Lancashire Teaching Hospitals NHS Foundation Trust

Evidence appendix
Royal Preston Hospital
Sharoe Green Lane, Fulwood
Preston
Lancashire
PR2 9HT

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Lancashire Teaching Hospitals NHS Foundation Trust has two hospitals delivering acute services from Royal Preston Hospital and Chorley and South Ribble Hospital. The trust service an estimate of 437,588 people

Royal Preston Hospital provides a full range of district general hospital services including emergency department, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children’s services, neonatal intensive care, women’s health and maternity, and several specialist regional services including cancer, neurosurgery and neurology, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria. The urgent care centre on the site is not provided by this trust.

Chorley and South Ribble Hospital provides a full range of district general hospital services including emergency department (8am-8pm), critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation,
midwifery-led maternity care, and a breast service. The urgent care centre on the site is not provided by this trust.

The trust is also registered to provide vascular surgery at Furness General Hospital, Royal Lancaster Hospital, Westmorland General Hospital and Blackpool Victoria Hospital.

In October 2016 to September 2017 there were 65,308 inpatient admissions, 597,651 outpatient attendances, 101,518 A&E attendances and 4,431 babies delivered. The trust had 915 general and acute beds, 68 maternity beds and 32 critical care beds.

As of October 2017 the trust had 6,986 WTE staff (medical 796, nursing 1,759 and other 4,431)
Is this organisation well-led?

Leadership

The trust had a unitary board which consisted of executive and non-executive directors. The board was made up of the following members:

- Chair
- Chief executive
- Finance director and deputy chief executive
- Medical director
- Nursing, midwifery and allied health professions director
- Operations director
- Seven non-executive directors
- Workforce and education director (non-voting member)
- Company secretary (non-voting member)

The board was supported by a governance director and continuous improvement director who were not board members. The trust was required by NHS Improvement to appoint a turnaround director in response to the financial challenges faced by the trust. The director had started in post shortly before the inspection. The trust previously had a strategy and development director on the board, but they were currently on secondment to a national organisation.

Since the last inspection, in September 2016, there had been significant changes to the board and other senior leaders. While there had been many changes these had mostly been planned. The nursing director had joined the trust shortly before the last inspection. The chair joined the board in January 2017 and three of the non-executive directors joined the board in 2017. The medical director was appointed in April 2018 and in April 2018 the operations director resigned and at the time of the inspection an interim director was in post.

The trust had identified areas of its leadership team which needed to be strengthened since the last inspection. Within the nursing director’s portfolio, a new deputy nursing director and governance director had been appointed and new posts for associate director of allied health professions and associate governance director had been created. The trust had created new posts for a continuous improvement director and head of continuous improvement who were appointed in December 2017.

Leaders and staff were positive about the changes and new positions created and the impact on quality and sustainability. Leaders and staff had highlighted the positive impact of the nursing director, deputy nursing director and senior nursing leadership since the last inspection.

In April 2018 at the time of the operations director resigning, the divisional directors in the medicine, surgery and diagnostics and clinical support had all resigned. The trust reported at the time that it was an ‘unfortunate coincidence of timing’ and the three divisional directors had been successful in posts in other organisations. The trust had appointed interim staff to the roles and senior leaders we spoke to on the inspection were confident that there was no significant impact.

We found the trust leadership team had an appropriate range of skills, knowledge and experience to deliver services at the trust. The performance of the executive leadership team was reviewed.
and monitored through an annual appraisal process led by the chief executive to ensure they maintained the skills, knowledge and integrity to carry out their roles.

There was an experienced finance director and deputy finance director who had both been with the trust for many years. The finance director had indicated his intention to retire within the next two years and given the scale of the sustainability challenge and the strategic ambition of the trust to achieve a single site operational model the trust needed early consideration of succession planning arrangements to ensure the appropriate skills and capability were sought for this key board role.

The board members’ portfolios covered all key areas to manage the trust’s business. The size of portfolios and staff varied between executive directors. For example, the nursing director had an extensive portfolio and staff while the medical director did not have staff to deliver her portfolio. Directors told us they had the capacity to deliver with the support from the teams they managed. The trust had not appointed to the strategy and development director during the secondment, although the medical director had taken responsibility for overseeing the Our Health Our Care work there was a risk that the board did not have the capacity to deliver the strategic agenda.

The chief executive, deputy operations director (the interim operations director had only been newly appointed), nursing director, workforce director all had a good understanding of the financial challenge facing the trust and the divisional teams were engaged in developing and delivering efficiency and productivity improvements while maintaining quality. Some good examples were provided during the inspection, for example, escalation beds decommissioning, decision making process for additional nurse staffing and benefit realisation, improved productivity through revised patient pathways.

The chair was knowledgeable on the financial position and committed to the attainment of improvement and sustainability albeit the latter was a medium-term objective heavily reliant on whole system working. Both the chair and chief executive were key players in the development of whole system working through the integrated care partnership and good progress has been made recently to reach consensus with partners on future care models across the local health system.

The trust had an established divisional structure and was currently reviewing this to strengthen clinical leadership.

The chief pharmacist reported to the operations director and was additionally accountable to the medical director, who was the executive lead for medicines optimisation. The pharmacy services sat in the diagnostics and clinical support division, the chief pharmacist was treated as a divisional director which supported ward to board communication. There were some gaps in staffing but this was being considered with recruitment plans. Work had been carried out to increase the medicines optimisation priorities within the trust. However, there was limited awareness of the patient group direction concerns that were highlighted during the core inspection or the severity of the risks within the pharmacy manufacturing unit.

Non-executive directors had a variety of skills, knowledge, and experience which was relevant to their roles. They had worked in leadership and senior management positions in the NHS, public sector and private organisations. They brought skills such as finance, IT, and change programmes. Recently appointed non-executive directors told us that there was a comprehensive recruitment process to appoint the best candidate for the role. Non-executive directors' performance was reviewed by an annual appraisal process led by the chair. Non-executive directors told us this process had become more structured and formalised since the new chair joined the trust.
The skills, knowledge, experience and behaviour types of the non-executive directors were reviewed when vacancies arose to ensure that there was a good mix of skills which represented the challenge, risks and opportunities for the trust. The chair told us that before the most recent non-executives had joined it had been identified that risk and capital development were areas of expertise which were needed. The trust was currently carrying out a skills audit for forthcoming vacancies which was being reviewed at the nominations committee, in August 2018. The trust had identified that it would be looking to recruit non-executives with experience in governance and partnerships.

The audit committee chair was an experienced accountant and was clear on the role of the audit committee in providing assurance to the board on the trust’s systems of internal control and risk management and there was appropriate interface with the other board committees in providing scrutiny of strategic risks.

Leaders had a clear understanding of the challenges to quality and sustainability faced by the organisation. Leaders interviewed had a good awareness of the size of the financial challenges facing the trust. They were not able to succinctly describe the key drivers of the trust’s underlying financial deficit although there was a common understanding that two site working was a significant factor. At the time of the inspection the trust was completing a diagnostic of the underlying financial position and this was going through due process with the board before submission to NHS Improvement.

The trust had formal and informal activities to ensure that senior staff were visible and approachable. The board had monthly structured walk rounds before board development sessions where they visited clinical areas and spoke to staff. The chief executive worked shifts in different parts of the hospital as part of the ‘back to the floor’ initiative and was involved in meetings and events with different staff and both sites. The nursing director worked shifts in different parts of the trust and carried out regular visits. Other executive directors did not have planned visits across the trust which the chief executive said they planned to do in the future. During the core service inspection staff across different core services and at both sites had mixed about the visibility of the senior leadership team.

The chief executive had set up other initiatives to enable staff to approach her directly. The chief executive set up a valuing your voice website where staff could give feedback directly to her, anonymously if they wished, about anything important to them. The chief executive also invited staff to shadow her in her role, an offer which had been taken up by two junior doctors and a consultant in the year before the inspection.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had a fit and proper person’s procedure for all directors which was in line with the regulation. We reviewed a sample of personnel files for directors and found the appropriate checks had been carried out to ensure that they were compliant with the regulation.

The trust carried out monthly board workshops for executive and non-executive directors. The programme included a mixture of operational, skills, knowledge and behavioural subjects. The time was protected and monitored quarterly through the board. The trust had recently had a joint board session with a nearby NHS trust board focussed on behavioural types.

The trust had a procedure for succession planning within the divisions and at executive level. Executive directors had a good understanding of the prospective leaders and gaps within their
portfolio. However, we saw no evidence that the succession plan which had started in 2017-18 had been approved by the workforce committee or the board.

**Board Members**

Of the executive board members at the trust, 0% were Black and Minority Ethnic (BME) and 83% were female.

Of the non-executive board members 0% were BME and 25% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)*

The diversity of the board was not representative of the staff as a whole. The chair had acknowledged that the board lacked diversity with no BME no executive or non-executive members. The chair told us that during the next recruitment of non-executive directors they were hoping to increase diversity on the board.

**Vision and strategy**

The trust had a clear vision and values with quality and sustainability as top priorities. The trust had well established values which had been developed more than five years ago in consultation with patients, staff and the public. These were relaunched in 2018 with the new patient experience strategy. The five values were: caring and compassionate; recognising individuality; seeking to improve; team working; and taking personal responsibility. The values were supported by a mission statement to provide excellent care with compassion.

The trust had three strategic aims: to provide outstanding healthcare to local communities; offer a range of specialised services to patients in Lancashire and South Cumbria; and drive innovation through world-class education, training and research. In 2016-17 the trust created four ambitions to underpin the strategic aims. Each of the ambitions were divided into objectives which were updated each year. The four ambitions were for the trust to be: a great place to work; fit for the future; consistently deliver excellent care; and deliver value for money.

The trust did not have an up to date strategic plan or other document which articulated the strategic aims and ambitions, the timescales, resource implications or how progress against them would be measured. The most recent strategic plan for 2014-19 did not reflect the trust’s current four ambition approach, it referenced previous delivery strategies no longer active the trust. While leaders could explain the overall strategic aims of the trust, they did not all articulate the strategy using the four ambitions which had been developed and adopted by the trust. Similarly, staff across the trust did not articulate the strategy in terms of the aims and ambitions.
The three strategic aims and four ambitions were referenced in business planning, performance reporting, board papers and in parts of the board assurance framework, usually by way of check boxes to identify which aims or ambitions were relevant. However, the trust did not document how each of the ambitions (or the objectives which sat underneath) would be achieved. We did not see any evidence that progress against each of the aims or ambitions was monitored or measured.

In terms of short term operational plan, the trust referred to the workstreams within the continuous improvement plan with its focus on safe and effective care pathways coupled with the financial improvement programme, with its emphasis on improving productivity and efficiency. These were captured under the banner of the trust’s three enduring strategic objectives and four ambitions. This framework seemed to be recognised by the operational teams and was mapped to a uniform set of templates for board and committee reporting.

The trust had a suite of strategies to support the delivery of the strategic objectives but not all of these were up to date. The trust planned to review the safety and quality strategy within the next year and were reviewing the clinical services strategy at the time of the inspection. The workforce and organisational development strategy and research strategy were both reviewed annually by sub-committees of the board.

In February 2018 the trust launched a new nursing, midwifery, allied health professional and care givers strategy and a new patient experience and involvement strategy. We saw evidence that the nursing and patient experience strategies were monitored at the board, with a quarterly update measuring progress against the strategies’ objectives. Each of these strategies were developed with feedback from staff, patients and the public.

The trust was about to launch a continuous improvement strategy which set out how it would deliver its continuous improvement agenda. The content of the strategy had been approved by the board and was being prepared for publication. In addition to the trust’s continuous improvement strategy it was contributing to the development of a continuous improvement strategy for the wider health and social care economy to support system wide improvements.

The trust had a hospital pharmacy transformation plan supported by a pharmacy business plan. There was a comprehensive workforce strategy for pharmacy looking at developing enhanced roles to support divisions. For example, an increase in the number of pharmacist non-medical prescribers, pilot of medicines management assistants at ward level, the development of medicines administration technician role and an emergency department pharmacy team. The trust had received support and funding via Health Education England to implement extended work in the emergency department to include a night service.

Good progress had been achieved in recent months in agreeing a strategic direction with commissioners and other partners across the local health system for future healthcare provision under the banner of Our Health, Our Care. The vision was to achieve clinical, operational and financial sustainability through a single site model for hospital services. The emphasis of the work undertaken to date was focused on sustainable care models and this had been achieved through strong clinical engagement across the health system. For the trust this was being led by the medical director. All parties recognised the importance of public engagement and endorsement to achieve this vision and it was a key next step. At the time of the inspection the trust was engaging with staff, patients and the public with drop in sessions about the initial plans, which included a single emergency and major trauma centre and a planned care centre. The trust aimed for the plan to go out for public consultation in January 2019.

Ahead of the Our Health Our Care programme being implemented the trust was carrying out a service portfolio review for 2018-19 to understand the vulnerabilities and opportunities within
services delivered, develop service improvement plans for vulnerable services and inform business planning for the following year. The process was led by the operations director and would run from August-November 2018.

In addition to plans for the future delivery of services in the locality, the trust had worked collaboratively with other NHS trusts to deliver some shared services. The trust had formed a procurement cluster with two local NHS trusts which had many benefits including getting better value for money and services.

**Culture**

Staff across the trust, at all levels, were positive about the organisation as a place to work and felt supported by the leadership team and other senior staff. Staff were committed to making improvements to patient care. In general, staff felt listened to and supported even during times of pressure caused by high levels of demand. For example, staff we spoke to in the emergency departments felt listened to when they raised concerns about safety issues and staffing issues.

The trust had an open and transparent culture which was evident in the interviews with board members and senior leaders. This was also reflected in our interviews during staff at all levels curing the core service inspections.

The trust was patient focussed with the needs and safety of the patient being the main priority. This was evident in decisions made by the executive team, such as the nursing and midwifery staffing review which proposed an increase in staff spending despite the financial pressures and deficit. Staff were positive about the new ward accreditation scheme (safety triangulation accreditation review) as a measure of quality and were positive about improving services for patients. Staff at all levels were engaged with the trust’s increased focus on continuous improvement.

In the NHS staff survey for 2017 the trust scored better in the following 15 key findings and worse in six key findings.

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust has 15 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. % experiencing discrimination at work in the last 12 months</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>KF18. % attending work in the last 3 months despite feeling unwell because they felt pressure</td>
<td>51%</td>
<td>52%</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>54%</td>
<td>51%</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>68%</td>
<td>72%</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>71%</td>
<td>70%</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in the last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. % reporting the most recent experience of violence</td>
<td>69%</td>
<td>66%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.68</td>
<td>3.65</td>
</tr>
<tr>
<td>KF19. Organisation and management interested in, and action on, health and wellbeing</td>
<td>3.69</td>
<td>3.62</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.74</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.33</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organization</td>
<td>3.48</td>
<td>3.45</td>
</tr>
<tr>
<td>KF32. Effective use of patient/service user feedback</td>
<td>3.76</td>
<td>3.71</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2017 – results worse than average of acute trusts**

The trust has six key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in the last 12 months</td>
<td>79%</td>
<td>86%</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in the last 12 months</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients/service users</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory, learning or development</td>
<td>4.01</td>
<td>4.05</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organization as a place to work or receive treatment</td>
<td>3.70</td>
<td>3.75</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.87</td>
<td>3.91</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.
The trust scored below the England average for recommending the trust as a place to receive care from December 2016 to November 2017.

(Source: Friends and Family Test)

The friends and family test was reported to the board monthly as part of the integrated performance report. The data was disaggregated between outpatients, inpatients, maternity and the emergency department.
Sickness absence rates

The trust’s sickness absence levels from September 2016 to October 2017 were higher than the England average.

(Source: NHS Digital)

Sickness absence had been identified as a challenge to the trust and we saw evidence that this had been escalated to relevant committees and the board. Senior leaders understood the significance of the issue in terms of the impact on service delivery and finances.

The trust had processes and procedures to address behaviour and poor performance. We saw evidence that action was taken to address behaviour and poor performance regardless of the level of seniority.

The board promoted openness with the public by only discussing business in the private part of the board meeting if there were good reasons for doing so. If board members wanted to add items to the agenda of the private part of the board they had to provide justification, for example because it related to commercially sensitive matters or personnel matters. While leaders were confident that the private part of the board meeting was being appropriately used some of the trust governors felt that some of the issues should discussed in private should have been discussed publicly.

The trust had a policy for the duty of candour requirements. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers. We reviewed a sample of serious incidents which had met the
threshold for the duty of candour and found that in all cases the trust had apologised and written to
the person to let them know what had gone wrong and in four of five cases it had sent, or offered
to send, the report of the investigation. Duty of candour was reported to the quality and safety
committee although was not reported in the monthly board papers.

The trust’s company secretary was the freedom to speak up guardian, with sponsorship from the
workforce and development director and a non-executive director. Freedom to speak up guardians
work with trust leadership teams to create a culture where staff can speak up to protect patient
safety. The role of the freedom to speak up guardians had been created as a result of
recommendations from Sir Robert Francis in February 2015. Awareness of the guardian role and
the current guardian was poor in many areas of the trust we visited. The guardian told us that
there were few approaches, although this may be because there were other existing ways that
staff could raise concerns.

The board had considered actions to develop the role in November 2017, April and July 2018. The
trust had recently established a network of freedom to speak up champions with a focus from staff
from diverse backgrounds and a raising concerns forum with representatives from human
resources, safeguarding and governance to triangulate concerns raised to the trust. The trust also
planned to increase visibility of the guardian by creating a dedicated email address, webpage and
promotion at different events such as staff inductions.

While senior staff were positive about the appraisal process, not every member of staff had an
appraisal. As of 30 April 2018, the trust reported that 79% of staff had had an appraisal within the
last year, which was lower than the target of 90%. The medicine division had the lowest appraisal
rates with 74% of staff having had an appraisal.

The appraisal system was achieving 90% for pharmacy staff. Opinions of staff were obtained via
workshops and staff engagement. Work was being done to increase incident reporting and
develop an open culture to speak up, incident reporting target set to 50% and had reached 46%.
The pharmacy team had developed training sessions and delivered them to wards to support
medicines safety and try to reduce errors.

There were good organisational development opportunities available to staff and a focus on talent
management. The trust offered a range of leadership development programmes to support current
and future leaders. The trust offered management and leadership, coaching and team leading
courses accredited by the Institute of Leadership and Management and leadership development
programmes for band six, ward manager and matrons. The trust had two management
programmes for new and existing consultants to develop future clinical leaders. The trust reported
that this had led to an increase in applicants for clinical director roles with competition for every
role. The trust had a career MOT as part of the talent management strategy to identify rising stars
and create individual development plans. We were told that around 70% of staff who had been
involved in talent management programmes had either been promoted or gained a new job. Staff
were also encouraged to participate in external programmes with three senior leaders completing
the Nye Bevan programme run by the NHS leadership academy.

The divisional team members, both managers and clinicians, were positive about the level of
support they received from their linked finance manager and there were good examples of how
finance had engaged with clinicians on patient pathways to bring about both qualitative and
productivity improvements.

There were opportunities for finance training provided internally by the finance team. The
“operating game” training session facilitated by the finance team was cited as a positive learning
experience and there were other more tailored finance sessions held within the divisional teams.
The senior leaders considered there was good awareness of the financial challenges facing the organisation which was covered in team briefings and staff on the front line would recognise the reality of this position through the controls on discretionary expenditure, effective rostering and the emphasis on avoiding waste and intelligent procurement.

The trust was committed to supporting the physical and mental health and wellbeing of staff. The trust had a dedicated health and wellbeing centre and ran many initiatives to promote health and wellbeing. The trust hosted many activities and groups such as gardening, lunchtime walking, knitting, mindfulness, yoga and Zumba as well as services such as a dedicated staff physiotherapist, mental first aid and since May 2018 a service to support staff involved with unexpected deaths or traumatic incidents. The trust reported that this had led to an improvement in the question about health and wellbeing in the 2017 staff survey.

The trust had an equality and diversity strategy for 2015-18, which was being refreshed at the time of the inspection with a plan to be approved by the board in September 2018. Progress on the strategy was monitored in an annual equality and diversity report against four national goals: better health outcomes for all; improved patient access and experience; a representative and supported workforce; and inclusive leadership at all levels.

The tables below show the diversity of staff at the trust and the responses of staff from a Black and Minority Ethnic in the staff survey to questions about harassment, bullying and equal opportunities:

### Staff Diversity

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Overall (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>79.1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>12%</td>
</tr>
<tr>
<td>Black</td>
<td>1.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>1.2%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

The trust was meeting the Workforce Race Equality Standard (WRES) requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from Black and Minority Ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.
Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 23%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>BME 21%</td>
<td>28%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 23%</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>BME 20%</td>
<td>27%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 86%</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>BME 78%</td>
<td>75%</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 6%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>BME 10%</td>
<td>15%</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF21
- Q17b

(Source: NHS Staff Survey 2017)

The trust was tracking the changes through an action plan and had carried out a deep dive on some of the key findings such as questions about recruitment opportunities and had made changes such as starting a talent management programme for BME workforce. The trust told us that ownership of equality objectives had been devolved to the divisions with support from the trust wide team.

The trust had appointed equality and diversity champions to speak up about equality and diversity issues and provide support to staff. In June 2018 the trust held its first valuing diversity conference with talks from staff about the importance of recognising and celebrating diversity.
In the 2016 General Medical Council Survey the trust performed the same as expected for all of the indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had many initiatives to recognise and celebrate excellence. The trust had an annual awards ceremony, “Our Peoples Awards” which celebrated successes in the previous year. Awards were given to best safety initiative; best innovation; team of the year; unsung hero, chair’s awards, governors’ award and most inspirational persons or team. The trust had a bi-annual staff magazine which included articles about staff members and teams who had won internal and external awards, had raised money for charity or had been involved in other events. The trust had recently launched a “thank you” toolkit following feedback from the staff survey which enabled staff to send thank yous to other staff.

Across the trust we found cooperative, supportive and appreciate relationships between staff in different teams and at different levels. Senior leaders we spoke with were positive about the working relationships between each other.

Governance

There was an integrated governance structure with reporting lines from divisions and committees to the board. The board met monthly and received reports from seven sub-committees: audit committee; finance and investment committee; safety and quality committee; workforce committee; education, training and research committee; charitable funds committee; and appoint, remuneration and terms of employment committee.

All of the committees were chaired by a different non-executive director with relevant experience to that committee, for example the chair of the audit committee had professional experience as an auditor and the chair of the quality and safety committee was a consultant and previously medical director of the trust. The chair of each committee presented a report to the board using a set form with the issues discussed, positive and negative escalation and a copy of the meeting minutes. The safety and quality committee had moved to monthly as it was identified as a priority for the business. We reviewed the papers from the recent committees and saw that attendance was generally good across the committees, apart from the quality and safety committee. In four of the five first meetings in 2018 fewer than half of the members had attended meetings.

The finance and investment committee was comprised of all board members and was the key scrutiny committee of financial and operational performance. A review of the minutes of the committee indicated a level of challenge and enquiry from the non-executive directors. The non-executive directors could outline to us the scrutiny applied to financial performance and to investment decisions such as additional nurse staffing. They considered there was better grip on the pay bill in 2018-19 coupled with an indication of improvement in a number of patient flow performance measures such as delayed transfers of care (DTOC) and length of stay, albeit recognising there was more work to do.

The effectiveness and terms of reference of sub-committees were reviewed annually by the members, led by the company secretary. The company secretary led workshops using an impact assessment tool adapted from a tool used by the internal auditors to check the effectiveness.
As well as processes to escalate issues to the board, the board had a standing agenda item to escalate issues beyond, to the board to health economy forums.

The trust had just developed an accountability oversight framework to ensure that a coherent set of performance indicators were systematically monitored and managed. The framework set out the board and divisional responsibilities. The indicators covered six areas: safety; quality; operational excellence; workforce and leadership; finance; and strategy. The framework set out the process for each area to be risk rated, on a monthly basis, and aggregated to allocate an overall risk rating to division and corporate team. These scores determined oversight and intervention from executive board members, with divisions gaining greater autonomy if scores were lower. At the time of the inspection the framework had only recently been implemented and had not yet been embedded into practice.

In December 2017 the trust had reviewed the governance structures in the divisions and had created an action plan. The work had continued with the appointment of a new governance director although changes had already been made to increase standardisation and consistency. The review had looked at a wide range of areas including structure, meetings, resource and information. Following the review, the trust had developed standardised monthly governance reports for divisions and in July 2018 introduced governance key performance indicators. In the core service inspection, we found that some of the changes had recently been made and were yet to be fully embedded in every area.

There was an established monthly performance review process with the divisional teams chaired by the chief executive which had evolved to reflect the recent changes to strengthen governance arrangements within the operational processes of the trust. These included the revised accountability oversight framework underpinning a standardised approach to divisional performance reviews using a RAG (red, amber, green) rated scorecard; the refreshed integrated performance report linked to good practice guidance to ensure coverage of all critical metrics; enhanced focus on workforce controls including premium rates, bank fill rates, sickness and refocus on hard to fill vacancies; and the review of the divisional structures currently on going to strengthen clinical leadership.

Currently there were separate roles of governance director, transformation director and continuous improvement director which had the potential for duplication and confusion. The trust recognised this and work was in hand to streamline the roles into a centralised programme management office arrangement.

The divisional teams were engaged in the budget setting process and held budgets for both income and expenditure and understood the critical interdependencies and the importance of achieving activity targets given the majority of the trust’s clinical income was earned under payment by results (PbR).

There was a business case approval process although the trust recognise was a need for streamlining as it was a cause of some frustration with the divisional teams. The recent completion of the sustainable care pathway work under Our Health, Our Care, coupled with a soon to be completed service portfolio review, would provide clarity on strategic priorities and improve this process going forward.

The trust’s governance team held a weekly case review meeting to review incidents, complaints, duty of candour and any other issues which divisions needed to escalate. Divisional representatives attended the meeting, including nursing, governance and clinical leads.

There were clear lines of communication between meetings which provided governance and oversight of medicines safety. We were told that an external medicines review had been
commissioned to look at medicines governance across the trust. The medicines safety officer was integral in increasing the error reporting and was currently working with all wards and departments to develop an innovative medicines safety champion for each area to increase engagement and ownership at ward level for medicines safety.

The trust had made changes to the management of cost improvement programmes which had previously been overseen by the programme board but were now led by the divisions, with support from the cost improvement delivery team. The trust had a process of quality impact assessment which was approved by the nursing director and medical director to ensure that any cost savings had no negative impact on patient care.

The trust had recently commissioned an external independent review of the leadership and governance of the trust using the well-led framework used by Care Quality Commission (CQC). Ahead of the review the board had completed a self-assessment against all of the well-led domains. The report had been shared with the trust shortly after the inspection.

**Management of risk, issues and performance**

The trust had a recently reviewed risk management strategy which set out the approach to managing risk at the trust. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the consequence. All risks were assigned a risk rating and controls, assurances and actions recorded. Risks were recorded on local, divisional or corporate risk registers depending on the current rating. If a risk scored 15 or higher it was recorded on the corporate risk register. Risks were all recorded on a case management system that all staff had access to.

Risks were monitored by the risk management committee which reported to the board and was chaired by the chief executive. The committee reviewed the high and significant risks of divisions and the committee was the conduit by which risks were escalated and de-escalated and mapped through to the board assurance framework. Risks on the board assurance framework were also reviewed by the relevant sub-committee and the board. This process was well understood by the divisional teams although they recognised there they needed to ensure operational risk registers were cleansed and validated in a timely manner.

The trust has made good progress in using its risk management system as a central repository of information on key risk issues. It had also developed a standardised format for divisional risk reporting including a suite of standard key performance indicators. As this had only recently been started it is not yet fully embedded.

At the time of our inspection the corporate risk register had 166 open risks with a score of higher than 15. A large number of the actions assigned to mitigate risks had not been completed by the due dates and not all of the risks recorded in the medicine division had any actions recorded to mitigate the risks, with one risk which was added in December 2017 having no action plan. The risk register only recorded the current risk rating, which appeared to be the initial risk rating before controls and actions were in place. Risks did not have a target risk rating which was a requirement set out in the risk management strategy. As the risk register did not record changes in risk ratings, it was difficult to monitor the effectiveness of controls and the impact on risk ratings. Descriptions of risks were not always clear and in line with the risk management strategy which gave guidance on how risks should be described.

Not all of the more serious risks we identified during our core service inspections, for example the understanding and application of the Mental Capacity Act were recorded on the corporate risk
register, which meant the risk management and board sub-committees did not have oversight until we raised them with the trust. Other risks that we had identified, such as the treatment of children at Chorley and South Ribble Hospital had not been mitigated to reduce the risk rating.

Board members and other senior staff we spoke with accepted that there were a large number of high level risks on the risk register. We were told that this meant committees of the board had oversight and the risks were discussed at the risk management committee. However, by giving risks higher scores to enable more detailed executive scrutiny may inhibit the trust from having a true picture of the risks.

The trust told us that the governance team were currently reviewing how lower risks were monitored to ensure that trends were identified and escalated where appropriate.

The trust had a board assurance framework which recorded the key risks which could impact on the trust achieving its strategic objectives. Risks on the board assurance framework reflected the risks senior leaders articulated to us told us which included sustainability, workforce and performance.

**Board Assurance Framework**

The trust provided a document detailing the 16 risks on the board assurance framework at the time of the provider information request.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1292148</td>
<td>Adherence to the agency ceiling introduced by NHSI may lead to the inability to fill key posts which may impact on patient safety, delivery of key targets and continuity of services (capacity and finance activity).</td>
<td>25</td>
<td>8-12</td>
</tr>
<tr>
<td>1292691</td>
<td>The risk of external cyber-attack on such a scale and nature to pose a risk to the Trust’s business continuity.</td>
<td>25</td>
<td>8-12</td>
</tr>
<tr>
<td>2050</td>
<td>The Trust is in financial deficit and in breach of its licence conditions. The Trust has provided enforcement undertakings to NHS Improvement, non-achievement of which will result in further formal regulatory action. The Trust has a challenging £34 million PET programme for 2017/18 and the Trust is committed to meeting its 2017/18 control total. The risk to the Trust's financial sustainability may impact on standards of patient care, the Trust's reputation, staff engagement and morale.</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>2195</td>
<td>High levels of bed escalation and occupancy are impacting on quality of care and our ability to discharge in a timely way, which may present a patient safety risk and a risk of sub-optimal patient experience, staff retention and staff training compliance.</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>2051</td>
<td>The supply of consultants and doctors in training in specialised roles is insufficient to implement plans for service concentration and growth and the high levels of vacancies is putting pressure on rota and EWTD compliance.</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Score</td>
<td>Time</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>1292168</td>
<td>The financial position of the Trust (and breach of its licence conditions) has resulted in a reduction in operational capital availability (for 2017/18). If this restriction is carried over into future financial years the Trust will run increased risk of operational failures in relation to its equipment and buildings, which will affect business continuity, patient safety and income.</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>1292133</td>
<td>Strategic Capital: The Trust has an ageing estate (40 years plus); its facilities are not sized to deliver capacity for the current demands placed on it and are not organised in an efficient manner; approximately £22 million is locked into the revenue base as a direct consequence of poor utilisation of the space. If we are unable to make progress in the redevelopment of the Trust's estates plan (as a consequence of our financial constraints) then we will not realise the cost reductions but also patient pathways and experience will continue to suffer as the buildings deteriorate. Additionally, if capacity growth is required in critical clinical areas there is limited ability to expand due to the congested nature of the RPH site and constraints on finances. Highest risk issue is Critical Care and the ED Capacity.</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>1292319</td>
<td>Corporate safety systems for fire safety auditing, fire safety training, health and safety auditing and Control of Substances Hazardous to health (COSHH) that have been found to have weaknesses in historic practices potentially causing the Trust to breach statutory duties</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>1292175</td>
<td>Current configuration of Quadramed limits our clinical pathway functionality and does not have an ability to run multiple clock stops and starts through clinical pathways. As a result, current 18 week incomplete RTT and CDS reporting is potentially inaccurate or incomplete and manual validation checks have to be made. This presents a patient safety risk, as patients may be left longer than required on their pathway or may be lost to follow up.</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>2292</td>
<td>If we are unable to recruit and retain the required number of nurses, midwives and AHPs it will impact on the delivery of quality services, patient and staff experience of care.</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>2053</td>
<td>If we are not able to deliver against the targets and indicators set within the Regulation and Compliance frameworks (including NHSI, CQC), this may lead to poor patient experience, outcomes and further regulatory action. Specific high risks for 2017/18 are: • Four hour standard • Cancer 62 day target • C-Difficile target • 18 week referral to treatment target • Finance</td>
<td>20</td>
<td>8-12</td>
</tr>
<tr>
<td>1292521</td>
<td>In seeking to implement seven day services, the Trust is at risk of destabilising its services by stretching capacity which could impact on clinical outcomes, patient experience and staff morale.</td>
<td>16</td>
<td>8-12</td>
</tr>
<tr>
<td>2407</td>
<td>There was an increase in the number of never events and near misses reported during 2014/15 and 2015/16. Whilst there has been a reduction during 2016/17, there is still a</td>
<td>16</td>
<td>8-12</td>
</tr>
</tbody>
</table>
risk (albeit reduced) to patient care and experience and reputation of the Trust.

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Description</th>
<th>Likelihood</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1292079</td>
<td>If the Our Health Our Care programme is unachievable we will have an ongoing resilience risk to acute services.</td>
<td>15</td>
<td>8-12</td>
</tr>
<tr>
<td>1292503</td>
<td>Risk of not delivering a sustainable emergency department service across both sites.</td>
<td>15</td>
<td>8-12</td>
</tr>
<tr>
<td>2061</td>
<td>System resilience is put at risk by the ineffectiveness of health economy forums to provide health economy wide solutions to deal with the demand.</td>
<td>8-12</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Board Assurance Framework)

The board assurance framework included the risk type, owner, board or sub-committee, linked strategic objective, controls, assurances and gaps in controls and assurances. For each risk a current and target score was given based on likelihood and consequence. At the time of our inspection there were 19 risks on the board assurance framework (three had been added since our provider information request). We saw evidence that the risks were reviewed by the sub-committee which owned the risk and the overall framework was reviewed by the risk management committee each month and every quarter at the board. Of the 19 risks on the board assurance framework only two were linked to strategic objectives, the others listed strategies, some of which were no longer used by the trust.

There were many high scoring risks on the board assurance framework some of which had been on the framework for many years, without evidence of movement and the impact of remedial action. This may indicate that the controls and assurance identified may not be effective in reducing the risks.

Senior leaders told us that there had been momentum in the action taken to address issues around performance in relation to access and flow, which was identified as one of the main challenges facing the trust. This had been attributed to the trust taking ownership for the performance, better working with external partners and the development of the continuous improvement team.

The pharmacy manufacturing unit was captured on the trust risk register, however, though mitigation was implemented this was not sufficient to prevent partial suspension of manufacturing licence by the Medicines and Healthcare products Regulatory Agency in June 2018. We were given assurance that an action plan was in place to address concerns, however, in the interim only limited manufacturing was permitted to be carried out on site and all other items were purchased. Though the trust had a selection of stock items, a lack of pharmacy manufacturing unit meant that the trust was less responsive to change in patients’ needs for bespoke products. The clinical team were meeting weekly and the incident management system was being used to capture impact.

The trust had a systemic programme of clinical and internal audit to monitor quality and processes. There was a risk-based approach adopted in setting the annual internal audit plan with oversight provided by the audit committee, with input from the nursing and finance directors to ensure that it was a balance of quality and financial audits and reflected the current priorities. The trust recognised there was a need to strengthen assurance on the implementation of internal audit recommendations and a tracking process was being implemented.

The trust had an annual clinical audit and effectiveness plan for the year which incorporated national audits, corporate audits, audits for the trust wide priorities, audit of national guidelines as
well as other audit priorities. The plan was approved by the clinical governance committee for the year ahead and reviewed by the audit committee.

Business plans were agreed annually at divisional level with key targets, objectives and service developments. Performance of divisions was monitored through monthly performance review forums with executives.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£436m</td>
<td>£464m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£29m)</td>
<td>(£15m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£465m</td>
<td>£479m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£34m)</td>
<td>(£15m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

There was a significant deterioration in financial performance during 2017-18. Against a planned control total deficit of £20m there were further in year financial pressures relating to medical and nurse staffing, a shortfall on the delivery of the efficiency and productivity programme along with additional costs associated with staffing the emergency department at Chorley and South Ribble Hospital. This resulted in the increased deficit of £42m in 2017-18. To provide cash flow the trust was in receipt of interim loan funding of £90m and this was expected to increase in 2018-19.

The financial performance of the trust was of concern having posted deficits and failed to achieve its financial control total in each of the last two years. A deficit of £46m was forecast for 2018-19 with a heavy reliance on distress funding to maintain adequate cash flow. Financial risk and the sustainability of the organisation featured as a significant risk on the board assurance framework and was subject to regular review through the board and finance and investment committee.

The trust was under NHS Improvement enforcement undertakings related to the potential breach of its license to operate on the grounds of financial stability. The trust has been required to appoint a turnaround director who has recently taken up post, was required by 31 July 2018 to submit to NHS Improvement a board approved diagnostic of its underlying financial position and by 31 October 2018 to agree a revised financial plan with NHS Improvement. At the time of our well led assessment the trust reported it was on track with these requirements and the financial diagnostic was in the process of being finalised by the board.

The finance report to the board contained a detailed financial risk log, however, there was no assessment of the probability of these risks materialising.

The trust had a programme of cost improvement plans to attain financial benefits from making changes. In 2018-19 the trust planned to derive a financial benefit of £25 million from cost improvement plans.
Information management

Performance was reported to the board in an integrated performance report which included a range of metrics covering quality, safety, performance, workforce and finance. The report used RAG (red, amber, green) ratings and sparklines (graph to plot trend) to demonstrate performance against agreed targets and over a period of time. The performance report had a good mix of quality, performance and financial measures. The performance report included the views of patients with friends and family test and complaints reported. The integrated performance report had recently been refreshed to ensure it was in line with good practice in terms of its coverage and presentation.

The integrated performance report was mirrored in the divisional performance review forums which used the same metrics set out in the same format but with relevant data for the division.

The finance report provided coverage of income and expenditure, balance sheet and capital programme along with a risk log. It was focused on the current period and year to date performance. However, it did not include any information about forecast/trend analysis, sensitised risk assessment or coverage of remedial actions being taken to address adverse performance.

There was a regular suite of reports covering performance on the efficiency and productivity programme although this did not cover what was being done to mitigate high risk and/or unidentified schemes.

The trust had made good progress with a range of business intelligence tools to provide timely and relevant information in areas of key operational challenge. The trust was using real time electronic boards for monitoring patient flow which were located in the operations hub and outside the executive offices. The trust also used a software package to enable staff to review relevant performance on their desktop with an easy access drill down tool. The trust was also rolling out a number of applications (apps) to enhance access to real time information.

The divisional teams reported that they considered they received finance and other performance information on a timely basis and in a growing number of areas they could track performance on a real-time basis.

Service line reporting was established within the trust and there was evidence through the divisional reporting structures and through the committees as to how this was being used to drive productivity improvements. There was a focus on the top 15 loss making services.

The trust was developing a quality and safety heatmap which will triangulate patient safety and quality metrics with staffing data at ward level. By using RAG (red, amber, green) ratings this will be used as a tool to monitor the performance of wards or clinical areas and identify if there are links to staffing. The heatmap was being presented to the clinical governance meeting in August 2018.

The trust had processes to ensures performance information was accurate, valid and reliable. The trust had a data quality assurance team to validate data entered into the patient record and other systems. Data quality reports were reported to the board twice a year and data quality assurances were built into the integrated performance report. The trust intended to carry out a review of business intelligence in 2018-19 and would be reviewing the business intelligence report and the business intelligence strategy. The team carried out internal audits of a sample of key performance indicators each year to ensure they were correctly recorded and reported.
The trust held two board workshops for board members on reviewing the integrated performance report to support effective challenge of the information presented.

At divisional level the trust had developed the use of information systems to monitor and improve quality of care, such as the use of electronic prescribing and medicine’s administration (ePMA) on four wards and the use of electronic recording of vital signs in surgery at Royal Preston Hospital and all areas of Chorley and South Ribble Hospital which had reduced documentation errors, improved audit and other clinical measures. The trust had also used an electronic clinical reporting programme which the trust said had improved quality markers and saved 2,500 of clinician time.

Full electronic prescribing and medicine’s administration (ePMA) implementation remained dependent on finances, ePMA had been piloted on four wards at the Preston site and a business case was due to be submitted to support further roll out of this to all areas. There was a dedicated ePMA pharmacist to support this project.

The trust was awarded level five by the Health Information and Management Systems (HiMMS) which is higher than the average score for other UK healthcare organisations. It is an eight stage (zero to seven) model which measures the adoption and utilisation of electronic medical record functions. The trust had also received above average results in all parameters in the peer review digital maturity assessment.

The trust was affected by the NHS wide cyber-attack in 2016 and had recorded cyber security as a risk on the corporate risk register and the board assurance framework. The trust had received positive assurance from internal audit about its security measures in April 2018. The trust had established a cyber security strategy and action plan overseen by a monthly cyber security committee.

The trust had recently standardised the use of the reporting system used, so all incidents, risks, complaints which were previously not all reported on the same system. Following an external review of the use of the system, the trust had identified improvements, such as the central monitoring of complaints and the completion of the action plans through the reporting system which is reported at divisional governance meetings and the quality and safety committee.

The trust received assurance for information governance through board reports, internal audit reports and the completion of the information governance toolkit. The trust had completed the information governance toolkit for 2017-18 and self assessed as satisfactory in every area. Data quality was reviewed as part of the annual quality report.

The trust was aware of its role to responsibilities under data protection legislation. In the last year it had reported two incidents to the Information Commissioner’s Office in relation to a breach of data protection due to printed material from handover meetings not been securely disposed of.

The board had monitored the trust’s progress to be compliant with the General Data Protection Regulations. The trust sought an external assessment to support compliance with the regulations and recognised that there were some areas still to complete.

Engagement

In February 2018 the trust launched a patient experience and involvement strategy for 2018-2021 with four aims: deliver a positive experience; improve outcomes and reduce harm; create a good care environment; and improve capacity and patient flow. The strategy was developed following focus groups and engagement with more than 3,000 patients from different communities. The trust had a patient experience improvement group which included 40 representatives of patients,
carers, governors and young people which monitors whether the objectives of the strategy were being met and was involved in reviewing information about changes and initiatives such as the carers charter and new telephony services. The group reports to the board with an annual patient experience report.

The trust was committed to gathering the views and experiences of people who used the service or lived in the local areas and may use services in the future.

The trust used the friends and family test and patient surveys to gather information about the experience of service users. The trust had a patient voice item at the start of every board meeting. This was an opportunity for a patient or staff to present a patient story, whether positive or negative, and to explore the experience and any actions which had been taken. The non-executive directors gave us an example of when they had asked for an investigation into some of the issues raised on a patient story which had been shared at a later board meeting.

The trust led and contributed to events in the local area to engage with patients, promote the services offered and seek patient views. This included events with hard to reach groups and people with additional needs. The trust had recently had celebrations at both sites for staff and members of the public to celebrate seventy years of the NHS. During the year the trust participates in a number of Health Mela events with the local community, with support from staff members and governors. The focus of the events is to promote health and wellbeing, with talks from key influential stakeholders, stands and health MOTs.

The trust held an annual day for patients with learning disabilities to share experiences and to gather feedback to design service provision. The most recent day had a focus on end of life and bereavement following feedback from attendees. The trust had also recruited learning disability nurses in the medicine and surgery divisions to support patients with learning disabilities.

In April 2018 the trust opened a LIFE centre (learning inspections for future employment) to educate young people from the age of five and promote a career in healthcare. The centre has a mocked-up ward area, mobile educational unit, augmented reality training and virtual reality headsets in a cinema.

The chaplaincy team engaged with local faith groups in the Preston and Chorley areas to promote partnership working between the team and local faith communities.

The trust was currently developing a transgender policy to support the needs of transgender patients.

The trust had arranged a one-day cricket tournament to raise awareness of cancer and the important of early intervention, particularly amongst BME men and to support people affected by cancer.

The trust used people’s views and experiences to shape and improve the services provided by the trust. People were engaged in the production of new strategies such as the patient experience and involvement strategy. The trust was holding sessions at the time of the inspection about the Our Health Our Care programme.

The trust was involved in the patients as educators programme, where service users become involved in training and educating the medical workforce by sharing their experiences of being patients and the quality of care received. The trust also worked with a National children’s charity to engage with children who used the service in the recruitment of senior staff in the children and young people’s services.
The trust had an active group of 30 governors made up of members of the public, members of staff and representatives from public organisations and NHS partners. Governors worked closely with non-executive directors and had joint development workshops and meetings. Governors had an induction and eight sessions a year about their role and the trust and were involved in different trust groups and the STAR accreditation scheme. Governors had an annual forward planning event to feed into the business planning for the following year. The trust was looking to revise the constitution to enable the appointment of a youth governor to represent the interests of children and young persons. The governor had been appointed in shadow form in November 2018 prior to becoming a governor.

