |
| Safeguarding Children (Level 2) | 96.00% |
| Safeguarding Children (Level 3) | 90.08% |

## Quality Assurance

Our Quality Account has presented the data, information and assurance required by NHS England. The Trust has provided information related to the statutory core performance indicators and assurance on our data quality. The Trust has presented progress with our key priorities for 2023-24 which were stated

in the 2022-23 Quality Account and highlighted new priorities for 2023-24 which align to Our Big Plan. The Trust has presented a review of activity in relation to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

Our Safety and Quality Committee promote a safety and quality culture in which staff are supported and empowered to improve services and care. The Committee provides the Board of Directors with assurance on the patient experience and outcomes of care by:

- Ensuring that adequate structure, processes, and controls are in place to promote safety and excellence in the standards of care and treatment.
- Monitoring performance against agreed safety and quality metrics and ensuring appropriate and effective responses occur when indicated.
- Ensuring compliance with NHS England and relevant CQC standards.

Trust governors continue to be actively supportive of the Trust's quality improvement activities and continue to play a major part in providing assurance by participating in STAR and other quality assessments as well as attending our Patient Experience Improvement group.

Our Governor involvement in the New Hospitals Programme has been hugely valued and much appreciated by the Trust. Our governors also continue to offer valuable insights and challenge contributing to continuously improving the services we offer patients and our wider communities. Our Quality Account for 2023-24 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care, and excellent experience.

# Annex 1:

## Statements from External Stakeholders

**Statement from the Lancashire County Council Health Scrutiny Committee in response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account for 2023-24**

This year the Lancashire County Council Health Scrutiny Committee have provided a comprehensive response to four of the eight Quality Accounts received (Blackpool, Lancashire and South Cumbria NHS Foundation Trust, NWAS and University Hospitals Morecambe Bay) due to the priorities in the Health Scrutiny work plan and this will be reviewed again next year.

The statement from is as follows: -

“Although we are unable to comment on this year’s Quality Account we are keen to engage and maintain an ongoing dialogue throughout 2024/25.”

**Statement from Healthwatch Lancashire In response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2023-24**

From: Jodie Carney
Manager
Healthwatch Lancashire,
Leyland House, Lancashire Business Park
Centurion Way, Leyland
PR26 6TY

# Healthwatch Lancashire
# Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 23-24

## Introduction

We are pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts for 2023-24.

It was pleasing to see the reference tool at the beginning of the document used to measure success throughout.

## Chief Executive's Statement

A comprehensive statement delivered from the Chief Executive Officer detailing challenges presented in Urgent Care pathways and the launch of the Patient Safety Incident Response Framework. Partnership working is highlighted and celebrated as being beneficial to the Trust, which we welcome any opportunities to support as a Healthwatch.

## Registration with the Care Quality Commission

### Trust Inspections

Urgent and emergency care, medicine and maternity at Preston requires improvement following an inspection in 2023. Although it is pleasing to learn that the Trust is no longer being monitored by the CQC regarding the management of mental health patients, we would be interested to learn about this concern and how it has since been resolved.

## Review of Quality Performance- Experience of Care

### Patient Care

Please note that the new role for the Maternity and Neonatal Voices Partnership is referred to as a lead now and not a chair.

It is pleasing to see ways in which there are opportunities for patient involvement, in terms of patient champions and the 16 forums, would it be possible to include how peoplecan become involved with these?

**Patient experience feedbackFriends and**

**Family feedback**

Patient experience of care is a key part of the role as Healthwatch and we are particularlyinterested in patients feedback which has been obtained by the Trust.

It is positive to learn that there has been a positive increase in response rates to feedbackand an increase of 11,359 pieces of feedback collect compared to last year. We look forward to learning of work that is underway to ensure that feedback is reflected frompeople of diverse communities.

**Major Service Developments and Improvements**

There is lots to celebrate here and this section highlights that although there are challenges, the Trust are continuing to implement developments and services that overallwill improve patient experience and care.