As a foundation trust the public and staff can become members of the trust to influence decisions and become elected to the council of governors. The trust held an annual meeting for members of the trust and sent bi-annual magazine featuring articles about the trust and updates from the governors.

The trust used its website, online videos and social media to engage with the public and keep them informed. The trust regularly posted information about staff, success and events. The trust published a corporate calendar on website which had details of all board and committee meetings throughout the year.

The trust acknowledged that it was not yet meeting the accessible information standard. The accessible information standard aims to make sure that people who have a disability, impairment or sensory loss receive information that they can easily read or understand and get support so they can communicate effectively with health and social care services. The trust was acting on this to ensure patients who needed support were identified on the IT system.

The trust actively engaged with staff so that their views were taken into consideration when changes were made. Staff were consulted, alongside members of the public, with the development of strategies such as the nursing, allied health professions and care givers strategy.

Senior managers and clinicians were positive about the opportunities afforded to them to contribute to the workstreams involved in the formulation of the local health system strategic direction Our Health, Our Care. There had been strong clinician involvement in the future model of care pathway work.

The trust had developed processes to engage with junior medical and nursing staff. The trust executives had a quarterly meeting with junior doctors to listen to their feedback and concerns. Leaders were positive about his forum and were looking to start a similar forum for middle grades doctors. The nursing director also connected with the student forums and welcomed all new student nurses to the trust.

The trust ran ‘Big Conversation’ events to seek the feedback and views of staff. In response to the 2017 staff survey the trust held ‘Big Conversation’ events at team, divisional and trust levels. The purpose of the events was to share the results of the survey, discuss staff experience and to identify actions and areas for improvement. The trust had fortnightly fabulous feedback Friday events where senior staff visited an area of the trust who had a chance to showcase good practice and share the challenges.

In June 2018 the trust held its first valuing diversity conference with talks from staff about the importance of recognising and celebrating diversity. Ongoing engagement with staff with staff with protected characteristics was enabled by the appointment of equality and diversity champions throughout the trust.
Leaders all told us that relationships with the local clinical commissioning group and other stakeholders in the local health economy had improved and developed significantly within the last year. The chief executive and other leaders were actively involved in system wide forums, such as being members of the integrated care partnership board and leading the A&E delivery board. In addition to formal meetings the chief executive held weekly meetings with system leaders including the accountable officer at the clinical commissioning group and chief executive of the local NHS mental health and community trust.

The trust had worked with and been involved in events with other local partners, such as events to improve flow, discharge from hospital and patient experience.

The trust was working with other health economy partners including the clinical commissioning group, the local NHS mental health and community provider and other partners to deliver future developments and improvements in health and social care, specifically with the Our Health Our Care programme. We were told that there had recently been improvements with relationships with the clinical commissioning group which had enabled momentum with the programme.

The trust was developing their relationships with Quality Control North West (an NHS organisation that provides research and scientific services), in support of the pharmacy manufacturing unit. There was good representation from the team at regional and national groups, for example the national association of pharmacy technicians and the regional chief pharmacist meeting providing the opportunity to share lessons learnt look at vision and strategy.

In February 2018 the board carried out a stakeholder mapping exercise to review the relationships with external stakeholders. The trust was also planning to develop a corporate communication strategy.

The trust also had links with other hospital trusts across the region through networks such as the North-West governance, assurance and risk network where good practice and learning could be shared. The trust was also a member of a regional quality organisation, which supported member trusts with implement quality improvement programmes and initiatives.

**Learning, continuous improvement and innovation**

Leaders and staff at all levels were positive about continuous learning, improvement and innovation. This was supported by the trust’s strategic aim to drive innovation through world-class education, training and research and the new continuous improvement strategy.

The trust had a strong focus on education and research. The trust had a modern healthcare academy centre which offered a range of education, training and development programmes to staff at the trust and from across the region. The trust was the first to set up a non-commissioned nursing degree and had been rated as one of the top 100 apprenticeship employers in 2017 with over 200 apprentices in post. The trust offered a wide range of simulation training in a dedicated simulation unit.

The trust developed and used videos as part of its blended learning programme. The trust had filmed a series of films about 24 hours in maternity which had been nominated for a national film award and was shortlisted for a national award for excellence in organisational development award. The trust was planning to follow this up with a series about 24 hours in theatres.

The trust supported the development of a clinical research facility in partnership with the local NHS mental health trust and a local university. The facility gained National Institute for Health Research status within the previous year. The trust was also one of the founder members of a
commercial organisation across the North of England helping companies and organisations globally to access the expertise in teaching hospitals and universities across eight cities.

The trust was involved in a range of clinical trials which is managed through five themes: cancer; chronic conditions; neurosciences; trauma and acute care; and women and children. At the time of the inspection there were more than 150 actively recruiting research studies with the trust exceeding the target of recruiting 2,200 patients to clinical trials.

The trust had been the lead UK site on internationally recognised research projects on the impact of chemotherapy after surgery for cancer of the upper urinary tract. The trust had also invested in a robot for surgery in 2017, with around 250 procedures in the first year, and had recently recruited the first patient in an international clinical trial to improve the outcomes of patients having minimally invasive surgery for rectal cancer. The trust, in collaboration with a local university, had developed an innovative design for new tracheostomy with a patent pending. The trust had an innovation pathway to assess and progress innovations.

The trust had recently developed the approach and commitment to continuous improvement with the appointment of a director and head of continuous improvement in December 2017 and the development of a continuous improvement strategy. We were told that staff across the organisation were trained in recognised continuous improvement methodology as part of the leadership development programmes and the continuous improvement team were beginning to enable and support staff with improvement projects across the organisation. The team and strategy would ensue a systematic approach to continuous improvement across the trust.

Board members had carried out a visit to an outstanding rated NHS trust to seek learning and advice about their approach to continuous improvement.

The trust had identified that all staff needed to be equipped to deliver continuous improvement in their daily work, so the new strategy included an objective to offer training to all staff which will be incorporated into existing leadership and development programmes offered by the trust.

In the six months before the inspection the focus of continuous improvement had been on improving flow across the trust and performance in the emergency department, which leaders identified as one of the biggest risks and challenges to the organisation. This work had been completed with support from the NHS Improvement emergency care improvement programme. The continuous improvement director had led a diagnostic review with an action plan to address ‘quick wins’. The trust had led a value stream analysis with system partners for the redesign of pathways for urgent and emergency care. In the first six months of 2018 there had been a number of changes such as the SAFER initiative to improve timely discharge, integrated discharge teams and an ambulatory care model, although the improvements were yet to be recognised at the time of our core service inspection. The next area of focus was on improvements to the paediatric pathway, with an event for system wide partners being held shortly before the well led assessment.

Through the continuous improvement programme there have been some early wins in bringing about improvements in patient flow, with benefits for patient safety and more effective use of resources, for example, reduced premium workforce costs in respect of escalation beds. However, more work was required on patient flow and the trust recognised this.

The trust was making use of model hospital to benchmark its performance, although getting it right first time (GIRFT) had been less well used. The trust had recently mobilised learning events for clinicians with relevant experts and would build this into the continuous improvement plan.
The trust had developed a safety triangulation accreditation review (STAR) quality assurance framework to monitor and assess standards in clinical areas across the trust. The accreditation visits gained assurance in 14 categories and gave a red, amber, green rating which determined the revisit frequency. Areas were awarded white, bronze, silver and gold stars to celebrate improvements and sustained performance. At the time of the inspection the framework had been used for a year and the first revisits had recently taken place. Staff and managers were positive about its use as a tool for monitoring quality and leading to improvements. The trust had carried out an internal audit of the process and received significant assurance.

The trust hosted an annual ‘Dragon’s Den’ style competition called Lancashire Lair, where staff can present ideas for change and our executive team panel choose which ones to invest in. Previous pitches selected included a plan to makeover the parent facilities and staff room in the neonatal intensive care unit, which was delivered in collaboration with interior design students from the local university.

Following the CQC inspection in September 2016, stakeholders across the health economy, led by NHS Improvement, set up an improvement board to monitor and implement improvements identified in the report. The trust had formulated a quality improvement plan which set out the actions required to address all the issues in the report set out under nine themes: staff development and engagement; medicines management; harm free care; governance; staffing; environment; patient flow; and audit. Since January 2018 the interim governance director had provided a monthly board report setting out progress against the actions, this was following feedback from the board that they were not getting the level of assurance required. The improvement board was now chaired by the continuous improvement director and had moved from a focus on delivery of the action plan to thematic deep dives in key areas of improvement such as safe staffing, training and flow.

The trust shared learning with staff in different ways. The trust had a monthly patient safety bulletin, monthly lessons learned email and lessons learned was a standard agenda item on divisional meetings. Since January 2018 the trust had published a monthly newsletter setting out progress against the nine themes set out in the quality improvement plan and reminders for staff involvement in the improvements, for example completion of mandatory training.

The trust had updated its mortality review and learning from deaths policy in December 2017 so it was compliant with the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 CQC report ‘Learning, candour and accountability’. The learning from deaths guidance required NHS trusts to produce and publish an updated policy on learning from death. We saw evidence of progress being monitored by the clinical governance committee, so the trust was reviewing deaths in line with the guidance.

During the inspection we reviewed a sample of serious incidents and found they followed an appropriate process, identified and investigated the key issues, set the root causes and identified learning. In the incidents we reviewed there was no evidence of the involvement of patients and their families.

The trust had used learning from never events involving the misplacement of a nasogastric tube to develop an innovative training package to doctors and other clinical staff. The programme led by a nurse consultant, including an e-learning package, had received National recognition and had been shared with other providers.

The trust had increased its number of prescribing pharmacists to 43% and was working to support enhanced roles for other team members, such as medicine management technicians administering medication and medicine management assistants being supported to have an
extended role on the wards. A business case was being prepared to enable a PhD student to review the ward based services. The pharmacy team had won tech project of the year 2017 for the ePMA project from a health technology newspaper.

The trust explained the process for identifying, reviewing and acting on any external reviews, external reports or National or regional concerns relevant to the trust. The process was monitored by the governance team with all information recorded on the incident and case management system.

In 2017 the trust had commissioned a cultural review to explore the perceptions of senior managers about culture to analyse what was driving the culture, the review identified themes from interviews and focus groups with senior leaders.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>35</td>
<td>85%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Following the inspection, the trust provided information that in June 2018 the performance was for completing complaints within 35 days was 100%.

Number of complaints made to the trust

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Complaints</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Outpatients</td>
<td>143</td>
<td>29%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>110</td>
<td>22%</td>
</tr>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>86</td>
<td>17%</td>
</tr>
<tr>
<td>AC - Urgent and emergency care</td>
<td>81</td>
<td>16%</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>7%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>16</td>
<td>3%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>12</td>
<td>2%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>11</td>
<td>2%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>
The trust received 497 complaints from April 2017 to March 2018. Outpatients received the most complaints with 143.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Following the inspection, the trust provided information that between April and June 2018 there had been a total of 533 concerns and only 9 of these became formal complaints.

We reviewed a sample of complaints from across the trust and found that the level of investigation was suitable for the complaints raised with appropriate response from the chief executive. The trust explained where things had gone wrong and created action plans were applicable. Where there were opportunities for shared learning this was incorporated into the action plans.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>October 2017</td>
</tr>
<tr>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td>October 2016</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Microbiology 8545 21/9/16; Biochemistry 8549 29/9/15; Cellular Pathology 8544 26/9/16; Immunology 8547; Haematology/Transfusion 8548 24/11/17</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

Staff and teams from the hospital had been nominated for many national awards and received national recognition for initiatives and work at the trust. Within the last year this included nominations and recognition for the ‘EndPJParalysis’ campaign, theatre cap challenge, work on nasogastric tubes, and cancer and tracheostomy clinical trials. Teams and individuals had also been nominated awards for cancer nursing, clinical photography and video, anaesthetic care, improvements to emergency care for upper gastrointestinal patients, cancer pathways and for excellence in organisation development.

The finance team had achieved Finance Staff Development (FSD) Level 3 which is an indicator of a high performing team and had achieved recognition for the good standard of costing and progress with service line reporting.
Urgent and emergency services are provided by the trust at the Royal Preston Hospital and at Chorley and South Ribble Hospital. Between 1 February 2017 and 31 January 2018, 91,272 patients attended the trust’s emergency departments, of which 15,790 were children aged 17 years and under. On average, during this time, 250 people per day attended the departments. The emergency department is part of the trust’s acute medicine directorate.

At the Royal Preston Hospital, the urgent and emergency service operates 24 hours a day, seven days a week. The emergency department is a major trauma centre, accepting adult patients with more severe injuries following trauma. These patients may be brought to hospital directly following the incident, or transferred from other hospitals. There is a helipad on site.

The department does not provide major trauma care for children. Instead more severely injured children are taken by ambulance or helicopter to a regional children’s hospital if their condition allows them to travel. If not, they are stabilised and treated or transferred in line with their needs.

There is a designated entrance for patients brought in by ambulance, who wait to be triaged in a designated cubicle or the main corridor before being assigned to a suitable area.

Ambulatory patients attending the department are either accepted and registered into the department or referred to the neighbouring on-site urgent care centre depending on the conditions and symptoms they are presenting with. The urgent care centre is operated by another healthcare provider and was not inspected as part of this inspection.

Following triage, patients receive care and treatment in one of four main areas: the ambulatory care unit, the minor injury/illness unit, the majors unit, or within the resuscitation bays.

People with minor illnesses or injuries are assessed and treated in one of ten bays. People with more serious illness or injury are seen and treated in the ‘majors’ area which has seven bays or in one of four resuscitation bays. One of the resuscitation bays and a cubicle in the major’s area are both suitable for children.

One resuscitation bay is assigned as the major trauma bay. This is situated directly behind a designated computed tomography (CT) scanner room.

A separate ambulatory care unit also provided care for suitable ambulatory patients, which were identified from the cohort of patients waiting to be seen.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We spoke with three patients and carers and 42 staff, including the departments senior leaders, doctors, nurses, emergency and advanced nurse practitioners, health care assistants, reception and domestic staff. We also reviewed 21 patient records and observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Facts and data about this service

Urgent and emergency care services at the trust are delivered at the following locations:

- Royal Preston Hospital
- Chorley and South Ribble Hospital

(Source: Trust Routine Provider Information Request)
Activity and patient throughput

From April 2016 to March 2017, there were 130,941 urgent and emergency care attendances across both sites at the trust. This can be compared to the number of attendances at other trusts in the table below, with this trust being represented by a purple bar.

Total number of urgent and emergency care attendances at Lancashire Teaching Hospitals NHS Foundation Trust compared to all acute trusts in England.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

As can be seen in the chart below, the percentage of A&E attendances at this trust that resulted in an admission decreased from 2015/16 to 2016/17. In both years, the rate was lower than the England average.

(Source: NHS England)
In addition to this admission data, a breakdown of attendance by disposal method can be seen in the chart below for the reporting period of January 2017 to December 2017.

**Urgent and emergency care attendances by disposal method, January to December 2017**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,901</td>
</tr>
<tr>
<td>Discharged*</td>
<td>44,256</td>
</tr>
<tr>
<td>Referred*</td>
<td>17,252</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>542</td>
</tr>
<tr>
<td>Died in department</td>
<td>200</td>
</tr>
<tr>
<td>Left department*</td>
<td>3,119</td>
</tr>
<tr>
<td>Other</td>
<td>166</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff; however, training completion compliance levels, including life support training, were consistently lower than the trust target of 90%. This meant that the service could not assure itself that staff providing care and treatment had the competence, skills and experience to do so safely.

Mandatory training was specified by the service as including fire safety (repeated every two years), health and safety (slips, trips and falls), infection prevention level one, and information governance. Additional role specific training was provided and monitored and included medicines management, moving and handling (clinical) adult and paediatric basic life support, and the Prevent Strategy.
**Nursing staff**

From March 2017 to February 2018, the service reported the following training compliance figures for nursing and healthcare assistant staff in the urgent and emergency care department.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Management Training</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 Years</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>70</td>
<td>156</td>
<td>44.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>101</td>
<td>237</td>
<td>42.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and healthcare assistant staff in urgent and emergency care did not meet the completion rate target for any of the seven courses made available to them. Staff failed to meet the target for training courses classified as ‘other’ with a completion rate of 42.6%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

At Royal Preston Hospital, by the end of May 2018, 76% of nursing and healthcare assistant staff in the service were compliant with the trust’s mandatory training modules; 62% of eligible staff were compliant with moving and handling training; and, 71% were compliant with Prevent Strategy training. A further 77% of eligible staff were compliant with adult basic life support training, which 44% of eligible staff were compliant with paediatric basic life support training.

Senior staff in the service acknowledged mandatory training levels had not met the trust’s target. High demand had reduced the service’s ability to release staff to undertake training and there had been a reliance on staff to undertake training as paid overtime. However, the practice educator had agreed an improvement trajectory to achieve compliance with the targets for individual courses between August and October 2018. Data provided by the service since our inspection showed an improving trend in completion rates.

The service sent emails to staff to remind them of training they needed to complete. Staff that had been provided with opportunities to complete training but had not done so were invited to a one to one meeting with the matron to discuss. The matron could restrict staff clinical duties if required if training remained outstanding.
Medical staff

From March 2017 to February 2018, the service reported the following training compliance figures for medical staff in the urgent and emergency care department.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>42</td>
<td>60</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>52</td>
<td>120</td>
<td>43.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the completion rate target for any of the six courses made available to them. As with nursing staff, they also failed to meet the target for courses classified as ‘other’, with a completion rate of 43.3%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Medical mandatory training figures were held at service level rather than by location. Across both Preston and Chorley, by the end of May 2018, 73% of medical staff in the service were compliant with the trust’s mandatory training modules and 57% were compliant with Prevent Strategy training. A further 47% of eligible staff were compliant with adult basic life support training, which 38% of eligible staff were compliant with paediatric basic life support training.

Safeguarding

The service provided training to staff on how to recognise abuse and to protect patients from abuse although mandatory safeguarding training completion compliance rates did not meet the trust’s policy target of 90%.

While not all staff had completed the appropriate training, staff could describe the types of indicators of abuse or neglect that would lead them to consider reporting a safeguarding concern. Staff were aware of the need to be vigilant and assess for indicators of child sexual exploitation, female genital mutilation and domestic violence which were covered in their training sessions.

Training covered the ten categories of abuse (including male domestic abuse), stalking and honour based violence (DASH) risk assessment. Training was also provided in the government’s counter-terrorism Prevent Strategy. Referrals for domestic abuse and Prevent were made to and managed through the multi-agency safeguarding hub.

Senior staff acknowledged that safeguarding training levels had not met the trust’s target. High demand had reduced the service’s ability to release staff to undertake training and there had been a reliance on staff to undertake training as paid overtime. There had also been a number of changes to the training ‘target audience’ within the department since November 2017 which had impacted on compliance levels. However, the practice educator had agreed an improvement trajectory to achieve compliance with the target by September 2018.
Reception staff checked the child protection information sharing system (CPIS) for any patient aged 18 or under and alerted staff if the child was known to have a child protection plan in place or was a looked-after child. The system which included social workers’ details also automatically flagged a known child’s attendance at the department to the relevant social worker. The service’s electronic patient record system flagged if a child was thought to be at risk of child sexual exploitation.

During our inspection the service identified and referred three children to the local safeguarding authorities. The service appropriately managed the care for these children to keep them safe while the referrals were being investigated.

Although safeguarding guidance and trigger indicators were available within the hard-copy records and ‘grab-packs’ (pre-printed assessment cards), there was inconsistent use of the paediatric minor injuries and paediatric minor illness assessment sheets, which included check-box reminders for staff to consider potential safeguarding indicators. This meant there was some reliance on individual practitioners’ professional curiosity, which limited the opportunity to consider the ‘think family’ approach or for the early identification of safeguarding issues.

Leaders in the department told us this had been identified during a records audit. Actions for improvement had been planned, including reviewing the questions on the form to become risk assessment, and to enable the documentation to travel with the patient into the paediatric assessment units or paediatric outpatient departments. The leaders also acknowledged further development of the trust’s IT system was required to enable automatic printing of these sheets for relevant patients. However, the electronic patient record system flagged up any previous known safeguarding concerns or referrals on the patient’s records. This meant that staff could identify patients who were previously considered potentially to be at risk.

Additional assurance on safeguarding was provided to the service’s leaders through the daily review of all child attendances and admissions to the hospital in the previous 24 hours, including children who left the department without being seen. This was carried out by a dedicated health visitor who reviewed all records and ensured any safeguarding concerns had been identified and reported appropriately to the safeguarding teams. All young adults, aged between 16 and 18, who were admitted were flagged to the safeguarding team for review.

The service hosted a multidisciplinary safeguarding meeting once a month to review all relevant cases in the department. Representatives included the lead consultant, a paediatrician, a child sexual exploitation lead nurse, a child and adolescent mental health specialist and an approved mental health practitioner. The service was also represented at the monthly joint Preston and Skelmersdale multi-agency child sexual exploitation meeting.

The service participated in a quarterly joint safeguarding champions forum with a local independent healthcare provider.

**Safeguarding training completion rates**

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and healthcare staff in urgent and emergency care.
### Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>49</td>
<td>64</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>105</td>
<td>156</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>50</td>
<td>75</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>36</td>
<td>80</td>
<td>45%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in urgent and emergency care did not meet the completion rate target for any of the four safeguarding training courses made available to them.

At the Royal Preston Hospital, by the end of May 2018, 65% of eligible nursing and healthcare assistant staff were compliant with the trust’s safeguarding vulnerable adults level two training, and 67% were compliant with safeguarding vulnerable adults level three training. By the same time, 67% of eligible nursing and healthcare assistant staff were compliant with safeguarding vulnerable children level two training, while 60% were compliant with safeguarding vulnerable children level three training. However, a review of the staffing rota indicated the service had at least one nursing staff member trained to children’s safeguarding level three on each shift.

### Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>20</td>
<td>27</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>17</td>
<td>26</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>38</td>
<td>60</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>9</td>
<td>33</td>
<td>27%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the completion rate target for any of the four safeguarding training courses made available to them.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Medical safeguarding training figures were held at service level rather than by location. Across both Preston and Chorley, by the end of May 2018, 67% of eligible medical staff were compliant with the trust’s safeguarding vulnerable adults level two and level three training. By the same time, 78% of eligible medical staff were compliant with safeguarding vulnerable children level two training, while 41% were compliant with safeguarding vulnerable children level three training.

### Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection.
The department and equipment used within it were visibly clean and tidy during our visit. Domestic cleaning services undertook the environmental and equipment cleaning in each bay and side room in line with a works schedule. The cleaning logs were checked by the provider’s supervisor and reviewed during a joint monthly meeting between the service’s matron and the cleaning provider. We viewed the cleaning logs, including the logs for cleaning toys in the paediatric waiting room. All the logs were up to date and completed appropriately.

There were sufficient numbers of antibacterial hand gel dispensers located throughout the department and we observed staff using these. Washbasins were in each side room and in the bay areas.

We observed staff following infection control and hygiene procedures, including washing hands and having ‘arms bare below the elbow’. There were sufficient quantities of personal protective equipment such as gloves and aprons throughout the department and within each bay. We observed staff using protective equipment appropriately.

Between June 2017 and May 2018, the service undertook five hand hygiene audits in the emergency department; May 2017 (33% compliance), September and October 2017 (both 100% compliance), April 2018 (73% compliance), and May 2018 (73% compliance). The service’s target for hand hygiene was 100%. Data on joint hand hygiene audits for the medical assessment and ambulatory care units, between December 2017 and May 2018 showed an average of 93% compliance.

In the 12 months prior to the inspection, no cases of methicillin resistant staphylococcus aureus, methicillin sensitive staphylococcus aureus, or clostridium difficile were contracted within the department.

We observed that a number of sharps bins in the department were not ‘part-closed’, and at least one sharps bin did not have the date of construction or the location recorded on the label. This posed a potential risk to safety of needle-stick injury.

Environment and equipment

The service’s premises were limited by the legacy layout and construction of the department and had the potential to impact on patient flow through the department, particularly during periods of increased demand. Cubicle four in the majors area, used for assessing monitoring and treating patients presenting with mental health symptoms, was not fit for purpose. This was a breach of regulation 12.

The department was located at the front of the hospital. Space in the department was limited due to the design of the building. The service had already developed its resuscitation area, and had plans for further development of the ambulance arrival and triage, and paediatric areas. Concern about space limitations, particularly resulting in patients waiting in the ambulance corridor, and the effect on patient flow was acknowledged by consultant staff we spoke with. However, senior managers told us of redevelopment plans for the unit, which were expected to improve performance and flow within the department. We saw plans of the drawings displayed in the staff corridor.

The adult waiting area was visibly clean and included adequate seating for the number of patients attending the department at the time of the inspection. Senior staff acknowledged that, at times of peak demand, it had been necessary to find alternative seating. Plans to merge the adult and urgent care centre waiting areas, which would increase the capacity of the waiting area, had been
approved and work was expected to begin within the next few months. Male and female accessible toilets were available in the waiting area and were clean.

The paediatric waiting area was visibly clean and tidy and included a small area equipped with children’s toys and a television. Accessible toilets and a baby changing room were available. Although there was no direct line of sight between the waiting and treatment areas, reception staff had direct visibility of the whole waiting area.

Since our last inspection, the service had improved the security of the paediatric waiting area. The main doors located in the waiting area were only used to exit the unit and were operated by a push-button at adult height. Parents and children entered the department via the adult reception and then through an adjoining corridor. This meant that inappropriate access to the area was appropriately restricted.

As part of the department’s reconfiguration plans, vending machines had been relocated from the waiting areas to the nearby urgent care centre waiting area. It was expected the temporary inconvenience this would cause to patients and carers would be resolved when the adult waiting area and urgent care centre waiting area were amalgamated.

The minor illness area included five rooms and five curtained seated cubicles. The ‘majors’ area were laid out to provide line of sight from the central nurses and medics station to all cubicles and side-rooms and cubicles. A side room, near the entrance to the majors area, was designated for the care and treatment of paediatric patients. The room had recently been painted in readiness for the service’s plans to develop it into a sensory room. This meant that the décor was stark and was not ‘child friendly’. Senior staff recognised that additional assessment room capacity was needed for the number of children being seen by the department. Plans for the development of a designated paediatric area were in the early stages.

The service had purchased high specification pressure relieving mattress for all trollies within the department. This helped to ensure patient comfort and to reduce the development of pressure ulcers. Specialised beds for use with bariatric patients were available on request from storage.

There was a room assigned for patients with mental health needs, which was not fit for purpose. The room had dual exits, one of which was alarmed if the door was opened. This was monitored remotely by security staff. There were a number of ligature risks including fixed wall taps, door handles and a pull-cord. A ligature cutter was kept in the resuscitation trolley within the department. The room had an alarm; however, this was a push-button rather than a strip alarm and was located next to one of the doors. This meant there was a small risk that staff would not be able to reach the alarm in an emergency.

The use of the room had been risk assessed to help minimise the risks to patients. The service provided us with copies of the risk assessment, plans, costings and a schedule of works that had been agreed in the week prior to our visit. In the meantime, the service had identified control measures to reduce the risk to patients. These included observation of patients left alone in the room, police monitoring of patients brought in to the service as a place of safety, and the provision of additional staff for one to one supervision of high risk patients.

There was only one toilet available within the majors area for use by patients and there were no showering facilities within the department. Patients who required a shower were risk assessed and then escorted to a nearby ground-floor ward area where showering facilities were available.

Since our last inspection, the service had refurbished and expanded its resuscitation area. The area was bright, airy and was maintained at a comfortable temperature. The area had six bays,
one of which was a side room that included telemetry facilities for remote monitoring of patients displaying symptoms of a stroke.

The first resuscitation bay was designated for the treatment of trauma patients and was located directly in front of a set of double doors into the unit’s computerised tomography (CT) scanning suite. The fourth bay was designated for the treatment of children, but could also be used for treatment of adults. A paediatric nurse had worked with the consultants to ensure the bay was appropriately standardised for the treatment of children.

The department was co-located to an X-ray area, which was shared with the fracture clinic. There was access to the X-ray area from the paediatric waiting area. This meant that children were not taken through the adult areas to be X-rayed.

Resuscitation trolleys were in the majors and resuscitation areas. Daily checks had been carried out and these were recorded in a log. The trolleys were appropriately sealed and tagged; however, we noted that the daily trolley check-list did not include an area to record the tag serial number. This meant that staff did not have assurance that the contents of the trolley were still intact. We raised this with staff who immediately updated the check-list and we saw that tag serial numbers were recorded during the remaining days of our inspection. The use of the new checklist was highlighted to staff during the nursing shift handover that we observed.

We checked a random sample of adult and paediatric equipment held within each of the areas throughout the department, including in the resuscitation trolleys. Most of equipment we viewed was within the manufacturers’ recommended expiry dates. We found a minimal number of pieces of equipment, including two forceps, one oxygen mask and three blood bottles that had passed their manufacturers’ expiry dates; staff immediately removed these. Electronic portable equipment including the defibrillators were observed to be working.

The department had a relatives’ room and a viewing room. The viewing room, which was used for family and carers to be able to spend time with deceased relatives, was located directly across a corridor from the resuscitation area which meant that deceased patients could be moved to the room discretely. Both rooms were small, but adequate for their purposes.

A separately located ambulatory care unit had recently been opened. This included a waiting area, a triage room, separate male and female ward rooms for patients that required a bed, a clean room and a sluice room. The unit was visibly clean and tidy, bright and airy. Electrical equipment had been appropriately tested.

**Assessing and responding to patient risk**

Patients who used the department were not always triaged in a timely way potentially leading to delays in diagnosis and treatment. This was in part due to the department being co-located with an urgent care centre.

The emergency department was co-located with an urgent care centre, operated by another healthcare provider. The centre aimed to provide assessment, care and treatment to patients with conditions that could reasonably be treated by GPs or advanced nurse practitioners. This meant the emergency department reception included staff from both the service and the urgent care centre. Reception staff were not clinically trained.

Patients self-presenting to the emergency department were asked to identify if they were experiencing symptoms from a list of serious or life-threatening conditions displayed behind the receptionist. A decision was made by reception staff to book the patient into the service’s system
or to refer them to book in with the urgent care centre. Patients were subsequently triaged by whichever service they had been registered into.

This meant there was a risk that patients with serious conditions could be incorrectly directed to the urgent care centre. This could delay diagnosis and treatment and place patients at unnecessary risk of harm. Although a 'crash call' button was available in the reception area, this was a risk if the patient deteriorated or collapsed while waiting to be seen in the urgent care centre as the patient would not be on the emergency department’s system.

Medical staff in the department told us it was not unusual for patients to be transferred from the urgent care centre as they required a level of care or expertise beyond that which could be provided by the urgent care centre. Senior leaders in the service acknowledged this was a known risk, which also impacted on the service’s performance figures. This was because measurement against the targets started at the time a patient was booked into the system irrespective of which provider they were to be seen by.

Senior leaders told us plans were in place, and due to be implemented in July 2018, to streamline the initial booking and triage process. This included using one patient information system, for both providers and undertaking nurse led triage using the Manchester triage system (an evidence based triage system widely used in emergency services).

Currently, for patients registered into the emergency department, nurse-led initial assessment and triage identified the most appropriate area for patients to be seen and to fast-track relevant patients for pre-emptive investigations. The service had one triage room, but it had identified a second room which it expected to be converted imminently.

Only nursing staff with a minimum of 18 months experience were assigned to triage patients; this ensured patients received a thorough assessment and were kept safe. All nursing staff undertaking triage were required to undertake triage training and be signed off as competent. A dedicated band six ambulance corridor nurse triaged patients arriving by ambulance.

Triage enabled identification of patients at risk of developing sepsis, patients with head injuries or other trauma related injuries. However, delays in initial triage meant there was an increased risk to the safety of such patients. Between June 2017 and May 2018, the average time to initial triage was 45 minutes, and for children the average wait time was 41 minutes. However, data provided by the service since our inspection showed an improving trend in triage times as a result of the planned changes to the triage system.

Risk assessments for pressure ulcer and falls assessments were carried out. High specification mattresses had been provided for all trolleys in the department to reduce the likelihood of pressure ulcers developing. Patients at risk of falls were identified by the use of purple socks. Patients living with dementia were identified by the use of the forget me knot symbol. The service also screened patients for frailty and referred them to the trust’s frailty team.

Compliance levels with life support training were poor. Measured against the trust’s target of 90% of eligible staff in each criterion, 50% of staff providing care to adults were compliant with basic life support training, and this reduced to 43% compliance for paediatric life support.

For immediate life support training, 50% of staff were compliant while only 31% of staff were compliant with paediatric immediate life support training. For advance life support training, 50% of eligible staff were compliant.

We reviewed future staffing rotas for May to August 2018. Out of 312 shifts, 49 shifts were identified as not having full staff cover for advance paediatric life support. However, the rota identified that staff scheduled on these shifts had paediatric immediate life support training.
Improvement trajectories had been set by the practice educator for compliance with the target for adult basic life support by August 2018, and by October 2018 for paediatric life support. However, the risk posed to the safety of people receiving care in the department because of the low compliance levels.

The trust had a sepsis nurse specialist team, and the service had robust systems in place for recognising sepsis and for initiating early treatment. The team provided cover from 8am to 6pm, seven days a week. The critical care outreach team supported the service, via bleep, when the sepsis nurse specialist team were not on duty.

All nurses carried sepsis six prompt cards. Sepsis six is a three test and three treatment bundle that has been shown to improve outcomes in septic patients. Posters advertising sepsis awareness, and a sepsis champion day, were displayed in the department. A trust-wide audit showed 89.3% compliance with sepsis training by staff in admission areas in the trust.

Sepsis screening was undertaken and the sepsis pathway commenced at patient triage, although there did not appear to be any specific sepsis ‘yes/no’ prompt questions on the adult triage card. Ambulance staff pre-alerted the service for any patients thought to be at risk of, or were showing symptoms of the development of sepsis. This enabled the service to alert the trust’s sepsis nurse specialist team. We were told of a recent neutropaenic sepsis case where the patient had been given antibiotics within 15 minutes of arrival by ambulance.

The department used a national early warning score system in conjunction with its escalation plan to ensure that deteriorating patients were appropriately escalated to medical staff. This was also used in the ambulatory care unit. Staff used an age-appropriate early warning system for paediatric patients. However, although all staff were given training in the care of the critically ill child, the service only had two paediatric nurses.

Patients presenting with symptoms of stroke where monitored in a side room in the resuscitation area. The room was equipped with a ‘telecart’, which enabled remote monitoring and diagnosis by consultants. This meant consultants could make timely decisions on whether or not the patient would benefit from thrombolysis treatment.

Patients presenting with mental illness, or brought by police to the service as a place of safety, were referred to the mental health liaison team, and mental health risk assessments were carried out. The liaison team could refer the patient onwards for psychiatric assessment or medicine prescription, and provided advice to department staff on the patient’s care plan.

Senior leaders acknowledged that local and national shortages of mental health in-patient beds had a significant impact on the department as patients could wait excessive amounts of time for a bed to become available. This was on the risk register, and the service was working with the central Lancashire quality improvement board and the local mental healthcare provider to improve the quality of care for mental health patients stranded in the department.

Only consultants could sign-off patients for discharge from the department. A process was in place for receptionists to check that the relevant doctor had completed patients’ discharge summaries.

Closed circuit television, with appropriate warning signage displayed, was in operation in the department.

**Emergency Department Survey 2016**

The trust’s scored worse than” other trusts for three questions and “about the same” as other trusts for the remaining two questions of the five Emergency Department Survey questions relevant to safety.
<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>6.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

From April 2017 to March 2018, the median time from arrival to initial assessment was worse than the overall England median in 11 of the 12 months. The trust is showing a decline in performance over the winter months.

**Ambulance – Time to initial assessment from February 2017 and January 2018 at Lancashire Teaching Hospitals NHS Foundation Trust**

(Source: Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

From May 2017 to April 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Preston Hospital.
The percentage of journeys with a turnaround time of over 30 minutes was 56% in June 2017, increasing to a high of 70% in April 2018.

A black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From February 2017 to February 2018, the trust reported 4,431 black breaches, with an upward trend over the period. There was a low of 86 in February 2017, with a high of 626 in December 2017.
Nurse staffing

The service had agreed and were recruiting to a staffing establishment that ensured it had enough staff with the right qualifications, skills, training, and experience to keep adults safe from avoidable harm and abuse and to provide the right care and treatment. However, the service only had two paediatric registered nurses.

The service had carried out a review of staffing numbers against the Royal College of Nursing Emergency Care Association and Faculty of Emergency Nursing’s baseline emergency staffing tool had indicated a shortfall in the service’s established staffing numbers when projected against patient acuity and demand. As a result, the trust had agreed and financed a recruitment programme to increase the establishment from seven to eleven qualified nurses per shift supported by four unqualified staff (healthcare assistant staff).

During our inspection, the urgent and emergency services department had sufficient staff available to fulfil the requirements of eleven qualified nurses and four healthcare assistant staff for each shift. However, the limited number of trained paediatric registered nurses, meant it was not possible to have a paediatric nurse on every shift as the department was open 24 hours a day, seven days a week. This was not in line with the Royal College of Paediatrics and Child Health’s updated guidelines Facing the Future - Standards for Children and Young People in Emergency Care Settings published in June 2018, which recommend a minimum of two registered paediatric nurses throughout opening hours, nor was it in line with the previous guideline published in 2015 which recommended a minimum of one registered paediatric nurse throughout opening hours.

Although the service had two paediatric trained emergency medicine consultants in the department and the service was supported by the paediatric team in the hospital’s children’s ward when necessary, senior leaders recognised the paediatric staffing levels was a risk. The service was trying to recruit sufficient numbers to ensure one paediatric nurse per shift but were struggling to attract staff to the department. It was hoped that further physical redevelopment of the unit to provide a dedicated paediatric area would encourage more interest from applicants. Leaders also told us that newly recruited paediatric nurses would initially be hosted by the paediatric ward to gain experience and then subsequently rotated down into the emergency department.

The service was funded for five advanced nurse practitioners. With three already in post, the service was out to advert for the remaining staff. The use of advanced nurse practitioners in the minors stream supported and reduced reliance on the medical staff in that area.

The ambulatory care unit was staffed by one band seven, one band six and one band five registered nurses, one advanced practitioner and one health care assistant.

Overall staffing rates

At the time of the inspection (excluding staff on maternity leave, long term sickness or suspension), the service at Royal Preston Hospital employed 64 (57.3 whole time equivalent) nurses. The service also employed 13 (12.0 whole time equivalent) healthcare assistant staff.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Vacancy rates
From February 2017 to January 2018, the trust reported a vacancy rate of 25.1% in urgent and emergency care. In Royal Preston Hospital for the same period the vacancy rate was 31.6%. This was worse than the trust’s target of 6%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Senior leaders acknowledged there had been a high historic level of vacancies in the department. However, following review of demand and patient acuity, the service had been authorised to recruit staff to meet a new establishment.

Turnover rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From February 2017 to January 2018, the trust reported an overall nurse staffing sickness rate of 4.3% for nursing staff in urgent and emergency care across both sites. This is similar to the trust target of 4.2%. At the Royal Preston Hospital, the sickness rate was 3.8%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Between June 2017 and May 2018, the service reported that 2409 (approximately 17%) qualified nursing shifts in the department were filled by agency or bank staff. Data supplied by the trust indicated a significantly higher usage rate between January 2018 and May 2018, which reflected the services increased staffing establishment while awaiting permanent staff to be recruited.
The service aimed to block-book agency staff to ensure consistency of knowledge with the departments policies and procedures.

Medical staffing
The service at Royal Preston Hospital had sufficient consultant staff in post to meet the requirement of 16-hour consultant cover seven days a week between 8am and midnight. A paediatric doctor, based at the hospital, was on-call 24 hours a day, seven days a week.
The services clinical director was in the process of writing a proposal for the board to increase medical staffing establishment to 32 across both sites. This was to support the new developments in the department including the introduction and implementation of a rapid assessment and treatment service model and a move to 24 hours a day seven day a week consultant cover model.
At the time of the inspection, the service did not have a 24-hour major trauma consultant cover. Leaders told us this had been put forward in the clinical director’s business case to be considered by the executive team. The business case included the conversion of a room for use as resident facility to enable 24 hour a day seven day a week on-call cover.

The ambulatory care unit was medically staffed by a consultant supported by a middle-grade doctor during its opening hours between 9am and 5pm.

Although the service used locum staff, leaders told us all locums required a full induction and training on the service’s electronic patient record system before working in the department. The service also preferred, and aimed, to use locum staff that had worked in the department previously.

**Overall staffing rates**

Medical staff establishment was monitored at service-wide level rather than by location. Across both sites, the service had 18 consultants (15.2 whole time equivalent), six middle-grade doctors (6 whole time equivalent), eight senior-trainee doctors (7.6 whole time equivalent), and 27 junior doctors (26.2 whole time equivalent).

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 13.5% in urgent and emergency care at Royal Preston Hospital. This is worse than the trust’s vacancy target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Medical staff turnover was monitored at service-wide level rather than by location. Across both sites, the service reported a turnover of 24.7% whole time equivalent staff. This figure included second year foundation doctors who had completed their foundation training and were moving to another trust for the next part of their chosen training programme.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 1.4% for medical staff in urgent and emergency care. This is better than the trust’s sickness target of 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

Medical staff agency locum usage was monitored at service-wide level rather than by location. Across both sites, between June 2017 and May 2018, agency locum staff filled 1080 shifts. Data provided by the trust did not enable us to determine an overall usage rate.

Although we asked the trust for the number of bank shifts covered and the usage rate for the same period we were only provided with the number of shifts covered in April 2018 (two middle-grade doctor shifts and three consultant shifts) and May 2018 (no bank shifts).
Staffing skill mix

As at January 2018, the proportion of consultant staff reported to be working in urgent and emergency care at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working in Urgent and Emergency Care at Lancashire Teaching Hospitals NHS Foundation Trust.

Records

Staff kept records of patients’ care and treatment that included consistent recording of risk assessments and observations, but the patient safety checklists were not consistently completed by staff.

The service used both electronic and paper records. Paper records included pre-printed ‘grab packs’ and the emergency department safety checklist.

Grab packs were available for adults, children (separate packs for each age-range), and patients presenting with mental health problems. The packs enabled staff to record the patient’s details, presenting complaint and initial assessment, risk assessments carried out, the patient’s vital signs and observations including national early warning scores, and included space for multidisciplinary team notes, and care and treatment plans.

(Source: NHS Digital Workforce Statistics)
The safety checklist detailed actions to be undertaken by staff every hour that the patient remained in the department, and was designed to ensure vital actions were not missed.

We reviewed 21 sets of records. Records were consistently clear and recorded patients’ allergies, risk assessments and vital observations. Where patients required additional support, or needed a mental capacity assessment because of a learning disability, autism, dementia or mental health, this was recorded. However, the safety checklists were not consistently completed, which meant there was a potential risk to the safety or comfort of patients if checks had not been completed appropriately.

Discharge letters were sent electronically through the system to each patient’s GP within 24 hours of discharge.

The service’s electronic system included alerts for patients that had known safeguarding needs, were known to be at risk of female genital mutilation or child exploitation, or who had previously attended with or were known to have mental health symptoms.

Medicines

The service prescribed and gave medicines well, but ‘to take out’ medicines were not labelled with the issuing location address and contact number, and daily checks of the controlled drugs were missed on a number of occasions.

Medicines were stored securely in two areas in the emergency department. Treatment rooms were key coded and medicine cupboards and fridges were locked. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Patients own controlled drugs were managed separately. We saw evidence of regular daily checks, and the stock balances we checked were correct.

The department had two fridges for the storage of temperature sensitive medicines. Maximum and minimum temperatures were recorded in line with trust policy. On the one occasion where the fridge temperature had exceeded the recommended range (8 degrees Celsius) staff recorded a reason (the door was open) and reset the thermometer. Staff were aware of the process to contact the pharmacy team for advice if the temperature exceeded the recommended range for a prolonged period.

Emergency medicines were readily available on emergency trolleys, which were secure, sealed and checked regularly. However, the daily check did not record the seal number, which meant that staff could not be sure that the contents remained intact. This was raised at inspection and the checklist was amended to enable staff to record the tag numbers.

We checked a sample of medicines in the majors and minors areas which were all found to be within the manufacturer’s recommended expiry dates, including anaphylaxis packs that were in each resuscitation bay.

We also reviewed a sample of the department’s controlled drugs. Although all entries were appropriately double-signed and stock levels appropriately tallied with the entries in the controlled drugs register, we found that in June the controlled drugs daily checks had not been carried out on 5 out of 21 days within the resuscitation area. With the majors area, we found the daily checks had not been done on 2 out of 21 days.

All appropriate staff had access to the trust intranet site and patient records were available electronically. Prescribing and administration guidance was available and a specific emergency
A patient group direction, signed by a doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription-only medicines to patients using their own assessment of patient need, without referring to a doctor for an individual prescription. Patient group directions were used in the department for administration of paracetamol, ibuprofen and co-codamol. Management of patient group directions was the responsibility of the clinical educator. Staff competency was regularly assessed and any changes to policies and procedures was communicated well.

Medicines were issued to patients to take home when the pharmacy was closed by emergency department staff. Prescriptions were generated and pre-prepared medicines were issued following a patient group direction.

Prescriptions issued out of hours were not audited against the medicines issued. The pharmacist we spoke to said this would be addressed. We looked at the stocks and found the medicines were issued without the name and address of the hospital which does not follow current medicines legislation; Schedule 25 Part 1 of the Human Medicines Regulations – Regulation 258.

The service did not have a dedicated pharmacist. However, a pharmacist prescriber visited the department daily to ensure patients had essential medicines. The pharmacist attended the service’s multidisciplinary and governance meetings. Following a pilot study with a local university which reduced the services medicines error rates by 60%, an application had been submitted to Health Education England for a pharmacist practitioner for the service.

A medicines management assistant was employed to work in the emergency department to improve the flow of medicines through the department. In addition to medicine housekeeping duties, staff could assist when transferring between locations, reducing waste and re-dispensing time.

**Incidents**

The service managed patient safety incidents appropriately. When things went wrong managers appropriately investigated to determine the contributory factors and to identify areas for individual and systemic improvement, and shared learning.

Staff could describe the types of incidents that may occur within the department, including near misses. Staff recognised incidents when they occurred and reported them appropriately on the trust’s electronic incident reporting system.

Between 1 January 2017 and 28 February 2018, staff reported a total of 1357 incidents in the emergency department at Royal Preston Hospital. The majority of these (1013) resulted in no harm, while 292 were classed as ‘near misses’. A further 366 resulted in low harm, 27 in moderate harm, two resulted in serious harm, and one resulted in the death of a patient.

Senior managers within the department reviewed, investigated and shared lessons learned from incidents with the whole team and the wider service where appropriate. Incidents were reviewed in the departmental case review meeting, and lessons learnt were shared with staff in a variety of methods; through staff handover huddles, five-minute briefings, staff meetings, by email, by social media secure messaging, and in the department’s ED Times newsletter.

We reviewed five completed 72-hour rapid review incident investigations, and the related serious incident root cause analysis investigations. These set out the details, background, and initial
findings and included action plans. The action plans were clear in providing descriptions of the actions to be taken, how this was to be done, the target date and actual date for completion.

Senior staff understood the requirements of the Duty of Candour. Under the duty, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

When things went wrong, staff apologised and gave patients honest information and suitable support in line with the principles and requirements of the Duty of Candour. Our review of serious incident investigations showed that the duty of candour had been complied with.

The service had recently reviewed its major incident plan, which was available to staff on the intranet. Staff received major incident training during their induction with decontamination training repeated every two years.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(***Source: NHS Improvement - STEIS***)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in urgent and emergency care across both hospital sites which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

- Commissioning incident meeting SI criteria: 16 incidents.
- Diagnostic incident, including delay meeting SI criteria: four incidents.
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident.
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident.

(Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018))
Safety thermometer

The service used safety monitoring results. Staff collected safety thermometer information and used information to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from April 2017 to April 2018 within the urgent and emergency care service.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment for adults based on national guidance and evidence of its effectiveness.

The urgent and emergency services department used pathways that were evidence based in line with National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments. These included although were not limited to head injury, transient ischaemic attack, sepsis and neutropaenic sepsis recognition diagnosis and treatment, and female genital mutilation pathways.

Staff could quickly access policies and procedures for the department, which were held on the trust’s intranet. Departmental guidelines were updated by the clinical lead consultant.

The department participated in the national Royal College of Emergency Medicine audits so it could benchmark its practice against other emergency departments.

The department’s trauma team submitted outcome data to the Trauma Audit and Research Network. The network reviewed the data and provided feedback in a themed report which was used to improve the services provided by the department. The trust’s trauma board, which sat across all the trust’s sites, provided multispecialty peer review process. The board reviewed all trauma deaths and trauma related incidents across the trust to identify areas of improvement, and findings were fed into the relevant quality groups.

The service also participated in the trust-wide programme of influenza screening and treatment for appropriate patients at the point of care in the department. This enabled early identification and assessment by the infection prevention and control team, which ensured that the department provided appropriate management of patients who tested positive for influenza. This work resulted in a reduction in patients’ lengths of stay despite a three-fold increase in the number of cases from the previous year.
Nutrition and hydration

Staff gave patients food and drink to meet their needs. The service made adjustments for patients’ religious, cultural, and other preferences.

A range of cold foods and sandwiches were available to suit patients’ needs. Hot foods were not provided routinely, but could be ordered by staff for patients that had been waiting in the department for an extended period.

The emergency department safety checklist included prompts for staff to check that patients had been offered refreshments (if not being kept nil-by-mouth). We also saw evidence of fluid balance being monitored for some patients. However, the completion of the safety check list and the assessment of nutritional and fluid intake was inconsistent.

At the time of the inspection, waiting room vending machines had been relocated to the neighbouring urgent care centre waiting area. Leaders told us this had been done in preparation for the physical re-development and integration of the adult emergency and urgent care centre waiting areas. However, the department was located close to the hospital’s main entrance area which included a small restaurant, coffee kiosks, and shops selling refreshments.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Pain relief

Staff gave patients pain relief when required, although not always consistently.

Pain relief including paracetamol, ibuprofen and co-codamol could be provided under the pre-authorised patient group direction.

In our conversations with patients, and in our review of records, on 14 occasions patients had been asked if they were in pain. Of these, four patients were not in any pain. Of the remainder, two patients had been assessed as or expressed they were in pain but did not receive pain relief in a timely way.

A visual pain scale, using ‘smiley face’ pictures, was used within the department. This provided an easy way for children to express the level of pain they were experiencing.

Patient group directions available in triage to enable immediate pain relief for patients.

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse than other trusts.
Question – Effective | Score | RAG  
---|---|---  
Q32. Do you think the hospital staff did everything they could to help control your pain? | 6.7 | Worse than other trusts  
Q35. Were you able to get suitable food or drinks when you were in the emergency department? | 5.1 | Worse than other trusts  
(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Patient outcomes

The service monitored the effectiveness of care and treatment. The service participated in the Royal College of Emergency Medicine audits between 2016 and 2017. It achieved variable results, but failed to meet any of the standards for moderate and severe asthma and consultant sign-off.

The audits against the Royal College’s clinical standards enabled the department to benchmark itself nationally and more locally against the trust’s other emergency departments. Where the audits highlighted areas of concern, the department had acted to address these. The service has not yet been re-audited by the Royal College, so we are unable to comment on whether or not the service’s performance has improved since the last audit.

The major trauma service submitted performance data, including patient survival rates to the Trauma Audit and Research Network (TARN). The service was benchmarked nationally and had demonstrated an improvement in trauma survival rates at 30 days or discharge from a negative position of more deaths to a positive position of more survivors.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, Royal Preston Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for one standard:

- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible: 5a: Within one hour of arrival (acute severe) and 5b: Within four hours (moderate)

The hospital was in the lower UK quartile for no standards.

The hospital's results for the remaining four metrics were all between the upper and lower UK quartiles.

List of standards in this audit:

- Standard 1a (fundamental): O2 should be given on arrival to maintain sats 94-98%. Hospital: 17.3%; UK: 19%.
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 32.1%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 19.8%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to
nebulised β2 agonist bronchodilator therapy. Hospital: 77.1%; UK: 77%.

- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Hospital: 50%; UK: 19%.

- Standard 5b (fundamental): within 4 hours (moderate). Hospital: 43.3%; UK: 28%.

- Standard 6 (developmental): Intravenous Magnesium 1.2 - 2g over 20 minutes to be given to adults with acute severe asthma who do not respond well to bronchodilators. Hospital: X%; UK: X%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
  Hospital: 57.5%; UK: 52%.

(Source: Royal College of Emergency Medicine)

The service’s action plan to improve in this measure included the introduction of an asthma proforma to the grab packs, to ensure staff awareness of the audit results, provide teaching to staff and multidisciplinary teams on the management of asthma, and to regularly include the topic of asthma in important reminders and in handovers of ‘lessons of the week’.

At the time of the inspection, all actions were complete except for the action to introduce the proforma was partially complete with a target of the end of September 2018.

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Royal Preston Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for two standards:

- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 19.6%; UK: 10%.

- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 30%; UK: 12%.

The hospital was in the lower UK quartile for no standards.

The hospital’s results for the remaining two standards were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)
The service’s action plan to improve in this measure included continuing education of staff in the department, inclusion of the standards in shift handover, redevelopment of the clerking pro-forma to include categories that required senior review for adults and children, and the additional of the four standards on the discharge summary.

At the time of the inspection, most of actions had been completed. Those that were partially complete had target dates for the end of August 2018.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 severe sepsis and septic shock audit, Royal Preston Hospital was in the upper UK quartile for two standards:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 92%; UK: 30.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 80%; UK: 18.4%.

The hospital was in the lower UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 46%; UK: 64.6%.

The hospital’s results for the remaining five metrics were all between the upper and lower UK quartiles.

(Source: Royal College of Emergency Medicine)

The service’s action plan to improve in this measure again included continuing education of staff in the department, including junior doctors and the multidisciplinary team, including the topic in regular handovers and reminder, and the introduction of a sepsis screening and action tool.

At the time of the inspection, most of actions had been completed. The only outstanding action was the introduction of the screening tool which was partially complete with a target date of December 2018.

However, we saw evidence of appropriate review and escalation of patients using the national early warning score system, including the review of children with fever. Sepsis reminder stickers were printed on the children’s grab packs, and the service had developed good links with the acute oncology team to deliver training on neutropaenic sepsis.

**Unplanned re-attendance rate within 7 days**

From April 2017 to September 2017, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% throughout the entire reporting period. The trust performed better than the England average from October 2017 until the end of the reporting period.
Competent staff

The service was not compliant against the trust’s target for completion of nursing appraisals or mandatory training. Managers could not assure themselves that nursing staff were competent for their roles.

The department had a full-time supernumerary practice based educator to support the training needs for staff, and to oversee the training processes for new and existing nursing staff.

The department had an induction programme for new nursing staff. This was tailored by the practice educator to individual staff needs. Induction included two days face-to-face training, including simulation based exercises on adult and child cardiopulmonary assessment and resuscitation, with the practice educator followed by a supernumerary period.

Staff with previous emergency care experience worked a two-week supernumerary period; this increased to four weeks for staff who were new working in an emergency department. During this time staff were supernumerary, were supported by a mentor and were expected to complete and sign-off job competencies as part of the induction programme. We reviewed three staff competency files which were up to date and appropriately signed-off.

A paediatric care study day was delivered twice a year to all qualified nurses. This was delivered in conjunction with the hospital’s paediatric team.

The practice educator also undertook departmental induction for new bank or agency staff. The department aimed to block book agency staff to ensure their consistency and familiarity with the department and its procedures. One agency staff member we spoke with confirmed they had been given an induction prior to commencing work.

Additional training was provided to staff, including awareness of the ionising radiation medical exposure regulations, and the provision of medicines under patient group direction authority.

Staff were encouraged to take advantage of free educational information via an external website designed by emergency department professionals. Medical staff also accessed a free educational board which shared learning from clinicians across the world.
The clinical director was also the directorate’s training lead. Medical staff induction including a half-day session with a consultant followed by a two-week supernumerary period. During this time the staff member’s performance was continually reviewed. At the end of the period, it was then decided if the department would appoint the medic to the role. The department had developed bespoke pocket-sized induction booklets for medics. The “I’m in ED – Get me out of here!” and “The only way is ED” booklets provided a comprehensive range of information about the department, the team, practices, procedures, forms and pathway flowcharts, and the code of conduct. Middle-grade doctors were provided with training every two weeks.

Qualified nursing staff were only able to undertake triage duties following completion of a triage training course. This course was provided to staff once they had gained at least 18 months experience of working in the department.

At the time of the inspection, 62% of eligible nurses had completed level one trauma nurse training, and 63% had completed level two trauma nurse training. The practice educator was developing plans to ensure full compliance within 12 months; however, this was dependant on securing funding for the course.

The major trauma lead told us future plans included the delivery of the European trauma course to all band seven nurses in the department. This would enable them to become nursing trauma leads. In addition, it was hoped bands five and six nurses would subsequently undertake the course, but without the final assessment.

The service was supporting the local NHS ambulance service in the development of advance paramedic practice; this included rotating relevant staff to work within the emergency department environment as well as on ambulances.

Appraisals were carried out over a rolling twelve-month period against the trust’s annual target of 90%. However, from February 2017 to January 2018, only 49.4% of nursing staff in urgent and emergency care at the trust had an appraisal. Medical staff met the target with an appraisal completion rate of 91.1%. By the end of May 2018, 51% of nursing and healthcare staff and 93% of medical staff in the service had received an appraisal.

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We observed effective multidisciplinary working between all groups of staff.

Nursing shift handover meetings were held twice a day at the beginning of each shift. We observed one of these handovers. The handover was led by the shift co-ordinator and detailed staff allocations including which area of responsibility they were working during that shift. Minimal patient information was provided during the handover we observed; however, a more detailed handover was discussed with staff in the majors area.

We also observed a medical shift handover meeting. These took place at the consultant shift co-ordinators’ desk in the department. Although this was within an open area of the department, it was sufficiently far away from the cubicles to maintain patients’ privacy. Each patient was discussed in detail, including the presenting conditions and symptoms, any tests undertaken or ordered, medicines prescribed for treatment, and any other relevant information such as interactions with other healthcare providers or safeguarding agencies.
Staff worked with, and received support from the on-site mental health liaison team, delivered by another healthcare provider. Service staff could directly refer appropriate patients requiring mental health assessment to the team.

Emergency nurse practitioner staff in the department worked closely with the trust’s therapy team, particularly within the minor illnesses area of the department. A specialist physiotherapist also worked in this area. This meant patients with musculoskeletal problems could be reviewed and receive specialist physiotherapy assessment and treatment which avoided the need for a longer stay in hospital and reduced doctors’ workloads in the minors area.

**Seven-day services**

The urgent and emergency service at the Royal Preston Hospital was open 24 hours a day, seven days a week. Computerised tomography (CT) facilities were co-located next to the resuscitation room, and X-ray facilities were located at the back of the department and could be accessed during the same operational hours.

Patients presenting with mental health issues could be referred to the on-site mental health liaison team. The team worked 24 hours a day, seven days a week.

**Health promotion**

Staff in the department identified and took opportunities to promote health to patients where appropriate.

Staff promoted smoking cessation to patients admitted who smoked. Alcohol consumption was an integral part of the adult assessment tool. With the agreement of patients, staff could refer patients to the trust’s alcohol liaison service or to the local mental health, drug and alcohol charity which supported patients with substance misuse problems.

Posters detailing support and advice services to people experiencing domestic violence were displayed in the service’s toilets, and advice leaflets were given to patients when appropriate.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their responsibilities to seek patients’ consent to treatment and to escalate care to medics if a capacity assessment was needed. Staff did not have a clear understanding or knowledge of the deprivation of liberty safeguards.

The practice educator told us that awareness of the Mental Health Act 1983 and the Mental Capacity Act 2005 was covered during induction training for new staff. Additional ad-hoc training was provided to staff by the mental health liaison team.

We observed staff taking consent appropriately. This included both verbal and implied consent. Staff understood their duties to ensure patients had capacity to consent and those we asked were aware of the two-stage nature of capacity to consent. We were not able to find consistent recording of consent to treatment in patient records. However, we saw evidence that where a patient potentially lacked capacity, nursing staff escalated this to the medical team to carry out a formal assessment of the patient’s capacity. Staff within the ambulatory care unit told us they would allocate a named staff member to any patient that appeared to be confused.
Nursing staff we asked did not have a clear understanding of the deprivation of liberty safeguards and did not have an awareness of the types of actions that could be restraint; for example, placing a walking frame out of reach of a patient or placing a tray table in front of a chair or over a bed to prevent a patient from getting out of bed. This was a risk as the service regularly provided extended periods of care for patients.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from March 2017 to February 2018, Mental Capacity Act (MCA) training had been completed by 77% of nursing staff and 74% of medical staff. Both staff groups failed to meet the trust’s mandatory training completion target of 90%.

(Source: Trust Provider Information Request P14/P49)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We observed kind, caring, and compassionate interactions between staff and patients. Staff introducing themselves to patients using the ‘Hello, my name is’ structure. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 3: “Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.”

Patients and carers we spoke with were positive about the care provided. One carer told us that staff were ‘caring and compassionate’, while another patient told us they and their family had ‘always been pleased with the care received’. This was reflected by the responses to CQC’s 2016 emergency department patient survey for the trust. Out of a maximum score of 10 (where a higher score is better), the department scored 8.7 to the question about people being treated with dignity and respect. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 1: “Patients are treated with dignity, kindness, compassion, courtesy, response, understanding, and honesty.”

Patients’ privacy and dignity was maintained within the majors and minors areas with cubicle curtains consistently drawn while patients were receiving care and treatment. This was in line with the Royal College’s Emergency Department Care (2017) Quality Standard QS4.

However, there were no facilities within the ambulance corridor to maintain patients’ privacy and dignity while waiting for a cubicle. On one occasion during the inspection, when interviewing a patient and their carer in the ambulance corridor, we heard staff discussing the medical conditions of two other people.

Staff referred patients known to be approaching the end of life to the specialist palliative care nursing team, who would attend the department to review assess the patient. The team could advise staff on a care plan for the patient, arrange any specialist end of life medicines and ensure do not attempt cardiopulmonary resuscitation orders were considered where relevant. Staff involved the trust’s bereavement team in conversations with appropriate patients and their families about organ donation.
Chaperones were available to any patients that requested one in line with the trust’s chaperone policy.

However, the trust’s urgent and emergency care NHS Friends and Family Test performance was consistently lower than the England average and between February and April 2018 had significantly dipped.

We discussed this with the service’s senior leaders. They told us the service had introduced the ability for patients to provide their feedback by mobile telephone text messaging, as well as hard-copy questionnaires which were available in the reception areas. However, the leaders were aware that a large part of the local patient demographic was elderly, which were less likely to use the electronic feedback facility. The leaders were also unaware of any specific issues other than winter pressures that could explain the significant drop in the friends and family test performance between January 2018 and April 2018.

**Friends and Family test performance**

From April 2017 to March 2018, the trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average for 10 of the 12 months.

Data in March 2018 shows the trust’s performance at 76.2% which was considerably lower than (worse) the England average of 84.3%.

**Emergency Department Friends and Family Test performance**

Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England Friends and Family Test)

Latest data published by the time of the inspection for April 2018 showed a similar figure of 77% of patients that would recommend the care and treatment provided by the service at the Royal Preston Hospital.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Staff were aware of the impact on patients and carers as a result of the care and treatment provided.
Staff undertook comfort rounds to check on patients and to ensure their needs were met. This was in line with National Institute for Health and Care Excellence Quality Statement QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety.

Patients with mental health needs were treated within a designated side-room near to the nurses’ station. Staff referred patients appropriately to the on-site mental health liaison service, who could support patients with psychiatric liaison and assessments. However, patients admitted to the department with primarily mental health conditions often experienced significant lengths of stay within the department when mental health inpatient beds at the local NHS mental health trusts were not available.

Paediatric patients were assessed and treated in a side room close to the nurses’ station.

The chaplaincy service was available 24 hours a day, seven days a week, via the bleep system. It could accommodate requests for support from all religious denominations. Senior staff told us the service was very responsive.

Relatives and carers of patients who had died in the department had access to the relatives’ room, which was co-located to the viewing room. The viewing room was situated immediately opposite an entrance to the resuscitation area, which meant that deceased patients could discretely be moved into the viewing room. Both rooms were small but were adequate for their purpose and were in line with the Royal College of Emergency Medicine guidance on emergency department care quality statement QS9: “in the case of a dying or recently deceased patient, is the relevant clinical area quiet, private, sensitively designed and readily identifiable as such to approaching staff?”.

Staff within the ambulatory care unit told us how they had supported a patient who attended the department at the end of Ramadan. Staff prioritised his care and treatment to enable him to be discharged from the unit in time to be able to attend Eid al-Fitr celebrations.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients spoke positively about their involvement in their care and treatment. The service introduced carer’s lanyards to help staff identify carers and to include them as much as possible in the provision of care to their relatives.

Care and treatment was provided in line with the National Institute for Health and Care Excellence QS15 statement 4: “Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care”.

One patient we spoke with in the waiting area had also attended the service on several previous occasions with their family. The patient told us their family was always involved in their care and treatment decisions. Another parent told us they were always included in the care about their child.

This was reflected by the responses to CQC’s 2016 emergency department patient survey for the trust. Out of a maximum score of 10 (where a higher score is better), the trust-wide urgent and emergency service scored 8.4 for patients having sufficient time to discuss their condition with a doctor or nurse, and 8.8 for doctors or nurses listening to what patients had to say. Patients scored the department 8.1 for staff explaining the condition or treatment in a way they could understand, and 8.7 for explaining any tests needed. When benchmarked, the scores were about the same as other trusts.
The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. It scored worse for Q40: Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. Did a member of staff tell you about medication</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Question | Trust 2016 | 2016 RAG
--- | --- | ---
side effects to watch out for? |  | other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car? | 4.3 | Worse than other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department? | 4.2 | About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 6.3 | About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.6 | About the same as other trusts
Q45. Overall... (please circle a number) | 7.6 | About the same as other trusts

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care and treatment in a way that met the needs of local people. It worked with local commissioners and other healthcare providers to understand current and future demand and to redevelop its services appropriately.

People attended the service primarily from the local population in the Preston area, although the service also received patients from the Chorley area. As a major trauma centre, trauma patients were also received from across the Lancashire area.

The department’s facilities and premises were confined by the building footprint. The service had developed plans in conjunction with the urgent care centre provider to integrate the patient reception booking system and to combine the adult emergency waiting room and urgent care centre waiting rooms. Integration of the booking systems was expected to start in mid-July with physical redevelopment of the environment to start once ongoing building work at the urgent care centre was completed.

The service worked with the local clinical commissioning groups, and the local mental health commissioning teams. The service’s business manager described the relationship with the commissioners as positive and supportive. The commissioners had agreed winter funding for additional ‘crisis hours’ to enable the mental health liaison team to maintain a presence within the department, and for falls care. Both the commissioners and the service recognised they needed to forward plan for next winter.

Oversight of the service, and developments within it, was maintained through the accident and emergency delivery group which reported into the accident and emergency delivery board. Developments agreed through the delivery group and board included the separation out of the minors stream into its own area, the use of emergency nurse practitioners overnight and, due to the lack of a clinical decisions unit, the introduction of second medical reviews for relevant patients prior to discharge to ensure their safety.

The service worked with the trust’s integrated discharge team, including discharge assessment nurses and discharge facilitators. This aimed to get people home from the department rather than
admitting them overnight, although the leaders recognised this could be challenging after 5pm. Processes were in place to escalate to the clinical commission groups situations where patients, attended the department from local nursing or care homes due to challenging conditions or behaviours that homes were unable to manage.

Leaders in the service planned in advance, with the local clinical commissioning groups, for local events to ensure sufficient staff were available to manage demands on the service. Events included a local Caribbean carnival, the world cup, religious festivals, and the local university’s ‘freshers week’.

Meeting people’s individual needs
The service took account of patients’ individual needs. It undertook patient risk assessments and ensured staff were aware of any patient communication needs or reasonable adjustments that were needed.

A large range of patient information leaflets were available within the department. These included a number of leaflets designed for children, which were identified by pictures of animals. However, the leaflets displayed were only in English, as was signage throughout the department. The practice educator told us that staff could access a limited printout of leaflets in Polish Urdu, Punjabi and Gujarati; however, the service did not routinely hold stocks of leaflets in other languages. The service was working with its translation providers, and local publishers on a plan to increase the range of leaflets for other languages.

Staff understood the importance of not relying on patients’ families or carers to interpret important information and conversations. Interpretation services were available by telephone, and face-to-face when appropriate; this included British sign language. One staff member was being supported with funding to learn British sign language.

Patients who required additional support, such as those living with dementia, at risk of falls, or who needed assistance with eating were appropriately identified and care adjustments made accordingly. The service had access to a learning disability specialist nurse.

Patients living with dementia were identified by the use of the forget me not symbol. The department held a resource box to support patients who were living with dementia while in the department. This included useful documents and information, twiddle mitts (a knitted sensory sleeve band muff to provide stimulation and stress relief) for patients to wear, and reminiscence cards. A tea set had been donated to the department for use with patients who were living with dementia.

The service had a dementia lead and dementia champions, and encouraged the use of hospital passports including the John’s Campaign ‘This is me’ approach. The trust had also commissioned work with a local university on the importance of identity and recognising people living with dementia as individuals. However, although dementia awareness training was available on-line for staff, this was not mandatory.

The service also focussed on making carers more visible to staff through the use of carers’ lanyards. Increased visibility meant that staff could involve carers more in the care and treatment provided to their relative.

The service had two band five learning disability nurses, who worked closely with patients living with learning disabilities. If a known attendance, the nurses would meet with the patient on arrival in the department. Stickers within patients’ notes identified if they had learning disability needs.
Staff undertook risk assessments of patients on admission, including any falls, pressure ulcer or social history risks. Patients identified with a risk of falling were provided with purple socks to make them more visible to staff and to enable additional support when required.

The department worked closely with the Lancashire integrated frailty team (LIFT team) to screen appropriate patients attending the department. Screening was applied to any patient over 65 years of age, or any patients attending from a nursing or residential care home or community hospital, or any patients attending from their own home with two or more pre-defined conditions. Early intervention by the frailty team was aimed at either avoiding the patient’s admission to hospital, or if admitted to ensure daily reviews, therapies and discharge planning were undertaken to minimise the patient’s length of stay.

A distraction box, donated and maintained by a local charity, was held in the paediatric resuscitation bay for children to use while receiving care. The service also used a book ‘What’s wrong with Jack’ to help young children understand why they were in hospital.

Patients with mental health needs presenting within the emergency department were referred to and seen by trained staff working in the mental health liaison team. The team, which was employed by a local mental health healthcare provider, undertook initial mental health assessments of patients in the department and could refer the patient for psychiatric assessment or for assessment under the Mental Health Act. Staff could access the mental health records and care plans for patients who were already known to the team. This enabled staff to identify the support and treatment patients were given by community mental health services to ensure patients received appropriate and continuous treatment, and to provide advice to the medical and nursing team in the department to keep the patient safe.

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for the three questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Access and flow**

The service’s performance against national targets was consistently poor and deteriorating. Leaders in the service could describe factors that impacted on performance and expected that increased staffing numbers, alongside plans for physical development of the department, would reverse the deteriorating performance trend.

Royal College of Emergency Medicine guidance indicates that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Average waiting times for self-presenting patients to be seen were displayed in the waiting areas. Times varied depending on demand during the day.
For patients arriving by ambulance between June 2017 and May 2018, the service at the Royal Preston Hospital only achieved this target on one month. The average time from arrival to initial triage assessment during this period was 30 minutes. For all patients, not arriving by ambulance, the average time to initial triage was 45 minutes, and for children specifically the average wait time was 41 minutes.

Median waiting times for patient at the Royal Preston Hospital from arrival to initial treatment were consistently worse than the national target of 60 minutes with the service only achieving this target in March 2018 and May 2018. The average time from arrival to initial treatment between June 2017 and May 2018 was 72 minutes.

Performance against the national target of 95% of patients admitted, transferred or discharged within four hours of arrival showed a downward trajectory that was significantly worse than the England average. The service did not meet the national target.

The data we received on this measure between June 2017 and February 2018 was trust-wide and incorporated both the Preston and Chorley sites and indicated an average of 75% of patients admitted transferred or discharged within four hours. Performance for children was better in the same period but again did not meet the target with 92% of children being admitted within four hours of arrival.

From March 2018 to May 2018, the data received was disaggregated by site and showed that for Royal Preston Hospital an average of 70% of patients were admitted, treated or discharged within four hours of arrival.

The percentage of patients waiting for a bed for more than four hours after a decision had been taken to admit them showed an increasing trajectory that was significantly worse than the England average. The trust-wide service had fluctuating performance in the number of patients waiting for more than 12 hours for a bed following the decision to admit. Given the limited opening times for the service at Chorley it was expected that most of these breaches occurred in the Royal Preston Hospital with 18 out of a twelve-month total of 20 occurring between January and March 2018. A further 24 breaches occurred in April 2018 and three in May 2018.

All 12-hour breaches were incident reported internally, reported externally to the clinical commissioning group, and discussed with NHS England. However, we identified further 12-hour breaches related to patients in the department that were presenting with mental health conditions. Between June 2017 and May 2018, 27 such patients waited more than 12 hours. The majority of which related to waits for mental health inpatient beds in another healthcare provider. Each breach had been incident reported; however, these were not included in the service’s overall 12-hour breach figures as the IT systems did not enable staff to input a decision to admit for patients that were to be admitted to another healthcare provider.

The service performed better than the England average, and against the trust target of 5%, for the percentage of patients leaving the department without being assessed by a clinician. Between June 2017 and May 2018, an average of 3.9% of patients left the department at Royal Preston Hospital without being seen.

We discussed performance with the service’s senior leaders who acknowledged the department had faced significant challenges. Risks related to performance were on the service’s risk register. Leaders told us there were several factors that contributed to the unit’s declining performance, including additional demand from winter pressures and increasing patient length of stay in the inpatient wards, which were compounded by legacy nursing staffing levels.
At the ‘front end’, the service’s leaders explained that performance was impacted by transfer of patients who had initially been directed to the urgent care centre. As the performance ‘clock’ started when those patients were first registered to the urgent care centre, late transfers meant the service had reduced opportunity and time to assess and treat the patients within the national target timescales. It was hoped that the new integrated joint booking-in model with the urgent care centre, expected to start in July 2018, would improve effectiveness in the early management of these patients.

At the ‘back end’, leaders told us the service faced challenges from ‘exit block’ (lack of available beds for patients waiting to be admitted) and a lack of available mental-health inpatient beds in the area, which meant that patients were waiting longer in the department. Exit block was cited as a contributory factor in a serious incident investigation that we reviewed, while significant delays in sourcing a mental health bed was cited in another root cause analysis of a mental health patient’s unsuccessful attempt to self-harm while in the department. However, leaders also expressed their views that patient safety was paramount and, despite the challenges faced, patients would not be signed off by consultants for discharged from the department until their safety was assured.

The service was in the process of recruiting to the additional nursing staff vacancies that had been agreed and increased by the trust in December 2017 following the staffing review. The leaders hoped the increased staffing numbers, including the planned future build of a new ambulance arrival and triage area along with the implementation of a rapid assessment and treatment model (with four rapid assessment cubicles) would reverse the service’s deteriorating performance.

The trust had very recently opened an ambulatory care unit. Although the unit was not accepting GP referrals at the time of our visit, it was ‘pulling’ appropriate patients from service’s waiting area. These included patients presenting with anaemia, atrial fibrillation, hypotension, diabetes, acute kidney injury, asthma, and patients discharged from the emergency department but who needed blood tests. This was expected to reduce the pressure on the emergency department.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for 10 months over the 12-month period from April 2017 to January 2018.

Performance against this standard showed a trend of decline. The trust met the target in April 17 with a median time to treatment of 59 minutes but in March 2018 this was 89 minutes.

**Ambulance – Time to treatment from February 2017 to January 2018 at Lancashire Teaching Hospitals NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust did not meet the standard throughout the duration of the reporting period.

The trust breached the standard 12 times from February 2017 to January 2018.

From April 2017 to March 2018, performance against this metric showed a trend of decline. In June 2017 the trust was performing better than the England average but this has deteriorated since from 92% to 73% in March 2018.

Four-hour target performance - Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England - A&E waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average for all month except May, June and July 2017.

From July 2017 onwards, the trust has seen a steep increase in the number of patients waiting more than four hours from the decision to admit until being admitted. There was a drop in November 2017 where performance was similar to the England average, before adopting an upward trend again for the remainder of the reporting period.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - Lancashire Teaching Hospitals NHS Foundation Trust


Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from February 2017 to January 2018, 20 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2018 with a total of 10 patients waiting.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>2</td>
</tr>
<tr>
<td>Oct-17</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1</td>
</tr>
<tr>
<td>Jan-18</td>
<td>10</td>
</tr>
<tr>
<td>Feb-18</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>7</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)

The trust subsequently provided data for April 2018; 24 patients waited longer than 12 hours. In May 2018, three patients waited longer than 12 hours.
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2017 to March 2018, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

Percentage of patient that left the trust without being seen - Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From April 2017 to March 2018, the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a slight improvement in January 2018, however the trust median time was 192 minutes compared to an England average of 153 minutes.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. However, complaint action plans were not always robust and included no detailed mechanism for the service to assure itself that staff had learnt from the events.

At the time of the inspection, the trust’s complaints policy and procedure was being reviewed prior to its expiry in August 2018. A new policy had been drafted and was awaiting review and sign-off.

Between April 2017 and January 2018, the trust received 48 complaints about care and treatment provided by the Royal Preston Hospital urgent and emergency service and one relating to the hospitals ambulatory and emergency medical care unit.

Complaints were co-ordinated by the trust’s customer care co-ordinators and sent to the department for investigation. The service’s matron and clinical director had oversight of all complaints received by the department. These leaders could describe the main themes of complaints received to us, which mainly reflected poor communication with patients and their carers (including poor communication by staff about long waiting times rather than the length of the wait).

Complaints were subsequently forwarded to the relevant nursing or consultant shift co-ordinator to investigate with the individuals involved.

Informal concerns, arising at the time of the patient’s attendance, were addressed by staff at the time and documented in the patient’s notes. We do not have details of the number of informal concerns received by the service.

Feedback was provided individually to any staff member involved in the complaint in a supportive manner with any relevant training needs identified. Learning from complaints was shared more widely with the team at team meetings, in five-minute briefing sessions, and in the service’s ED Times newsletter (where consent had been provided by the complainant).
We reviewed eight complaints about the urgent and emergency service at the Royal Preston Hospital, received in the period between April 2017 and January 2018. All the responses included an explanation of the events that had occurred, provided apologies, and included action plans for improvement where appropriate. We also saw a good example of an effective joint complaint response with another healthcare provider.

Six of the seven complaints (where we noted the date of receipt and response) had been responded to within the trust’s extended target of 40 working day. This target applies to complex or multifaceted complaints. Although action plans were developed, these were not always robust and included no detailed mechanism for the service to assure itself that staff had learnt from the events. For example, plans identified actions for staff to ‘reflect’ on the events or shared learning through the ED Times newsletter, but did not have any mechanism for subsequently checking staff knowledge or competency.

The service collated and shared information on compliments from patients, carers and families. Between June 2017 and June 2018, the service at the Royal Preston Hospital received 145 compliments. One patient wrote, “I can only award five stars as not any higher to attach; in my opinion 11 out of 10 for the whole staff [team] here”. Another patient wrote, “You are jewels in the crown of the NHS”. We also saw a thank you poem written for staff from a patient who had received life-saving treatment in November 2017.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing quality sustainable care.

The urgent and emergency services at the Royal Preston Hospital were provided within the trust’s acute medicine directorate. The service was clinically led by the clinical director, matron and business manager. It was supported by a clear governance structure and clear lines of accountability for staff at all levels.

The departmental and divisional leaders we spoke with understood the challenges facing the service, which included current staffing levels, incidents, and complaints. The leaders were also able to clearly describe the actions that had already been taken, or were planned, to meet these challenges. The leaders for the department were motivated to improve the service provided by the department and worked closely with the trust’s director of continuous improvement.

Leaders told us that a recruitment, appointment and induction process for new staff was ongoing at the time of the inspection, which would bring the department up to full establishment and was expected to help improve performance.

Staff on the unit that we spoke with were aware of who the department and divisional leaders were. Staff spoke positively about their local leaders, who they considered were visible on the unit, approachable and very supportive. However, staff were less consistent when speaking about trust the trust senior management team. Although there was a scheduled weekly meeting with consultants and executives, we received mixed views from staff when describing the visibility and supportiveness of senior hospital or executive staff on the unit.
We observed senior leaders within the unit working with the teams in an approachable manner. This was in line with the Royal College of Emergency Medicine's Emergency Department Care (2017) Quality Standard 14.

**Vision and strategy**

The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action which were developed with involvement from key staff, commissioners and other stakeholders.

The strategy for the unit was developed following a review of a service review, which identified six key priorities for 2018-19. These included the improvement of performance against the four-hour target; focus on actions arising from previous CQC reports; planned reduction in agency and locum spending; development of a robust resilient workforce strategy; maximisation of improvement opportunities; continuous improvement in standardisation of process; and, evolution of the department into a best practice clinical business unit. The strategy was underpinned by the divisional business plan, and physical development plans for the department.

Leaders and senior staff within the urgent and emergency service had a clear understanding of the challenges faced by the service, including those where performance was impacted by factors external to the department. They could describe the department’s strategy for improving performance which focused on delivering appropriate staffing levels; the physical development of the department in the Royal Preston Hospital to improve ambulance arrival and handovers; the provision of a dedicated paediatric assessment and treatment area; the implementation of a rapid assessment and treatment model of care; and, closer integration with the urgent care centre.

Further staffing plans included increasing the ‘depth of cover’ into the evenings to ensure senior staff were available at times of peak demand. This included the use of emergency nurse practitioners and advanced nurse practitioners to support the flow of patients requiring treatment.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff at all levels in the urgent and emergency services department in the Royal Preston Hospital spoke positively about the local leadership team. We were aware of some recent cultural and operational challenges within the service, which had been highlighted in a letter from the consultant body to the trust’s leadership. However, nursing and medical staff told us they were motivated, proud and felt supported by their managers to provide good quality care, even though this was sometimes challenging due to demands on the service.

One nurse we spoke with told us staff felt valued and doctors and nurses “worked really well together”, and that there was flexibility in working patterns. Another nurse told us they felt that rotation between both sites was a positive experience. A student nurse told us they had been made to feel very welcome in the department. A middle grade doctor described how they had received good support from, and had been ‘nurtured’ by, the medical team.

The culture encouraged openness and honesty at all levels in the department. Staff were supported to report incidents and feedback to individuals was provided in a positive way. We saw no evidence of a ‘blame culture’ in the department. This was in line with the Royal College of
Emergency Medicine’s Emergency Department Care (2017) Quality Standards including QS12, QS18, QS21, and QS50.

**Governance**

The service used a systematic approach to continually improve the quality of its services. There was a clear escalation and governance committee structure in place with clear lines of accountability for staff at all levels that ensured a line of sight from the service to the board.

Staff were clear about their roles within the structure, what they were accountable for, and to whom. The service had a consultant governance lead.

The service’s consultant governance lead chaired the monthly governance meetings which was attended by the service manager, the matron, two consultants, the practice educator and representatives from reception staff. The governance meeting discussed the service’s high risks every month and cross-linked these with incident reports. Low risks for the service were discussed every quarter. The departmental governance meeting fed into the divisional risk governance meetings which provided a direct route through to the executive board.

The service also undertook a monthly case review meeting. This focused on individual patient cases, highlighting good practice as well as issues arising from incidents and complaints. The meeting also included mortality and morbidity review of deaths in the department. The meeting was open to a wide range of multidisciplinary team staff, including senior and middle-grade medics, nursing staff and other disciplines. Feedback and direct actions from reviews was shared with individual staff were appropriate, and learning from both meetings was shared with wider staff through emails, alerts, and the department newsletter; the ED Times.

A separate major trauma mortality and morbidity review was undertaken each month by the trauma team, which fed into the bi-monthly trauma board.

The service was involved in several other joint governance meetings with the paediatric team, the mental health partnership, and the urgent care centre.

A monthly department ED Sisters meeting was held and minuted. We reviewed the minutes of the last three meetings. The agenda varied with each meeting, but we saw evidence that performance, safety risks and learning from incidents and complaints were discussed and shared at the meeting. A separate departmental staff meeting was also held month which reflected the agenda and discussions arising from the ED Sisters meetings.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, despite the service’s leaders appropriately identifying the risks and contributory factors affecting the department, the service did not meet most of the national targets for urgent and emergency care. Performance in a range of internal trust targets in training, safeguarding, and staff appraisals remained below trust target. Improved performance as a result of staff recruitment and physical developments, including the creation of the minors area and installation of additional computers in the department, had yet to be fully embedded but was starting to be realised.

The service’s leaders could describe, understood and had oversight of the risks and issues affecting the service at the Royal Preston Hospital. The service had a risk register which,
excluding risks solely affecting the Chorley site, held 20 open risks that were either trust-wide or affected the department at Royal Preston. Of these, four open risks were classed as high risk, 13 were significant risks, and the remainder were moderate risks.

The high risks included those we would expect to see, including delays in triage at the front end and exit block at the back end, and medical staffing. Significant risks reflected a range of issues, including the co-location of the urgent care centre, delays in the mental health pathway and the use of the mental health assessment room, the children’s emergency care pathway, and the risk of misdiagnosis or late diagnosis. Moderate risks included blood transfusion errors, band seven staffing cover, and breaches of confidentiality.

Each open risk identified controls and assurance measures, review dates, actions and action progress fields. The copy of the register provided to us did not include details of the risk owners and inconsistently noted the names of action takers, although the trust subsequently provided evidence that this information is held within their local risk recording systems.

A separate risk register was held by the major trauma team. The leaders of the trauma team could describe the risks they faced, including risks arising from different systems used across the local Lancashire major trauma network. Risks were reviewed at the bi-monthly major trauma board, which had a large multidisciplinary team representation. The board also reviewed service developments, key performance indicators and, in the minutes we reviewed, the mass casualty plan. Action plans were in place, including for learning from trauma mortality and morbidity reviews.

Risk and clinical performance was monitored through the departmental governance meetings, the divisional safety and quality committee meetings which met monthly. These fed into the trust’s multidivisional risk management committee which was chaired by the chief executive or deputy chief executive.

Quality and risk management was underpinned by an audit programme within the service. In 2018-19 the programme was ongoing and aimed to deliver audits in a range of areas including, although not limited to, sepsis and antibiotic guidelines, radiation awareness, review of patients who had suffered heart attacks, cardiac chest pain, head injury and concussion, and Royal College of Emergency Medicine audit themes for procedural sedation, consultant sign off, venous thromboembolism, feverish child, and vital signs in adults.

Audit meetings were held every three months and were open to all staff. Learning and urgent actions from audits were fed back to staff during handover meetings and through the ED Times newsletter.

A representative from the service attended the trust-wide bi-monthly clinical audit and effectiveness group meeting.

The service had a robust training and support mechanism in place for the recognition and management of sepsis. Staff carried Sepsis Six pocket cards and could request review by the trust’s specialist sepsis nurses. This was in line with the National Institute for Health and Care Excellence Guideline NG51 Sepsis: recognition, diagnosis and early management. The Sepsis Six aimed to implement three diagnostic and three therapeutic actions within one hour of a diagnosis of potential sepsis. These included monitoring of oxygen levels, fluids and urine output, measurement of lactate levels and the commencement of blood culture tests and antibiotics.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan and staff were aware of where the plan could be accessed. We observed staff following the department’s evacuation procedure during the inspection as a result of
a fire alarm (false) being activated. Staff managed the situation professionally, ensuring rapid evacuation of staff and visitors from the department, while maintaining support for patients within the clinical treatment areas.

**Information management**

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems.

Performance information was collected and analysed by the department and used to develop and support the services the department offered. This included the collection of data to support national audits and surveys including those by the Royal College of Emergency Medicine, the Safety Thermometer, the NHS Friends and Family Test, and interactions with the ambulance service.

Performance data was benchmarked against urgent and emergency against the trust performance, and where appropriate against national standards.

The service had implemented an electronic dashboard system within the department which provided a detailed overview of all patients in the department. This included a range of metrics including the patient’s time of arrival, how long they were in the department, and the time of any decision made to admit the patient to the hospital for further treatment or monitoring. This also enabled performance tracking with the real-time data available to the executive team.

Staff had access to the relevant information needed to care for their patients. The mixed use of paper and electronic records meant the service was reliant on staff remembering to check all the relevant information held, including system flags and notifications, safeguarding information, and existing care plans if patients were known to have one (including frail and vulnerable patients or those presenting with mental health needs).

Patients’ communication needs were noted on the electronic system, and through stickers in the hard-copy paperwork. Hospital passports were also used when needed. This was in line with the accessible information standard; however, there was limited ability for the service to provide information in easy to read or pictorial formats.