**Summary**

In accordance with the current NHS reporting requirements, mandatory quality indicatorsrequiring inclusion in the Quality Account, we believe that the Trust has fulfilled this requirement. The quality indicators, results and supporting narrative are clear and welllaid out.

Overall, this is a fair and well-balanced document which acknowledges areas for improvements and actions being taken to further improve patient treatment, care andsafety.

We welcome these and as a Healthwatch we are committed to supporting the Trust toachieve them.

**Jodie Carney**

**Manager- Healthwatch Lancashire**

**Statement from NHS Lancashire and South Cumbria Integrated Care Board in response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2023-24**

Our ref: Quality account/2023-24

Please contact: Sarah O'Brien

Email: sarah.obrien19@nhs.net

Personal assistant: Una Atton

Email: una.atton1@nhs.net

24 May 2024

Silas Nicholls
Chief Executive Officer
Lancashire Teaching Hospitals NHS Foundation Trust

Dear Silas

**Re: ICB Response to Lancashire Teaching Hospitals NHS Trust Quality Account 2023/24**

The Lancashire and South Cumbria Integrated Care Board (ICB) would like to take this opportunity to comment on the annual Quality Account from Lancashire Teaching Hospitals NHS Foundation Trust.

The ICB would also like to recognise all the challenging work that has been undertaken during 2023/24.

- Compliance with the year 5, 10 safety actions for maternity services demonstrating continued progress on the Trust's maternity improvement journey.
- Successful reduction in 104-week waiters in line with NHSE recovery plans
- Participation in 95% of national clinical audit (the Trust did not participate in Improving Quality in Crohn's and Colitis (IQCC), national diabetes footcare audit and national ophthalmology database (NOD) audit), the ICB acknowledge non-participation due to service pressures, appropriate staff to undertake and system requirements to undertake these but look forward to seeing participation in future years. It is also noted that the Trust participated in 100% of national confidential enquiries.
- Ensuring services were able to be safely operated whilst supporting staff during a period of continued industrial action, which impacted on services.

The CQC have undertaken inspections throughout 2023. The CQC ratings of services remain the same, "requires improvement" (rating remained since November 2019) The CQC rated safe, effective, responsive, and well led overall as requires improvement and caring as good. Surgery at Preston and urgent and emergency care and maternity at Chorley was rated good. With urgent and emergency care, medicine and maternity at Preston as requires improvement. The ICB notes CQC's acknowledgement of progress with performance, but echo the further work needed to address bed pressures, flow, and delivery of the financial plan. The ICB continues to support the Trust through engagement work with the One Plan.

The ICB acknowledges that Infection Prevention and Control (IPC), and most notably Clostridioides difficile (C. difficile) was a key priority for the ICB and Trust last year. It is recognised that in 2023-24 the Trust had a 3.6% increase (203 compared to 196 in 2022/23) in cases. However, the ICB is aware

that there has been a national increase in C. difficile infections across a significant proportion of Trusts nationally. The ICB is also aware that there are wider IPC issues linked to E. coli, Pseudomonas and Klebsiella species infections all being above the target objective figures. The ICB is assured of the risk management approach and the mitigating action plans in place, and also appreciate the constraints of success due to the estate.

In 2023/24, Trust performance in relation to NHS Constitutional targets was again adversely impacted by the residual effects from the pandemic as well as industrial action, the ICB value the progress that the Trust has made in attaining the NHSE recovery trajectories for 104 week waits and will continue to support the Trust in its plans for achievement over the coming year.

It is disappointing to note that the readmission rate for 0–15-year-olds is higher than the England's average, and showing a deteriorating position, the ICB looks forward to collaborating on the Trust's plans to improve and sustain this position.

The ICB acknowledges the increasing reporting rate for patient safety incidents, demonstrating a positive reporting culture, and recognises the driving themes for these relating to boarded patients, Thrombectomy service provision, treatment target breaches and prolonged waiting times. The ICB appreciates the work ongoing to improve these areas and commends the continued use of the Always Safety First Learning and Improvement forums to respond to learning from incidents.

The ICB recognises the Trust's commitment to improving the care it delivers to patients and the experience they received, despite the challenges that the last few years have brought. It is important to acknowledge increased service provision, including:

- A number of schemes undertaken through the Continuous Improvement Strategy, including "Flow Coaches" and "Big Rooms" for areas under pressure. These schemes provide multi-disciplinary staff with an opportunity for discussion, review and focused approaches for shared learning and identifying improvements for patient care and outcomes.
- PSIRF has been implemented and embedded into practice (phase 1 Nov 23, phase 2 Mar 24). With the culmination of five local PSIRF priorities – delayed recognition of a deteriorating patient, due to gaps in monitoring (including pregnant women), delayed, missed or incorrect cancer diagnosis, prescribing or administration error or near miss of anticoagulation medication, adverse discharge due to gaps in communication or misinformation and delay in responding to a critical pathology finding. The ICB will continue to work closely with the Trust and wider system to develop shared learning platforms and inform service improvements.
- The ICB acknowledge the 3 Never Events relating to wrong site surgery and mis-placed nasogastric tube. The ICB has seen the action plans and is assured that learning has been implemented and systems put in place to mitigate the risks identified. The ICB appreciate the regular engagement with the patient safety team and the open and transparent approach to the work around these Never Events.
- Safety Triangulation Accreditation Review (STAR) visits. Out of 126 clinical areas registered for these visits, 82% have achieved silver ratings and an increase of 25 areas (total of 52) have achieved gold awards. The ICB has been invited to participate in the STAR visits during 2024-25

The Trust acquired Finney House in November 2022 to enable the Trust to improve patient flow by providing 64 out-of-hospital health-led community bed capacity, reducing medicine bed capacity in hospital as a result. The ICB recognises the actions being taken to improve overall patient flow and support collaborative system working across the health economy. The ICB acknowledges the higher level of falls that have occurred within Finney house and appreciate that a thematic review and bespoke action plan has been put in place for the unit.

The Trust co-produced a new three-year Patient Experienced Involvement Strategy for 2022 to 2025 in collaboration with patients, families, carers, governors, and staff. It is positive to note that this

strategy links closely to a number of existing Trust strategies including Equality, Diversity, and Inclusion; Mental Health; Learning Disability and Autism; Dementia; and the Always Safety-First strategy. Actions will be monitored through the Patient Experience and Involvement Group, which in turn provides assurance to the Trust Safety and Quality Committee.

The ICB also notes that there have been some key achievements to support improved patient safety and experience including:

- Establishing links with underrepresented group the 'Sahara Centre'
- Creating an open and accountable reporting culture where staff are encouraged to identify and report issues.
- An increase in completed FFT surveys has been seen through 2023/24. Most services were over 90% for some or all quarters, except for ED which was consistently under the target. A re-design of ED is taking place to address the number of patients in the department and the number of patients waiting extended periods of time.
- Digitising food ordering systems with increased diverse options
- Redesigned gynaecology and women's assessment unit, and emergency department redesign and creation of an acute assessment unit
- 7-day bereavement services and recruitment to a full-time bereavement lead for women's services
- Development of day case surgery on the Chorley site
- Increased satisfaction of patients attending radiotherapy

The ICB appreciates that the Trust Quality Account for 2023/24 acknowledges that there are a number of areas where the Big Plan metrics were not met but some have been carried forward into 2024/25. It is positive to note the continued focus on these areas:

- Reduce pressure ulcers by 5%.
- Deliver the C. difficile measure within nationally set trajectory.
- Reduce sickness absence to 4%.
- Reduce vacancies by a further 5%.

To conclude, 2023/24 was a challenging year for the Trust in terms of the operational and workforce challenges, including through industrial action, financial pressures within the NHS and restoration recovery plans to reduce waiting lists. The ICB notes that these will continue into 2024/25 in terms of restoring services to full capacity and addressing the backlog of patients still waiting for treatment.