**Engagement**

The service engaged with patients, staff, and the public and local organisations to plan and manage appropriate services.

The department participated in the NHS Friends and Family Test scheme. This was primarily driven by a text messaging service; reception staff took people’s consent when booking them in to meet the requirements of the general data protection regulations. The service’s leaders acknowledged that the department served a large elderly population, who did not always use mobile phones. As such, hard-copy feedback cards were also available in the department’s reception areas.

The service worked with the education centre to enable work experience for local adolescents.

The major trauma team worked with a local charity who visited the hospital weekly to help trauma patients obtain external advice and additional support where needed. The trauma team also worked with the regional ambulance and police services on the ‘Safe drive Stay alive Lancashire’ campaign on road safety.
The service held joint meetings with the urgent care centre to review services, to understand how they could work better together, and to develop service improvements.

The clinical director introduced a monthly staff newsletter, the ED Times. This was designed to reflect a range of items of interest to the department including news history, performance, learning, practical information and light-hearted articles.

The matron and clinical director ran drop-in sessions for staff to discuss areas of concern, improvement, or good practice that could be shared. As a result of these sessions, the service obtained and installed more computer work stations and an additional blood gas analyser. The services’ leaders told us the trust was very responsive in agreeing to additional equipment.

The drop-in sessions were also open to ambulance service staff, and as a result an ‘ambulance triage lanyard’ was introduced so that ambulance staff could more easily identify the ambulance triage nurse.

The service had introduced an encrypted social media group messaging system for staff. This was used to provide staff with updates on training, staffing shortages and shifts available, safety alerts and other relevant changes.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There was a culture of supportive learning, improvement and development embedded in the department, which was supported by the trust’s director of continuous improvement. The practice educator, matron and consultants were pivotal in the development and training of new nursing and medical staff. Shift leaders were involved in reviewing and investigating incidents and complaints.

The service worked with the regional ambulance service provider to develop a rotational paramedic role working within the department. This helped to improve knowledge in both services to drive improvements.

The service participated in the trust’s safety triangulation accreditation review (STAR) quality assurance framework. The system measured the quality of care delivered in each department or ward against a set of trust standards that had been developed by staff, and triangulated a number of key performance measures to identify and put in place additional support for areas that need it, and to recognise and reward areas of good performance.
Medical care (including older people’s care)

Facts and data about this service

The medical care service the trust provides care and treatment for 15 specialities. There are 482 medical inpatient beds located across 25 wards.

A site breakdown can be found below:

- Royal Preston Hospital - 339 beds across 16 wards
- Chorley and South Ribble - 143 beds across nine wards

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 44,536 medical admissions from November 2016 to October 2017. Emergency admissions accounted for 20,691, 1,346 were elective, and the remaining 22,499 were day case. Admissions for the top three medical specialties were:

- Gastroenterology 10,755
- Respiratory Medicine 7,909
- Geriatric Medicine 4,441

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Staff received effective training in safety systems, processes and practices. Throughout the service, staff compliance with mandatory training was high.

Mandatory training rates were sufficient to ensure there were appropriately trained staff across each shift to deliver safe and effective care and treatment. During out inspection, we found that mandatory training compliance had increased since the submission of the provider information return as detailed below.

Staff we spoke to told us they were accountable for ensuring they stayed up to date with mandatory training and any gaps would be reviewed during their annual appraisals.

There was support for newly qualified staff for the duration of their preceptorship. The newly qualified staff we spoke to told us they felt well supported in their role and had ample opportunity for further training and development as well as time for peer support.

Junior medical staff we spoke to told us there was ample opportunity for training and development beyond mandatory training and they received support from senior medics in their roles.

We observed that training events and study days around sepsis and dementia were advertised on notice boards across various wards in staff areas. On two of the wards we visited there was a clinical skills mentor in place whose role was to support newly qualified staff through their preceptorship and to provide more specialist training to ward staff.
During our inspection, we observed the use of sepsis six pathways and there were sepsis six bundles clearly labelled on each ward. The staff we spoke to could articulate signs and symptoms of sepsis and had received training in relation to this.

The trust has set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in medical care.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>20</td>
<td>23</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>345</td>
<td>419</td>
<td>82.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>298</td>
<td>415</td>
<td>71.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in medical care did not meet the mandatory training completion target for any of the seven training courses made available to them. The provider did not include details as to what training was included in the category of “other” for which compliance was reported as 82.3%.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>76</td>
<td>94</td>
<td>80.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>200</td>
<td>47.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in medical care at the trust met the target for four of the six training courses made available to them. As with the nursing staff group, they also failed to meet the target for courses classified as other with a rate of 47.5%. The trust did not provide us with information regarding the content of these courses.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)
Safeguarding

There were systems, processes and practices in place to keep people safe and safeguarded from abuse. Staff were aware of how to access support from the safeguarding team and had received training at the appropriate level.

During our inspection, we saw consistently good examples of safeguarding practices at ward level. In particular, on ward 23 (respiratory ward) managers had implemented a system for sharing safeguarding information which worked despite a lack of a central system for flagging safeguarding concerns. As well as this, we saw that a closed social media group was used by staff to share examples of good practice and changes to guidance around safeguarding.

Staff we spoke to were aware of how to make safeguarding referrals where there were concerns and how to contact the trust safeguarding team. However, some staff commented they would benefit from trust safeguarding support out of hours and at weekends so they had a point of contact for any safeguarding advice during these times.

The trust has set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff in medical care.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>347</td>
<td>417</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>334</td>
<td>417</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>140</td>
<td>176</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in medical care at the trust did not meet the target for any of the three safeguarding training courses made available to them.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>58</td>
<td>98</td>
<td>59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>54</td>
<td>98</td>
<td>55%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff met the training completion target for one of the three safeguarding courses made available to them. It should be noted that the one course which met the target had only three members of staff eligible to partake.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene

During our inspection we found the wards and clinical areas to be visibly clean and we spoke to patients who told us they observed staff members washing their hands regularly.

There was a housekeeper assigned to each ward we visited who was responsible for carrying out daily cleaning tasks. We observed the use of green “I am Clean” stickers throughout the service which were dated to indicate when equipment had been cleaned and it was ready for use.

Regular audits were carried out in relation to hygiene and infection prevention and control. As of May 2018, the service achieved 98% compliance for hand hygiene, 96% for mattress audits, 92% for intravenous access devices and 95% average across daily commodes audits.

Staff completed regular checks of patients with indwelling catheters and cannulas to monitor for signs of infection and took action where this was observed.

Staff observed infection prevention measures such as barrier nursing for patients with suspected or confirmed infection and there were reversible signs on the doors to bays and side rooms which would indicate if these measures were needed. However, we found on one ward the door was left open to a side room of a patient with neutropenic sepsis and we observed various staff entering and exiting without using personal protective equipment or washing their hands. We escalated this to the nurse in charge at the time of our inspection.

Following our inspection, the service provided information around infection rates. Between May 2017 and May 2018 there were no incidences of methicillin resistant Staphylococcus aureus (MRSA) across the medical care core service. There were 14 incidences of methicillin-sensitive Staphylococcus aureus (MSSA) and 25 cases of Clostridium difficile infection across the service at Royal Preston Hospital. The total cases of Clostridium difficile were below the trust objective and each case was subject to a review. On wards we visited where there had been cases of infection staff were able to tell us of learning which had taken place such as increased awareness of barrier nursing and infection prevention measures.

Environment and equipment

We carried out checks of emergency trolleys and resuscitation equipment on each of the wards we visited as part of our inspection. We found that daily checks were completed and documented. A random sample check of perishable items found these were all within their expiry date. Although some of the wards had limited space along corridors we found that emergency equipment could be accessed quickly when needed.

We observed that portable electronic devices had undergone safety checks and records were maintained detailing when these tests had been carried out. We found that all equipment was within the expiry date.

We observed throughout the service that waste was disposed of appropriately using separate bins for sharps, clinical and general waste.

For patients who had acquired pressure ulcers there were pressure reliving mattresses available and staff we spoke to knew how to assess patients need and access this equipment.

Assessing and responding to patient risk

Risks to patients were assessed, monitored and managed so that they were supported to stay safe. Staff used national early warning scores when appropriate to detect deterioration in a patient’s condition and these were acted on as needed.
There was a trust procedure for the Timely Recognition and Response for Patients at risk of Deterioration. This was used across the service which included a clear escalation plan for patients with a national early warning score greater than zero. The procedure included reference to patients who gave cause for concern without a raised national early warning score and those whose condition did not improve despite intervention. The procedure was based on best available evidence and current national guidelines.

We reviewed 19 patient records across six inpatient areas and found that national early warning scores were consistently recorded, documented and escalated in line with trust procedures.

There was a sepsis pathway which was in accordance with UK Sepsis Trust guidelines and there were clearly marked sepsis six bundles in each of the wards we visited.

The trust provided information around compliance with national targets in relation to the treatment of patients with sepsis. This showed that the trust had met their target against five of the eight measured indicators.

Indicators around the screening and monitoring of patients and administration of antibiotics within three hours exceeded the target of 79.7% however; collection of samples for blood cultures within three hours, commencing second litre of intravenous fluids within four hours and senior review or assessment by critical care within four hours were below target.

There was a sepsis lead nurse in the trust whose responsibilities included reviewing education and training for staff and monitoring performance against sepsis targets. There were also sepsis champions throughout the service who shared information with staff around best practice in relation to sepsis.

Risk assessments for; venous thromboembolism, nutrition, patient falls and pressure ulcers were recorded on an electronic recording system although some areas were also using paper-based records which had the potential to cause confusion for staff.

We reviewed the electronic risk assessments for 10 patients across two of the inpatient areas we visited and found that not all records were consistently completed. We found that seven records had risk assessments that were completed and up to date. The remaining three were either partially completed or not documented in the online system.

We found that on some wards, staff were duplicating risk assessments by documenting using the electronic recording system and hand writing these within the patient’s paper-based notes. This meant staff had to review both paper records and the electronic records system to determine whether risk assessments had been completed.

Some wards had implemented a paper based checklist that staff used to indicate whether risk assessments had been completed and reviewed although this was not standard practice across the service.

There were processes to provide care for patients who required enhanced care due to complex social needs. It was not always possible to achieve one to one care for these patients due to staffing shortages and where this was the case, ward staff told us that they allocated a bay for enhanced patients and one member of staff would be in there at all times.

There was a transfer form for use when patients were discharged to a care home which included information around their medical history, psychological and physical needs as well as any follow up needed. This accompanied a discharge letter which was written by a medic and a copy sent to the patient’s GP.
Nurse staffing

There were not always adequate numbers of suitably qualified staff in place to ensure that people were safe at all times.

During our inspection we visited ward 17 (neurology) and found there was one nurse to 14 patients at that time. The staff we spoke to told us they had come to expect this as although shifts were filled by agency staff they often cancelled at the last minute or failed to attend for their shift.

We were informed of four incidents for ward 17 which had been reported during May 2018 and June 2018 in which staffing levels had been similar to those we observed during our inspection. Of these incidents it was reported that medications, tube feeds and antibiotics were given late due to staffing shortages and one incident detailed a missed medication for a patient who was acutely unwell which was, again, attributed to staffing shortages.

The trust provided information around staffing as part of the provider information request. This showed that for January 2018 the daytime fill rate for registered nursing staff on ward 17 was below 75%. A recent staffing review had concluded that the nursing establishment for ward 17 should be increased due to the level of acuity of patients admitted to the ward. At the time of our inspection the ward was not recruited to establishment level.

The Safer Staffing tool was used by the service to determine appropriate staffing levels based on the acuity of patients and bed management meetings were held daily to deploy staff to areas of high demand. Where there were shortages in qualified nurse staffing this was often compensated for by increased levels of unqualified nursing staff such as healthcare assistants.

We saw on ward 17 that healthcare assistants were used to provide enhanced care to patients who required one to one observation usually due to complex needs or cognitive impairment. It was not always possible to care for these patients on a one to one basis due to staffing shortages and so two bays on ward 17 had been allocated as enhanced care bays where one member of staff would be in the bay at all times.

Following our inspection, the service provided staffing figures for the period April 2017 to March 2018. These figures are displayed as fill rates in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDU (RAU)</td>
<td>197%</td>
<td>219%</td>
<td>205%</td>
<td>188%</td>
<td>198%</td>
<td>213%</td>
<td>223%</td>
<td>230%</td>
<td>218%</td>
<td>196%</td>
<td>84%</td>
<td>85%</td>
<td>167%</td>
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<tr>
<td>Ward 8</td>
<td>98%</td>
<td>101%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>106%</td>
<td>103%</td>
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<td>95%</td>
<td>95%</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>CCU RPH</td>
<td>92%</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>94%</td>
<td>93%</td>
<td>94%</td>
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<tr>
<td>Ward 20</td>
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<td>93%</td>
<td>88%</td>
<td>81%</td>
<td>79%</td>
<td>90%</td>
<td>123%</td>
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<td>80%</td>
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</tr>
<tr>
<td>Ward 25</td>
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<td>93%</td>
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<td>92%</td>
<td>95%</td>
<td>85%</td>
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<td>86%</td>
<td>81%</td>
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<td>76%</td>
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<td>86%</td>
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<td>69%</td>
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<td>73%</td>
<td>78%</td>
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</tr>
<tr>
<td>NRU</td>
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<td>85%</td>
<td>79%</td>
<td>78%</td>
<td>63%</td>
<td>58%</td>
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<td>58%</td>
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<tr>
<td>Barton ward</td>
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<td>78%</td>
<td>68%</td>
<td>70%</td>
<td>87%</td>
<td>69%</td>
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<tr>
<td>Bleasdale Ward</td>
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<td>67%</td>
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<td>66%</td>
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</tr>
<tr>
<td>Ward 21</td>
<td>67%</td>
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<td>66%</td>
<td>61%</td>
<td>59%</td>
<td>58%</td>
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<td>69%</td>
<td>59%</td>
<td>58%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td>Ward 19 (MAU)</td>
<td>54%</td>
<td>62%</td>
<td>51%</td>
<td>58%</td>
<td>55%</td>
<td>49%</td>
<td>62%</td>
<td>66%</td>
<td>58%</td>
<td>54%</td>
<td>53%</td>
<td>51%</td>
<td>56%</td>
</tr>
</tbody>
</table>
The table above shows that five out of 14 wards achieved a fill rate of below 75% across the period for registered nurse staff. Ward 19 (MAU) was being used as a short stay ward throughout the period and reported the lowest staff fill rates with an average of 56% for the period.

We observed two nursing handovers as part of our inspection. One of these took place on ward 21 (stroke unit) and the other was on ward 19 (medical assessment unit). We observed that handover included a safety huddle where any high-level information or safety concerns were shared with staff and then a summary of care for each patient was presented in turn.

All relevant information such as patient history, presenting condition, working diagnosis, treatment plan, outstanding tests, social history and some consideration of discharge planning was conveyed as part of the handover. Staff spoke of patients and their relatives in a respectful and compassionate manner.

However, the handover which took place on ward 21 (stroke unit) was carried out at the patient’s bedside. This meant that other patients or relatives could overhear the sensitive information that was being shared about each patient and did not protect patients’ confidentiality. We were told by staff that this was trust policy to carry out handover at the bedside.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 20.3% in medical care. This is worse than the trust’s target of 6%. The breakdown by site can be seen below:

- Royal Preston Hospital – 22.3%
- Chorley and South Ribble Hospital – 12.4%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates

From February 2017 to January 2018, the trust reported an overall sickness rate of 4.2% for nursing staff in urgent and medical care. This is the same as the trust target of 4.2%. A breakdown by site can be seen below:

- Royal Preston Hospital – 4.2%
- Chorley and South Ribble Hospital – 4.3%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

There was adequate medical staffing to provide safe care and treatment. We found that each patient had a named consultant and their care was reviewed regularly during daily ward rounds. This regular medical review was evident in the records we looked at for 19 patients across six inpatient areas. At weekends, ward rounds were completed by middle grade doctors but there remained a consultant on call who could be contacted for advice if necessary.

Nursing staff we spoke to told us they could contact a medic when needed to attend and review a patient. Junior medical staff told us they received support from more senior staff and could escalate to senior medics when needed.

The service used long-term agency and locum medical staff to cover gaps in the medical rota and where there were specialist medical vacancies. The service had an action plan to recruit into these vacancies which included overseas recruitment.

However, staff reported that there were often difficulties in arranging a medical review for patients who were medical outliers. Medical outliers are patients who are placed on escalation areas or wards outside of the required specialty due to there being no available beds on the relevant specialist ward.

The medical staff we spoke to informed us that there was an electronic document which contained the locations of medical outliers for review but this system was open to human error as it relied on various members of staff to keep the document up to date.

Some staff told us that there was a locum or agency medic allocated to cover medical outliers although other staff told us that is was “very difficult” to get a medical review for patients who were outliers.

At the time of our inspection, we did not find evidence of patients who had not had a medical review and there was a workstream in place to minimise the number of medical outliers across the trust.

Overall staffing rates

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From February 2017 to January 2018, the trust reported a vacancy rate of 21.9% in medical at Royal Preston Hospital. This is worse than the trust’s vacancy target of 6%.

The trust did not provide vacancy data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 1.1% for medical staff in medical care. This is better than the trust’s sickness target of 4.2%.

The trust did not provide sickness data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As at January 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.
Staffing skill mix for the 207 whole time equivalent staff working in medicine at Lancashire Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff had access to information and up to date records they needed in order to deliver safe care and treatment to people.

As part of our inspection, we reviewed the records of 19 patients across five inpatient wards. We found that all of the records were recorded and stored chronologically and as such it was easy to follow the patient journey from initial presentation to discharge. Nursing and medical notes were paper-based as were observation charts.

We found that observation charts and intentional rounding tools were completed as per trust policy and repositioning charts were in place for patients who had acquired a pressure ulcer.

There was a booklet for the documentation of nursing care and medical reviews for each patient. The majority of entries we reviewed were legible, signed and dated. Within these booklets we saw evidence of multidisciplinary care such as review by physiotherapists and dieticians.

Care plans were not individualised but there were separate assessments available for patients with learning difficulties and we observed that the Forget Me Not booklet was used for patients with dementia. As there was no electronic flagging system, staff relied on handover to identify patients with complex needs.

Test results were accessible to staff on an online reporting system and staff reported no issues or concerns with regards to this system. We found test results had been documented in patient’s paper-based records which meant that this information was more easily accessible if needed for an urgent medical review.

Risk assessments were documented on an electronic records system which was accessible to staff when needed although we found inconsistencies in recording of risk assessments.

Records were readily available to staff when needed and contained relevant information. Records from previous episodes of care were stored separately within files kept in a locked room however notes for the current episode of care were usually kept at the patient’s bedside.
We observed that records were stored at the patient’s bedside on four of six inpatient areas we visited. In this instance, there was a consent to bedside storage form to be completed by patients and the nurse caring for them. This form had not been signed in 14 of 15 records we reviewed. We escalated this at the time of our inspection.

**Medicines**

There were processes in place to ensure the proper and safe use of medicines. We found that medicines were stored correctly and administered as prescribed.

As part of our inspection, we reviewed 36 medicines administration records across seven inpatient areas. We found that medicines were administered as prescribed and that prescriptions were legible and signed for. Any allergies were clearly documented within the medicines administration records.

Medicines administration charts were paper-based on all of the wards we visited except for ward 25 (renal) where an electronic prescribing system was in use. Staff who had used the electronic prescribing system spoke positively about its implementation although highlighted that where intravenous fluids had been prescribed nursing staff were unaware of this until they logged onto the system. This had the potential to cause delays in the administration of intravenous fluids.

We reviewed the storage of medicines across seven inpatient areas and found that medicines were stored securely and in accordance with national and manufacturers guidelines. Fridge and ambient room temperatures were checked daily and there was a clear escalation process for temperatures which fell out of range.

Controlled drugs were securely stored and we reviewed the controlled drugs records of the seven inpatient areas we visited. We found the use of controlled drugs was recorded and checked by two qualified professionals prior to administration. Any wasted controlled drugs were recorded and appropriately disposed of. Staff we spoke to were aware of the process for the disposal of wasted controlled drugs.

There was a list of medications which were rarely used or not standard ward stock and their location within the hospital available to staff on the trust intranet and there was an emergency medicines stock on ward 24 for use out of hours.

There was an on-call pharmacist available through switchboard and staff we spoke to were aware of this.

We observed during a multidisciplinary team meeting that the use of medicines to assist in withdrawal and associated side effects was considered for patients who were dependent on alcohol or drugs.

**Incidents**

Staff were aware of how to report incidents and most could provide examples of changes to practice which came about through learning from incidents.

Staff we spoke to were able to explain what they would report as an incident and how they would do this using the online reporting system.

We saw examples throughout our inspection of patient safety incidents such as falls and incidents which had the potential to cause harm, such as low staffing levels, which had been reported. However, not all staff we spoke with said they reported incidents which could impact upon the service’s ability to effectively monitor incidents and learn from them. Some of the staff we spoke to
had stopped reporting incidents such as low staffing as they felt that nothing was done with this information.

Learning from incidents was shared with staff through safety huddles which took place at each nursing handover. We saw on one ward an example of a form which had been signed by staff to indicate they had reviewed lessons learned from an incident which had occurred elsewhere in the trust in relation to a patient fall. The ward manager kept a copy of this form as assurance that learning had been shared with staff.

Staff we spoke to were able to articulate the principles of duty of candour and when this would apply. Staff told us there was a culture of openness and honesty although, when asked, just one staff member could recall who held the position of Freedom to Speak Up Guardian within the trust. Despite this, staff said they would feel comfortable to raise any concerns with their line manager or another manager within the service if they felt the need to.

There was a process for the review of patient mortality in which all deaths had a peer review by a consultant within 40 days and there was a clear escalation pathway in place. This pathway was implemented in January 2018 and between January and March 2018, 41% of deaths had been reviewed and support was put in place for specialities that were struggling to make the 40-day target. Action plans were implemented following the review of deaths where suboptimal care had been identified.

There were safety boards displayed on each of the wards we visited which included information around infection rates, falls, staffing and patient feedback. Some wards used this board as a focus for “5-minute learning” sessions with staff to share key pieces of information or learning which took place during working hours.

One staff member shared with us a how they had used the online incident reporting system to identify wards with the highest number of falls and common themes in lessons learned from falls. From identifying and actioning learning points in this way there had been a year on year reduction of patient falls. They told us this type of work was carried out within divisions to form thematic reviews on incidents.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for medical care.

*Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2017 to April 2018.
Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 11 (92% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (8% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 42 new pressure ulcers, 17 falls with harm and 20 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Lancashire Teaching Hospitals NHS Foundation Trust
1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

The pressure ulcer prevalence rate fluctuated between 0.0 (August 2017) and 1.5 (June 2017) from April 2017 and April 2018.

The falls with harm prevalence rate has seen a general downward trend over the reporting period with a particular dip in August and September to a rate of 0.0.

With regard to catheter acquired urinary tract infections in medical care at the trust, the prevalence rate has fluctuated throughout the entire reporting period.

Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

The care, treatment and support provided by the service were based on best practice guidance. We found policies and pathways which reflected current national standards and guidelines.

Care and treatment was based on the National Institute for Health and Care Excellence (NICE) guidelines. There was a trust procedure outlining the arrangements for the implementation of NICE guidance which detailed a clear process for the completion of gap analysis to identify where the service was non-compliant with NICE guidance. However, this relied upon clinical leads setting aside time to complete compliance statements against relevant guidelines which was not always completed in a timely manner.

Care pathways were in place for different conditions, including sepsis and acute kidney injury. Specialist services followed local care pathways, for chronic obstructive pulmonary disease, Crohn’s disease and ulcerative colitis.

Patients with alcohol dependency were treated following an alcohol detoxification pathway. The service had a frailty pathway which identified patients with higher or more complex care needs and we saw evidence that use of this pathway had helped to reduce length of stay of frail patients.

Guidelines, policies and standard operating procedures were discussed at monthly governance meetings. Policies we reviewed were mostly up-to-date and followed national guidance. However, the trust’s Mental Capacity Act and Deprivation of Liberty Safeguards policy referenced out of date legislation, regarding death whilst subject to a Deprivation of Liberty Safeguards.

Nutrition and hydration

A nutritional assessment was carried out on admission for people using the service. This assessment was completed using the electronic records system which sent an automatic dietician
referral if required. This ensured that patients who needed input from a dietician received this quickly.

Fluid balance charts were used when needed and we saw that on some wards completion of fluid balance charts had been a focussed piece of improvement work. We observed that fluid balance charts were generally completed to a high standard although there were some occasions where the total fluid balance had not been calculated despite recording of input and output.

There were blue trays in use at mealtimes to indicate patients who required additional assistance with eating and drinking. Patients we spoke to told us that they had access to food and drink as needed and that the food provided was of a good standard.

**Pain relief**

Patients’ level of pain was assessed as part of the national early warning score. Patients we spoke to told said they received pain relief as needed and we observed that pain management was discussed during multidisciplinary meetings and at handover.

**Patient outcomes**

People’s care and treatment outcomes were monitored and compared with similar services.

The service participated in regular local and national audits with national audits being used to benchmark performance against other services. The service had improved its performance against the sentinel stroke national audit programme having achieved a rating of B from a previous rating of D. Staff working within the stroke unit believed this improvement to be the result of re-introducing a two-bedded assessment area within the unit.

Where audit results indicated poor or worse than average performance there were action plans in place to make improvements to the service.

Sepsis management was regularly audited within the service and measured against Commissioning for Quality and Innovation (CQUIN) national goals. There had been a marked improvement in sepsis performance between quarter one and quarter four against inpatient sepsis screening and timeliness of antibiotics administration in diagnosis of red flag sepsis.

The endoscopy unit at Royal Preston Hospital was accredited with the Joint Advisory Group on endoscopy (JAG) and made an annual submission to provide evidence that the accreditation standards were maintained.

The service held monthly divisional performance reviews to monitor performance against key performance indicators such as infection rates, serious incidents and patient experience.

The service participated in regular safety triangulation accreditation reviews (STAR) which formed part of the trust quality assurance framework. As part of this ward accreditation scheme, a monthly review was completed which included department led audits, automated and external audits and covert monitoring in the form of patient observations and outreach.

Accreditation visits were carried out on each ward by an auditor within the trust at a minimum of six-month intervals. Each accreditation visit consisted of documentation reviews, environmental checks and the gathering of staff and patient feedback. Following an accreditation visit, each ward or area was awarded a scored or red, green or amber. For wards scoring red or amber an action plan was put in place and followed up with another accreditation visit.
Trust level

From January 2017 to December 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology and medical oncology had a higher than expected risk of readmission for elective admissions.
- Patients in respiratory medicine had a lower than expected risk of readmission for elective admissions.

Elective Admissions – Trust Level

![Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in respiratory medicine, geriatric medicine and diabetic medicine had a lower than expected risk of readmission for non-elective admissions.

Non-Elective Admissions – Trust Level

![Non-Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (01/01/2017 - 31/12/2017))

Royal Preston Hospital

From January 2017 to December 2017, patients at Royal Preston Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology and medical oncology had a higher than expected risk of readmission for elective admissions.
- Patients in respiratory medicine had a lower than expected risk of readmission for elective admissions.

Elective Admissions - Royal Preston Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

- Patients in respiratory medicine, geriatric medicine and diabetic medicine had a lower than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - Royal Preston Hospital**

Sentinel Stroke National Audit Programme (SSNAP)

Lancashire Teaching Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the both Chorley and South Ribble and Royal Preston hospital achieved grade D in latest audit, April 2017 to June 17. This has remained the same as the previous quarter.

**Chorley and South Ribble Hospital**

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<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>2) Stroke unit¹</td>
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<td>A</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
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<tr>
<td>4) Specialist Assessments</td>
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<td>B</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
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<td>B</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
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<td>E</td>
</tr>
<tr>
<td>8) MDT working</td>
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<td>N/A</td>
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<tr>
<td>9) Standards by discharge</td>
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<td>B</td>
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<tr>
<td>10) Discharge processes</td>
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<td>D</td>
</tr>
<tr>
<td>Team-centred SSNAP level (after adjustments)</td>
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<td>D</td>
</tr>
<tr>
<td>Team-centred Total KI level</td>
<td>B</td>
<td>C</td>
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</table>
Royal Preston Hospital

Team-centred KI levels

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<tr>
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<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>C</td>
<td>C</td>
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<td>2) Stroke unit¹</td>
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<td>Team-centred Total KI level</td>
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Overall scores

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<th>Apr-Jun 17</th>
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<tbody>
<tr>
<td>SSNAP level</td>
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<tr>
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<tr>
<td>Audit compliance band</td>
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<tr>
<td>Combined Total Key Indicator level</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

¹ Included in IM reporting, indicator SSNAPD02

Heart Failure Audit

In-hospital Care Scores

Results for Lancashire Teaching Hospitals NHS Foundation Trust in the 2015 Heart Failure Audit were better than the England and Wales average for two of the four of the standards relating to in-hospital care and worse for the remaining two.
2015 Heart Failure Audit results for Lancashire Teaching Hospital, relating to in-hospital care

Results for Lancashire Teaching Hospitals NHS Foundation Trust results were better than the England and Wales average for all of the seven standards relating to discharge.

Discharge Scores

Results for Lancashire Teaching Hospitals NHS Foundation Trust results were better than the England and Wales average for all of the seven standards relating to discharge.
2015 Heart Failure Audit results for Lancashire Teaching Hospital, relating to discharge scores

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.

Chorley and South Ribble Hospital

The 2016 National Diabetes Inpatient Audit identified 30 inpatients with diabetes at Chorley and Ribble Valley. Of these 30 patients, 80% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. This is similar to the England average.

Within the 16 metrics, Chorley and South Ribble Hospital was in the top quartile for two metrics and the bottom quartile for three metrics.

Royal Preston Hospital

The 2016 National Diabetes Inpatient Audit identified 30 inpatients with diabetes at Royal Preston. Of these 30 patients, 81.1% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. This is similar to the England average.
Within the 16 metrics Royal Preston were in the top quartile for two metrics and the bottom quartile for three metrics.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 37.1% of Chorley and South Ribble Hospital’s nSTEMI patients and 34.3% of Royal Preston Hospital’s nSTEMI patients were admitted to a cardiac unit or ward, compared to an England average of 96.2%.

88.6% of Chorley and South Ribble Hospital’s nSTEMI patients and 89.5% of Royal Preston Hospital’s nSTEMI patients were seen by a cardiologist or member of the team compared to an England average of 55.8%.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>nSTEMI patients seen by a cardiologist or a member of team</td>
<td>nSTEMI patients admitted to cardiac unit or ward</td>
<td>nSTEMI patients that were referred for or had angiography (incl. after discharge)</td>
<td></td>
</tr>
<tr>
<td>Chorley and South Ribble</td>
<td>84</td>
<td>35</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>88.6%</td>
<td>37.1%</td>
<td>31.7%</td>
<td></td>
</tr>
<tr>
<td>Royal Preston</td>
<td>85</td>
<td>33</td>
<td>34.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>89.5%</td>
<td>34.3%</td>
<td>36.1%</td>
<td></td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082 (38099)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6% (No data)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit. The proportion of patients seen by a Cancer Nurse Specialist was 84%, which was worse than the audit minimum standard of 90%, but better than the 2016 figure of 57%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 19.5%. This is about the same as the national level.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 65.2%. This is about the same as the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 77.2%. This is the same as the national average.

The one-year relative survival rate for the trust in 2017 is 38%. This is about the same as the national level.

(Source: National Lung Cancer Audit)

**National Audit of Inpatient Falls 2017**

The trust did not have a multi-disciplinary working group for falls prevention where data on falls
are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 19%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 26%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 95%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff
The service ensured that staff had the right skills, knowledge and experience in order to deliver effective care, support and treatment. Staff had regular appraisals in which they could identify any additional training needs.

There were nurse champions across the service who had a particular interest or knowledge of a specialist area such as diabetes or learning difficulties. These champions attended study days or groups around their area of interest and fed this information to staff within their area. Staff we spoke to knew who the champions were working within their area and told us they could go to them for any specialist support or advice.

On two of the wards we visited there were clinical skills mentors who worked part of their hours in a clinical role and the rest of their time in an educational role. The clinical skills mentors we spoke to were enthusiastic about the role and could demonstrate where their work had a positive impact such as through increased compliance with staff competencies.

Part of the role of clinical skills mentor was to provide additional support and supervision to newly qualified members of staff but they also supported more senior staff with identified learning needs or professional development. The staff we spoke to were positive about the introduction of clinical skills mentors and valued the additional training they received as a result.

On ward 23 (respiratory) there was a separate bay for high care patients who required non-invasive ventilation. Historically, there had been a core group of nursing staff who worked in this area and other staff worked solely within the larger respiratory ward. Staff told us there had been a recent move to rotate staff through high care and the ward in order for less experienced staff to gain competence and confidence in caring for more complex patients. The staff we spoke to told us this was working well and had helped to improve staffing levels as more nursing staff were able to work in the high care bay.

Staff who were new to a specialist ward or area received a local induction which included peer assessment of competencies in the use of medical devices. Any specialist training was provided as part of the local induction and staff we spoke to said this worked well.

Learning and training needs were identified as part of staff annual appraisals however staff told us they were encouraged by their managers to be proactive in identifying any learning needs they might have and seeking out the relevant training.

Appraisal rates
From February 2017 to January 2018, 77% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%.

Qualified nursing midwifery staff had a slightly lower rate of 75%, while medical staff achieved 89%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

Staff across the service worked effectively together in order to deliver effective care and treatment.

During our inspection, we found that all necessary staff were involved in assessing, planning and delivering care and treatment.

As part of our inspection we observed a multidisciplinary team meeting board round on ward 23 (respiratory) which involved ward staff, nursing staff, medical staff, allied health professionals and a discharge planning coordinator. During this meeting, staff took a systematic approach to discussing each patient in turn and their plan of care, treatment and estimated date of discharge.

Consideration was given to liaison with other relevant professionals such as social services and the mental health liaison team. There was evidence of discharge planning although staff told us that earlier discharge planning was part of a wider trust improvement plan and was not yet fully embedded. This was evident as some of the actions required such as arranging packages of care had not been considered until patients were medically fit for discharge.

The dietitians, dietetic assistant practitioner and dietetic assistants attended daily nutrition team ward rounds, weekly head and neck ward rounds, weekly multidisciplinary team nutrition ward rounds, regular stroke board rounds, and regular gastro board rounds. The team also attended family meetings, best interest meetings and other board rounds if required.

There was a weekly multidisciplinary team meeting which was attended by speech and language therapists, dietetics and the nutrition nursing team to review and plan for patients both as outpatients and inpatients.

Patients requiring artificial feeding devices could be referred to the nutrition nursing team to be assessed in conjunction with dietitians and speech and language therapists if required. A management plan would then be put in place to cover care planning from admission to discharge.

The hospital alcohol liaison service worked with all wards and liaised with social services and alcohol services in the community to ensure rapid assessment and support for those patients who had an alcohol dependency.

During our inspection, we spoke with the trust lead for allied health professions who told us of work that had taken place to raise the profile of allied health professions across the service. There had been a recruitment drive to decrease vacancy rates and the lead for allied health professions had access to trust executives and was an established part of the senior leadership team. This improved the visibility of allied health professions within the division.
Seven-day services

The table below shows the Seven Day Services National Survey 2017 results for Lancashire Teaching Hospitals NHS Foundation Trust. These results could not be broken down by core service.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Seven Day Results</th>
<th>Weekday Results</th>
<th>Weekend Results</th>
<th>National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Consultant Review (within 14 hours of admission)</td>
<td>70%</td>
<td>75%</td>
<td>59%</td>
<td>90%</td>
</tr>
<tr>
<td>Access to Diagnostics</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>90%</td>
</tr>
<tr>
<td>Access to Consultant-Directed Interventions</td>
<td>94%</td>
<td>100%</td>
<td>89%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>On-going Review (Daily or twice daily)</td>
<td>86%</td>
<td>95%</td>
<td>69%</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Source: https://www.england.nhs.uk/publication/survey-results-for-individual-trust-performance-for-7-day-hospital-services/)

The national standard was met for two of the four indicators; access to diagnostics and access to consultant-directed interventions. Time to consultant review was the poorest performing indicator across the trust however the service was engaged in delivery of the Our Health, Our Care programme which was a collaborative across the local health economy and it was intended that delivery of the programme would see an improvement to seven-day services.

Health promotion

The service supported people to live healthier lives. Staff took a holistic approach to planning care using health assessments where appropriate.

We saw there were information leaflets available in inpatient areas around health promotion such as smoking cessation, obesity, diabetes and coronary heart disease.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

During our inspection we were not assured that staff understood the relevant consent and decision-making requirements of the Mental Capacity Act (2005) and Mental Health Act (2007).

It was unclear what training was available to staff around the requirements of the Mental Capacity Act (2005) and Mental Health Act (2007). A narrative summary within the provider information request outlined that specific training modules were available to managers and medical staff and that other staff received this training as part of level three safeguarding training.

We requested that the trust provide us with accurate training figures following our inspection and the trust responded that 1592 of 1814 eligible members of staff (88%) had completed level one Mental Capacity Act training this year. 244 of 292 eligible staff members (84%) had completed level two training this year across the service.

We found that mental capacity assessments were not consistently completed for patients who were deemed to lack capacity to make decisions about their care and treatment. We reviewed 31 records of patients who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. Of these, 26 patients were documented as lacking capacity and for 25 of these there was no evidence of a mental capacity assessment being completed. The remaining five were for
patients who had capacity to consent to the DNACPR but these forms had not been fully completed. Sections around end of life care planning and organ donation had been left blank.

We escalated this concern at the time of our inspection and discussed the requirements of the Mental Capacity Act with staff present at the time. These staff members told us they did not think that a mental capacity assessment needed to be carried out for patients with diagnosis of dementia or those who could not communicate verbally.

On speaking to a member of the medical team we heard of a patient who was deemed to lack capacity because they seemed unable to communicate verbally which may have been as a result of their illness. It was not clear that non-verbal means of communication had been attempted with this patient in order to involve them in decisions around their care and treatment. On review of the patient’s records, there was no evidence that a mental capacity assessment had been completed. While the patient’s relatives may have had involvement in decision-making this also had not been documented and it had not been established that this patient was unable to consent to care and treatment. We escalated this at the time of our inspection.

However, on ward 21 (stroke unit) we saw one DNACPR form which had been completed for a patient who lacked capacity and a mental capacity assessment was in place.

Staff we spoke to were able to articulate an understanding of deprivation of liberty safeguards (DoLS) and we found that for patients who were subject to a deprivation of liberty the relevant application had been submitted. As part of the provider information return the trust had informed us that 191 deprivation of liberty safeguard applications had been made to the local authority between 01 March 2017 and 28 February 2018. One of these applications had been approved. Staff within the trust safeguarding team told us that there was a delay in applications approval by the local authority due to high demands however it was positive to see that staff recognised the importance of continuing to complete these applications.

As part of our inspection we spoke to staff around the care of patients with complex mental health needs and those detained under the Mental Health Act. A senior member of staff told us the service worked well with the hospital security team and continually referred to good working relations with the security team.

**Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training completion**

From March 2017 to February 2018, 79.5% of nursing staff at the trust completed mental capacity act training, while 100% of medical staff completed the course.

The trust has not provided information regarding DoLS training. This could be queried during the inspection.

*(Source: Trust Routine Provider Information Request – Training tab)*

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**Is the service caring?**

**Compassionate care**

Staff throughout the service treated people with kindness, dignity, respect and compassion. We observed staff interacting with patients in a way which was sensitive to their needs.

We interviewed 43 members of staff and found that staff displayed an understanding and non-judgemental attitude towards patients including those with complex mental health and social needs.
During our visit to ward 21 (stroke unit) we observed an example of a member of staff taking the time to interact with patients and their relatives who appeared upset and distressed. The member of staff was comforting and sensitive to their needs.

Patients we spoke to described staff as “wonderful” and told us staff were “polite and friendly”. One patient told us this was the case for most of the time however felt that occasionally staff would “take it out” on patients if they were having a bad day themselves by being “snappy”.

We found that people’s privacy and confidentiality was not always maintained. We observed a nursing handover on ward 21 (stroke unit) which took place at the patient’s bedside. This meant that discussions about a patient’s care and treatment could be overheard by other patients or relatives. Staff we spoke to on other wards confirmed that it was trust policy to carry out handovers at the bedside.

The table below shows the results of the Patient-Led Assessment of the Care Environment (PLACE) 2017 in relation to care and treatment.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Privacy, Dignity and Wellbeing Score</th>
<th>Condition, Appearance Score</th>
<th>Dementia Score</th>
<th>Disability Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHORLEY AND SOUTH RIBBLE DISTRICT GENERAL HOSPITAL</td>
<td>81%</td>
<td>96%</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>ROYAL PRESTON HOSPITAL</td>
<td>81%</td>
<td>98%</td>
<td>79%</td>
<td>87%</td>
</tr>
</tbody>
</table>


The table below shows the overall trust results for the CQC Inpatient Survey 2017. The results were “about the same” as other trusts who took part in the inpatient survey. The overall score for questions on care and treatment was 7.8 out of 10 and the lowest scoring question was around talking about worries and fears.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy for examinations</td>
<td>9.3</td>
</tr>
<tr>
<td>Information</td>
<td>8.7</td>
</tr>
<tr>
<td>Confidence and trust</td>
<td>8.5</td>
</tr>
<tr>
<td>Staff teamwork</td>
<td>8.4</td>
</tr>
<tr>
<td>Privacy for discussions</td>
<td>8.3</td>
</tr>
<tr>
<td>Confidence in decisions</td>
<td>8.0</td>
</tr>
<tr>
<td>Pain control</td>
<td>8.0</td>
</tr>
<tr>
<td>Communication</td>
<td>7.9</td>
</tr>
<tr>
<td>Getting help from staff</td>
<td>7.4</td>
</tr>
<tr>
<td>Involvement in decisions</td>
<td>7.1</td>
</tr>
<tr>
<td>Emotional support</td>
<td>6.6</td>
</tr>
<tr>
<td>Talking about worries and fears</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Overall for care and treatment</strong></td>
<td><strong>7.8</strong></td>
</tr>
</tbody>
</table>

(Source: https://www.cqc.org.uk/provider/RXN/survey/3#undefined)
Emotional support

Staff we spoke to were understanding of the emotional needs of patients and their families. There were specialist staff available, such as nurse specialists and spiritual leaders, to provide for patients’ emotional needs. This included psychological assessments and support.

Specialist nurses were available to provide information and support to patients who had certain medical conditions such as coronary heart disease, diabetes, long-term respiratory conditions or cognitive impairments.

We observed staff respecting the privacy and dignity of patients who became distressed. There were not always quite rooms available on each ward and so staff considered the use of side rooms for patients who required additional emotional support due to life-changing diagnosis.

There was a bereavement and donor support service which provided emotional and practical support to families following bereavement and supported staff to care for patients who approached their end of life and their relatives. The service gathered feedback from bereaved families and the response rate across the medical care service was comparatively high and results for 2017 were generally positive with regards to care and support.

A butterfly logo had been adopted to represent a care area where a patient was at end of life or had died. The idea being to alert staff to the situation and allow them to process this and act respectfully, to enhance post bereaved care.

Understanding and involvement of patients and those close to them

Staff supported people to express their views and be involved in decision making about their care as well as involving those close to them such as relatives and carers.

We observed staff communicated effectively with patients and their relatives to ensure they understood the care and treatment they received.

Patients and relatives, we spoke to said they received enough information about their condition and treatment plans. They also said they could speak to a doctor when they needed to. We found an example where, following feedback from relatives, a time could be pre-agreed for relatives to meet with the consultant providing care and treatment.

During a multidisciplinary team meeting we observed that patients’ views were taken into account when planning their care, treatment and discharge.

However, we found that patients who lacked capacity to consent to decisions about their care and treatment and those close to them were not always involved in decisions about their care. The process for identifying, assessing capacity and recording best interest’s decisions for individual patients who lacked capacity was not consistently applied.

Is the service responsive?

Service delivery to meet the needs of local people

Services were planned to meet the needs of local people.

At the time of our inspection, the medical assessment unit and ambulatory care unit at Royal Preston Hospital had been operating for just two weeks. Ward 19, which had previously been a short-stay ward, had been converted into the medical assessment unit which accepted patients
from the accident and emergency department to either receive treatment and be discharged or wait to be admitted to a specialist ward.

This mirrored the system being operated at the Chorley and South Ribble site and as such the leads for the assessment units across each site had been working together to share pathways and processes.

The ambulatory care unit accepted patients who attended the accident and emergency department and needed minor treatment and procedures. This meant that patients did not need to be admitted to the hospital in order to access this treatment and could go home on the same day. This new process aimed to improve access to treatment and ease pressures on the emergency department.