We look forward to working closely with the Trust with the 2024/2025 priorities and further developing our collaborative partnerships to continue to improve the quality of care to our patients.

Yours sincerely

SO'Brien

**Professor Sarah O'Brien**
**Chief Nurse**

**Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust**
**Quality Account: Feedback from Council of Governors Meeting on 16th April 2024**

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 16th April 2024, governors were invited to consider and input into the two Quality Indicators for inclusion in the 2024-25 Quality Account.

The agreed topics which support putting patients are at the heart of what we do support delivery of The Patient Experience and Involvement Strategy 2022–2025 and the Patient Safety Incident Response Framework and are as follows: -

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact statements and patient surveys. This will ensure the patient and family voice is truly "heard," especially of those hear less often.

Indicator 2. The involvement of patients, families, carers when they have experienced an incident is meaningful, individualized and they are treated with respect and compassion ensuring leading to genuine and compassionate learning from incidents, especially of those involved less

# Annex 2:

## Statement of directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support data quality for the preparation of the Quality Report.

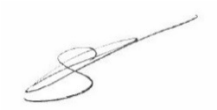
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2023-24 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2023 to March 2024.
- Papers relating to quality reported to the Board over the period April 2023 to March 2023.
- Feedback from Integrated Care Board 24th May 2024
- Feedback from Healthwatch 29th May 2024
- Feedback from Overview and Scrutiny Committee 31st May 2024
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2023-24.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHSI's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Peter White
Chair Date: 18th June 2024



Silas Nicholls
Chief Executive Date: 18th June 2024

## List of Tables

## List of Figures

## Glossary of Abbreviations

| | |
|---|---|
| **A&E** | Accident & Emergency |
| **AHP** | Allied Health Professionals |
| **AMaT** | Audit Management and Tracking System |
| **AMG** | Antimicrobial Management Group |
| **AQuA** | Advancing Quality Alliance |
| **BAF** | Board Assurance Framework |
| **BAUS** | British Association of Urological Surgeons |
| **BI** | Business Intelligence |
| **BRC** | Biomedical Research Centre |
| **CAHPR** | Council for Allied Health Professions Research |
| **CBG** | Capillary Blood Gas |
| **CDH** | Chorley District Hospital |
| **C.Difficile** | Clostridioides Difficile |
| **CDOP** | Child Death Overview Panel |
| **CEMD** | Confidential Enquiry in Maternal Deaths |
| **CI** | Continuous Improvement |
| **CIWA** | Clinical Institute Withdrawal Assessment for Alcohol |
| **CMP** | Case Mix Programme |
| **CNST** | Clinical Negligence Scheme for Trusts |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **CP-IS** | Child Protection Information Sharing System |
| **CQC** | Care Quality Commission |
| **CQUIN** | Commissioning for Quality and Innovation |
| **CrCu** | Critical Care Unit |
| **CSAP** | Child Safeguarding Assurance Partnership |
| **CSC** | Children's Social Care |
| **CTG** | Cardiotocograph |
| **CYP** | Children & Young People |
| **DIPC** | Director of Infection Prevention & Control |
| **DNACPR** | Do Not Attempt Cardiopulmonary Resuscitation |
| **DNAR** | Do Not Attempt Resuscitation |