There were learning disability and dementia champions throughout the service and Forget Me Not stickers were used to identify patients with dementia.

The trust previously identified a gap in gathering feedback from patients with a learning disability. In order to more effectively gather feedback from this group of patients and use this information to plan service delivery, service users, carers and organisations were invited to an annual event within the trust. This provided an opportunity for education and health promotion and activities such as music therapy and singing. The topic for the day was decided by attendees. This included dealing with death and loss, the next event scheduled was to include information around mindfulness.

The one-day event provided an opportunity for patients to have a health check and a consultation with a clinician regarding the results.

During our inspection we found that the facilities and premises were appropriate for service delivery. It was well recognised by leaders within the service that the estate appeared ageing and that some wards and clinical areas required refurbishment.

There was a lack of storage space on many of the wards we visited which meant that corridors appeared cluttered and we observed on ward 18 (cardiology) a patient being transferred on a bed and equipment needed to be moved out of the way in order for the bed to pass by. Managers we spoke to told us that limited storage space was a concern which had been raised through the service governance processes.

**Average length of stay**

**Trust Level**

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 6.5 days, which is higher than the England average of 5.8 days.

For medical non-elective patients, the average length of stay was 7.0 days, which is higher than the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology, neurology is higher than the England average.

- Average length of stay for elective patients in nephrology is lower than the England average.

**Elective Average Length of Stay – Trust Level**
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in respiratory medicine is similar to the England average.

- Average length of stay for non-elective patients in geriatric medicine and diabetic medicine is lower than the England average.

**Non-Elective Average Length of Stay – Trust Level**

Royal Preston Hospital

From February 2017 to January 2018 the average length of stay for medical elective patients at Royal Preston Hospital was 7 days, which is higher than England average of 5.8 days.

For medical non-elective patients, the average length of stay was 7.9 days, which is higher than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology, neurology is higher than the England average.
- Average length of stay for elective patients in nephrology is lower than the England average.
Elective Average Length of Stay - Royal Preston Hospital

Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in respiratory medicine and diabetic medicine is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.

Non-Elective Average Length of Stay - Royal Preston Hospital

Note: Top three specialties for specific site based on count of activity.

Chorley and South Ribble Hospital

From February 2017 to January 2018, the average length of stay for medical elective patients at Chorley and South Ribble Hospital was 2.6 days, which is lower than England average of 5.8 days.

For medical non-elective patients, the average length of stay was 5.7 days, which is lower than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in nephrology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in respiratory medicine is higher than the England average.

Elective Average Length of Stay - Chorley and South Ribble Hospital
Meeting people’s individual needs

We saw examples where people’s individual needs had been taken into account as part of service planning.

Throughout the service we found that staff understood how to provide effective care to people with dementia. On ward 23 (respiratory) the quiet room had been turned into a “reminisce room” which was furnished in a 1940’s style and contained a memory box for patients to use.

In all areas of the hospital we visited we found the environment had been adapted to be more dementia-friendly. For example, the toilet seats, handrails and emergency call bell were coloured red so these would be more easily recognised for people with dementia.

Staff told us that for patients with dementia or complex social or psychological needs, relatives were encouraged to visit patients daily and stay throughout the day if they wanted. We also found staff provided a booklet to relatives of patients with dementia for them to complete with details about the patients’ likes, dislikes and usual routine which would help staff to tailor care and treatment accordingly.

The service worked with a local learning disability team to provide education and training in respect of patients who had a learning disability. This team was made up of people who had a learning disability. Teaching films had been produced to demonstrate the correct way to approach patients with learning disabilities.

There were translation services available for those who needed it and staff were aware of how to access this service. We did not see any information leaflets or signage throughout the service.
which was written in a language other than English however, staff told us there were information leaflets available to print in other languages which were accessible using the trust intranet.

There was a mental health liaison team who were accessible within the service and could attend to urgently review patients if needed. Staff we spoke to who had used this service told us the team responded quickly.

Discharge planning for patients with complex social needs took a multidisciplinary approach to ensure the needs of patients were catered for. There were discharge coordinators available to assist in more complex discharges and they could liaise with social care services to arrange care packages for patients who needed this.

However, we observed that discharge planning was not always considered from the time of admission which caused some patients to remain in hospital longer than necessary while care packages and equipment was arranged.

**Access and flow**

People could not always access care and treatment in a timely way. The service had reported referral to treatment times against the 18-week target which were consistently below the England average. The use of the cardiac catheterisation suite as an escalation area meant that procedures had been cancelled for some patients.

During our inspection, we found that demand for beds on specialist wards and pressures on reducing blockages within the accident and emergency department impacted upon the quality of patient care.

In the provider information return, the trust told us that between 01 March 2017 and 28 February 2018 there were 1507 moves at night (between 10pm and 6am). During our inspection we spoke to one patient who reported they had been moved from one ward to another in the middle of the night and told us this had caused them some confusion.

Staff working in an escalation area of the hospital told us patients were frequently moved between 1am and 3am and this was a common cause for complaints amongst patients. Staff working on wards told us that moves at night happened regularly, at least once a week.

The service had worked on reducing the numbers of medical outliers (patients awaiting a bed on a specialist ward who are placed elsewhere in the hospital). The average daily medical outliers for May 2018 was 31 outliers which was a reduction on 50 the previous month.

However, we spoke to staff across the service who told us patients who were medical outliers did not always get a daily medical review by a consultant. Nursing staff told us this was because there was no doctor assigned to the review of medical outliers however medical staff told us there was a locum doctor assigned but the system for keeping account of outliers was open to human error.

We were not assured that escalation areas were used appropriately within the service. During our inspection we found the cardiac catheterisation suite had been used regularly as an escalation area. When the cardiac catheterisation suite was in use as an escalation area this meant that one of the theatres needed to be closed and used as a recovery area for cardiac patients attending for testing. As such, clinicians had to prioritise patient’s dependent on severity of their condition and postpone a small portion of tests.

Staff we spoke to felt that while this was manageable, the quality of patient’s experience was diminished as a higher volume of patients were needed to be tested over a shorter time period due to one theatre being unavailable. One incident had been reported of a patient whose test was completed because they were an inpatient and their condition was found to have deteriorated. The
clinician who reported the incident was concerned that their test would have been postponed if they had been an outpatient which could have caused the patient harm.

However, the service had plans to improve timely access to care and treatment. The medical assessment unit had recently opened at the time of our inspection which was part of a wider plan to improve access and flow throughout the hospital. Senior leaders within the service acknowledged that the winter period 2017/18 had been particularly challenging and were focussed on creating plans to cope with demand for the forthcoming winter.

Part of the wider plans to improve access and flow included earlier consideration of discharge planning and improving the rates of patients who were discharged before 11am. Staff told us they were aware of the need to improve discharge planning and arrangements but this was a fairly new concept to staff and as such was not fully embedded at the time of our inspection.

There was a discharge lounge in use within the service. This was a small waiting area located within the outpatient department where there was access to refreshments and there was a television for entertainment.

At our last inspection we found there were concerns within the discharge lounge with regards to access to medications and the suitability of the environment. During this inspection we found these concerns had been resolved; staff had access to medications if needed and there was a pharmacy technician allocated to the discharge lounge. The manager for the discharge lounge reported that there was a clear exclusion criteria for patients accepted to the discharge lounge which meant the environment was safe for these patients.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The referral to treatment time has been worse than the England average for the entire reporting period with the exception of February 2018 where the trust had performance of 88.6% compared to the England average of 88%.

![Graph showing referral to treatment percentage within 18 weeks](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

All four specialties were below the England average for admitted RTT (percentage within 18 weeks).
### Specialty grouping

<table>
<thead>
<tr>
<th>Specialty Grouping</th>
<th>Result</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>66.7%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.4%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>0%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

### Learning from complaints and concerns

Concerns and complaints were listened to and used to improve the quality of care. Feedback from patients formed part of the Safety Triangulation Accreditation Review on each ward.

The service responded to complaints and concerns appropriately and in a timely manner. We did not see public information about how to raise a complaint or concern although patients we spoke to told us they would raise any concerns verbally with a member of staff and that they would feel comfortable to do so. Staff we spoke to told us they would respond to any concerns that patients raised and try to resolve these before escalating to their manager.

On ward 21 (stroke unit) details of patient and relatives feedback was displayed as part of their ward safety board. On the board, there was a comment which had been made by relatives about visiting hours being restrictive. Underneath, was the ward’s response which had been to move to open visiting with protected mealtimes. This demonstrated that the ward had learned from feedback without a formal complaint being raised.

Staff we spoke to felt comfortable to raise any concerns in relation to patient safety or experience with their managers although none except one member of staff could recall who the trust freedom to speak up guardian was.

### Is the service well-led?

#### Leadership

There was effective leadership throughout the service with the capacity to deliver high-quality, sustainable care. Although the current leadership structure was in its infancy, staff spoke positively about the impact of this leadership within the service. The leadership structure consisted of a divisional medical director and divisional director of nursing with oversight of clinical and operational management who were accountable to the clinical governance and risk manager for the division who was new in post.

At the time of our inspection, the divisional lead was newly appointed and the senior leadership team was newly formed. We found that leaders throughout the service had the right skills, knowledge and spoke to us with openness and honesty about current concerns within the division and plans for the future.

Although new in post, leaders within the division had taken time to identify key risks and concerns to quality and safety of care across the service and spoke candidly with us about the changes which needed to be implemented in order for positive changes to be made.

The leaders we spoke to conveyed a desire to build momentum and move forward with improvement plans but were conscious that, in a service which a number of staff referred to as stagnant, it was important to consider pace of change in collaboration with staff.
The leadership team was consistent in their approach that improvement planning should be carried out in partnership with staff in order to build a positive culture, improve morale and create a work environment that staff wanted to be part of.

This was reflected in our conversations with staff across the service. While some spoke negatively about the leaders who had gone before, all of the staff we spoke to were positive about current leadership and felt very much part of a journey towards improved care and outcomes for patients.

Staff felt that leaders were visible at ward level as they carried out regular walkabouts and attended staff meetings and training events. Staff we spoke to were aware who their line manager was and who the manager for their business unit was. All staff told us they felt the senior leaders within the service were approachable, open and honest.

While succession planning was not evident during our inspection, we found examples where managers and leaders had been deployed to areas where their skills and talents could be most beneficial. For example, we spoke to one manager who had been moved from one ward to another on the advice of their line manager to improve staff morale and provide training as they had demonstrated good leadership whilst working on another ward.

**Vision and strategy**

There was not a clear strategy for the service. Staff at all levels were unable to explain how their work aligned to the service strategy.

At the time of our inspection there was no finalised strategy for the division and the divisional leads we spoke to were candid in this regard. However, there were plans to finalise and implement a strategy which would focus on quality improvement and which would align to some of the work already taking place as part of the Our Health, Our Care programme.

Our Health, Our Care was a collaboration covering Preston, Chorley and South Ribble with a focus on five key challenges to health and social care services; patient experience, clinical challenges, financial challenges, workforce and estates. The trust worked in partnership with other local organisations as part of the collaborative to develop and deliver the Our Health, Our Care programme.

Staff we spoke to had a limited understanding of the Our Health, Our Care programme and were uncertain of how their work contributed to delivery of wider strategic objectives. When asked about a vision and strategy for the service, staff told us of improvements that had been made within their ward or clinical area and most were able to articulate the trust values.

However, leaders we spoke to had a clear vision for improvement within the service and some of this work had already begun. For example, the divisional lead had been in post seven weeks at the time of our inspection and during this time had overseen the opening of the medical assessment unit and ambulatory care, something which staff told us had been in the planning for a number of years.

**Culture**

There was a culture throughout the service which focussed on the delivery of high-quality, sustainable care. Staff spoke with passion about their roles and were supported by their colleagues and managers.

During our inspection we found that most staff felt supported, respected and valued however a small number of staff expressed frustration that they felt their concerns around staffing or patient safety were not being heard. This was of particular note among staff who worked within areas which were used as escalation areas at times of high demand within the service.
There was a feeling among ward staff and managers that culture and staff morale had been a focal point for improvement over recent times and this had a positive impact within the service. Staff we spoke to were proud to work within the service and positive about the impact that their work had on the lives of other people.

Staff we spoke to were aware of duty of candour, where this applied and their responsibilities under the legislation.

There were development opportunities for staff across the service where staff wanted to take these opportunities. For example, staff could opt to become champions for a particular specialty or area of practice that was of interest to them and could then attend study days and additional training to help them in this role.

However, the safety and wellbeing of staff was not always taken into account across the service. We found some examples where this was being considered and worked well. Some wards had created “hydration stations” which consisted of a table with a pitcher of water which would encourage staff to keep hydrated during their shift and also provided opportunity to step away from the clinical area and take a moment for reflection. This was something which had been well received by staff. In other areas, staff told us they felt overworked and they were often unable to take breaks during their shift.

Staff were not always encouraged to be open and honest with regards to reporting incidents or concerns. We spoke to staff who had raised incidents in relation to staffing levels who had been told to "get on with it" and who felt that blame was placed at ward level when, if the concerns had been escalated, more senior intervention might have improved the circumstances.

**Governance**

There had not always been clear systems of accountability to support good governance and management throughout the service however a new governance structure was under development within the service.

Historically, there had not been effective systems to support good governance within the service. Risks had not been effectively mitigated and monitored and performance issues had not been adequately resolved which had meant that improvement within the service was limited. Key concerns had been prioritised and worked on but there had not been systems in place to effectively govern the service. The current leadership had identified this as a concern and built and implemented a clear governance structure within the service however this was in its infancy at the time of our inspection.

Leaders were confident they now had a system through which concerns could be escalated and actioned as appropriate and allowed for communication up to divisional level and back to ward level.

There was some evidence this was taking effect as the concerns identified throughout our inspection and detailed within this report were known to the senior leadership team within the service. There was assurance that many of our concerns were also considered to be priorities for the leaders we spoke to. For example, the divisional lead recognised that the cardiac catheterisation suite was not best used as an escalation area and was committed to ensuring that this remained de-escalated however acknowledged that managerial staff within the service defaulted to using this area at times of pressure.

We found that staff at all levels were clear about their roles and understood what they were accountable for and to whom.
However, we found that at trust level there were not robust systems in place for monitoring incidents in relation to safeguarding.

The trust safeguarding team had implemented a dashboard which showed the numbers of deprivation of liberty safeguard applications which had been submitted and the number of safeguarding alerts against the trust. They also used the online incident reporting system to track the number of safeguarding incidents reported. However, this system was not used to identify areas within the service with higher or lower numbers of safeguarding incidents and it did not allow for any theme or trend analysis in relation to incidents. This meant that the trust was not able to identify hotspots within the service or areas for concern in order to put actions in place to mitigate these risks or concerns. As such, the trust safeguarding team was reliant on ward managers to monitor themes and trends and address these at a local level.

Management of risk, issues and performance

There were not always clear and effective processes for managing risk, issues and performance across the service. Risks were not always escalated appropriately and the service was sometimes slow to implement changes to mitigate risks.

During our inspection, we found that areas of risk were not always appropriately escalated, monitored and mitigated. As of 26 March 2018, there were 74 open risks listed on the divisional risk register which were rated “moderate” or above. Some of these risks dated back to 2005 and could potentially have been closed sooner. For example, “poor attendance to mandatory training” was added to the register on 15 July 2010, the associated actions had been completed and this remained as an open risk within the register. The volume of open risks impacted the division’s ability to mitigate and appropriately manage risk and impeded progress within the service.

We found that systems for performance management required improvement within the service. There were divisional dashboards which monitored performance against key performance indicators in relation to patient experience, safety and referral to treatment times however the service provided information which demonstrated there had been a significant decline in completion of clinical audits which could not be determined from the divisional dashboard. Therefore, it was not clear how the service monitored performance in relation to effectiveness.

In 2016/17 the medical division participated in 23 mandatory national audits however this figure was 14 for 2017/18. The service completed compliance statements against guidance published by the National Institute for Health and Care Excellence (NICE) and from January 2018 a new IT system was used to initiate the reporting process. Since implementation of this system, as of June 2018, 60% of compliance statements were outstanding for the medicine division. This meant that the service could not be certain of gaps in compliance with national guidance and could not be assured the service was providing care and treatment in accordance with best available evidence.

Information management

At the time of our inspection, most wards were not using an electronic records system for patients’ notes except for risk assessments which were completed online. This meant that collating information about patients for purposes such as audit was time consuming, unreliable and open to human error.

Paper records were scanned onto an online storage system but when we reviewed patient records we found that notes were not always scanned chronologically and it was difficult to locate specific information within the records.
We found that paper records were not always stored securely and in a way which protected patients’ confidentiality. On wards, patient notes were commonly stored by the bedside which meant they were accessible to passers-by. There was a consent to bedside storage form for patients to sign however we found this had not been signed in 14 out of 15 records we reviewed.

**Engagement**

The service engaged with people who use the service, the public and external organisations to support high-quality, sustainable services. Service leads could provide examples where patient feedback had been considered when redesign work was undertaken within the service. This included a review of any relevant incidents, complaints or feedback from patient experience groups. In particular, the service was engaged in working with local Healthwatch to gather information about experiences of patients with learning difficulties and autism in order to make service improvements which would specifically benefit this group of patients.

The service worked in collaboration with external partner agencies to implement improvement plans across local services. A four-day event with local commissioning groups, mental health providers, ambulance services and patient representatives had taken place to determine how wider systems improvement could be undertaken.

There was a staff awards scheme in place within the service and divisional leads described consideration of how members of staff could be recognised for achievements which might otherwise go unnoticed.

**Learning, continuous improvement and innovation**

Leaders throughout the service encouraged staff to strive for continuous learning and improvement, although some of this work was in its early stages, we saw examples where staff were engaged in service improvement.

Staff we spoke to throughout the service could provide examples of changes which they had implemented within their ward or clinical areas for the purposes of improvement to patient safety and experience.

On ward 23 (respiratory) there was a continuous improvement plan poster which staff could write their own improvement ideas. Managers told us this had been well received by staff and we observed that the poster was filled with ideas from various members of staff. One idea which had already been implemented was the introduction of the “reminisce room” which specifically catered to the needs of patients with dementia and provided a quiet space away from the bays for patients to use.

We found that improvement was taking place at a local level with ward staff implementing new improvement ideas. We found that these improvements were not being shared across the division so that other areas could also take on the improvements. There were divisional structures in place to drive improvement forward but there appeared to be silo working where a more joined-up approach might have helped to build momentum in improvement plans.

While we did not observe practice within the service which could be described as “innovative” and service leads acknowledged this themselves, there was an eagerness to learn from other organisations in order to build on improvement work already taking place.
The trust provides surgical services to patients at Royal Preston Hospital.

There are 14 surgical wards incorporating 277 inpatient beds and 22 theatres including one emergency theatre, four-day case theatres and two new hybrid theatres, one of which has interventional radiology capability.

Whilst the hospital has both gynaecological and maternity theatres we did not review these as part of this core service inspection.

The hospital had 33,179 surgical admissions from April 2017 to March 2018. There were 16,138 day case patients, 5,452 elective patients and 11,589 non-elective patients cared for by the service during this time.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and prompted them to complete it. Our findings were similar to those of our previous inspection in 2016.

Topics are listed below. They were refreshed annually or biannually so that knowledge could be updated.

Staff knew when training was due to be completed. The trust’s electronic system sent them regular reminders using a red, amber or green rating system and they could also access their training profile at any time to review current training status.

The trust has set a target of 90% for mandatory training completion.

Between March 2017 and February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in surgery.

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing staff in surgery met the training course completion target for one of the courses made available to them.

Managers worked to raise areas of low compliance. For example, at the time of our inspection staff were developing specific manual handling training for theatre staff to improve compliance and reduce muscular skeletal injuries amongst staff.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>257</td>
<td>297</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>257</td>
<td>297</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>257</td>
<td>297</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>257</td>
<td>297</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>251</td>
<td>293</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff within surgery at the trust met the completion target for none of the courses made available to them.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

**Safeguarding**

Staff understood how to protect patients from abuse and had training on how to recognise and report abuse.

An up to date trust policy based on national guidance by the National Institute for Health and Care Excellence covered issues associated with both children and adults including physical and emotional abuse, neglect, female genital mutilation, and also defined staff responsibilities.

Staff used flow charts which helped decipher the process for reporting concerns. During office hours the trust safeguarding team were available to provide advice. Outside these hours, on call trust staff were available or the local authority could also be contacted.

Staff knew what to do if they had concerns about a child or adult. Issues associated with child sexual exploitation were covered in a separate trust policy. Both policies were available on the trust intranet. We saw examples of staff identifying and reporting safeguarding concerns.

**Safeguarding training completion rates**

We saw an improvement since our previous inspection in 2016 where rates of safeguarding training had been well below the trust target. Now they were rising although managers acknowledged they had not quite yet reached the target.

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff in surgery.
The trust has set a completion target of 90%.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>218</td>
<td>254</td>
<td>85.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>611</td>
<td>718</td>
<td>85.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>604</td>
<td>725</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in surgery at the trust met the 90% training completion target for none of the four safeguarding courses made available to them. However, one of these courses, Safeguarding Children (Level 3), had a much lower number of staff eligible to attend. Therefore, each member of staff eligible represented a higher proportion of the total than those eligible for the other safeguarding courses.

Senior nurses told us the majority of nurses were trained to level two in safeguarding for children but none were trained to level three, which national intercollegiate guidance states staff caring for children should have (Safeguarding Children - Roles and Competences for Healthcare Staff. Third Edition March 2014). Whilst nurses on wards tended only to care for older children (aged between 16 and 17 years), nurses in theatres did provide care for children undergoing surgery.

Despite this, senior nurses told us that they referred any concerns or queries directly to the safeguarding team or on call members of staff who did have level three training and were therefore able to provide the right level of advice if required.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>199</td>
<td>293</td>
<td>67.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>190</td>
<td>289</td>
<td>65.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>53</td>
<td>81</td>
<td>65.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in surgery at the trust failed to meet the target for all four safeguarding training courses made available to them. As with the nursing staff section above, Safeguarding Children (Level 3), had a much lower number of staff eligible to attend. Therefore, each member of staff eligible represented a higher proportion of the total than those eligible for the other safeguarding courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene

In line with findings from the previous inspection, the service continued to control infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The areas we inspected were visibly clean and tidy including wards, theatres, corridors, toilets, shower areas, bays, side rooms, sluices, utility and equipment storage areas.

Domestic staff worked on wards between 8am and 3pm and between 4pm and 8:30pm Monday to Friday, and from 8am until 3pm at weekends. In theatre areas staff worked mornings and evenings mid-week and overnight seven days a week when operating theatres were not in use.

Deep cleaning was undertaken on a planned schedule in theatre areas when unoccupied.

Cleaning staff used colour coded systems to make sure cloths and mops for certain areas (such as toilets and sinks) were not mixed up. They used schedules listing required tasks for each day of the week to keep areas including kitchens, fridges, bins, cupboards and general rooms clean. They recorded completed tasks on a tick list which were then collated and stored centrally.

Cleaners confirmed that supervisors visited areas weekly to check cleanliness. We saw audit reports which supervisors completed following visits. These included details of areas reviewed and any failures identified, along with dates by which action must be taken to resolve them. Records showed actions were completed.

Nurses were responsible for disinfecting areas and cleaning away body fluid spills. They used special cleaning products to make sure areas was properly disinfected.

Stickers were placed on items that had been disinfected to confirm they were clean and ready for use.

During our previous inspection we reported issues with the wear and tear of the theatre environment and a potential infection control risk in some areas. This issue had now been resolved.

Commodes on wards were stored, ready for use. Senior nurses confirmed they were cleaned after each use or every two hours, although nurses confirmed some omissions did occur during busy periods. Records we checked on one ward confirmed this where we saw two omissions on two days during the week we viewed.

Staff took responsibility for keeping areas clean and free of infection risk by adopting good practice with ‘bare below elbows’, sleeves rolled up, no watches and ties tucked in.

Staff used the World Health Organisation’s Five Moments of Hand Hygiene process which helped ensure hands were cleaned effectively.

Theatre staff wore uniforms including ‘theatre scrubs’ to reduce contamination during surgery.

In theatres, equipment was either sent away for cleaning or decontaminated on site. Staff were responsible for cleaning equipment. For endoscopic equipment (a thin, flexible tube with a camera at one end which is inserted into the body) cleaning involved a one-way cycle to help ensure dirty and clean equipment was separated. A dedicated decontamination practitioner worked to ensure cleaning was done effectively.

The trust told us checks should be done daily in the endoscopic cleaning area but that due to staffing limitations on one day each week there had been at least two occasions recently when checks were omitted. To ensure this did not occur again the issue had been added to the
department risk register, a risk assessment completed, and actions put in place to ensure alternative staff members were assigned to check the area when required.

Handwashing stations and gel dispensing units were placed at ward and theatre entrances to encourage people to clean hands before entering. The dispensers we examined were full and in good working order.

We inspected clean and dirty utilities on wards. These were visibly clean and contained items which were stored in an organised way.

Staff helped make sure visitors understood how infection spread by displaying information on noticeboards in public areas on wards.

The service monitored infection rates. Between December 2017 and May 2018 there were no cases of meticillin-resistant Staphylococcus aureus (MRSA), three cases of meticillin-sensitive Staphylococcus aureus (MSSA) and seven cases of Clostridium difficile (CDT). Where staff identified infections, they reported these using the trust incident reporting system and investigations were undertaken to identify the cause and prevent recurrence in partnership with the local clinical commissioning group.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

We reviewed rooms storing equipment on wards and in theatre areas. Items were stored in an organised way.

We checked a range of equipment in theatre areas, all of which were within their annual service testing dates.

The trust’s clinical equipment manager was working with the service training and development coordinator to update a database of all medical devices. This would improve monitoring of service contracts and identify obsolete equipment items. The coordinator estimated approximately 70% of the devices had been updated at the time of our inspection.

Specific equipment used to treat patients suffering with sepsis was stored separately, enabling staff to identify it quickly.

Some equipment was stored in rooms kept at a constant temperature which was monitored daily by staff to help make sure it did not fall out of range. Records we checked confirmed this.

Resuscitation trolleys were stored on wards and in theatre areas. They were checked weekly or after use. Nurses confirmed that housekeepers checked oxygen cylinders daily.

Specimens were sent away for processing which ensured they were kept safe. Samples requiring urgent processing were taken personally by staff. Non-urgent samples were collected by porters or sent in the hospital pod system. Porters were called to attend any emergency resuscitation procedure and took samples for immediate processing should this be required.

**Assessing and responding to patient risk**

The service monitored and responded to risks in good time so that the impacts to patients were limited. This was in line with findings from the previous inspection.
Staff recorded clinical observations on electronic monitors which calculated early warning scores. An early warning score system uses clinical observations to produce an overall score to indicate how unwell a patient may be. Higher scores indicate that a patient is unwell and observations should be increased accordingly. Scores were mandatory which helped ensure early warning scores were calculated accurately.

Compliance was monitored across the service to ensure staff used it effectively. Between January and April 2018, a random sample of 50% of ward records showed that 98% of staff documented a score for each set of clinical observations taken and 85% completed observations as often as required. Action plans were implemented to improve the latter result with a review due in July 2018.

Pre-operative checks were completed to ensure patients were safe to undergo surgery and capture details of risks so these could be managed safely. This included confirmation of general health, allergies, mobility, open sores or dressings, ability to swallow, eat or drink. Any metal work in or on the body, circulatory issues and clinical observations were also noted.

A designated team of anaesthetists prioritised patients requiring emergency surgery in order of urgency using nationally based criteria.

The service performed emergency surgery and had a dedicated theatre to ensure space was always available to accommodate patients. Patients requiring surgery were prioritised in accordance with categories developed by the National Confidential Enquiry Into Patient Outcome And Death (NCEPOD). This ensured surgery was completed within a suitable timeframe on either an immediate, urgent, expedited or elective basis.

Staff used an up to date trust pathway and nationally recognised ‘toolkit’ to help identify warning signs and start treatment for patients with sepsis. Sepsis is a life-threatening condition where a severe infection spreads through the body in the bloodstream. Designated sepsis stations held specific equipment on each ward were clearly identified to help staff locate them quickly and reduce delays providing sepsis treatment.

Staff used the World Health Organisation checklist called ‘five steps to safer surgery’ which reminded them to confirm a series of details at set times, referred to as ‘sign in’ ’time out’, and ‘sign out’. These details included patient details, procedure, surgery site and equipment items present which helped reduce the risk of making mistakes by ensuring that anomalies could be addressed immediately. Checklists differed slightly depending upon the speciality which helped ensure the checks were appropriate.

We observed the checklist being undertaken and recorded correctly in theatres involving all team members with all required elements covered. Compliance was audited monthly by clinical managers who by observed a sample of checklists completed by other specialities. Results were displayed for all staff to view in theatre areas. The table below shows compliance with the checklist for both the Royal Preston Hospital and Chorley and South Ribble Hospital.
The matron and clinical director told us that all staff reviewed WHO audit results and focused as a team on areas requiring improvement. At the time of our inspection staff were devising new ways to improve the debrief following a decline in performance caused primarily by later finishes in theatre leading to less time to complete debriefs before finishing duty. Risk assessments were completed for patients on wards to help staff measure the risk of them falling or developing pressure ulcers. In respect of falls, occupational therapists and physiotherapists made assessments before hanging small luggage labels onto each patient’s individual walking frame with a red, amber or green sign to indicate the level of assistance they needed. This helped both staff and the patient remember to seek help before mobilising if required. We also saw larger signs above beds to clearly indicate patients at risk of falling.

(Source: additional data request)
Other post-surgery risks such as blood clots were also assessed and mitigated by issuing pressure stockings pre-operatively which helped reduce the risk of blood clots forming.

Defibrillators were situated strategically across all areas of the service. Numbers were increased in theatre areas where the risk of multiple cardiac arrests at one time were higher.

Staff understood the National safety standards for invasive procedures (NATSSIPS) and Local Safety Standards for Invasive Procedures (LOCSSIPS). We reviewed one example of a LOCSSIP which was within date and outlined the process clearly.

When issues occurred, we saw staff responded by mitigating the chance of recurrence. For example, when a piece of equipment broke up during surgery, staff took immediate action to report the incident, stop using the piece of equipment, record the issue in the operation log and discuss the issue in the debrief.

For patients at higher risk of wandering, or sustaining injury such as falling, staff could place them under ‘enhanced care’, which had three levels; either a member of staff sitting with them, close by to them or simply to know their whereabouts. The level was determined by a nurse. We saw enhanced care being used on our inspection.

Call bells were provided for patients to ensure they could summon help quickly if required. In the areas we inspected we saw call bells had been placed within reach of patients. Staff displayed notices such as ‘life’s a peach when the call bell’s in reach’ to remind them to seek assistance mobilising.

**Nurse staffing**

Previously and during this latest inspection we found that the service had enough staff with the qualifications and experience to keep people safe and provide the right care and treatment. Where staffing levels were low, actions were in place to manage and improve them.

**Overall staffing rates**

Staffing figures for nurses and support staff on surgical wards between April 2017 and 2018 showed levels were mixed. For example, on ward 11, only 68% of nurses were rostered during the day and 69% at night. The figures were similar on ward 12. Wards 14 and the major trauma wards showed levels were sufficient. Where nurse staffing was low, support staffing numbers were increased. We saw evidence of this with some wards showing rates 30% above what was required.

Managers confirmed that regular calculations of acuity were done to make sure staffing levels reflected ward requirements, using a recognised tool. Nurses on all the wards we visited said the tool had been used in the last six months and some were due to be repeated.

Staffing levels were also monitored each day in formal checks completed by matrons.

Additional increases in staffing numbers had recently been made in a number of areas. For example, on the vascular ward four new nurses were due to start work in the next few weeks. On another ward staff reported six nurse vacancies, but four of these were due to maternity leave. There was a vacancy for a practitioner post but two new staff had been recruited and were due to start in September 2018.

In theatre areas staffing was planned in association with national guidance by the Association of Perioperative Practice Staffing (AfPP) which required two scrub practitioners, one circulating staff member, one registered anaesthetic practitioner and one recovery practitioner to be present for each theatre list.
Theatre matrons were clear about staffing requirements when asked. We were told that under exceptional circumstances such as short notice sickness, risk assessments were undertaken to decide whether one theatre area could operate with less so that staff could be moved to a higher risk area.

**Vacancy rates**

From February 2017 to January 2018, Royal Preston Hospital reported a vacancy rate of 17.3% in surgery which was above the trust vacancy rate target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Ward vacancy rates had been reviewed and changes to recruitment strategies had led to improvements. On one ward the issues identified were a lack of teaching, development and appraisals. To try to improve this, new incentives were introduced, allowing new starters to choose three rotations across the surgical service. In another area, potential applicants were invited to visit wards for coffee mornings to meet staff and visit the ward.

Staffing rates were improved in theatres by employing a part time member of staff to coordinate recruitment, arrange advertising, interviews and shortlist. This had improved numbers and helped ensure clinical staff were not drawn away from patient care to undertake these duties.

Out of 240 theatre staff, managers reported 8.8 whole time equivalent vacancies for theatre practitioners with 13 new staff starting work in September 2018, three healthcare support workers vacancies for which 27 staff had been shortlisted. Three anaesthetic practitioners were due to leave as part of natural turnover.

**Turnover rates**

The annual turnover rate for nursing staff between April 2017 and March 2018 was 5.8%

**Sickness rates**

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 4% in surgery which was below the trust sickness target of 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

To reduce sickness rates staff in theatres had invested in a new storage system to reduce the amount of lifting and handling of equipment trays. It was hoped this would reduce musculoskeletal injuries amongst staff.

Long term sickness on wards was managed in accordance with trust policy.

**Bank and agency staff usage**

Between April 2017 and March 2018, the rate of agency staff use on surgical wards and in theatre areas was approximately 5%.

Staff predominantly used the trust’s own pool of bank staff to back fill vacant shifts before approaching agencies and a ward sister told us the trust had recently stopped using agency nurses.

Figures we reviewed showed the use of agency nurses had certainly reduced on the wards. For example, where we saw over 20 agency nurses staffing wards in April 2017, we saw figures fall
Handovers

Nurse handovers took place each morning, afternoon and evening and were based on the acronym ‘FORCED’ which ensured staff covered; fluid balance, observation, risk assessment, care plans, escalation of care needs and discharge plans. We saw this in use across wards in the surgical service. A matron confirmed this had been introduced following a serious incident whereby a poor standard of handover was found to be a contributory factor. The service now promoted safe handovers as a core requirement of nursing practice on wards.

Medical staffing

The service had enough medical staff with the right qualifications and experience to keep people safe and to provide the right care and treatment. Our findings were similar to those of our previous inspection in 2016.

Overall staffing rates

Across wards and theatre areas there were 18 whole time equivalent vacancies out of a total of 373. This was across all specialities.

Vacancy rates

From February 2017 to January 2018, Royal Preston hospital reported a vacancy rate of 12.0% in surgery. This is worse than the trust’s vacancy target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

The annual turnover rate for medical staff between April 2017 and March 2018 was 11.3%.

Sickness rates

From February 2017 to January 2018, Royal Preston hospital reported a sickness rate of 1.3% in surgery. This is better than the trust’s sickness target of 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

Between April 2017 and March 2018, middle grade and consultant locum doctors worked 6765 shifts across the surgical core service. This was an average of 19 shifts across all areas every day.

Staffing skill mix

As at October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.
Medical handovers and surgical rounds (including a consultant review) took place daily, including weekends.

In theatre daily team briefs prior to surgical lists starting were done to make sure all staff present (surgeons, anaesthetists practitioners and nurses) received an introduction of each team member, concerns about any patients or procedure, confirmation of the theatre list, each patient and associated risks, pressure area concerns, allergies, World Health Organisation checklist details and overall feedback.

**Records**

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.

Records were a mixture of paper and electronic. For example, observations and early warning scores were electronic and prescription charts were paper.

We reviewed four records from a range of surgical wards during our inspection. These contained the right details about patients which enabled staff to provide care. This included legible, accurate information. Allergies and pain were recorded, risk assessments and clinical observations were completed within a suitable time frame, and consent was also properly recorded.

**Medicines**

In line with findings from our previous inspection the service stored medicines well but did not always identify patients’ details or give medicines as often as required.
For example, on ward 12 four out of five medicine administration charts we reviewed had incomplete header details which should contain the patient’s identification details. This posed a risk that the patient could not be identified on the chart.

On ward three we reviewed five medicine charts and found three with evidence of missed doses for patients. This meant patients had not received their medicines when they should have done.

Medicines and controlled drugs were stored correctly in the areas we reviewed. They were stored securely, in an organised way and were within their expiry date. This was in line with trust policy.

Medicines requiring storage at low temperature were kept in fridges. To make sure temperatures did not exceed the required temperature staff were required to monitor and record fridge temperatures daily. We saw this done in all the areas we visited.

Rooms storing medication should not exceed 25 degrees Celsius. Air conditioning units were installed in these rooms which helped maintain temperatures and rooms we inspected were monitored by staff who recorded temperatures daily to ensure suitable temperatures were maintained.

Where room or fridge temperatures fell outside of suitable range we saw that action was taken to report it in line with trust policy some but not all of the time. For example, in June this year we saw eight occasions when one fridge temperature exceeded maximum range but saw no evidence of escalation or reporting.

Patients’ allergy status’ were completed in all except one of the medicine charts we reviewed. We referred the outstanding status to staff which was updated by them at the time of our inspection.

Patients’ medicine administration charts had a dedicated page for antimicrobial information and we saw evidence that patients were provided with antimicrobial reviews and stop dates.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and told us the types of incidents they knew should be reported. They knew how to report them using the complaint management system accessed via the trust intranet and we saw examples of the incidents they reported. Managers and senior nurses investigated incidents using root cause analysis and shared lessons learned with the whole team and the wider service.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

We saw an increase in never event occurrence since our previous inspection in 2016. From May 2017 to April 2018, the service reported two incidents classified as never events for surgery. Both were classified as surgical/invasive procedure incidents.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 21 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from May 2017 to April 2018. This was an increase since our previous inspection in 2016 where only four incidents were
reported and provided evidence of a positive culture where staff were open and honest when things went wrong.

Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 13 (62% of total incidents).
- Slips/trips/falls meeting SI criteria with three (14% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (14% of total incidents).
- Treatment delay meeting SI criteria with one (5% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (5% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Eighteen of these incidents occurred at Royal Preston Hospital.

Staff understood the principles of Duty of Candour which is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Staff told us the trust adopted a culture of being open and honest when things went wrong and shared lessons learned following investigations to help prevent recurrence. This was done in feedback, noticeboards, staff meetings or in communication folders.

Action plans were formulated to capture outcomes and ensure required changes were made to improve services. These were monitored weekly by the trust to ensure progress was made.

Senior managers described actions including reviewing and adjusting trust policy, and introducing additional checks to surgical safety checklists. Training was also provided. We saw evidence on formal action plans that these had been completed.

Mortality reviews were undertaken regularly (including both expected and unexpected deaths) and changes were made as a result. For example, following review of deaths following blunt chest trauma an improved protocol was developed with the cardiothoracic team. A mortality review completed in May 2018 by the trust however showed the division had only completed 51 of the required 86 reviews between January and March 2018. The trust was reviewing the report at the time of our inspection.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the service showed that between January and May 2018 staff reported 18 grade two pressure ulcers, four deeper tissue ulcers (grade three, or four) and two upgradeable ulcers, all of which were avoidable. A further 20 pressure ulcer incidents (reported in May) were awaiting final outcome to determine whether they were avoidable.

Data showed that between January and May 2018 staff reported 40 falls on wards. Data for catheter acquired urinary tract infections showed that two were reported on wards between January and May 2018.

Staff told us about the work they had done to improve care for patients and reduce the number of safety thermometer incidents. This included work with tissue viability nurses to educate staff about pressure ulcers and improve practice in theatres. We saw actions to reduce the risk of pressure ulcers forming during long surgical procedures. This included examining patients prior to and after surgery, performing 90% surgery on pressure relieving mattresses, foam boots and sacral pads. Staff were satisfied the pressure ulcer figures would start to reduce. We saw pressure relieving equipment in use during our inspection.

Is the service effective?

Evidence-based care and treatment

In line with findings from our previous inspection in 2016, the service continued to provide care and treatment based on national guidance and evidence of its effectiveness.

We saw guidance available for staff to access should they require it. This included guidance and standards set by the Association of Anaesthetists of Great Britain and Ireland and the National Institute for Health and Care Excellence.

We also saw guidelines to manage patients with suspected sepsis by the UK Sepsis Trust as well as recognised scales to determine health status prior to surgery with the American Society of Anaesthesiologists physical status classification system.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

We saw examples where staff were assigned to feeding and hydration tasks so that tasks were not forgotten. For example, on one ward we visited staff were assigned to meal assistance, hot drinks trolley, toast preparation and evening drinks at the beginning of their shift.
We saw recent campaigns to promote hydration and healthy eating for patients. This included helping patients identify signs of dehydration. Guidelines for fluid balance, tips on how to incorporate fluids into a daily routine and information about how hydration helps wound healing. Information was also provided about food groups and how much of each group to include in each meal. For patients struggling with solid food, information about food thickening and foods that may cause blockages was also provided.

We observed staff checking whether patients were experiencing any signs of nausea. Treatment could be provided to help manage this symptom if required.

**Pain relief**

The service monitored the level of pain in patients and provided pain relief when required. This mirrored previous inspection findings.

The trust Acute Pain Team were available from 9am until 5pm Monday to Friday. Outside of these hours nurses confirmed they could call on call medical staff and anaesthetists should they require very strong pain relief. The pain team consultant conducted twice weekly ward rounds.

There was guidance for staff to help them assess pain in patients. These included using a scale from zero (no pain) to three (severe pain). Patients who could not understand scales (for example children or those with a learning disability or living with dementia) pictorial scales were used with sad faces to indicate pain and smiling faces to represent no pain.

The guidance also showed staff how to recognise pain in patients unable to verbalise pain by recognising facial or body movements, or identifying physiological changes such as an increased heart rate.

We observed staff assessing pain in patients under their care during our inspection.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them which was the same as we found previously.

**Relative risk of readmission**

**Trust level**

From January 2017 to December 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery and general surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions – Trust Level

From January 2017 to December 2017, all patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and trauma & orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

A breakdown by site can be seen below:

Royal Preston Hospital

From January 2017 to December 2017, all patients at Royal Preston Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

- Plastic surgery and neurosurgery patients at Royal Preston Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.
- ENT patients at Royal Preston Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions - Royal Preston Hospital

From January 2017 to December 2017, all patients at Royal Preston Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and trauma & orthopaedics patients at Royal Preston Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Royal Preston Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Royal Preston Hospital

Non-Elective Admissions - Royal Preston Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. Top three specialties for specific trust based on count of activity

Hip Fracture Audit

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.7% which was within the expected range. The 2016 figure was 8%.

The proportion of patients having surgery on the day of or day after admission was 67%, which was worse than the national standard of 85%. The 2016 figure was 66.4%.

The perioperative medical assessment rate was 80.5%, which failed to meet the national standard of 100%. The 2016 figure was 79.1%.

The proportion of patients not developing pressure ulcers was 97.7%, which falls in the middle 50% of trusts. The 2016 figure was 96.9%.
The length of stay was 21.6 days, which falls in the middle 50% of trusts. The 2016 figure was 19.5 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 77.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 77.8%.

The risk-adjusted 90-day post-operative mortality rate was 1.8% which was within the expected range. The 2016 figure was 7.2%.

The risk-adjusted 2-year post-operative mortality rate was 20.3% which was within the expected range. The 2015 figure was 20.8%.

The risk-adjusted 30-day unplanned readmission rate was 6.1 which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 72.3% which was a negative outlier. The 2016 figure was 74.4%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.4% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2016 figure was 3.5%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 11 days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 2.7% which was in the expected range. The 2016 figure was 2%.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The 90-day post-operative mortality rate was 2.7%, which is within the expected range. The 2015 rate was 2.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9% which was within the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer
units and specialist centres); the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2016 National Emergency Laparotomy Audit (NELA), the Royal Preston Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 148 cases.

The Royal Preston Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 143 cases.

The Royal Preston Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 82 cases.

The Royal Preston Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 68 cases.

The risk-adjusted 30-day mortality for the Royal Preston Hospital was within expectations, based on 148 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was worse than the England average.
For Varicose Veins, performance was better than the England average.
For hip replacements, performance was about the same as the England average.
For Knee replacements was about the same as the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Practice educators supported this process.

New staff received corporate inductions. These ran twice monthly and provided details about the trust, its values and other general information.

For nurses, ward inductions for each speciality were provided during which time they were supernumerary. We reviewed the induction for new nurses on the orthopaedic ward. Staff rotated across three wards, fracture clinic, theatre and visited specialist nurses over a period of two weeks.