| | |
|---|---|
| **DoLs** | Deprivation of Liberty Safeguards |
| **DSPT** | Data Security and Protection Tool |
| **E.coli** | Escherichia coli |
| **ED** | Emergency Department |
| **EDI** | Equality Diversity Inclusion |
| **EOS** | Early Onset of Sepsis |
| **EPMA** | Electronic Prescribing and Medicines Administration |
| **EWS** | Early Warning Score |
| **FFFAP** | Falls and Fragility Fractures Audit Programme |
| **FFT** | Friends and Family Test |
| **FGM** | Female Genital Mutilation |
| **FTSU** | Freedom to Speak Up (FTSU) guardian |
| **FY1** | Foundation Year 1 |
| **FY2** | Foundation Year 2 |
| **FY3** | Foundation Year 3 |
| **GAS** | Group A streptococcus |
| **GDPR** | General Data Protection Regulations |
| **GGI** | Good Governance Institute |
| **GICAP** | Gastro-intestinal Cancer Audit |
| **GIRFT** | Getting It Right First Time |
| **GMC** | General Medical Council |
| **GP** | General Practitioners |
| **GSK** | GalaxoSmithKline |
| **H&N** | Head and Neck |
| **HCG** | Human chorionic gonadotropin |
| **HOHA** | Healthcare Onset/Healthcare Associated |
| **HSSIB** | Health Services Safety Investigation Body |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **HQIP** | Healthcare Quality Improvement Partnership |
| **HVLC** | High Volume, Low Complexity |
| **IARC** | International Agency for Research on Cancer |
| **IBD** | Inflammatory Bowel Disease (Programme) |

| | |
|---|---|
| **ICB** | Integrated Care Board |
| **ICNARC** | Intensive Care National Audit & Research Centre |
| **ICO** | Information Commissioner's Office |
| **ICS** | Integrated Care System |
| **IDA** | Iron Deficiency Anaemia |
| **iGAS** | Invasive group A Streptococcus |
| **INCS** | Integrated Nutrition and Communication Service |
| **IPC** | Infection Prevention and Control |
| **IPL** | Inter-professional learners |
| **IT** | Information Technology |
| **LCRF** | Lancashire Clinical Research Facility |
| **LeDeR** | Learning Disability Mortality Review Programme |
| **LFPSE** | Learn from patient safety events |
| **LMNS** | Local Maternity Neonatal Systems |
| **LSAB** | Lancashire Safeguarding Adults Board |
| **LTHTR** | Lancashire Teaching Hospitals NHS Foundation Trust |
| **MASH** | Multi Agency Safeguarding Hubs |
| **MAU** | Medical Assessment Unit |
| **MBRRACE-UK** | Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK |
| **MCA** | Mental Capacity Act |
| **MCCDs** | Medical Certificate of Cause of Death |
| **MDT** | Multidisciplinary Team |
| **ME/MEs** | Medical Examiner/s |
| **MEO/MEOs** | Medical Examiner Officer/s |
| **MHRA** | Healthcare Products Regulatory Agency |
| **MIAA** | Mersey Internal Audit Agency |
| **MINAP** | Myocardial Ischaemia National Audit Project |
| **MITRE** | Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit |
| **MRSA** | Methicillin Resistant Staphylococcus Aureus |
| **MSK** | Musculoskeletal |
| **MUST** | Malnutrition Universal Screening Tool |

| | |
|---|---|
| **NABCOP** | National Audit of Breast Cancer in Older Patients |
| **NACAP** | National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme |
| **NACEL** | National Audit of Care at the End of Life |
| **NAIF** | National Audit of Inpatient Falls |
| **NCAA** | National Cardiac Arrest Audit |
| **NCAP** | National Cardiac Audit Programme |
| **NCEPOD** | National Confidential Enquiry into Patient Outcome and Death |
| **NCMD** | National Child Mortality Database |
| **NCPRES** | National Cancer Patient Experience Survey |
| **NDA** | National Adult Diabetes Audit |
| **NELA** | National Emergency Laparotomy Audit |
| **NGT** | Nasogastric tube |
| **NHFD** | National Hip Fracture Database |
| **NHS** | National Health Service |
| **NHSE** | NHS England |
| **NHSI** | NHS Improvement |
| **NICE** | National Institute for Health and Care Excellence |
| **NICU** | Neonatal Intensive Care Unit |
| **NIH** | National Institute of Health (USA) |
| **NIHR** | National Institute for Health and Care Research |
| **NJR** | National Joint Registry |
| **NLCA** | National Lung Cancer Audit |
| **NMAHP** | Nursing Midwifery Allied Health Professionals |
| **NMPA** | National Maternity and Perinatal Audit |
| **NMPs** | Non-Medical Prescribers |
| **NNAP** | National Neonatal Audit Programme |
| **NOGCA** | National Oesophago-gastric Cancer Audit |
| **NPCA** | National Prostate Cancer Audit |
| **NPDA** | National Paediatric Diabetes Audit |
| **NPSA** | National Patent Safety Agency |
| **NRLS** | National Reporting and Learning System |
| **NVR** | National Vascular Registry |