Competencies were signed off by approved staff. These were reviewed monthly to help make sure staff remained up to date. Device competencies were also maintained and refreshed annually.

For nurses in training we saw preceptorship periods offering training in a range of clinical competencies such as cannulation. Student nurses we spoke to told us the training programme was thorough and at a suitable pace. They felt they could refer any questions or concerns to staff.

Staff were provided with opportunities to develop professionally. These included academic
development. We saw examples of staff undertaking Master's degree level qualifications which helped improve care for patients as well as further careers.

Link nurses (nurses with a specialist interest in a particular area) helped maintain specialist knowledge amongst staff in areas including safeguarding, dementia, pressure ulcers and student nursing.

In theatres, staff were trained to provide basic, intermediate or advanced life support dependent upon their role. For example, we saw evidence that recovery staff were trained to provide advanced life support to adults, and paediatric life support.

All band six recovery nurses were trained to provide intermediate adult and paediatric life support. Duty anaesthetists were all trained to provide adult and paediatric advanced life support. Anaesthetic practitioners rotated between recovery and anaesthetic areas to help ensure competencies were maintained.

Theatre staff completed human factor training with a multi-disciplinary approach. Approximately six sessions had taken place over the last year, which covered the effects of never events, what makes an expert team, situational awareness, decision making, leadership and communication. The training covered a range of specialities including urology, neurology, day case and general surgery with further plans to schedule head and neck surgery training over summer 2018.

Theatre staff maintained competencies through regular scenario training in topics including massive haemorrhage, difficult ventilation and paediatric emergencies.

Surgeons held core competencies in robotic surgery, enabling them to use a piece of revolutionary equipment to perform innovative surgery in the main theatre complex. Having completed 30 hours simulation training dependent upon speciality, each surgeon then completed surgery with the equipment representative present for at least six sessions.

Training was also provided to help nursing staff manage conditions including sepsis. We saw regular three-hour training sessions scheduled across the year covering new guidelines, the role of sepsis champions, sepsis treatment and information about the UK sepsis trust. Staff had opportunities to develop in their roles. For example, nurse associate roles were available for staff to progress from band two NHS apprenticeships to progress to gain qualifications to an operating department practitioner programme.

The nurse revalidation process was also undertaken by staff in the service and nurses we spoke to who had been through the process said this worked well.

### Appraisals

From April 2017 to March 2018, 80% of nursing staff in the service completed an appraisal which worse than the trust target of 90%. However, medical staff achieved an appraisal rate of 91.7%, (data provided at trust level only) meeting the target. This was generally in line with previous inspection findings which found that nurse appraisals were just below trust target and medical appraisals were slightly better.

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals and DR18)

Nursing and medical staff starting employment with the trust received inductions to help make sure they had an overview of how the service worked, and to make sure they could use systems and
understood processes. Medical staff told us they were well inducted and supported when starting employment with the service.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Our findings mirrored those of our previous inspections which showed evidence of good multidisciplinary team working particularly between nurses, surgeons, doctors, physiotherapists, occupational therapists, dieticians and care support workers.

These staff spoke highly of each other when liaising with members of the inspection team. Physiotherapists described strong links with ward nurses allowing them to overlap tasks and increasing responsiveness to patient needs while keeping hospital stays to a minimum. Multidisciplinary meetings were held daily with nurses, occupational and physiotherapists.

The daily theatre team brief involved a range of staff who all came together to discuss the requirements for patients on the list that day. Led by a consultant, we observed one vascular team brief comprised of surgeons, anaesthetists, healthcare assistants, theatre practitioners, radiologists, radiographers, students and nurses.

Radiology staff were included in theatre meetings due to joint work in orthopaedic, vascular and urology surgery.

In theatre recovery areas, we observed staff working closely with critical care staff to organise care for patients by determining bed allocation and care requirements.

**Seven-day services**

Theatres were available 24 hours a day seven days a week all year round for emergency cases. However, the majority of theatres operated Monday to Friday between 8am and 6pm. Wards were open at all times except the day case ward which was open between 8am and 8pm.

Ward rounds took place seven days a week by a consultant.

Occupational and physiotherapists worked between 7:30am and 6pm Monday to Friday and occasionally at weekends (on a voluntary basis).

**Health promotion**

Patients were comprehensively assessed so that their clinical needs and general health status (including smoking and alcohol habits) could be considered.

An up to date trust policy helped staff support patients withdrawing from substance misuse.

National priorities such as smoking cessation and alcohol dependency were noted during nurse assessments. The trust alcohol liaison nurses were available upon request to provide support for patients should they wish to improve their health by reducing alcohol consumption.

Physical activity could also be noted on patients’ records but on the records, we reviewed these had not been completed. Despite this, height and weight were recorded.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

An up to date trust policy was available for staff to access which explained consent to examine patients. It included details about patients whose first language was not English, different types of consent (verbal, written) and those who were not well enough to provide consent themselves.

Consent for surgery was provided in a two-stage process unless emergency surgery was required where the process differed. Children 16 or 17 years of age were presumed capable of providing their own consent unless limited by particular circumstances or overridden by a parent, guardian or court. The details were clearly explained for staff in trust policy.

We observed consent being checked with a patient pre-operatively. Where consent was not complete nursing staff confirmed with the patient the surgeon would need to meet with them to discuss the procedure and gain their consent to proceed.

The trust had an up to date policy relating to the Mental Capacity Act and Deprivation of Liberty safeguards (DoLS). Flowcharts were included to help guide staff through the process should they need to apply either of these legal elements to the care of a patient. The chart included undertaking a capacity assessment if they felt the patient was unable to make a decision, and to consider friends or relatives, the patient’s best interests and to access the trust safeguarding web page for further information. Daily checks were completed by matrons which included confirming whether any patients on wards were under DoLS.

Nurses told us they completed incident reports when making DoLS applications.

From April 2017 to March 2018, the trust reported that 87% of nursing staff and 79% of medical staff in the service had completed the Mental Capacity Act Level 2 course. This is worse than the trust target of 90%.

We saw examples of staff caring for patients who lacked capacity, making best interest decisions. Staff included family members, recorded meetings led by safeguarding team members and recorded decisions appropriately using trust templates. They noted important details including the presence of confusion, risks to the patient, care requirements, options considered, decisions made and actions taken.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from all patients confirmed that staff treated them well and with kindness. Our findings remained unchanged following our previous inspection in 2016.

Friends and Family test performance

The Friends and Family Test response rate for surgery at the trust was 27% which was similar to the England average of 29% from December 2016 to November 2017.
Friends and family test response rate at Lancashire Teaching Hospitals NHS Foundation (Source: NHS England Friends and Family Test)

The service provided results across both trust sites rather than Royal Preston Hospital site alone. However, the results showed that between April 2017 and March 2018, 92% of respondents said they would recommend the service to friends or family.

Wards displayed the results of Friends and Family questionnaires which included comments made by patients. Some patients on the vascular ward said, ‘staff couldn’t do enough’ for them. All of the patients on this ward said they would be likely or extremely likely to recommend the care to friends or family.

Staff introduced themselves by name to patients which helped create a friendly atmosphere on wards and treatment areas.

Patients told us staff treated them with dignity and gave them the privacy they needed when caring for them. Staff explained they would ensure patients were fully covered before taking them down for surgery providing extra gowns if required. Patients described staff as helpful in the way they accommodated these needs.

Staff pulled curtains around beds in ward areas to maintain privacy for patients.

Post operatively ward staff helped patients adjust to staying in hospital by making it feel as normal as possible. We saw the campaign advertised throughout wards to end pyjama paralysis – a national campaign to get patients up and out of bed as soon as possible after surgery to help boost recovery.

When observing patients in theatre we saw staff taking great care to preserve patients’ dignity during treatment, particularly when repositioning them during vascular surgery.
Emotional support

In line with previous findings in 2016, staff continued to provide emotional support to patients to minimise their distress whilst in hospital.

Staff on the neurosurgery ward gave numerous examples of their appreciation of patients’ needs. We heard of one example where staff went above and beyond to ensure emotional support was provided for a learning disability patient suffering with a terminal illness. Staff described their assessment of the patient’s emotional needs, identifying preferences such as headphones for television and assisting with benefit forms and a hospital passport (a document to explain likes, dislikes and needs while in hospital). Staff worked with doctors, Macmillan support staff, and family members to help the patient understand their diagnosis.

Other examples included providing holistic support for a patient with a genetic disorder and learning needs. Staff accompanied the patient for tests and scans and explained what was happening using appropriate language and enabling the patient to take personal items with them to alleviate distress. Staff collected a range of information about support groups for family members and took notes during meetings with the doctors so the patient and their family could refer to them later. Senior nurses told us the family wrote to the local newspaper to thank the staff publicly.

Extended visiting hours had recently been introduced and in some areas patient’s relatives could visit them between 10am and 8pm which helped increase emotional support for them whilst in hospital.

Patients we spoke to told us they felt their views were respected and staff respected their thoughts and views when discussing their care.

Staff showed an understanding of the impact of surgery on peoples’ wellbeing. On the orthopaedic ward, staff set up a self-help group for new amputees which met weekly if staffing allowed. Here patients and loved ones could attend to find out about ways to adjust to new ways of living, talk to other amputees or relatives to find support.

Staff were aware of the support patients and families needed when patients were approaching the end of life. They told us they allowed open visiting and they worked with families about where patients would like to be. For example, whilst many patients and families preferred side rooms, some liked to remain in bays close to patients they had made friends with.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We saw the dedication of staff involving family and loved ones in the care of their patients. Staff described how they quickly identified were patients or their relatives were not coping with the illness and staff worked quickly to identify ways to ensure there was good communication and information sharing.

On wards we saw photographs and descriptions of staff, enabling patients and loved ones to get to know them during their stay.

Patients we spoke to described feeling they were given enough time to ask all the questions they wanted to and that staff took the time to listen without making them feel rushed.

Patients also told us that where appropriate, the thoughts and views of family members were ‘very much’ taken into account when discussing care and treatment.
Staff provided carers with lanyards to clearly identify them. They told us this helped ensure staff did not stop them, should they be on the ward with a loved one outside of core visiting hours.

Staff on wards we visited had access to alternative communication aids, including books with pictures to help explain care needs.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people which mirrored our previous inspection findings.

Wards had waiting areas for visitors to wait or discuss care with staff in a quiet room. These areas had comfortable chairs and coffee tables and were situated close to leaflet stands with a range of information leaflets about pressure ulcer care, health and wellbeing, wound care and discharge planning.

Other wards had enhanced areas for visitors. For example, staff on the vascular ward had self-funded a ‘VIP lounge’ for patients and visitors to use which had soft furnishings, a dining table, access to board games, television and music.

**Average length of stay**

**Trust Level – elective patients**

From February 2017 to January 2018, the average length of stay for all elective patients at the trust was 5.3 days, which was higher than the England average of 3.9 days.

Trauma & orthopaedics elective patient at the trust were 4.2 days, which was higher than the England average of 3.9 days.

Neurosurgery elective patients at the trust were 5.3 days, which was as expected, compared to the England average of 5.0 days.

Urology elective patients at the trust were 3.5 days, which was higher than the England average of 2.5 days.

**Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay for different specialties.](chart.png)

*Note: Top three specialties for specific trust based on count of activity.*
Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 6.6 days, which is higher than expected, compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at the trust was 4.4 days, which is as expected, compared to the England average of 3.8 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 12.2 days, which is higher than expected, compared to the England average of 8.7 days.

The average length of stay for Urology non-elective patients at the trust was 2.9 days, which is the same as the England average.

Non-Elective Average Length of Stay – Trust Level

Royal Preston Hospital - elective patients

From February 2017 to January 2018, the average length of stay for all elective patients at Royal Preston Hospital was 5.8 days, which is higher than expected, compared to the England average of 3.9 days.

The average length of stay for Neurosurgery elective patients at Royal Preston Hospital was 5.3 days, which is as expected, compared to the England average of 5.0 days.

The average length of stay for Plastic Surgery elective patients at Royal Preston Hospital was 3.8 days, which is as expected, compared to the England average of 3.4 days.

The average length of stay for Vascular Surgery elective patients at Royal Preston Hospital was 5.7 days, which is as expected, compared to the England average of 5.2 days.

Elective Average Length of Stay - Royal Preston Hospital

Note: Top three specialties for specific trust based on count of activity.
Royal Preston Hospital - non-elective patients

From February 2017 to January 2018, the average length of stay for all non-elective patients at Royal Preston Hospital was 6.6 days, which is higher than the England average of 4.9 days.

The average length of stay for General Surgery non-elective patients at Royal Preston Hospital was 4.4 days, which is as expected, compared to the England average of 3.8 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at Royal Preston Hospital was 12.2 days, which is higher than the England average of 8.7 days.

The average length of stay for Urology non-elective patients at Royal Preston Hospital was 2.9 days, which is the same as the England average of 2.9 days.

Non-Elective Average Length of Stay - Royal Preston Hospital

![Chart showing average length of stay for different specialties at Royal Preston Hospital and England average.]

Note: Top three specialties for specific trust based on count of activity.

Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service took account of patients’ individual needs which mirrored the findings from our previous inspection in 2016.

We saw dementia friendly signage to help patients and visitors locate toilets, entries and exits more easily throughout the service.

The service had recently employed two specialist learning disability nurses. The nurses identified patients who might need extra support and try to improve their hospital stay. This was done by making adjustments to their care, making sure they had a suitable healthcare passport (a document that tells healthcare professionals about the patient; their likes and dislikes, and about any specific needs)

The nurses told us they tried to cater for specific requests as far as possible with the specific aim of making learning disability patients feel as calm and safe as possible. They provided examples which included providing a specific colour gown to wear to theatre, sourcing headphones from a nearby shop. Matrons daily checks included noting whether learning disability patients were staying on the ward.

A red tray feeding system helped clearly identify patients who required help with feeding.

Patients living with dementia were identified forget me not stickers on records and above beds. This helped staff identify them and adjust language or care if required. We saw stickers displayed during our inspection.
For patients living with dementia or those feeling agitated staff on the orthopaedic ward had access to an electronic therapy system preloaded with a range of vintage music, poetry and wartime speeches. Nurses spoke enthusiastically about the system, saying it helped calm patients.

Additionally, teddies and distraction blankets were available and staff were hosting a ‘cupcake dementia day’ to raise money for a new bladder scanner to help patients recognise toilet needs. Tables were decorated with wartime memorabilia and we saw posters on walls.

Transgender patients had access to single use toilets on wards and in theatre areas depending upon which gender they identified as.

The service provided care for young people aged 16 and 17 years. Nurses on the neurosurgery ward told us they tried to provide them with extra privacy in side rooms where they could have family to support them. Matrons daily checks including noting whether any young people were staying on the ward.

A consultant ortho-geriatrician was available to see elderly patients on the trauma ward and an elderly care physician held a weekly clinic. Medical staff confirmed a business case was being written to increase ortho-geriatricians to care for patients with fractured neck of femur injuries at the time of our inspection.

A dedicated psychologist worked to support patients on the major trauma ward.

Translation was available using a recognised translation company either face to face or by a telephone interpreter. There were clear instructions for staff explaining how to book this service.

One staff nurse entered a competition and won funding for landscaping a small area which was named after a patient who passed away. The area had outdoor light and sound capability and was enabled patients and loved ones to come for some emotional respite.

**Access and flow**

People could access the service when they needed it but waiting times for treatment and arrangements to admit, treat and discharge patients remained a challenge.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery the trust has been similar to the England average for the entire reporting period.

The latest information available shows that as at March 2018, 80% of this group of patients were treated within 18 weeks compared to an England average of 68%
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Two specialties were above the England average and three of specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>78%</td>
<td>61%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>Urology</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>65%</td>
<td>72%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>37%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

In Q1 2017/18, this trust cancelled 276 surgeries. Of the 276 cancellations, 235 occurred at the Royal Preston Hospital site. 25% of the total number weren’t treated within 28 days. This has improved through to Q3 2017/18 where we can see, of the 311 cancellations, 12% weren’t treated within 28 days.

Over the two years, the percentage of cancelled operations at the trust has been higher than the England average.

Service leaders confirmed this and added that further improvements were seen through to March 2018. They explained that some cancellations were unpredictable due to vascular and major trauma emergency work occurring in clusters of which there was no identified cause.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Lancashire Teaching Hospitals NHS Foundation Trust
Over the two years, the percentage of cancelled operations at the trust has been similar to the England average.

(Source: NHS England)

Managers said the majority of same day cancellations occurred due to lack of bed availability post procedure. They prioritised cancer and emergency surgery patients and undertook procedures as day case if possible to limit the number of overnight stays required.

Staff involved in scheduling theatre sessions said regular meetings were held where vacant sessions were reviewed and efforts made to fill slots. Weekly reports were generated which showed staff how much theatre time had been left vacant, how many delays and how many late sessions had occurred. A weekly meeting was held where the reports were then discussed.

When the hospital struggled to accommodate the number of patients, nurses and doctors said they struggled to place patients on surgical wards. Instead, they told us some patients were placed across other wards which meant surgical teams had to work harder to monitor them. To try to reduce this, the service protected particular areas. For example, major trauma patients could not be moved away from the ward and vascular beds were ring-fenced only for these patients. Despite this, medical staff told this remained an issue.

In addition to this, bed moves increased. Nurses told us they did not like moving patients once they were settled on wards. They told us moves occurred more on vascular and neurosurgery wards. Vascular care was provided regionally which meant demand was high, and neurosurgery care was provided on an emergency basis which meant that patients needed to be placed into beds at shorter notice and in order of priority. Despite this, medical staff told us the frequency of bed moves was minimal and that most moves occurred during the day.

For inpatients there were occasional difficulties ensuring they were admitted to the right wards. This was particularly the case for patients receiving vascular care or treatment. This was because the demand for beds usually exceeded the available capacity on the one vascular ward in the hospital. Senior nurses confirmed that despite there being 26 beds available on this ward there were usually up to another 25 other patients requiring care elsewhere in the hospital. To manage the care of these patients, vascular doctors (registrar or consultant level) were provided with a printed copy of their whereabouts each day to ensure they could visit them. Post-operative patients were generally brought to the ward to keep them together.
When we asked the trust to provide details of how they cared for surgical patients who occupy non-surgical beds, they told this did not happen, and that in the unlikely event this occurred, the patients would be brought back to the correct wards at the earliest opportunity.

Medical staff explained that sometimes patients did not want to leave hospital which caused delays and meant other patients experienced delays accessing beds. During our inspection a doctor told us three patients had refused to go home from the orthopaedic ward due a lack of confidence in available support at home.

Consultants confirmed that difficulties arose when accepting patients from other regions because once care had been provided there were often difficulties repatriating patients to their own areas. This could mean longer stays in the hospital.

To try to manage flow, discharge meetings were held daily with a range of staff including occupational and physiotherapists and pharmacy staff to try to facilitate discharges quickly.

Weekly ward meetings were held where managers reviewed two groups of patients; those who had been fit for discharge for at least seven days, and those fit for discharge for at least 21 days. A standard operating procedure supported this process.

Daily reports detailing reasons for delayed discharges were generated and reviewed by managers. Reasons included nursing or care home availability issues, family choice or funding issues. On one particular day, we saw 11 patients delayed going home. Three were because the family had not yet chosen a place of care, two were waiting for equipment and four had not yet had an assessment of needs completed before leaving hospital.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Nurses explained the complaints process to us which involved de-escalating concerns at the time they occurred wherever possible. This could be done by speaking directly with family members. If escalation was required, matrons were contacted to attend wards to try and resolve concerns.

The patient advice and liaison service was available for patients or loved ones to refer concerns or complaints. Patient advice and liaison service staff facilitated the complaints process, by handing out details to ward staff who had set timescales for investigating and returning findings. This helped ensure concerns and complaints were investigated and responded to effectively.

Leaflets were available for patients explaining the role of the patient advice and liaison service.

Between April 2017 and March 2018, the service received five formal complaints compared with seven the previous year. The service had experienced issues meeting the trust target to close complaints within 35 days. To improve this, managers adopted a zero-tolerance approach and recruited a new head of customer care to monitor the process. Whilst previously only one of the seven complaints were closed within the response time, we saw so far in 2018 all responses were dealt with within the required timescale.

We saw examples of sharing learning following complaints. In one example, staff welcomed a patient into the theatre department to meet staff, after they sustained skin damage following awkward positioning during surgery. Here the patient explained the impact of the issue to staff so this could be taken into account when caring for other patients.

Changes were made following a second patient visit following their experience of feeling privacy
was not sufficiently maintained during surgery. Following this, screens were obtained to limit views to improve the experience for others.

Action plans following complaints were monitored electronically by a central team to ensure they were completed.

Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

During our previous inspection a new divisional structure had been introduced the previous year. In this trust, two divisions spanned the surgical core service. These sat under a clinical business unit. Each was led by a divisional medical director and divisional nursing director and supported by a governance and risk manager. Wards and theatre areas were managed day to day by matrons, team leaders or senior nurses.

At this inspection we saw the benefits this structure was bringing after being fully embedded and more recently new leaders had renewed the existing positive approach of the service.

Leaders were aware of the challenges when they arrived in the service such as pressure ulcer prevalence and delays, and had worked to make improvements following their arrival in post.

Nurses, doctors and support staff we spoke to told us ‘I feel valued here by management’, and ‘happy and supported in my role’. They told us they felt they were given autonomy from above and given the freedom to manage but that leaders were available when needed.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The vision was clearly defined to provide ‘excellent care with compassion’ and a strategy to ‘provide outstanding healthcare to local communities, to offer specialised services and drive innovation’

Staff we spoke to were aware that trust values existed and that there was a strategy but not everyone was aware of the details. Some staff told us ‘it would be nice to have the time to look at it’. Medical staff we spoke to described the vision as ‘a bit artificial’ and ‘things we take for granted’. However, they also acknowledged that ‘they want to be a high performing trust’. A junior doctor we spoke to told us they had ‘no idea’ what the values were.

The learning disability staff were enthusiastic about their own vision to create a bespoke service for patients with specific service needs. Being relatively new in post they were in the early stages of this project but it was clear to see they were cited on the goals they wished to achieve from the outset.

Culture

Managers promoted a positive culture amongst the majority of staff that supported and valued them, creating a sense of common purpose based on shared values.
Staff described the culture as supportive, open and honest. Some had returned following retirement. One nurse described feeling 'like part of an experienced team'. Other nurses said they felt supported by each other, especially with the revalidation process or when pressures on the wards were high.

However, some staff in theatres also described a stressful culture caused by repeated overruns in theatre sessions which caused them to finish shifts later than planned.

Others described limited car parking causing consistently longer hours due to parking off site and using public transport.

The service had helped staff by bringing hot catering down to the theatre area. This meant staff did not have to get changed to go and get lunch, which they agreed was helpful, although they advised this was not available after 2pm or at weekends.

**Governance**

Following on from the previous inspection, the trust continued to use a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Wards used an accreditation system to review quality against a set of core standards covering infection prevention and control, safeguarding, medicine management, documentation, harm free care, discharges, acutely unwell patient management and staff health and wellbeing. Wards received a red, amber or green rating which showed how soon a review should be repeated.

The service had started to review all the wards. However, we identified that some wards rated red had not been reviewed again within the required timescale of two months, because managers were still completing the first wave of reviews. This meant some wards were rated red (low assurance indicating higher areas of risk) but had not been checked to see if the risks had been addressed.

Regular meetings were held to review governance in terms of complaints, risks, incidents and risks. Information was then shared in monthly matron, ward manager and theatre meetings. Information was cascaded to remaining nurses and support staff in safety huddles. Other meetings included monthly harm free care meetings and clinical lead meetings which were mandatory and minuted so that information could be shared with wards and theatre areas.

Governance information was supplied to the trust board through clinical business units which fed into subcommittee groups for; quality and safety, strategy, workforce, and finance and performance. The committees were directly linked to the board.

**Management of risk, issues and performance**

The trust maintained existing and effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service used two risk registers, each for one of the two divisions. We reviewed the division of surgery register, which listed each risk, when it was opened, the risk rating, controls and actions in place to mitigate it. We saw evidence that risks were reviewed regularly and updates added.

A risk management committee met monthly and a risk management report was submitted by the service to the committee quarterly for discussion.
Managers were provided with a divisional risk report covering risks in both wards and theatre areas. These were discussed at service level each month and where appropriate were discussed at ward meetings so that staff on wards and in theatres were aware of them.

Senior leaders monitored performance monthly using a dashboard which provided figures for a range of elements including treatment times, cleanliness, infection, cancelled operations, safeguarding training, appraisals, patient experience, complaints, job vacancies and overall financial status. This enabled them to review areas of concern and plan focus points as well as celebrate areas of success.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems.

The service coped well with a mixture of both paper and electronic records. Staff were clear about where information was and where to locate it. Paper files were neatly organised and staff told us they could find the information they required to care for patients.

Theatre service leads told us they were planning to implement a new electronic theatre utilisation system which would help plan and manage theatre lists in a more organised way.

Managers confirmed this would allow for more accurate scheduling, provide enhanced visibility of expected start and finish times based on average running times, provide alerts when an operation was running late, prompt staff if patients required diagnostic tests or equipment and provide the correct surgical safety checklist for staff to use. Wards would also have an overview of the progress of surgery, enabling them to prepare beds in advance.

**Engagement**

The trust continued to engage with patients, staff and the public to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff morale was given priority in the theatre service. We saw examples of investment to raise morale such as bringing canteen services closer to theatres to make it easier for staff to source hot meals, investment in a new equipment transport system to lessen staff moving and handling needs and a new cleaning team which reduced the workload of staff at the end of each day.

The trust engaged with staff in the service through their newly launched health and wellbeing newsletter. In the June edition they encouraged staff to complete a questionnaire about health and wellbeing. They also advertised social groups for runners, mindfulness, smoking cessation, yoga and social trips for staff.

The trust had recently undertaken engagement with approximately 3000 patients from a wide range of organisations by holding public events in the local community. From this a new three-year strategy focusing on improvements which were most important to patients and their loved ones was published.

Strategies relevant to the surgical core service included extending visiting times for carers, ensuring patients are on the right wards at the right time and having early discussions about discharge so that patients and families feel informed.
Learning, continuous improvement and innovation

The service remained committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The service was forward thinking in relation to providing a bespoke service for learning disability patients or those living with dementia. Staff were in the early stages of developing this service but had identified gaps in care provision for those with mild learning disabilities who did not receive support services but were struggling to cope with managing hospital processes.

Staff were building networks across the North-West region and meeting with system designers to help make sure patients with needs might be more easily identified on trust systems when accessing care.

Theatre staff were working innovatively with new technology to treat patients. Surgery using robots was now common practice covering specialties such as urology, gynaecology, upper gastrointestinal and colorectal surgery.

Patient safety champions in theatres involving a range of staff grades met regularly to explore and discuss patient safety issues. This led to the group receiving a trust patient safety champion award.
Maternity

Facts and data about this service

The Royal Preston Hospital has 60 maternity beds across the two wards, delivery suite and the birth centre.

(Source: Trust Provider Information Request – Acute sites)

From January 2017 to December 2017 there were 4,046 births at the trust.

The service has 62 maternity beds at the Sharoe Green Lane site. These consist of an antenatal ward (21 beds), a post-natal ward (23 beds), a labour ward (12 beds) and the alongside midwifery led unit (4 beds) which also has two postnatal rooms. The department also facilitates a home birth service.

Outpatient areas include the hospital antenatal clinic, maternity day unit, a triage assessment area and obstetric sonography (pregnancy scanning) service.

Community antenatal clinics were held in GP surgeries and children’s centres.

A comparison from the number of births at the trust and the national totals during this period is shown below.

Number of babies birthed at Lancashire Teaching Hospitals NHS Foundation Trust – Comparison with other trusts in England.

A profile of all births from January 2017 to December 2017 can be viewed below.
The percentages of single and multiple births at the trust are the same as the England birth profile. With regard to mother age comparisons, the trust has more births to mothers under the age of 34 than the England rate and fewer births to mothers over the age of 35.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.

Number of births at Lancashire Teaching Hospitals NHS Foundation Trust by quarter.

2016/17 quarter one saw the highest number of births at the trust with 1,123, whereas 2017/18 quarter one saw the lowest number with 953.

SOURCE: HES - Births (October 2016 - September 2017)
Is the service safe?

Mandatory training

Mandatory training completion rates

The service provided mandatory training in key skills to all staff. The completion of mandatory training was higher than the target of 90% compliance.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from March 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>159</td>
<td>176</td>
<td>90.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>176</td>
<td>37.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity have met the 90% completion rate target for six of the seven courses made available to them.

The trust has not reported medical staff training data for maternity.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Staff had to complete red and blue mandatory training days which included PREVENT (introductory training around the risks of radicalisation and roles involved in supporting those at risk), clinical governance, bladder care, saving babies lives, cardiotocograph, intermittent auscultation, safeguarding and antenatal screening. The obstetric emergency training was mandatory and separate to this training.

Safeguarding

Staff we spoke with understood how to protect women and their babies from abuse and the service worked well with other agencies to do so. Completion of all safeguarding training was close to the trust target of 90% and the service had robust procedures to identify and act on safeguarding issues to prevent baby abduction.

The trust set a target of 90% for completion of mandatory safeguarding training.

A breakdown of compliance for safeguarding courses from March 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>162</td>
<td>176</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>160</td>
<td>176</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>147</td>
<td>175</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity met the safeguard training target for three of four courses made available to them.

(Source: Trust Provider Information Request P18)

Each clinical area had a file containing relevant documentation about each safeguarding concern. There was a pink form in each of the set of maternity notes where safeguarding had been identified as an issue to highlight to alert staff of the concern.

A red flag recording system safeguarding could also be inputted onto the intrapartum maternity information technology system where appropriate.

On the labour ward there was a white board in the office that was kept updated with details of women with safeguarding concerns who were expected to give birth over the next few weeks.

We were told that a member of the safeguarding team attended the daily huddles on labour ward to make the team aware of ongoing safeguarding issues.

The enhanced support midwifery team included midwives for substance misuse, perinatal mental health and teenage pregnancy.

The named midwife for safeguarding informed us that she and her team received good support from the leadership team and excellent support from the head of midwifery.

Data supplied by the department during our inspection highlighted that the safeguarding children level three figure was at 85% which was a slight improvement from the previous figure supplied.

Maternity staff had three hours of safeguarding training on the mandatory study days. Subjects covered within the time frame were female genital mutilation and domestic abuse alongside level three children and adult updates.

We were told that there was a good working relationship with the local children’s social care team and other relevant external agencies.

We were told of future plans of a joint audit into child protection plans and looked after children with the children’s social care team to review plans and actions.

The maternity service used an electronic baby identification and security system which was a system that provided an automated alarm alert for unauthorised movement of a baby. There were sufficient identification tags for all babies and all the babies we observed during our inspection had one fitted. We observed this security system working effectively and setting off the alarm during our inspection.

There were posters informing people about tailgating near the main entrances to clinical areas to prevent unauthorised access to the clinical areas.
Cleanliness, infection control and hygiene

All clinical areas and equipment were visibly clean.

Staff followed the trust’s dress code and their arms bare below the elbows’ in the clinical areas during our inspection.

All of the sharps bins that we saw were not filled above the advisory level and they were used appropriately.

We saw “I am clean” stickers on some pieces of equipment but not on others. However, all equipment was visibly clean.

There were wall mounted hand washing solutions at clinical sinks in clinical areas and we observed these being used appropriately by staff.

The department carried out monthly hand hygiene audits. Hand hygiene audits for the month of May 2018 showed that the birth centre was 100% compliant.

There were wall-mounted hand sterilising gels at the entrances to all clinical areas and in appropriate places elsewhere and we observed these being used by staff and visitors.

We observed a woman, her partner and staff during an elective caesarean section birth and all were wearing appropriate theatre attire.

All women were advised by the maternity staff to have their Pertussis vaccination and, during the influenza season, their flu vaccinations.

Environment and equipment

Equipment was within dates for servicing and calibration. There was sufficient equipment for staff to use to carry out their duties.

Entry to the core clinical areas was via a controlled access system in order to monitor staff, patients and visitors.

The department had a dedicated antenatal clinic, obstetric scanning facilities and a maternity day unit.

The maternity unit had a triage area that was open 24 hours per day. There was a four-bedded bay with an en-suite toilet and shower room and a single room which we were told was used for intimate examinations and private conversations. There was a separate waiting room for triage. Triage was sited within the antenatal ward.

There was sufficient equipment to monitor maternal and fetal wellbeing such as cardiotocograph machines, pinnards and blood pressure machines. All of the equipment we saw was visibly clean and had “I am clean” stickers on them. All equipment was within date for service and calibration.

The antenatal ward consisted of 21 beds. These were arranged into four, four bedded bays, four single rooms and one bereavement room. The ward area was visibly clean and there was sufficient equipment for staff to work with. There were two baths in this area. All of this equipment appeared clean.

The postnatal ward consisted of 23 beds, of which 3 were single rooms. All women were encouraged to express breast milk from their 37th week of pregnancy and we observed a locked fridge on this ward for storage of expressed breast milk. This was an improvement from our last inspection. This fridge, and the two medications fridges in this area, appeared visibly clean and were checked appropriately.
The birth centre at the unit consisted of four birthing rooms, all with birthing pools and two family rooms that women could use in the immediate postnatal period should they require further assistance, such as with breastfeeding, for up to 24 hours. We were told that women were actively encouraged to stay in these rooms and that their partners could stay with them throughout. All of the areas in the birth centre were visibly clean, there was sufficient equipment for the maternity staff to use in caring for the women. All of the equipment was visibly clean, were in date for servicing and had “I am clean” stickers on.

The labour ward consisted of 12 single rooms, one of which had a pool installed. The unit had birthing pools that could be assembled and used by women on the labour ward should they wish. One of the rooms was being used as a recovery room and another as a bereavement room. There were three theatres adjacent to the labour ward. One of which was a dedicated obstetric theatre, one for gynaecology procedures and one that was available overflow.

Women who birthed their baby by elective or emergency caesarean section were recovered in the immediate postnatal period in a dedicated bay on the labour prior to being transferred to postnatal ward. The service always used a theatre nurse or operating department practitioner to recover these women, with a midwife in.

All areas had fridges and store rooms that were locked to prevent unauthorised access and we saw evidence that fridges were checked daily.

Emergency equipment to be used in the event of a neonatal or obstetric emergency was available in all relevant areas and the daily checks were complete.

Staff told us that there was an issue with capacity in theatres whereby if there was a second obstetric emergency there was not always a theatre available. This was on the department’s risk register and had been since September 2013. There was an escalation policy in place and staff were reminded to complete an incident form each time this escalation procedure occurred. The options in place if a second emergency theatre was required were to open another theatre if there was one free, delay or cancel elective surgery and perform the procedure in that theatre or perform the procedure outside of the theatre area if needed, such as the recovery room. Following our inspection, we requested and received the previous 12 months of incident data and subsequent investigations. There were no incidents relating to this issue.

Staff identified another risk with us of the occasional lack of consumable equipment, such as syringes and specific equipment for certain surgical procedures, in the theatres used for obstetric and gynaecological procedures. It was stated at this time that this never stopped the procedures going ahead, but that they sometimes had to use other equipment as an alternative. We raised this issue with the leaders of the maternity department and they told us that this whilst they knew there was an issue regarding consumable equipment in these theatres, they were not aware of the specific examples that we gave. However, they did say that it was on the theatre risk register and that they were monitoring it.

Assessing and responding to patient risk

Since the removal of midwifery supervision, the department had put in place a second band seven midwife who was contactable via a bleep system. Unit posters highlighted to staff when to contact the maternity bleep holder. Reasons include sickness, safeguarding issues, staffing shortages, lack of 1:1 care, delay in pain relief and staff unable to take breaks.

The service used the World Health Organisation (WHO) Five Steps to Safer Surgery checklist for all women birthing their babies by caesarean section. During our inspection we observed an
elective caesarean section that was performed during a busy shift with high risk cases when there was capacity in the workload. The staff followed most of the World Health Organisation checklist, however they did not perform the team brief or introductions immediately prior to the commencement of the procedure. This is not in line with the World Health Organisation checklist. The woman later asked if she had been introduced to the theatre staff prior to her operation and she stated that she had been. The service had a shortened World Health Organisation checklist for use in emergency time critical caesarean sections that did not require all the checks. The service carried out monthly audits into compliance with the World Health Organisation checklist. We reviewed the outcomes of the audits for the last three months and the results were April 100%, May 96.5% and June 100%.

We observed telephone advice being given by a midwife to pregnant women who had rang the department on four separate occasions and noted that appropriate advice was given in all instances.

The service had risk assessments in place to mitigate potential risks to women and staff, such as one for community midwives carrying nitrous oxide (Entonox) to be used at a home birth.

The service used a modified early obstetric warning score. This is where vital signs are recorded and may give an indication of an underlying infection and risk assessments to ascertain whether a woman should be placed under the low risk care of the midwife or the higher risk care of the obstetrician. We saw that modified early obstetric warning score had been recorded in the patient records we reviewed.

**Nursing and midwifery staff**

The service acknowledged that they were of short of midwives. However, they had put in place plans to mitigate the risks caused by this to the extent that patient satisfaction and staff morale was improving. All midwife vacancies would be filled by a new intake of midwives in September and October 2018.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The maternity service had a significant vacancy rate of 16.7%. Furthermore, we were told during our inspection that 18 registered midwives employed by the department were currently on maternity leave. However, the department acknowledged these issues and had put in place measures to mitigate this risk as much as was reasonably possible.

Midwifery staffing was reviewed as a minimum, every six months and more frequently if required.

The head of midwifery told us that their midwives were offered to work extra hours, that they had set up an external bank system as well as their internal bank staff and were currently in the process of establishing links with an external midwifery agency to provide extra staff when needed.

The department had produced a series of films entitled ‘24 hours in maternity’ which highlighted
what it was like to work in their maternity department. These films were available for all to watch on their internet page.

In the community we were told by one staff member about the band 3 maternity care assistants who worked as part of the teams. They facilitated support such as visits to carry out baby weighing, breast feeding support and baby heel prick tests, which is a blood test taken to screen for specific conditions.

There were two safety huddles per day, sometimes three if circumstances necessitated, that looked at the staffing across the service and were attended by representatives from all areas of the unit. They looked at the whole service and any anticipated upcoming issues women potentially arriving at the unit, or if there has been a lot of discharges, meaning that community midwifery teams would be busy. During our inspection we observed that because of the morning huddle, a midwife from the ward had agreed to work in community because they were busy.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 16.9% in maternity. This is worse than the trust’s target of 6%. The breakdown by site can be seen below:

- Royal Preston Hospital – 16.7%
- Chorley and South Ribble Hospital – 57.1% (based on four members of staff)

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

During our inspection we were informed about a recent recruitment drive by the department that had resulted in twenty-three band five midwives being recruited to start employment with the trust in September 2018. We were told that once these midwives started employment then the trust would be up to establishment.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From February 2017 to January 2018, the trust reported an overall sickness rate of 4.2% for nursing staff in maternity. This is the same as the trust target of 4.2%. A breakdown by site can be seen below:

- Royal Preston Hospital – 4.2%
- Chorley and South Ribble Hospital – 9.4%

Maternity staff numbers at Chorley and South Ribble Hospital are significantly lower than at Royal Preston Hospital. The figure of 9.4% is based on 35 permanent staff sickness days compared to the 2,258 sick days at royal Preston Hospital.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Existing midwives could work extra shifts that were advertised on the department’s closed Facebook page.

During our inspection we were informed that the department were in the process of working with local staffing agencies to improve staffing in their clinical areas.

**Midwife to birth ratio**

As of September 2017, the trust had a ratio of one midwife to every 27 women which is the same as the England average.

(Source: Electronic Staff Records – EST Data Warehouse)

**Medical staffing**

The trust has not provided staffing, vacancy, turnover, sickness or banks and locum data for medical staff in maternity.

The consultant obstetrician presence on the labour ward was, as highlighted in the maternity dashboard, been consistently at 77.5 hours per week between June 2017 and May 2018. During our inspection we were told that these hours were made up of 12.5 hours per day Monday to Friday and the rest of the hours at weekend for handovers morning and evening.

We were informed that they were monitoring this and that there had been no incidents that involved or were due to consultant obstetrician numbers on the labour ward.

**Staffing skill mix**

As at January 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.
Staffing skill mix for the 33 whole time equivalent staff working in maternity at Lancashire Teaching Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients care and treatment. Records were clear, up to date and available to all staff providing care.

Documentation in the department was on a combination of paper based records and maternity information technology system.

The department used paper copies of maternity notes for antenatal, intrapartum and postnatal care. Within the unit the intrapartum documentation was inputted straight onto a maternity information technology system and "fresh eyes", a system of reviewing cardiotocograph printouts during labour, were completed straight onto this. However, we were told that on the birth centre it was usual practice to document in the paper intrapartum notes contemporaneously and then to input relevant parts onto the maternity information system to enable the births to be registered which was a duplication of this documentation.

Women’s records were stored securely in either locked offices or in locked filing cabinets.

We reviewed 13 electronic and paper maternity records which up to date and completed correctly.

During our inspection we were told of plans to use one maternity information system that would be used across all maternity departments.

Medicines

The service prescribed, stored, documented and gave medications well. Women received the right medication at the right dose at the right time.

The maternity department used paper drug charts. We reviewed 13 drug charts during our inspection and saw appropriate documentation on allergy status in all records. There was input from the trusts pharmacy department.
The medicine store for community midwives was in a locked fridge in a locked room on the birth centre. Each medication was supplied in its own box with a label on advising how long the drug may be carried out of the fridge and in the midwife’s bag before being discarded. The midwives had to document on the box the date removed and, as per the policy, it was their responsibility to ensure that they complied with the instructions.

The department had developed a standard operating procedure for community midwives carrying nitrous oxide to home births, which was a requirement highlighted in the last inspection. We saw evidence of the risk assessment for community midwives to carry these gases in their cars to attend home births. This highlights that an e-learning training package was being developed for midwives to complete when ready and that until then 67% have been made aware of the standard operating procedure for transporting these gases via 1:1 and team meetings. This was an improvement from our last inspection.

Medications in all clinical areas were kept in locked fridges or cupboards and we saw evidence that relevant daily checks had been made.

We reviewed controlled drugs stock and storage in all clinical areas. Correct procedures, such as two staff members checking and signing and correct disposal of unused medications were followed, and were completed in all areas.

Intravenous fluids were, on the whole, stored securely to prevent unauthorised access to them. However, on the birth centre we noted that the emergency equipment used to deal with postpartum haemorrhage and cord prolapse was kept in an unlocked bay on the birth centre and contained intravenous fluids. This issue was raised during the inspection to the birth centre manager.

The Bacillus Calmette-Guerin (BCG) vaccine, which is one primarily used to vaccinate eligible newborn babies against tuberculosis was on the maternity risk register. Eligible babies were offered the vaccine at two clinics in the hospital following discharge and if their parents did not attend with them, these babies were referred to the community screening and immunisation team.

All medicines and most intravenous fluids were stored in locked cabinets and were in date.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Incidents were investigated by a multi-disciplinary team and lessons from learning were shared with the whole team. When things went wrong, staff apologised and gave women honest information and suitable support.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents which were classified as never events for maternity.

*(Source: Strategic Executive Information System (STEIS))*
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the two types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate an infant) with one (50% of total incidents)
- Slips/trips/falls meeting SI criteria with one (50% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We reviewed the details of these two incidents, the subsequent investigations and lessons learnt. They were reviewed by a multidisciplinary team that thoroughly investigated the causes where applicable and shared the lessons learnt and put in place appropriate action plans.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, women using the services and visitors.

We observed the departments dashboard displayed on the “How are we doing” boards in the clinical areas of the unit. The birth centre board displayed the results of hand hygiene audits, optimal cord clamping, water birth, breast feeding initiation, comments from the friends and family test and thank you cards.

The department’s dashboard highlighted the average monthly statistics such as postpartum haemorrhage over 2000 ml 1.8%, 3/4th degree tear 3.2%, stillbirth rate 0.42% and vaginal birth after caesarean section rate 20%.

The department’s safety thermometer had equalled or exceed its own target of 75% for half of the months in the previous year. The safety thermometer was rated against five markers which included maternal infection, 3/4th degree tears, estimated blood loss greater than 1000mils, term babies admitted to the neonatal unit and term babies with an Apgar score of less than 7 at five minutes.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. The service carried out audits to ensure both compliance and effectiveness of care provided and to benchmark their performance and highlight areas for improvement.

Whilst care and treatment was evidence based, 21% (38) of their guidelines were either currently being updated, were under review or were in the process of being ratified.

Staff used guidelines from the National Institute for Care Health and Excellence and the relevant Royal colleges as a basis to determine the treatment they provide.