| | |
|---|---|
| **OGD** | Oesophago Gastro Duodenoscopy |
| **ORDER** | Overseas Registrar Development and Recruitment |
| **PALS** | Patient Advice and Liaison Service |
| **PAU** | Paediatric Assessment Unit |
| **PCR** | Polymerase Chain Reaction |
| **PEWS** | Paediatric Early Warning Score |
| **PHSO** | Parliamentary and Health Service Ombudsman |
| **PIRs** | Post Infection Reviews |
| **PMRT** | Perinatal Mortality Review Tool |
| **POP** | Plaster of Paris |
| **PPE** | Personal protective equipment |
| **PQIP** | Perioperative Quality Improvement Programme |
| **PROMs** | Patient Reported Outcome Measures |
| **PROMPT** | Practical Obstetric Multi-Professional Training |
| **PSCF** | Procedure-Specific Consent Form |
| **PSII** | Patient Safety Incident Investigation |
| **PSIRF** | Patient Safety Incident Response Framework |
| **PUL** | Pregnancy of unknown location |
| **QIPs** | Quality Improvement Programmes |
| **RAG** | Red, Amber and Green |
| **RALP** | Robot-Assisted Laparoscopic Radical Prostatectomy |
| **RCN** | Royal College of Nursing |
| **RCOG** | Royal College of Obstetricians and Gynaecologists |
| **RCP** | Royal College of Physicians |
| **REJOIN** | Emergency ureteric injury management |
| **RPH** | Royal Preston Hospital |
| **SAMBA** | Society for Acute Medicine Benchmarking Audit |
| **SAS** | Speciality and Specialist grade |
| **SAU** | Surgical Assessment Unit |
| **S. aureus** | Staphylococcus aureus |
| **SBAR** | Situation-Background-Assessment-Recommendation |
| **SDEC** | Same Day Emergency Care |

| | |
|---|---|
| **SHMI** | Summary Hospital-level Mortality Indicator |
| **SHOT** | Serious Hazards of Transfusions |
| **SIRO** | Senior Information Risk Owner |
| **SJR** | Structured Judgement Review |
| **SLT** | Speech and Language Therapy |
| **SMR** | Standardised Mortality Ratio |
| **SMRC** | Specialist Mobility Rehabilitation Centre |
| **SPC** | Statistical Process Control |
| **SPCMHT** | Specialist Perinatal Community Mental Health Team |
| **SSNAP** | Sentinel Stroke National Audit Programme |
| **ST 1-2** | Speciality Trainee 1-2 |
| **ST 3+** | Speciality Trainee 3+ |
| **STAR** | Safety Triangulation Accreditation Review |
| **StEIS** | Strategic Executive Information System |
| **SUDC** | Sudden Unexpected Death in Childhood |
| **SUS** | Secondary User Service |
| **TACT** | Tobacco and Alcohol Care Team |
| **TARN** | Trauma Audit and Research Network |
| **TED** | Team Engagement and Development Tool |
| **TVNs** | Tissue Viability Nurses |
| **UGI** | Upper Gastro-Intestinal |
| **UKCRF** | UK Clinical Research Facility |
| **UKHSA** | UK Health Security Agency |
| **VTE** | Venous Thromboembolism |
| **WHO** | World Health Organisation |