The service carried out audits to benchmark their performance against national guidelines and to highlight possible areas for improvement. These audits included 1:1 care in labour audit for the birth centre. In the period from July to December 2017 this audit highlighted a 68.5% compliance
with this. However, changes in the birth centre which included a new system to capture this data were introduced in January 2018. Between this date and May 2018, the 1:1 rate has improved to 88%.

Copies of policies and guidelines were available to all staff working in the unit via the trust intranet. However, community staff were not able to access these guidelines from their trust issued mobile phones, they could only access them from their personal mobile devices.

We saw evidence of the work that the department was involved in with other trusts within the region to standardise care provision such as working with two neighbouring maternity providers to standardise training across the geographical area.

**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Women who were admitted to the department had access to hot meals 24 hours per day, seven days per week.

The trust employed a specialist infant feeding coordinator whom had been in post for 11 weeks at the time of our inspection.

We were told that although the trust was not currently working towards the UNICEF baby friendly initiative they were working to the standards of the initiative.

Between June 2017 and May 2018, the breastfeeding initiation rate in the department was an average of 69.7% which was below the trust’s target of 70%. However, the last three months in this period were above the trust target with May 2018 being 72.6%.

The department facilitated two antenatal breastfeeding skills workshops per month that women and their partners could book onto free of charge. Topics covered included practical skills of breastfeeding, expressing breastmilk and the benefits of skin to skin contact following birth.

All midwifery staff had a one-hour update on infant feeding on their yearly mandatory training days in order that they could maintain their competencies in supporting women to feed their babies.

Additional breastfeeding support in hospital and community was provided by a peer support group called families and babies. This was a service commissioned and funded by the county council which complimented the service provided by the department.

Skin to skin was promoted at all births, including those by caesarean section. This has many benefits, one of which is that it promotes infant feeding.

Tea and coffee facilities were easily accessible 24 hours per day for women and their partners in the inpatient areas.

We observed feeding support to new mothers who were artificially feeding their baby, which included sterilisation, baby led feeding and positioning.

**Pain relief**

Staff managed pain well. Women had access to a variety of analgesia in labour if they wished, including paracetamol, nitrous oxide, pethidine, epidural and remifentanil.

Alternative forms of pain relief were available including the use birthing pools and aromatherapy in both the labour ward and the birth centre.

Women had access to all forms of pain relief 24 hours per day, seven days per week.
There was a supply of pethidine stored on the birth centre that community midwives could access for women birthing their baby at home if their GP had not prescribed it.

The department had an extra four birthing pools on the labour ward that may be used for pain relief, that could be moved and used in whatever room the women wished.

**Patient outcomes**

The service achieved good outcomes for women and babies. The staff offered support and guidance to assist women with breastfeeding.

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other maternity service providers in their locality to share learning and to learn from them via the strategic clinical networks and their local maternity system.

We were told during our inspection that there had been a rise in the induction of labour rate, largely as a result of the recent implementation of the small for gestational age pathway and the national saving babies lives work around reduced fetal movements. We were informed that the service was forming a group to look at any reasons for this rise.

The service employed a dedicated specialist midwife for public health who was leading on the saving babies lives package to reduce stillbirths and neonatal deaths.

Following system restructuring of the departments newborn hearing screening programme, over 90% of babies now get appropriate referrals to the trusts audiology department within the four weeks’ time frame that is set nationally.

**National Neonatal Audit Programme**

In the 2016 National Neonatal Audit, Royal Preston Hospital performance was as follows:

*Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?*

The 2016 report showed there were 76 babies born at <32 weeks included in the audit measure for the unit. 99% of these babies had their temperature measured within an hour of birth; this was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Following inspection, further information was provided by the trust to demonstrate that between the 1 April 2017 to the 31 March 2018, the percentage of eligible babies having their temperature taken within one hour of birth was 100%.

*Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?*

The 2016 report shows there were 142 eligible mothers identified for inclusion in this audit measure for the unit. 94% of these mothers were given a complete or incomplete course of antenatal steroids; this was above the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From January 2017 to December 2017, the total number of caesarean sections was similar to
The standardised caesarean section rates for both elective sections and emergency sections were also as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Lancashire Teaching Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>489</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.6%</td>
<td>543</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.0%</td>
<td>1,032</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Source: Hospital Episode Statistics January 2017 to December 2017

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from January 2017 to December 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Lancashire Teaching Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>1,032</td>
<td>25.5%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>427</td>
<td>10.6%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>2,576</td>
<td>63.7%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>11</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,046</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.08. The comparator group was 6.44 this was up to 10% lower than the average for comparator group.

(Source: MBRRACE UK)

The department had been carrying out audits into a variety of areas such as optimal cord clamping. Between January and May 2018 inclusive the optimal cord clamping rates were 93.2%.

Competent staff

Appraisal rates had only improved slightly since our last inspection of this service when they were 54%. At this inspection they were 65% which was still below the trust target.
During our inspection we spoke to student midwives at different stages of their training who all stated that they were supported in their learning with mentors and other staff.

The department had used the practical obstetric multi-professional training (PROMPT) (a package that trains the attendees how to deal with obstetric and neonatal emergencies, primarily for hospital emergencies). However, we were told that the scenarios used on the day were tailored to the needs of the individual attendees, such as community midwives receiving a home birth scenario.

Since January 2018 the trust had been working, with two neighbouring maternity providers as part of the better births programme which is a national initiative to improve safety in maternity, to standardise training across the geographical area. We were told that 85.1% of staff had completed this training.

Prior to attendance at this training day staff had to have completed an online cardiotocograph training course aimed at enhancing their competency in caring for both low and high-risk women in labour and interpretation of the cardiotocograph printouts.

There was a closed social media page that staff were encouraged to access for learning and development.

Since the removal of midwifery supervision, the department told us that they had immediately put in place a band seven bleep holder 24 hours per day, seven days per week to ensure that all staff, especially newly qualified staff, had a point of contact should they need advice or assistance.

Following our last inspection, the trust was told that they must improve the medical devices training rates. However, the figures we received for the last year only equate to an average of 45.5%. This was an improvement from our last inspection which found only 28% compliance against the trust target of 75%. We were told an action plan already in place and they expect the department to achieve 90% compliance by September 2018.

The trust’s pharmacy department had been providing training to maternity staff to ensure that the newly purchased breast milk refrigerators were checked appropriately.

Maternity staff had received simulation training in caring for labouring and birthing women in their birthing pools.

**Multidisciplinary working**

Staff of differing professions worked together as a team to benefit women and babies. Midwives, obstetricians and other healthcare professionals supported each other to provide good care.

There was effective internal multi-disciplinary working that included pharmacists, sonographers, theatre and housekeeping staff.

There was effective external team working with other maternity providers, social work departments and the local NHS ambulance service.

We observed collaborative working of all pertinent health professionals such as midwives, obstetricians, anaesthetists, operating department practitioners and theatre nurses, on initiatives in maternity theatre such as offering delayed cord clamping, skin to skin immediately following birth and the theatre cap challenge.

**Seven-day services**

Maternity services were available 24 hours per day, seven days per week. Midwifery, obstetric and anaesthetic cover was provided outside of normal working hours and the midwifery staff told us that they felt supported during these periods.
There was antenatal clinics held in the unit on weekdays where women could be seen by in consultant obstetrician clinics.

There were antenatal clinics in the community, across the geographical catchment area, on Monday to Friday where women could access antenatal care with their named midwife or their buddy.

Maternity triage was open 24 hours per day, seven days per week and women were encouraged to telephone the dedicated number at any time if they had concerns and following this they might be asked to attend for review if necessary.

Routine ultrasonography was available weekdays in the maternity outpatient department and urgent ultrasonography could be accessed outside of these hours.

There was consultant obstetric cover seven days per week.

**Health promotion**

The service promoted the health and wellbeing of mother and baby at various opportunities throughout the pregnancy and supported women leading healthier lifestyles.

At the booking appointment, all women were advised of the recommendation and importance to have their pertussis (whooping cough) and flu vaccination (when applicable).

All women were offered carbon monoxide screening by their community midwife. Eligible women were then offered referral to the local smoking cessation service.

All women were given information, at pertinent points during their pregnancy, regarding issues such as healthy eating in pregnancy and reduced fetal movements.

There were leaflets accessible to women on the trust internet page regarding various health promotion subjects such as smoking cessation, antenatal screening and emotional wellbeing.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 2015. They knew how to support women experiencing mental ill health and those who lacked capacity to make decisions about their care.

**Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training completion**

From February 2017 to March 2018, 92% of nursing staff at the trust completed the Mental Capacity Act level 2 training. Information regarding MCA training for medical staff in this service was not provided; therefore, we are unable to provide a full analysis of performance.

*(Source: Trust Provider Information Request – Training tab)*

Staff that we spoke with understood their roles and responsibilities under the Mental Health Act 2015. They knew how to support women experiencing mental ill health and those who lacked capacity to make decisions about their care.

The department employed a safeguarding lead midwife who supported all maternity staff with any MCA or DoLs issues.

MCA and DoLS training was included on the ‘blue’ mandatory training day and we were informed that as of May 2018, 88.9% of midwives had attended.
We observed on numerous occasions that consent for procedures was obtained, verbal and written where applicable, and documented prior to undertaking the procedures.

**Is the service caring?**

**Compassionate care**

Staff cared for women and their families with compassion. Feedback and observations confirmed that staff treated them well, with kindness and compassion.

Women described care from midwifery and obstetric staff as good or excellent.

**Friends and Family test performance**

Friends and family test performance (antenatal), Lancashire Teaching Hospitals NHS Foundation Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average, with one particular dip in performance in September 2017 where the trust scored 81% compared to the England average of 97%.

Friends and family test performance (birth), Lancashire Teaching Hospitals NHS Foundation Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.
From March 2017 to March 2018, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average for the duration of the reporting period.

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.  

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed about the same as other trusts for all of the questions it completed in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.01</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.54</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.79</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.10</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.25</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left</td>
<td>7.51</td>
<td>About the same</td>
</tr>
<tr>
<td>Area</td>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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</tr>
<tr>
<td>alone by midwives or doctors at a time when it worried you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.45</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.65</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.96</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.50</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.24</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.68</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.10</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.44</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.88</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

All staff introduced themselves and communicated well to ensure that women fully understood. Women were encouraged to ask questions and were given sufficient time to ensure that they understood what was being said to them.

We observed staff involving women and those close to them in decisions about their care and treatment.

Women were encouraged to provide feedback about the service they had received in a variety of ways.

In theatre, we observed staff preserving a woman’s dignity as much as possible during the birth of her baby by caesarean section.

**Emotional support**

Staff provided emotional support to women and their partners to minimise their distress.

We observed staff providing reassurance and comfort to women as required.

The service employed an antenatal screening specialist midwife to inform and support midwives, women and their families throughout the screening processes.
The service had a bereavement specialist midwifery team consisting of two midwives and a maternity support worker to provide support to women and their partners whose baby had died. The named midwife for each woman, or her “buddy midwife”, was responsible for ensuring that women who do not access care as recommended were followed up to check on their wellbeing and to ensure that an appropriate plan was put in place if applicable.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in decisions about their care and treatment. We observed staff interacting positively with women and those close to them.

Staff spoke to women and their families sensitively and appropriately, dependent upon individual need.

From our observations of women and staff interactions and from what women and their families told us during our inspection, staff respected women’s choices and delivered care with an individualised, person centred approach.

Women and their families told us that they received relevant information in a manner which they understood.

Partners were encouraged to attend with the women for their care.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services to meet the needs and wishes of its service users.

Services were provided to meet the needs of the local population such as specialist clinics. Examples of these include the birth afterthoughts clinic, which is a free service whereby women could talk through what happened during their labour and birth with a dedicated midwife who had her notes and a birth options clinic where women who have a pregnancy deemed as high risk were informed of their options and choices for birth.

The born before arrival (BBA) or unplanned home birth figure for the trust between June 2017 and May 2018 was 34 births. It was a recommendation in our last report that they should look at such cases to ascertain if there was any learning. We were told that this had taken place and that there were no themes or trends into such births.

The waiting area for triage had tea and coffee facilities and small children’s play area.

Midwives working in the triage clinical area were being trained to carry out presentation scans to facilitate women being seen and reviewed in a timelier manner.

Since our last inspection the trust had started a new service where the department loan out birthing pools to women planning a home birth at no cost to the women.

The service had an initiative whereby low risk women were assessed at home to establish the onset of labour and they were then able to choose whether to attend the alongside birth centre or stay at home.

The unit referred babies to the frenulotomy clinic, facilitated by the trust, where they assess and, if necessary cut, the excess piece of skin under a baby’s tongue which can restrict breastfeeding and also speech development later in life.
The service had plans to refurbish the bereavement room on the labour ward in response to feedback from women and their families who had used it. Planned work would include soundproofing and redecorating.

The service had a range of clinics to meet the needs of women. These included a vaginal birth after caesarean section clinic that gave relevant information to women so that they could make an informed choice about their next birth. The breech clinic, for women whose babies were bottom down as opposed to head down, ensured that women were informed of their options for birth.

Aromatherapy was available to women to use as a form of relaxation and pain relief.

There was a small team of midwives who provided care for women birthing their baby by elective caesarean section from the time they were admitted through to them being admitted onto the postnatal ward. This provided continuity of care to women at what may be an anxious time.

The department had leaflets on display around the unit that women and their families were encouraged to read and/or take away for further reference. However, during our inspection we noted that some of these, such as the ones in the triage waiting area, were out of date.

The service had a newborn hearing screening team which aimed to screen newborn babies hearing prior to discharge home from the hospital.

We saw evidence that the department was involved in with another trust as part of the Royal College of Midwives (RCM) initiative, better births by co design. The department, which is one of only two maternity services in the country chosen to work with the RCM on this, are improving the birthing environment for all women who give birth at the trust. Work already completed included mood lighting in the labour ward rooms and obstetric theatres, emergency equipment being hidden from view, black out blinds in the birthing rooms and the beds being placed in the sitting position as opposed to laid down. Staff held fund raising events to finance some improvements and further funding was obtained from a dedicated charity which raises money with the aim to maintain and raise standards in preventative care and foetal wellbeing at the maternity unit at Royal Preston Hospital. Their funding financed four birthing pools and three telemetry units. This is monitoring equipment that enables monitoring of the baby’s heartbeat in labour whilst allowing the mother to move about during labour and to labour and birth in the pools, instead of being restricted to the bed.

**Bed Occupancy**

From Q2 2016/17 to Q3 2017/18 the bed occupancy levels for maternity were generally similar to the England average, with the trust having 60% occupancy in Quarter Q3 2017/18 compared to the England average of 60%.
Meeting people’s individual needs

The service took account of people’s individual needs. The service provided additional support and services to women such as pregnant teenagers, women with mental health needs and women who did not speak English as a first language.

There was a system in place whereby maternity staff could contact an interpreting service for women whose first language was not English. All of the staff we asked about this process could describe how to access this service.

Previously women whose language was not English had to attend the antenatal clinic in the hospital to access appointments such as the booking appointment to receive the services of an interpreter. However, women were now seen in the place of their choice such as their local children’s centre, GP surgery or their home, and the interpreter went to the appointment with them and the midwife.

Similarly, there was now a similar service for women with hearing loss who used the service. Such women now had the same choices of where to receive their care as all other women and a British sign language interpreter would accompany the midwife to the appointment. We were told that the initiative arose because of one of the department’s community midwives recognising a gap in the service provision for such women.

On the department’s internet page there were five videos relating to pain relief that were all subtitled and British Sign Language signed. The department has worked with a local deaf society to produce these resources.
The department had a very comprehensive internet page with information for expectant and new parents, several videos for information and links to leaflets. However, there appeared to be a limited number of leaflets in languages other than English.

Where women with a history of mental illness were identified, there was a clear pathway for their care during and after pregnancy. The service had a combined clinic held for women with perinatal mental health issues which was facilitated by specialist midwives, obstetricians and members of the psychiatric team.

The trust employed a specialist mental health midwife who was part of the Enhanced Support Midwifery Team.

**Access and flow**

Women could access the service when they needed and wanted to.

We were told during our inspection that the doctor covering the triage area out of hours was the same doctor who was covering the gynaecology area and we were not assured whether this caused any delays in access and flow. The trust provided us with information about waiting times for triage. Between 1 January 2018 and 24 June 2018 over 90% of women were seen within 30 minutes and only on one occasion did they fail to get their target of 95% of women getting seen within 30 minutes, when they scored 85.85%.

The service was working with the maternal and neonatal health and safety collaborative which is a national quality improvement programme to reduce the rates of stillbirths, maternal and neonatal deaths. The trust had identified four projects in relation to this that were ongoing which included, “call the midwife” which aimed to improve women’s access to midwifery care and reducing times that women had to wait in the antenatal clinics.

The home birth service had not been cancelled due to midwives being called into the unit as part of the escalation policy at any time in the last 12 months.

The maternity unit had not closed or had to divert women to another maternity unit any time in the last 12 months.

**Learning from complaints and concerns**

The service treated complaints and concerns seriously, investigated them and shared the lessons learnt in a variety of formats.

In the period between March 2017 and April 2018 there were 17 complaints about maternity, this was a reduction from 20 in the previous time period. Themes were women/family experience, communication, delays in clinical service provision and staff attitude.

The service was learning from complaints in a variety of different ways. Examples of this were the antenatal care project to reduce waiting times in clinics and the enhanced elective caesarean section project that provided continuity of care to those undergoing such a birth with information in podcast and leaflet format.
Is the service well-led?

Leadership

The service had managers at all levels with the skills and abilities to run a service providing high quality sustainable care.

There were clearly defined and visible leadership roles across the maternity service.

The head of midwifery was supported in her leadership role by a consultant midwife, midwifery matrons and lead midwives.

All staff told us that their leaders and managers in their clinical areas were supportive of them.

The labour ward manager was awarded the British Journal of Midwifery Practice Award for Midwifery Leadership in February 2018. She was nominated by one of the midwives working on her team.

Staff told us that the leadership team were visible and approachable in the unit.

We were told by all staff and students that we spoke to during our inspection that the head of midwifery was always approachable and supportive to them, especially when they wanted to improve practice, such as one student midwife working at the trust who was supported to establish the theatre cap challenge in the department. This was an initiative whereby staff in theatres have their name on the theatre caps so that women and their partners can observe at a glance who everyone is.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from women and their families, staff and key groups representing the local community.

The department was included in the trust’s nursing, midwifery, allied health professionals and care givers’ strategy for 2018–2021 looking at projects such as reducing the time that mothers and babies were separated. This had been partly achieved by administrating babies who require intravenous antibiotics on the postnatal ward whilst they were still with them.

The service had already successfully gained funding to recruit the extra midwives needed to achieve their vision and strategy.

During our inspection we were informed that the vision for improving care for all women had taken a step nearer as they had been successful in negotiating an extra elective theatre list each week.

Senior leaders told us that they were working well with their local maternity system.

We were told during our inspection that the trust was exploring options to work towards the UNICEF baby friendly initiative accreditation with another maternity department to reduce the cost.

Culture

Leaders across the department promoted a positive culture that both supported and valued staff, creating a sense of common purpose based on shared values. All staff were positive about the improvements to the service since our last inspection.
All staff that we spoke with felt the culture within the unit was good and, for those that had worked here for some time, they told us that it was much improved over the last four years. Staff told us it was a good place to work.

All staff told us that while the service was currently understaffed it was managed well by moving staff to where they were most needed and that the extra band seven bleep holder ensured they received help when needed.

**Governance**

The trust employed a clinical governance and risk lead for neonatal and women’s health and a consultant obstetric lead for governance. They facilitated weekly risk meetings within the maternity department.

During our inspection we reviewed guidelines on the trust’s intranet about maternity and found many were past the review date. Following the inspection, the trust provided evidence which showed that of 179 policies 38 were either out of date or under review. This was on the maternity risk register and the trust was aware of this. This is similar to what we found during our last inspection.

We found that there was good attendance at governance meetings, which was an improvement from our last inspection.

The department produced a monthly governance magazine for all maternity staff entitled ‘women zone’. Subjects covered in these magazines include a message from the head of midwifery, updates in ongoing work within the unit such as midwifery recruitment and lessons learnt from incidents.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The department had a dashboard which monitored how they rated against specific targets and where they should target their work. For example, the department’s 3rd and 4th degree tear rate was 3.2% between June 2017 and May 2018 which was within target. However, the dashboard also highlighted that there had been an increase in the induction of labour rate in April and May 2018 to almost 43%. The trust told us during our inspection that they had already noted this and were planning work to see if they could identify a cause.

The department had a risk register which listed the risks that affected the department, what the likelihood and impact of those risks were and the mitigation and controls in place. If risks scored over a certain score they were escalated to the medicine division’s risk register or the corporate risk register.

There were 20 risks on the register that were specific to maternity that highlighted issues such as midwifery staffing, limited theatre capacity for elective caesarean sections and high dependency (HDU) unit care not being provided by trained staff on labour ward. We had already been informed about the new staff recruitment and also about the extra caesarean section list that had been agreed.

Risks were identified in a variety of ways, for example following a reported incident or recognition of a theme or trend. The incidents were discussed at a weekly case review and necessary learning and actions taken.
There were over 130 incidents reported in the two months prior to our inspection that highlighted trends, the most common one being blood sampling errors. This was discussed at the weekly incident reporting meeting, which was well attended, and an appropriate action plan was put in place that will be continually evaluated and monitored.

The trust carried out safety triangulation accreditation reviews (STAR) using a quality assurance framework. The system measured the quality of care delivered in each department or ward against a set of trust standards that had been developed by staff and triangulated a number of key performance measures to identify and put in place additional support for areas that needed it and to recognise and reward areas of good performance. The birth centre had received such a visit two months prior to our inspection and received a rating of green, for which they had an overall score of more than 95%.

The service undertook local and national audits and used the data to review clinical outcomes, resources, safety and areas of improvement. Monitoring performance and improving practice was also benchmarked against other local and national trusts.

We were shown an audit plan for the coming year which contained 22 differing planned audits including induction of labour audits, fetal heart rate monitoring in low risks labours and postpartum haemorrhage audits.

Senior maternity staff informed us that patient safety issues were identified through a variety of ways such as incident reporting and feedback from staff and women.

**Information management**

The maternity service had a robust data collection system in the form of a dashboard. It was presented in way, using a colour coded system, so that it was easy to see where any issues may be. We reviewed a copy of this dashboard on the information board in the ward areas.

The community midwives could use an online resource on their mobile phones to access trust guidelines, such as what to do in the event of a postpartum haemorrhage. However, the mobile phone that the community midwives were supplied with did not facilitate this access so the community midwives had to use their own phone to access it.

The service held huddles twice a day, and sometime three times a day if the unit was busy, and they discussed all areas of the maternity service, issues such as staffing, safeguarding, inductions of labour and planned home births in order that all of the staff were aware of potential issues in the whole service and in order that staff could be moved to the areas of most need.

**Engagement**

The service engaged well with women, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

There were white boards on the walls in the unit where women and their partners were encouraged to write their comments so the service could use the feedback to shape future maternity provision.

The unit had signed up to the Royal College of Midwives caring for you campaign which is an initiative set up to promote maternity services to care for and look after their staff.

The trust held maternity voices partnership meetings that were well attended by maternity staff, service users and external agencies and charities. Peoples views were sought to help shape the service of the future.
The weekend before our inspection the department held an engagement event at the trust named bumps, birth and babies, which had been advertised within the unit and on their social media page. We were told that there were between four and five hundred previous and potential service users in attendance throughout the day.

The service published a monthly staff magazine named Womenzone. This included a written message from the head of midwifery, friends and family feedback, maternity incidents, root cause analysis, learning points and areas for improvement.

The trust produced a magazine Connect which, amongst other issues covered, celebrated staff achievements and offers tips on health and wellbeing tips for staff.

The department held quarterly birth forum meetings. Staff members that were invited included the head of midwifery, varying levels of midwifery staff, theatre staff, obstetricians, anaesthetists and neonatologists. The purpose of these meetings was to discuss pertinent issues regarding the labour ward and the birth centre. Areas discussed included staffing issues and their effect on access and flow and improving the birth environments such as soundproofing the labour ward rooms following finances being raised by service users. The March 2018 meeting did not occur due to low attendance and this was on the risk register and was being reviewed.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The service had started innovative initiatives led by staff.

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which staff were encouraged and supported to implement improvements. One such example was the catheter challenge, initiated by one member of staff, where theatre staff not needed for the catheterisation move out of the way to protect the woman’s dignity. All staff members that we spoke to during our inspection told us that they were supported to make improvements to care provision such as this by the midwifery leaders and in particular the head of midwifery.

The department was working with the trust to make improvements following the last CQC inspection and this work was detailed in the monthly newsletter our journey to outstanding care.

The maternity department had been selected as a beacon site for their midwife led birth centre by being one of three trusts in the country to achieve the gold standard of offering women the choice of four places of birth for their baby. They were selected for this by the midwifery unit network which is a leading initiative to support women with positive birth experiences.

The department held a celebrating transformation in maternity event in February 2018 with speakers ranging from midwives, obstetricians, student midwives and service users. The event was attended by approximately 80 people consisting of midwives, obstetricians, maternity support workers, women and their families. This event was held to showcase the work being undertaken within the department to improve maternity care for women and their families.

A band six midwife, as part of her leadership development, was leading the home birth project whereby they aimed to increase the home birth rate in accordance with women’s choices and national recommendations. This was done by facilitating monthly home birth meetings that midwives, first time parents and parents that already had a home birth previously, get together and communicate with each other. The home birth rate last year was 1.9% and has risen this year to its current level of 2.3%.

All staff said that they felt supported to contribute to better care for women. We were told of several examples, one of which included that of a student midwife training at the trust. She had
heard of the theatre cap challenge in maternity in another part of the country and she was supported to implement this initiative at this trust. The theatre cap challenge was originally the idea of an Australian anaesthetist to write his name and profession on his theatre cap to avoid delays in treatment and had the effect of saving lives. The added benefit in the maternity theatre was that, as most women were awake and accompanied by their partner at such a birth, her and her partner knew who everyone was.

The labour ward team were one of only two maternity departments in the country to have been chosen to work with the Royal College of Midwives (RCM) as part of the better births by co-design project. Being part of the better births by co-design project had facilitated them to engage with families and staff to develop the environment of the delivery suite to be a place that met everybody’s needs. The main change that was taking place was in improving the birthing environment for all women on labour ward and in maternity theatres with the principle that the “theatre is a birth room” and as such having the same music and lights as the other birthing rooms.

The department were one of the first wave of maternity providers in the country to be chosen to be part of the maternity and neonatal health and safety collaborative. Working in partnership with the trust’s neonatal department and other similar teams across the country, they were leading on a three-year initiative to improve the experience of parents and babies and reducing harm.
Services for children and young people at the trust operated mainly from Royal Preston Hospital, although outpatient clinics were held at Chorley and South Ribble Hospital. The services for children and young people comprised of seven main areas:

- Paediatric ward with 30 inpatient beds.
- Paediatric assessment unit based on the ward with eight bed spaces.
- Paediatric day case area on the ward containing seven bed spaces (one as a separate room).
- Paediatric isolation with 10 cubicles at one end of the ward.
- Neonatal intensive care unit, which comprised of 30 beds, six of which were intensive care beds, eight high dependency beds, 14 special care beds and two transitional beds for parents to use with their babies prior to discharge.
- Paediatric outpatient clinic at the Preston site, which had its own entrance. Within this department, there were 10 clinic rooms, eight consultation rooms and a room for clinical interventions and a room for weighing and measuring. There are some paediatric clinics that held at the Chorley site.
- Two community clinics were held at two sites across the trust.

There was a paediatric outreach nursing team who provided continuity of care for children in their own homes.

During inspection we visited all these areas, except for the two community clinics.

We spoke with 24 members of staff including senior managers, matrons, nurses, medical staff, play specialists, health care assistants, students, housekeepers and domestics. We also spoke to three patients and five parents.

We observed care and treatment and looked at ten patient care records as well as service performance data.

The trust had 8,383 spells from December 2016 to November 2017.

Emergency spells accounted for 92% (7739 spells), 7% (591 spells) were day case spells, and the remaining 1% (53 spells) were elective.

| Percentage of spells in children's services by type of appointment and site, from December 2016 to November 2017, Lancashire Teaching Hospitals NHS Foundation Trust. |
Total number of children’s spells by Site, Lancashire Teaching Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Preston Hospital</td>
<td>8,380</td>
</tr>
<tr>
<td>This trust</td>
<td>8,383</td>
</tr>
<tr>
<td>England Total</td>
<td>1,099,209</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all employees and generally compliance figures were high and close to the trust target of 90%.

The mandatory training covered medicines management, manual handling of objects, health and safety (slips, trips and falls), infection prevention and control (level 1), information governance and fire safety.

Some clinical staff had to complete additional training dependent on their role, which included manual handling and life support for adults and paediatrics, with some staff having completed paediatric advanced life support. Training was delivered either face to face or by an online training package and new staff underwent an induction programme.

The figures below indicate that whilst the trust target of 90% had not been met for some of the mandatory training modules, compliance rates were sufficient to ensure there were adequately trained staff across each shift.

The trust set a target of 90% for mandatory training completion. Mandatory training included health and safety (slips, trips and falls), information governance, fire safety and infection prevention.
Nursing staff
From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in services for children and young people.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td>76</td>
<td>81</td>
<td>93.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>151</td>
<td>170</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>151</td>
<td>170</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>151</td>
<td>170</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>151</td>
<td>170</td>
<td>88.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>301</td>
<td>340</td>
<td>88.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>62</td>
<td>89</td>
<td>69.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

In May 2018, 92% of eligible staff had completed adult basic life support training, 83% had completed neonatal life support training, 94% had completed paediatric basic life support training, 84% had completed paediatric intermediate life support training and 93% had completed advanced paediatric life support training.

At the time of our inspection, staff from the paediatric outpatient team, except for one person, were compliant with mandatory training and this was due to a booked session being cancelled.

Medical staff
Medical staff within the trust were expected to complete the required training. Medical staff said there was training if a new piece of equipment was used on the unit and that staff received regular teaching sessions and clinical updates.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in services for children and young people.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>38</td>
<td>41</td>
<td>92.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>38</td>
<td>41</td>
<td>92.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>38</td>
<td>41</td>
<td>92.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>38</td>
<td>41</td>
<td>92.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>34</td>
<td>37</td>
<td>91.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>54</td>
<td>82</td>
<td>65.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In May 2018, 59% of eligible staff had completed adult basic life support training, 100% had completed adult intermediate and advanced life support, 60% had completed neonatal life support training, 62% had completed paediatric basic life support training, 100% had completed paediatric intermediate life support training (one member of staff) and 78% had completed advanced paediatric life support training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Safeguarding training levels had improved significantly since the last inspection, although were still lower than the trust target.

The trust had a safeguarding policy which was available for staff on the trust’s intranet page. The policy contained relevant information, contact details and flow charts to assist staff members with any safeguarding concerns.

There was a named lead nurse and a designated doctor for safeguarding children and young people. The trust had recently appointed a safeguarding practitioner for children to oversee neonates, although they had not yet started in post at the time of inspection.

There was safeguarding support available to all staff. The safeguarding team operated a duty rota system, allowing staff to speak with a member of the team for advice or support by telephone from Monday to Friday 9am to 5pm. The trust had safeguarding champions across all departments who offered support and advice to colleagues. The role of the safeguarding champion was open to all staff.

Additional staff were recruited to the safeguarding team. Each had a designated portfolio in paediatrics, urgent care, maternity, neonates, child and adolescent mental health services and the learning disabilities team. The safeguarding team attended daily handovers in paediatrics.

The named nurse for safeguarding for children and young people had experience in paediatrics and safeguarding and was keen to ensure that the Lancashire Continuum of Need and Thresholds Guidance would be embedded within practice. The Lancashire Continuum of Need provides guidance on assessment and planning procedures to meet need or prevent the escalation of need or support de-escalation from statutory services. It supports practitioners in determining how their service can support and work with families.

The trust safeguarding team held a seat on the Local Safeguarding Children Board for adults and children. The role of the Local Safeguarding Children Board is to co-ordinate what is done by members of the board to promote the welfare of children in the local area.

We saw safeguarding information boards in the urgent care department at both sites across the trust which offered guidance and advice to staff. Safeguarding had been strengthened by a consultant safeguarding lead in the urgent care department, supported by other senior medical and nursing staff.

The trust computer system allowed staff to check if a child was subject to a child protection plan, or was a child looked after. Records were flagged and tagged for easy identification if the family had been referred to the Multi-Agency Risk Assessment Conference (MARAC).
Systems allowed for records to be tagged if a child had been a victim, or at risk of child sexual exploitation. The safeguarding team told us there was close liaison with safeguarding teams in other areas for any children subject to a child protection plan, children looked after and any other child under review by the safeguarding team.

There were two health visitors who covered paediatric liaison and worked well with the trust to safeguard children and young people. There was close working with the specialist safeguarding midwife and we were told there was a task and finish group who were looking at concealed pregnancy, to improve outcomes. Staff told us within midwifery, there was now routine enquiry around domestic abuse, however this was not standard practice within paediatrics.

Children over the age of sixteen could be admitted to an adult ward within the hospital. Staff told us in this situation, they would try to offer a cubicle to the patient when this was possible, however this would depend on the number of patients requiring isolation cubicles. We were also told that the safeguarding team ran checks on any individual under the age of 18 on an adult ward, to see if there were any safeguarding concerns for them to be aware of and that they would support the ward if required.

**Safeguarding Training**

The trust had set a target of 90% for mandatory safeguarding training completion.

In May 2018, the trust reported the following compliance for nursing staff and medical/dental staff in services for children and young people. Level one training was not delivered separately, since this was incorporated as part of level two training.

### Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate %</th>
<th>Trust Target %</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>82</td>
<td>92</td>
<td>89</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>74</td>
<td>93</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Nursing staff within services for children and young people at the trust have met the target for one of three safeguarding courses they were eligible for.

### Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate %</th>
<th>Trust Target %</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>107</td>
<td>125</td>
<td>86</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>98</td>
<td>130</td>
<td>75</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Medical/dental staff within services for children and young people at the trust have met the completion target for one of the four safeguarding training courses they were eligible for.

Although nursing and medical staff had not achieved the trust target for level three safeguarding children training, this was an improvement compared to 12 months ago where the training rate was 22%.

Staff had training on how to recognise and report abuse and they knew how to apply it. Safeguarding training had been reviewed and a new training programme created. All staff across the trust were expected to be trained to level two safeguarding and all staff (except for administrative staff) within paediatrics, neonates, midwifery and the urgent care departments were to be trained to level three. This followed the intercollegiate guidance ‘Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014).

We were told that all newly qualified staff attended a full day of training which covered all forms of abuse, inclusive of child sexual exploitation, female genital mutilation and serious case reviews.

The trust safeguarding policy, included a section on female genital mutilation, which contained links to further guidance from the trust and from Lancashire Safeguarding Children's Board.

Serious case reviews were held if a child died (including death by suicide) and if abuse or neglect was known or suspected to be a factor in the child’s death. Guidance was provided in the trust policy and following a serious case review, an action plan with specific learning was completed.

There was a new policy planned for staff safeguarding supervision. Staff said they had time for reflection on specific cases during supervision sessions. We were told that staff would contact the duty telephone line for supervision, or the safeguarding champions based within departments. For learning and experience to be shared, a monthly multi-disciplinary team meeting was held on the paediatric unit where cases were presented.

We were told that medical staff received peer review monthly and the medical staff we spoke to told us they had received recent talks on female genital mutilation and they were aware of the risks.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. All the areas we visited, inclusive of the ward; the neonatal unit and outpatient clinics, were visibly clean and tidy.

During inspection, we spoke to the dedicated domestic for the children’s ward who told us about the cleaning schedules they followed. We reviewed the schedules, which included the daily tasks and specific areas to be cleaned. All areas were completed in line with the schedule. A deep clean was completed on the unit each week.

The playroom and other toys and areas of play were the responsibility of the play specialists to clean and they also advised us they cleaned toys. Cleaning schedules in the playroom were fully completed.

One of the play specialists told us toys used in the sensory room were cleaned in-between each child. Staff told us the domestic staff helped clean the isolation cubicles. Within outpatient areas, staff running the clinics were responsible for cleaning toys which was completed prior to the clinic
opening.

Hand gels were readily available in all areas, particularly on the wards. There were plenty of handwashing sinks to use and dispensers for aprons and various sized gloves, which were all fully stocked.

We observed staff using personal protective equipment and washing their hands before delivering patient care. There were signs to encourage hand washing for parents, carers and visitors. Parents and carers, we spoke with were happy with the cleanliness of the ward and always saw staff using gels before entering bays or cubicles. During inspection, we had observed staff members washing their hands and vigilantly using hand gel before entering different areas of the unit.

Infection, prevention and control was audited monthly and the results of this showed that between 1 April 2018 to 30 April 2018 results were 100%, with only one dip to 95% in April 2018. All the paediatric areas were audited monthly by a member of the infection, prevention control team to ensure protocols were being followed.

We observed all staff followed arms ‘bare below the elbow’ and infection, prevention and control protocols. We spoke to a student delivering care to a patient in a cubicle who advised us there was a stethoscope in each side room to minimise the risk of cross-infection on the ward.

In the isolation area, cubicles had clear signs on the door to advise regarding infection, so that anyone approaching the cubicle would be aware of this.

The trust had introduced post infection reviews led by the multi-disciplinary team and lessons learned were shared with staff.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.32 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. This was an improvement since the last inspection. The trust had improved the security in all areas and was checking resuscitation equipment daily.

During our previous inspection we had concerns with security. During this inspection, we saw security had improved. There was video monitoring in use and the entrance to both the paediatric ward and the neonatal ward were found to be secure. There were four doors onto the paediatric unit and there was a buzzer for entry at the main entrance for use by family, carers and visitors. There was a bell at the paediatric assessment entrance for use by ambulance staff. Patients had to be let out by staff, to avoid absconding and tailgating.

The paediatric ward was a combination of other previous wards, which meant that the ward was very long and big in size. Due to the layout of the ward there had been an issue, in that staff were not able to hear the emergency buzzer in all areas of the ward. Staff said a new emergency buzzer system would have cost implications, therefore to mitigate risks, the emergency buzzers were all checked on a weekly basis, with individual buzzers checked daily. We were also told that
staff in each sub-section of the ward could hear the buzzers in their own section and that there was enough staff in each of those areas of the ward who would act in an emergency if required.

Resuscitation trollies were available in each area and were sealed with a plastic tab that made it apparent to others if this had been opened. The trollies and defibrillator were checked daily by the housekeeper. The trolley in urgent care was the same as the one on the ward, so staff could easily locate vital equipment more easily in an emergency.

We checked the equipment on all the trollies and found only one piece of equipment to be out of date, which staff had been aware of and it was labelled to indicate the replacement piece had been ordered. Dressings and syringes were found to be stored appropriately and were all in date.

The clean utility rooms had air conditioning. Rooms were clean and tidy. Needle sharps bins were stored correctly and none were seen to be overfilled during our inspection.

Within the children’s outpatient area at Preston, there was a toilet situated within one of the treatment rooms. During our inspection, urine samples were seen in the toilet, but this was because there was no designated sluice for the outpatient area. After we had raised this concern, this risk was escalated and put on the risk register.

In the paediatric ward there was a playroom that was situated centrally on the ward, with easy access for all children and their parents and carers. This room was welcoming and contained a variety of different age appropriate toys.

The paediatric assessment unit had a variety of toys for children to play with whilst waiting. There was sufficient storage.

On the neonatal intensive care unit, there was a bubble room with seating so that parents, carers and babies could enjoy the facilities in a private and quiet space.

There were milk kitchens on both the paediatric unit and neonatal intensive care unit. Sterilising units were all labelled by patient name. The changing of the sterilising fluid was done by the housekeeper each day. The milk kitchens were tidy and well organised. The milk kitchen on the neonatal unit had a satellite freezer for the storage of donor breast milk.

The kitchen area on the paediatric ward was locked with a keypad entry system to ensure that only staff members could enter. Within the kitchen, we saw the appropriate storage of food and drinks and looked at schedules which logged daily checks.

On all units, there were both male and female toilets. In the neonatal unit, there were two rooms available for parents or carers to ‘room in’ overnight if their baby was soon to go home, or if the baby was particularly unwell.

On the paediatric and neonatal intensive care unit, there was a room for use by parents and carers, which contained comfortable seats and a kitchen with a fridge to store their own food. On the Royal Preston Hospital site, Bowland House provided accommodation for parents/carers and family members when needed.

**Assessing and responding to patient risk**

The service was taking action to assess and respond to patient risks. The service was using early warning scores to monitor deteriorating patients which was an improvement from the last inspection.
Children on the paediatric unit had vital signs reviewed using the paediatric early warning system (PEWS), which identifies children at risk of clinical deterioration. Audits showed the service was 100% compliant with PEWS.

Staff we spoke to, said if they had any concerns with a child’s PEWS, this was escalated to medical staff and documented. If there was no immediate response from medics, it would be escalated further.

The 2013 Royal College of Nursing states that at least one nurse per shift in each clinical area (ward/department) will be trained in advanced paediatric life support/European paediatric life support depending on the service need. We saw evidence to say that in the months of April and May 2018, there were between 1-4 nurses on duty either in the day or at night with advanced paediatric life support training and often there was also an advanced paediatric nurse practitioner with this training on shift most evenings, ensuring that children and young people on the unit had access to staff with this training at any time of the day, minimising patient risk.

Children requiring more intensive observations, were placed in one of the bays by the nurse’s station, or within the high dependency unit. There were also two high dependency beds and these could be increased to three if required. The beds were staffed by one or two nurses depending on patient needs.

Safety huddles were implemented in February 2018 on the paediatric unit. The huddles were held daily in the early afternoon in which key issues were discussed and any patient concerns identified.

During the last inspection, there were concerns with the management and safety of a room used for young patients with a risk of self-harm due to ligature points being present.

Staff told us the room would only be used for a patient with mental health concerns following a risk assessment. The patient would not be in the room on their own. The room contained a bed, chair and bedside table, with an en suite facility containing a shower and sink. All cords and blinds were ligature proofed with piping, however the room did have an electric cable to power the bed and suction and oxygen tubing. Staff said all the equipment posing risks would be removed before the patient was admitted.

At the time of inspection, there was no standard operating procedure for the management of children and adolescents with mental health issues.

For children who required mental health support, a risk assessment was completed in partnership with the child and adolescent mental health service. Any child, or young person presenting up to 2pm would be seen the same day by a member of the child and adolescent mental health service team. Children admitted after 2pm, would have an overnight, for review by the team the following day.

Staff told us if the initial assessment showed no immediate risk for the child or young person, they would potentially be able to go home that night and re-attend for review the next day. A checklist was completed in partnership with the parent or carer, with them signing to say they would monitor the young person and maintain their safety overnight.

The child and adolescent mental health service team provided staff with telephone advice out of hours if required.

The neonatal unit at Royal Preston Hospital was a level three unit, which meant it cared for very small or sick new-born infants. Patient needs were assessed prior to transfer and any patients who required surgical procedures were referred to a specialist centre.
A weekly multi-disciplinary grand round took place on the unit. Grand rounds involve the presentation of medical problems and treatment of a patient to various doctors and medical students.

Safety huddles occurred on the neonatal unit every morning to share relevant information between staff and to identify risks or concerns. Medical staff had a daily handover based on a system that looked at the need to escalate patients at risk called ‘Situation, Background, Assessment and Recommendation.’ Neonatal staff also attended the safety huddle in maternity, so they were made aware of any babies that were at risk.

There was a trust wide commitment around sepsis. The trust had a sepsis pathway and escalation policy. There was a sepsis team in the trust to focus on teaching and educating staff on the signs of sepsis and the need for early identification. We saw information detailing sepsis signs and symptoms within the paediatric outpatient area during our inspection.

**Nurse staffing**

**Overall staffing rates**

In our previous inspection we reported that staffing levels in both the neonatal and children’s unit needed to be maintained in accordance with national guidelines. On this inspection, we found that on the neonatal unit, they were still not British Association of Perinatal Medicine (BAPM) compliant although had taken action to mitigate the risks, such as closing cots. There were still some issues with medical staffing, although nursing staffing levels were nearly up to establishment.

During inspection we saw that the actual number of nurses for each shift matched the planned number of nurses. The off duty was done monthly. If there was a shortage of staff, then senior staff reviewed patient activity and closed beds if necessary.

The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) regarding staffing levels. BAPM was recorded daily and we were told by senior staff the neonatal unit was 83% compliant with BAPM guidance. Although not operating at 100%, risks were mitigated as staffing and acuity were reviewed daily and the unit would close cots if staffing decrease. Staff said it happened less than in other units.

The neonatal unit had successfully recruited seven nurses to commence in September 2018 and reported no problems with recruitment. Within the unit, there were Advanced Neonatal Nurse Practitioners with additional skills and knowledge.

At the time of inspection, there were 76 whole time equivalent staff. Senior managers reviewed staffing each day and escalated any concerns.

The staff from the paediatric outpatient department also staffed the children’s clinics held at Chorley and South Ribble Hospital.
Vacancy rates

From February 2017 to January 2018, Royal Preston Hospital reported a vacancy rate of 4.1% in services for children and young people. This is better than the trust’s target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 4.9% for nursing staff in surgery and young people. This is slightly worse than the trust target for 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

During our inspection, senior staff on the paediatric unit told us that although agency staff were used to maintain safer staffing numbers, they could book as many as they needed, to maintain safety, whilst trying to ensure that permanent staff did not work excessive hours on the bank.

We were told by senior staff on the neonatal unit that agency staff were used, but that there was a checklist for nurses to be signed off prior to being able to work on the unit.

Medical staffing

The paediatric assessment unit was staffed by a consultant on call, a registrar and a junior doctor, with a named consultant with responsibility for the assessment area.

Newly qualified doctors completed a two-month rotation in paediatrics and neonates. Doctors we spoke with felt there were shortages on the senior house officer rota. We were told that a business case had been put forward to escalate staffing as an issue and this had been put on the risk register.

Following inspection, we requested data for the percentage of children with an acute medical problem seen by a middle grade paediatrician within four hours of admission, and data to show how many children admitted with a medical problem were seen by a consultant within 14 hours of admission during April and May 2018. In response to this request, we were advised there was no information readily available for this but the clinical director for the service had started to audit these areas.

Overall staffing rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by care services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates
From February 2017 to January 2018, Royal Preston Hospital reported a vacancy rate of 9% in services for children and young people. This is worse than the trust’s vacancy target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Medical staff told us that there was a 0.5% gap at middle grade level.

**Sickness rates**

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 0.2% for medical staff in services for children and young people. This is better than the trust’s sickness target of 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was also higher.

Staffing skill mix for the 50 whole time equivalent staff working in children’s services at Lancashire Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>50%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career *</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group ~</td>
<td>33%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior *</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

The service kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Although signatures were not always clearly identifiable. Records in outpatients were kept securely which was an improvement from the last inspection.
The ward used paper records and there were separate records for both nursing and medical staff. Staff told us they were awaiting a new electronic record system.

Records stored on the paediatric ward were kept securely and locked with a digital keypad for entry.

We reviewed 10 sets of records during our inspection and found these were contemporaneous and comprehensive. Although we found records were completed, with paediatric early warning scores and pain scores being recorded appropriately, there were some inconsistencies in relation to signatures, which although always present, the name was not always printed next to the signature and names were not always legible.

Minimal personal identifiable information was used in the outpatient clinic and the details that were used were placed face down in trays at the reception desk and were placed facing the wall in slots outside the consultation rooms to maintain patient confidentiality.

There was a flagging system used on the computer system to identify any children with safeguarding needs and all staff we spoke to were aware of this.

**Medicines**

While the service prescribed, gave and recorded medicines well, all the hard copies of the patient group directives, were out of date and that there were lots of dates for different fridges where the temperature had either not been checked, or not recorded.

Medication was stored securely, the treatment rooms were temperature controlled, brightly lit and tidy.

Controlled drugs checks were regularly carried out and a random check of stock found drug balance charts were correct. Fluids were stored securely and potassium fluids were segregated.

Oral liquid medication was used as stock but open bottles did not always have a date of opening recorded on them. We saw one bottle of patients own drugs in the stock cupboard, this was destroyed immediately once staff were aware.

We reviewed the use of patient group directions (PGD) for nursing staff. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. We found that the PGDs we reviewed were all out of date. A revised draft of a patient group direction policy had been produced at the time of inspection. We were unable to see any evidence of PGD training that had been undertaken and we were unable to locate evidence of named staff being authorised to use PGDs.

We found gaps in recording of maximum and minimum fridge temperatures to ensure that medicines were stored safely.

During the inspection we saw various prescribed medicines in the fridge on the paediatric assessment unit which had not been collected, some of which had been there for a few months. This was discussed with senior staff who told us they would action this.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.01 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other
In the CQC Children and Young People’s Survey 2016 the trust scored 7.13 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

**CQC Children and Young People’s Survey 2016 questions, safe domain, Lancashire Teaching Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.13</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.01</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately using the trust’s reporting system.

Staff we spoke to were all fully aware of how to report incidents and during inspection we saw evidence of lessons learned from an incident.

All the incidents reported for the children and young people services were seen by the matron and sent to the clinical governance team who offered direct feedback to staff who had completed the notification. Staff told us they were encouraged to be open and honest and report incidents. Most staff said they found the feedback useful.

During inspection, two senior managers spoke openly about changes to clinical practice following incidents. This included the development of a New-born Initial Physical Examination (NIPE) learning package, management of equipment during an invasive procedure, increased awareness of vulnerable children and improved infection prevention and control procedures.

All staff we spoke with understood the meaning of duty of candour, although some staff did not fully recognise it under its correct terminology.

When things went wrong, staff apologised and gave patients honest information and suitable support. Two senior managers gave us a detailed example of when this had happened and how duty of candour was applied. All the results of lessons learnt were cascaded to staff through a variety of ways, in order that all staff had access to the information.

The trust had a policy for child deaths. A mortality and morbidity meeting had been held a few months prior to inspection, but meetings were to be held on a quarterly basis moving forward and any serious cases discussed. All child deaths were referred to safeguarding using the incident reporting system. The safeguarding team would then inform the child death overview panel. Any learning was shared with staff through training and use of the safeguarding champions.
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for children’s’ services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SI) in children’s services which met the reporting criteria set by NHS England from May 2017 to April 2018.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used the information to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from April 2017 to April 2018 for children’s services. This met the trust target of 98% harm free care.

Is the service effective?

Evidence-based care and treatment

Although the service provided care and treatment based on national guidance, during inspection we looked at eight policies and found that six of those were out of date.

Policies and procedures were available on the trust intranet page for all staff, making them easily and readily accessible. Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence and
Royal Colleges. The documents contained clear guidance, referral flow charts, escalation pathways and other guidance.

However, during inspection, we looked at eight policies, we found six to be out of date. This included guidance on asthma, diabetes, head injury and fever.

The service complied with national audits, which included the national asthma and pneumonia audits, as well as participation in the epilepsy audit.

The trust had a dedicated sepsis nurse who offered staff further education regarding the screening of sepsis. The service was developing a sepsis pathway and reviewing national early warning score charts to include recommendations from the National Institute for Health and Care Excellence sepsis guidelines. The service was using the Sepsis Commissioning for Quality and Innovation to monitor its performance.

On the neonatal intensive care unit, the team had implemented Family Integrated Care which is a new model of neonatal care that supports partners to be primary care givers, as there is evidence to suggest that it can help in reducing the length of stay in hospital, as well as reducing parental distress.

There was also protected quiet time on the wards between 4pm-6pm, when the lights would be dimmed and during this period, the doctors would try to avoid any unnecessary interventions, as there is evidence to suggest that babies experiencing better quality of sleep can recover and grow more quickly.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

The service adjusted for patient’s clinical, religious, cultural and other preferences, with various choices available. We saw different menu choices for patients, that included a separate menu for those with allergies and a multi-cultural menu. At lunch, two trollies came, one for the main ward and one for the isolation rooms. Staff ensured patients had a jug of their preferred drink in the morning and would re-fill this as required.

The main kitchen on the ward was locked with a key pad entry system and this was where patient food was stored. The kitchen was seen to be clean, tidy and clutter free. The fridge was seen to be full of individually packed sandwiches, yogurts, fruit, juice, biscuits, crackers, which could be given to any patient needing something, particularly those in the day case area returning from surgery.

Staff told us all staff on the wards had received food hygiene training, so were aware of how to correctly give food to patients.

On both units there were parent’s rooms which had a fridge for parent’s own foods and a microwave was also available. Staff told us that parents would bring food in for their child if the child preferred home foods, or other foods.

The service used the Paediatric Yorkhill Malnutrition Score, which was completed within 24 hours of the patient’s admission. The tool is to assist nursing staff and other health professionals to identify hospitalised children who might be at risk of malnutrition and uses four stages of assessment to form a score which then indicates the risk of malnutrition and what action to take.

We saw that supporting breast feeding was a priority for the nurses working on the neonatal intensive care unit. Staff provided support for breastfeeding mothers, with very positive results, as the breastfeeding figures had increased on the unit. The trust had been successful in gaining finds
to commence the UNICEF baby friendly initiative. There was no designated breastfeeding room on the unit, but we were told by staff that a cubicle, or private room was available if needed. A newly appointed infant feeding co-ordinator had been recruited by the trust.

The neonatal intensive care unit had been investing in specific breastfeeding chairs, to accommodate breastfeeding mothers in a supportive and comfortable way to promote effective breastfeeding.

Parents on the unit could bring food to meet the individual needs of their own child if preferred. There was a fridge in the parent’s room for the storage of this food. Parents had access to drink making facilities and a fridge for them to store food for themselves.

**Pain relief**

Staff gave pain relief to patients when required. There was an effective process to ensure patients’ pain relief needs were met and pain was well managed by the service.

The service used a ‘smiley faces’ assessment chart to assess pain, which was in every patient folder.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service participated in the National Diabetes audit between 2015 and 2016.

Data from national audits showed positive results for the paediatric diabetes audit 2015/16 with two indicators improving from previous results. However, these figures were for 2015/16 and we were told during inspection by a member of the medical team that the service was an outlier for this audit, meaning they were achieving worse results than other areas.

**National Diabetes Audit**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 diabetes audit Royal Preston Hospital performed better than the England average.

The proportion of patients receiving all key care processes annually was 53.7% which was significantly better than expected, compared to a national aggregate of 35.5%, the previous year’s score was 32%.

The average HbA1c value (adjusted by case-mix) at the trust was 70.1% which was within the expected range, compared to a national aggregate of 68.3%, the previous year’s score was within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 67, which was better than the previous year’s median which was 69.3.

*(Source: National Paediatric Diabetes Audit 2015/16)*
**Emergency readmission rates within two days of discharge**

The data shows that from December 2016 to November 2017 there were no emergency readmissions after an elective admission for patients aged under one and a higher percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

**Emergency readmissions within two days of discharge following elective admission among the 1-17 age group**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Lancashire Teaching Hospitals NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>ENT</td>
<td>1.0%</td>
<td>611</td>
</tr>
</tbody>
</table>

No other specialty at the trust had six or more readmissions.

Source: Hospital Episode Statistics

Notes: These tables show the three treatment specialties at the trust with the highest volumes of readmissions; only those specialties where the trust had 6 or more readmissions recorded are shown in the tables.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.
Readmission rates were recorded on the incident reporting system used by the trust (within 48 hours) and incidents usually related to a new condition.

The trust’s readmission rate is higher than the England average in both age groups, for all specialties.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From January 2017 to December 2017, the trust performed better the England average for the percentage of patients aged 1-17 who had multiple readmissions for asthma. However, the trust performed worse than the England average for patients aged 1-17 who had multiple readmissions for epilepsy.
National Neonatal Audit Programme

The National Neonatal Audit Programme (NNAP) involves clinical audits that aim to improve care to babies needing specialist care, some of which look at screening for eye disorders and babies’ temperature recordings.

In the 2016 National Neonatal Audit, Royal Preston Hospitals’ performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were seventy-nine babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to Royal Preston Hospital for ROP screening. 99% of these babies were screened on time in accordance with the National Neonatal Audit Programme extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the National Neonatal Audit Programme extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 406 first episodes of care that were eligible for inclusion in this audit measure at
Royal Preston Hospital. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 97% of the eligible episodes; this was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission. *(Source: 3, Royal College of Physicians and Child Health)*

Comparing this unit to other units in the 2016 National Neonatal Audit, performance was better in five out of the eight metrics compared to national data and following inspection, further evidence was received from the trust to support this.

The audit standard met for three criteria (retinopathy of prematurity (ROP), consultation with parents and antenatal steroids).

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

**Competent staff**

The service made sure staff were competent for their roles and managers appraised staff’s work performance. The service provided opportunities for development and further study. The service had improved its induction in response to feedback about the retention of staff.

The target compliance rate for staff appraisals for the trust was 90%. In May 2018, the number of staff (nursing and medical) who had an appraisal within the last year was 82%.

The trust supported the continuing professional development of staff and actively encouraged staff to apply for development posts, secondments and managerial positions. Staff we spoke to who were new in management positions were participating in a leadership programme.

During the inspection, we spoke to two students, one of which was an allied health professional and one a nursing student. Both students reported to have been welcomed onto the unit by staff and felt that they had been supported with their learning needs.

The paediatric unit had a practice educator role which was shared by two staff members. The role was to monitor, teach competencies and assess. Within the department there was one full time advanced nurse practitioner and a further three trainees due to qualify in September 2018.

The induction package for new starters on the unit had been changed, after it had become apparent that there had been an issue with retention of staff. The service increased induction time from two weeks to six weeks, with the opportunity for staff to work alongside the practice educator, to build their skills and knowledge. Senior staff said the retention of staff had improved.

Six staff on the paediatric unit had completed the ‘care of the highly dependent child’ training, two had completed ‘recognition and responding to the acutely unwell child’ and 13 staff had completed training on ‘high dependency’.

Staff on the neonatal unit had qualifications in nursing and midwifery. They had additional skills training to be able to work on the neonatal unit. All staff had achieved neonatal life support training. The compliance rate for this, at the time of inspection was 77 %, but senior staff told us they had been waiting for the return of some certificates, so compliance was up to 90 %.
Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other health care professionals supported each other to provide good care to children. As well as good working within the department the service worked well with other areas of the hospital.

Multidisciplinary grand rounds were held weekly and facilitated good communication between members of the multidisciplinary team.

Within the children and young people service, there were two play leaders and two play specialists. They worked closely with nurses, doctor’s physiotherapists, occupational therapists, dieticians and audiologists. This ensured that children received the interventions needed in the most appropriate and child-friendly way.

Physiotherapists ran clinics within the paediatric outpatient department and attended the ward up to twice a day to see patients. We were told the physiotherapists worked closely with the team on the unit.

We saw evidence that the paediatric unit worked closely with the team from surgery as they had day case patients on the unit. The neonatal unit worked very closely with maternity to identify risks and to ensure a seamless service.

The nursing staff worked in partnership with the nursing staff in the emergency department and plans had been discussed regarding a rotation of staff to the emergency care department to increase knowledge and competence.

There was effective multidisciplinary working with children and adolescent mental health services team and staff said they were full supported by the team.

Feedback from students who had been on placement on the ward were very positive and the student we spoke with told us they had been well supported and found all staff to be approachable and helpful.

CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 7.99 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was worse than other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Seven-day services

- Children and young people could access a full inpatient, service seven days a week.

Paediatric therapies, such as physiotherapy and play therapy, provided a week day 9-5pm service. Therapies covered all paediatric wards including the neonatal intensive care unit. During inspection, we found no evidence of overnight cover and no weekend on call cover for paediatric therapies, however following inspection we were told that the paediatric on call service was covered through the trust respiratory on call seven days a week.
Child and Adolescent Mental Health Services (CAMHS) were available during office hours Monday to Friday for telephone consultation and individual visits to children on the ward. For children admitted after 2pm, someone from the child and adolescent mental health services reviewed the child first thing the next morning.

With a qualified advanced nurse practitioner on the unit and another three to qualify, there was an aim to extend cover to seven days a week with further recruitment for the Paediatric Assessment Unit.

The paediatric outreach team operated over a period of five days, however there were plans for staff to work longer days, to extend the service hours to the evening.

**Health promotion**

The service promoted the health and wellbeing of children. The service had leaflets, information boards and posters about information such as alcohol, eating disorders and healthy eating.

On the paediatric ward, there were information leaflets available for parents and carers to use and we were told that these had been produced based on NICE guidance.

Within the adolescent area in the paediatric outpatient department, there were posters with tear off contact details for support services in relation to the quit squad, child sexual exploitation, learning difficulties, drugs, alcohol and eating disorders which staff reported were used by young adults who attended.

In the paediatric outpatient department, we saw health promotion information on boards with information on varying topics such as, asthma, allergies, bed wetting and healthy eating. Information was all current and detailed.

Breast feeding results had increased on the neonatal unit following a pilot trial undertaken by a staff member working 10-15 hours a week in a designated role to support with breastfeeding.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood their roles and responsibilities under mental health and capacity legislation. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The clinical staff we spoke with were knowledgeable about Fraser and Gillick competencies to help assess whether a child had the maturity to make their own decisions without consent of a parent or guardian.

Staff were aware of consent processes when assessing capacity and decision making in children.
Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training completion

This information is requested as part of the routine provider information requests; however, the trust has not provided information for MCA or DoLS training for either nursing or medical staff.

(Source: Routine Provider Information Request – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Throughout our inspection, we saw all staff interacting with patients and their parents, carers and family members in a very caring, polite and friendly manner. All the people we spoke with during the inspection were very happy with the care and treatment provided by the service.

The unit participated in the NHS Friends and Family Test. In May 2018, the paediatric ward was recommended by 82.5% people.

During inspection we spoke to five parents of children attending various areas of the children and young people service. All of them reported the care to be good and staff to be very kind and supportive. We observed all staff speaking to the patients in an age appropriate way and in a calming manner.

Although neither the paediatric or neonatal intensive care unit had a dedicated breastfeeding room, we were told that when mothers were breastfeeding, a room or cubicle could always be found for them to maintain privacy.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for three questions and about the same as other trusts for the remaining seven questions relating to compassionate care in the CQC Children and Young People’s Survey 2016

<table>
<thead>
<tr>
<th>CQC Children and Young People's Survey 2016 questions, compassionate care, Lancashire Teaching Hospitals NHS Foundation Trust</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.50</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.37</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.05</td>
<td>Worse than other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>8.76</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>
Do you feel that your child was well looked after by the hospital staff?

0-7 adults 8.28 Worse than other trusts C1

Do you feel that you (the parent/carer) were well looked after by hospital staff?

0-15 adults 7.09 Worse than other trusts C1

Was it quiet enough for you to sleep when needed in the hospital?

8-15 CYP 5.85 About the same as other trusts C1

If you had any worries, did a member of staff talk with you about them?

8-15 CYP 8.17 About the same as other trusts C1

Do you feel that the people looking after you were friendly?

8-15 CYP 9.01 About the same as other trusts C1

Overall, how well do you think you were looked after in hospital?

8-15 CYP 8.65 About the same as other trusts C1

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Emotional support

Staff provided emotional support to patients to minimise their distress. We saw staff involving both patients and parents and carers in their own care, allowing time to answer any questions and supporting them if they were distressed.

With permission, we followed one patient down to theatre and from the minute the patient was taken down, everything was explained clearly to the patient in a way that they understood. Once in the anaesthetic room, both the anaesthetist and the anaesthetic nurse explained necessary procedures in a calm and reassuring way, but also used distraction in an appropriate manner. Parents we spoke to told us that all aspects of their child’s care had been explained to them.

There was a dedicated play team, comprising of play specialists and play leaders who worked very closely with doctors, nurses and therapists to incorporate play into clinical interventions and therapies.

The play specialist carried a bleep, in order that they would assist in any situation if a child needed calming and distraction prior to a procedure being carried out. They would do this either by using distraction techniques, or by using age appropriate toys, or sensory equipment.

The play specialists assisted in emotionally preparing children prior to admission for surgery or other procedures. They would try and see the same children through the patient journey to build rapport and help put the child or young person at ease.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for two questions and about the same as other trusts for the remaining three questions relating to emotional support in the CQC Children and Young
CQC Children and Young People's Survey 2016 questions, emotional support, Lancashire Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>8.28</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think</td>
<td>0-15 adults</td>
<td>7.68</td>
<td>Worse than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>staff did everything they could to help them?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after</td>
<td>0-7 adults</td>
<td>9.00</td>
<td>About the same as other</td>
<td>C3</td>
</tr>
<tr>
<td>your child?</td>
<td></td>
<td></td>
<td>trusts</td>
<td></td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and</td>
<td>8-15 CYP</td>
<td>8.82</td>
<td>About the same as other</td>
<td>C3</td>
</tr>
<tr>
<td>treatment?</td>
<td></td>
<td></td>
<td>trusts</td>
<td></td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff</td>
<td>8-15 CYP</td>
<td>8.51</td>
<td>About the same as other</td>
<td>C3</td>
</tr>
<tr>
<td>did everything they could to help you?</td>
<td></td>
<td></td>
<td>trusts</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. All the carers we spoke with told us they were involved in their child’s care and everything had been explained to them in a language that they could understand.

We observed doctors, nurses and therapists working in partnership with parents and families. Staff in all the children and young people’s services demonstrated a patient-centred approach which encouraged family members to take an active role in their baby or child’s healthcare.

The parents we spoke with told us nurses were very supportive, explained treatments and what was going to happen. Doctors kept them informed of progress, clinical interventions and referrals to other services.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for seven questions and about the same as other trusts for the remaining 13 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. There was evidence on the ward and in the outpatient department of ‘You said, we did’ boards with examples of changes that had been made because of patient and carer feedback.
Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people. The service provided a 24-hour service for the babies, children and young people of the local population. The service employed play specialists and had age appropriate toys for children.

The paediatric areas and neonatal areas were located at the Royal Preston Hospital site, within easy reach of the nearest motorway and with clear signage from the main roads and ample car parks, with clearly marked areas for disabled parking. The hospital was also accessible by different bus routes. The site at Chorley and South Ribble Hospital was also easily accessible by car, or bus and the children’s clinics were in the main hospital, but were not signed as specific children’s clinics.

The neonatal intensive care unit was situated near to the maternity unit and was calming in its environment. Staff told us there was a ‘quiet time’ each day, in which babies were left to sleep peacefully and doctors would only do interventions that were necessary during this time. There was also a ‘bubble room’ on the neonatal unit, which had sensory lights and seating, offering a calm and tranquil environment for babies, parents and carers.

The neonatal unit offered two rooms for parents to stay over if they needed to and there was a comfortable parents room for parents and carers to use as needed, with facilities to make drinks or warm food. There was also an area for mothers to express milk and a designated milk kitchen. The paediatric ward had a room with en suite facilities called the ‘Edeilweiss Suite’ which was used for young oncology patients who attended if unwell and needing tests or antibiotic treatment for infections, as the unit acted as a shared-care centre for one of the specialist paediatric oncology units, enabling these children to be nearer to home without having to travel to a specialist unit.

There was accommodation for parents and families on site (Bowland House), with 18 rooms and a communal area which was funded by the trust.

The trust had open visiting hours across the service, which allowed family members to be able to stay with children.

The paediatric ward was easily accessible by lift from the main hospital. One staff member designed a sign that parents would see on entering the ward entitled ‘your patient begins here’ that was child friendly and pictorial to welcome children and their parents/carers to the ward.

There were very few child friendly decorations to help make the environment more welcoming to babies, children and their parents and carers. Staff told us some child friendly pictures had recently been removed, as they were expecting new decorations as part of a new woodlands theme which would be throughout the department.

The clinic room used for children at Chorley and South Ribble Hospital, had various child friendly stickers to the walls. Staff also said brightly coloured disposable curtains had been ordered for bed spaces on the paediatric unit which would add colour and brightness to the area.
For children attending the day case area on the paediatric ward there were no child friendly pictures or toys in the anaesthetic room. Staff told us that if needed they would use a phone to play a video as distraction for a child, or they would talk or sing to the child to help reassure them.

There were toys in all the waiting rooms, as well as an adolescent area in the paediatric outpatient department and there was a large bright playroom on the paediatric ward filled with a variety of different age-appropriate toys. We spoke to one play specialist and saw that play provision included access to a range of distraction toys and games. The provision of play was very good within the children’s ward with a play specialist available Monday to Friday.

The paediatric ward had a sensory room which was used by different aged patients and their parents and carers for relaxation and distraction and staff told us the room was very popular with a variety of patients. There was a milk room on the ward, but there was no designated breastfeeding room available, although staff told us that a room could be used if needed. Parents were welcome to stay overnight with their child and ‘pull out’ beds were made available with bedding for those parents wanting to stay over.

The paediatric unit offered a designated space for adolescents and young people to relax in. There was a separate area within the outpatient department for young people to wait, without having to wait with younger patients and their toys. Staff told us there were adolescent sessions in an afternoon on the unit if required.

The children’s community outreach team was part of the children and young people services. They provided continuity of care for children in their own homes, allowing children to be cared for at home where they were most comfortable. The outreach team helped staff in the unit on a late shift, which gave further continuity for community patients who might be admitted to the unit.

Meeting people’s individual needs

The service took account of patients’ individual needs. The service provided separate rooms for patients with mental health needs or other additional needs. The service offered translation services and children’s books in different languages.

Side rooms were available for autistic children. Staff told us they would do whatever suited each individual child and could place the child within the main ward if this was the preference of the child and parent. The play specialist we spoke with had attended specific training for autism and could work closely with any children or young people who were autistic to meet their needs. The specialist provided further training for staff to share learning.

We were told that a bid was submitted for a specialist chair for children with special needs, or distressed children.

Senior staff told us most patients who attended the hospital were British white, 11% Pakistani and 11% other minority ethnic groups. For patients, parents or carers whose first language was not English, there were translating services available and we were told that there were books in different languages on the paediatric unit to meet the needs of children with languages other than English. Staff told us that there had been decorative displays within the paediatric ward that were coloured in different colours and all said ‘welcome’ in different languages, however these had been taken down, prior to new decorations being put up.

Children with mental health needs were accommodated on the unit. There was a side room that was used for children with thoughts of self-harm. Senior nursing staff we spoke with told us relationships between service staff and the child and adolescent mental health services was
positive and worked well. Staff told us there was a dedicated eating disorders team that worked closely with the dietician.

Children at the end of life were allocated a private cubicle. Bereaved parents were given bereavement boxes which contained items to comfort and provider memories to parents. The matron told us the team had been fundraising to buy a pram for the unit, so that if a child dies, there was a more appropriate way of taking the child away from the unit.

There was a quiet room that could be used for the delivery of ‘bad news’, or for parents to use if their child was unwell.

One staff member from the service was a ‘buddy’ for the local hospice, this meant they maintained links with children and parents to ensure continuity of care.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for the 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.78</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.52</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>7.50</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.46</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>6.28</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>7.98</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>6.95</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.70</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.11</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.16</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.00</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>RAG</td>
<td>KLOE</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>----------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>6.09</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.24</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>7.85</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>8.38</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
<tr>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>2.96</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>8.99</td>
<td>About the same as other trusts</td>
<td>R3</td>
</tr>
</tbody>
</table>

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Access and flow**

People could access the service when they needed it. Even at times of higher demand the service had capacity to admit patients 24 hours a day, seven days a week.

We were told that the unit was much busier in the winter months due to winter pressures and medical staff told us that there had been 1000 attendees in one month over winter, compared to 400-500 over summer time, but the unit were able to accommodate these pressures without needing to transfer patients out.

The service attended the hospital bed meetings every morning. The matron for the unit attended these meetings and if it was reported that there were children waiting in the urgent care department, they would be initially triaged in the emergency department, to assess risk, but if stable and well enough, the child would then be taken up to the paediatric unit for further assessment and treatment in a more child-friendly environment.

Children arriving to the paediatric assessment unit were triaged in a dedicated room, then directed to the separate waiting area to wait for review. If a child was suspected of having an infection, the child or young person would be seated in a separate cubicle to minimise infection. We were told there was no clear plan as to how long patients would have to wait and that it could be up to the time of admission, which could take up to six hours.

The Royal College of Paediatric and Child Health’s facing the future standards are that every child admitted to a paediatric department with an acute medical problem, should be seen by a healthcare professional on the tier two (middle grade) paediatric rota within four hours of admission and by a consultant with 14 hours of admission. On asking the trust to provide further data in relation to this, they were unable to provide this, so it is unclear how long children are waiting to be assessed by the appropriate person.
We spoke to one of the medical team who told us they were not achieving 14-hour review by a consultant at present, but there was an aspiration to improve with expansion to seven days to achieve the target. Advanced nurse practitioners were also helping to improve the flow through the department, working with nursing and medical staff.

The paediatric assessment unit had its own dedicated junior doctor allocated to this area and a consultant was available from 2pm to 10pm, with evenings covered by a registrar, senior house officer and an advanced nurse practitioner.

Within the paediatric ward, there was a doctor’s room and within that there were white boards detailing expected referrals, children waiting for review and what was wrong with them. So that any doctor could see this information and be aware of where each child was up to.

The paediatric outreach team could provide care to children with complex needs, chronic as well as some acute conditions in the community, allowing some children to be discharged home into their care.

For children attending day case surgery, we were told they would always try to be prioritised when possible for theatre slots.

On the neonatal intensive care unit, there was a hand over which allowed staff to review how babies had been overnight and what the plans were for the next day. The neonatal intensive care unit were implementing a neonatal early supportive transfer (NEST) for babies at 34/35 weeks of age to reduce time spent in hospital. We were also told of the early to home project to allow the early discharge of babies on nasogastric feeds with help from the outreach team.

The paediatric outpatient clinic ran seven clinics in the department and waiting times were reassessed each time a patient was seen. A white board would then be updated to advise patients what the wait times were.

**Neonatal Critical Care Bed Occupancy**

From January 2017 to December 2017, the trust has seen neonatal bed occupancy fluctuate across the entire reporting period. For most of the reporting period, the occupancy rate was below the national average, however in April 2017, the rate was similar, while in June 2017 and October 2017 it was greater than the England average.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. Staff were open and honest and gave us examples of changes that had been made following complaints. Within the trust, there was a patient advice and liaison service to provide support to patients, carers and families.

Staff we spoke to said when mistakes were made, they were shared in an open and honest way. There was a culture of openness, honesty and learning from mistakes. Staff told us there were regular monthly governance meetings to discuss complaints, incidents and risks which were minuted and circulated to all staff by email and a hard copy was also printed for staff to sign during handover. Neonatal staff also receive these on the ‘lessons of the week’ sent by email and posted on a closed social media group.

There had been a complaint which had been escalated to senior managers, which contained issues around infection and prevention control and equipment used in procedures. The complaint was considered fully and senior staff told us about the actions that had been taken because of this and changes had been implemented.

Staff we spoke with listened to complaints and acted on them accordingly, implementing changes as needed and staff were familiar with how to manage any complaints and would escalate them to the senior nurse in charge.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. While a number of the leaders were new in post, staff were positive about the leadership team.

The children and young people service sat within the medical division and the neonatal intensive care unit sat separately within the surgical division.

Staff told us senior leaders of the service were visible, approachable and supportive and they felt that children’s services were well-led.

All the staff we met with told us that service leaders had a good understanding of frontline challenges on wards and in clinical areas and we heard of positive working relationships.

There was a new matron for children’s services and a new divisional nurse director overseeing the children and young people service, who also oversaw the adult critical care unit. Both had taken a lead role in addressing areas for improvement identified following the last CQC inspection. We heard staff speak very highly of these new staff members.

There were two new ward managers in post on the children’s ward. One was managing the ward and the high dependency area and the other managed the day case unit and the assessment area. The neonatal intensive care unit had an experienced manager who was overseen by the divisional midwifery and neonatal nursing director. The paediatric outpatient department had a manager who started in April 2018. A new manager for the outreach team, had not yet started in post at the time of inspection.
Senior managers said they received support to fulfil their role and had enrolled in a leadership course to help build their leadership qualities and skills. We were told that all consultants had been on leadership courses.

Senior managers told us that with the support of the nursing director, children and young peoples’ services had become a lot more recognised within the trust.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action. These were developed with involvement from staff, patients and key groups representing the local community.

The trust’s patient experience and involvement strategy for 2018-2021 had specific objectives for children’s services. The strategy was designed around the trust wanting to consistently deliver excellent care and the strategy’s four main ambitions. The specific objective was in relation to plans to invest in a new access system to keep children safe and to create facilities on the ward that reduced the need to leave as often.

On the neonatal intensive care unit, there were plans to introduce family integrated care, which is a model of care that integrates families as partners in the neonatal intensive care unit team and provides a structure that supports the implementation of family-centred care. The team on the unit were committed to introducing that model of care.

Staff we spoke to were aware of the strategy and its goals. Within all the areas we visited, there were posters displaying the trust’s values and staff were very familiar with the values.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All the staff we spoke with reported an approachable, open and honest culture and leaders were easily accessible and supportive.

During inspection, we saw enthusiasm, pride and achievement from speaking to staff. All the staff we spoke with regardless of role, were open, honest and very helpful.

The staff we spoke to recommended the trust as a place to work and many of the senior staff had worked in the trust for many years. They reported there to be a positive, supportive, open and honest culture amongst staff within the trust.

We did not see, or hear of any evidence of harassment or bullying during inspection.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. There was a clear governance structure and clear lines of accountability for staff at all levels.

Within the children and young people service, staff were clear about their roles, what they were accountable for, and to whom they were accountable to. The service held regular planned governance meetings. During the meetings, members discussed complaints, incidents and risks. The minutes of the meetings were circulated to all staff.
The service held mortality and morbidity meetings every three months and any serious cases, or deaths would be discussed, with learning to be taken and shared amongst staff. There was a process and flow chart to be followed when there had been a death and any lessons learned were shared, acted on and reported to the board via the clinical governance committee.

There were separate monthly audit meetings attended by the multidisciplinary team.

We were told that children’s services were now considered at board meetings, however at the time of inspection, there was no non-executive director named for children or maternity services.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

All risks to the service had been rated, with control measures documented, a date the issue was raised, with dates for actions reviewed and dates when actions were completed. There were four of which were classed as ‘high’ risk and the other as ‘significant’. These related to the lack of psychology provision for children at Royal Preston Hospital, the risk of ligature points on the children’s ward, the risk of patient safety as the trust moves towards a paperless system, the poor state of repair of the estate in the children’s inpatient area and the timely triaging of babies on choose and book. The only action point without an action closed date was the lack of psychology provision for children at Royal Preston Hospital, which remained an issue, although we were told that the child and adolescent mental health service had now recruited, but on inspection, we could see evidence that the other issues had been addressed.

Risks were owned by each of the divisional sub committees for safety and quality, workforce, strategy and finance. The divisional risk register was reviewed by the safety and quality committee.

Senior leaders were aware of risks and performance issues within their own area and had addressed key risk areas. With winter pressures, there was an increase in the admission of patients, particularly with infections. As an action to address this, the infection, prevention and control staff visited the ward daily and worked with staff to effectively manage the risk of infection using cohorting, particularly with infections, such as bronchiolitis.

Children’s services contributed to local and national patient outcome and performance audits.

The trust uses the safety triangulation accreditation review (STAR) quality assurance system to monitor performance and compliance for different areas, inclusive of infection control, hand washing, safeguarding, the use of the appropriate tool and the management of the deteriorating child, environment and the safety thermometer. The aim of the safety triangulation accreditation review accreditation was to provide objective evidence to provide assurance of performance.

**Information management**

There were gaps in the information the service collected, analysed, managed and used to support all its activities.
The service was unable to provide us with information to support whether it was meeting the standards for middle grade and consultant review in the Royal College of Paediatrics and Child Health’s facing the future standards. The service informed us that the clinical director for the service had set up an audit tool and this had started following the inspection and was already on the dashboard as a future field for reporting.

There was an understanding of performance, which sufficiently covered and integrated people’s views with information on quality and operations.

Ward-level dashboards were available for review by all staff.

There were computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers for staff to access information. The trust’s policies and procedures were accessible for all staff members via the intranet.

We saw there were standardised quality information and performance boards on both the neonatal intensive care unit and the paediatric ward which provided current quality data such as staffing levels and safety performance.

There were clear notice boards on the main corridors within each unit containing patient feedback for staff, patients and carers to see, as well as safety thermometer information on the main units.

**Engagement**

The service engaged well with children, their parents and carer, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. The service had started a number of initiatives to support engagement and listen to children using the service.

The service was working in conjunction with young people with disabilities, to renovate a bathroom, to ensure that the design of the new bathroom and facilities would be user friendly. The feedback was given to the trust and the bathroom will be designed according to the recommendations made by the young person and their parent.

This service listened to what service users suggested and involved users from all different backgrounds, such as learning disabilities. One young person accompanied by their parent reviewed the unit in terms of patients with disabilities. This young person had never been an inpatient on the unit, but would be giving feedback for the unit to take on board and make improvements.

The service had proposed setting up a youth forum focus group following consultation with a national children’s charity. The proposal which was written by young people would be taken to the board for discussion.

One local young person attended the national youth parliament as a governor and had presented at a local event with the deputy nursing director. This patient story was heard at the trust board. The deputy nursing director had promoted strong patient engagement with children.

This service had started an initiative whereby children and young people sat on interview panels for new staff. Staff members who had experienced this at their interview recommended this as good practice and found it very rewarding.

We were told that there had been some issues around communication amongst staff members, but staff were starting to engage more. Staff we spoke to also told us about closed groups on
social media where they could obtain further support from colleagues and team members outside of the work environment.

There was a noticeboard on the ward that had details of ‘you said’ ‘we did’. One example that we saw on the board of patient feedback was that vending machines were introduced in the waiting area after the feedback stated a lack of facilities. Another example was regarding the play area not catering for children with special needs, which had resulted in mats and sensory toys being available on request for children needing them.

The unit also used the idea of ‘pants’ and ‘tops’ for children/young person feedback, with them indicating ‘tops’ if things were good and ‘pants’ if not so good, which was child friendly and very visual, encouraging younger patients to give honest feedback about the service they received.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong. The service had made changes since the last inspection and was using the ward accreditation tool to drive improvements.

The service had worked on making improvements to the neonatal intensive care unit, including a focus on parent’s experience whilst on the neonatal unit, reducing the time that mothers and babies were separated, the addition of two transitional rooms and reducing admissions to the unit.

Staff told us that there was now an open visiting policy across the trust, based on families and carers saying that they wanted to spend longer visiting their loved ones, also making it easier for people to visit whilst balancing other commitments.

Following the last CQC inspection, the service had made improvements to the environment of the high dependency area on the ward, by improving facilities and improving the storage of medicines and medical equipment, enabling the nurse to access what was needed without having to keep leaving the room, which had been better for the nurse and the parent or carer.

Throughout inspection, senior leaders referred to the safety triangulation accreditation review (STAR) system implemented within the children and young people service. The system measured the quality of care delivered in each department or ward against a set of trust standards that had been developed by staff, and triangulated a number of key performance measures to identify and put in place additional support for areas that need it, and to recognise and reward areas of good performance. This review system fed into the clinical governance committee, then to the safety and quality committee and then up to the trust board.

Within the service, there was a culture of supportiveness and learning. It appeared evident that the service learnt from mistakes and continued to strive to be the best they could be.

Since the last inspection, there had been a dashboard developed and there had also been the introduction of the safety huddle, which was proving to be effective.

Staff told us that if anyone left, they would be offered an exit interview and within that they were encouraged to speak open and honestly about the reasons for leaving.
Outpatients

Facts and data about this service

The acute outpatients service at Lancashire Teaching Hospitals is delivered at Royal Preston Hospital and Chorley and South Ribble Hospital.

Total number of first and follow up appointments compared to England

The trust had 547,861 first and follow up outpatient appointments from February 2017 to January 2018. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from February 2017 to January 2018.
<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Preston Hospital</td>
<td>408,119</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>184,734</td>
</tr>
<tr>
<td>Burnley General Hospital</td>
<td>1,427</td>
</tr>
<tr>
<td>This Trust</td>
<td>594,280</td>
</tr>
<tr>
<td>England</td>
<td>105,531,002</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from February 2017 to January 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Lancashire Teaching Hospitals NHS Foundation Trust from February 2017 to January 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

The service had a main outpatients' department, but also had outpatient clinics for the surgical department and medicine department. The data above relates to the main outpatients only. We reviewed the related data for other clinics. As the service does not centralise this data we were unable to get fully accurate data. The service is aware of this and is working on a methodology to ensure that this information can be retrieved in the future.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and most courses had a completion rate in line with trust targets.

The trust has set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in outpatients.

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>133</td>
<td>186</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>73</td>
<td>120</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in outpatients at the trust met the completion target for five of the eight mandatory training courses made available to them. They failed the target for courses categorised as ‘other’ by the trust, however the trust has not provided any details about what these courses entail.

It should also be noted that medicine management training and manual handling – object training have very low numbers of eligible staff; therefore, each staff member represents a higher percentage than those on other courses.

Medical Staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Medical staff in outpatients at the trust met the training completion target for five of the six courses made available to them. However, the five courses have only two eligible members of staff assigned to each of them with the course classified as 'other' having four eligible members of staff. Therefore, each member of medical staff represents a higher proportion of the total than nursing staff for the same training course.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Managers and staff confirmed the service had core mandatory training which was undertaken on a rolling basis this included areas such as health and safety and fire. In addition, other training was compulsory such as resuscitation. Training uptake was reported and monitored across the divisions.

Staff told us they were encouraged to complete their mandatory training; however, this was difficult on occasions due to workload. Managers were aware of these concerns and were undertaking an approach to support staff to attend training as necessary.

The trust met most of its mandatory training targets for outpatients.

Safeguarding

Staff understood their role in recognising and preventing potential abuse. There were systems to ensure that patients were appropriately protected and action taken when potential abuse was recognised.

Safeguarding training completion rates

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff within outpatients.

<table>
<thead>
<tr>
<th>Nursing staff</th>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>115</td>
<td>122</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>110</td>
<td>122</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>22</td>
<td>28</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Nursing staff in outpatients met the completion target for three of four safeguarding courses made available to them.
Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in outpatients met the completion target for one of the safeguarding courses made available to them. However, as with the above training section, there is a very low number of medical staff eligible for each of these courses, therefore they represent a higher proportion of the total than nursing staff for the same courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The department had a clear system and process for the identification and management of adults and children at risk of abuse (including domestic violence). An alert could be added to the IT system to highlight if patients had previous safeguarding concerns. Staff and managers told us the department had good links with the services safeguarding lead. There was accessible support available to staff and managers for advice 24 hours a day, seven days a week.

Nursing, medical and administration staff we spoke with could explain the process of safeguarding a patient and provide us with specific examples when they would do this.

We observed staff accessing the trust safeguarding guidelines, which were readily available. This provided information of how to make referrals when staff had concerns about a child or adults’ safety.

Junior staff told us any safeguarding concerns were escalated to the senior nurse and doctor. Staff were aware of the assessment for child exploitation and female genital mutilation. This was covered within the safeguarding training they undertook.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection in most areas.

We saw that all clinic areas were visibly clean environments. Cleaning schedules were in place and kept up to date to show when cleaning had taken place and what areas had been cleaned. The service had in place “I am clean” stickers to identify equipment that had been cleaned.

Staff told us and we saw that they could access infection control and hand hygiene policies on the services central computer system.

We observed good hand washing and infection control practices throughout. This included the use of personal protective equipment where appropriate, for example, disposable gloves and plastic aprons.

There was a suitable supply of alcohol hand gel dispensers and hand washing facilities which were readily accessible by all staff as needed, to reduce the potential spread of infection.

The service carried out internal audits and checks for hand washing. Data provided by the service showed these were in house checks and compliance was 100% in most areas.
Staff told us they would see patients with infections, for example in the dermatology clinic last on the list and carry out a deep clean after the treatment session.

**Environment and equipment**

The service had well-maintained premises and equipment but some outpatient areas were crowded and lacked an effective ventilation system.

Staff told us and we observed that it was not always possible to separate patients and reduce the risk of infection for some specialities. All patients were in the same waiting area, including immunosuppressed cancer and transplant patients, renal patients, infective patients and patients attending hepatitis clinics. The lack of adequate ventilation in waiting rooms which may increase the risk of spreading infection. Managers we spoke with were aware of this risk which was due to the lack of facilities available in the building. They had plans in place over the coming years to reorganise some of the clinical spaces and move other clinics to new buildings at other sites.

In one area we saw that a naked flame (Bunsen burner) was in use in an area with flammable equipment and flammable materials were not stored safely. We raised this with the service who immediately reviewed the area and put into place arrangements to make the area safer.

In another area we saw that ophthalmic lenses were cleaned in a solution that gave off significant fumes. There was no sign on the door stating that decontamination was taking place in accordance with the services risk management plan. Additionally, we observed that staff undertaking this process did not consistently use personal protective equipment to protect themselves. The room was used by many staff and on occasions patients, we observed that the door was not secured whilst clinics were in place. We asked the service to address the arrangements and ensure that their policies were followed.

The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded and lacked an effective ventilation system. Senior managers acknowledged the aging estate and the lack of space in the outpatients’ areas.

Throughout the outpatient area we noted that the corridors were busy and it was difficult to manoeuvre wheelchairs in some of the secondary waiting areas.

All the emergency trolleys we looked at were stocked correctly and located in an area which was easy to access in the event of an emergency. All trolleys sampled contained consumables which were within the expiry date and the relevant equipment which was checked daily. This ensured that if the equipment was needed it was suitable to meet the needs of patients.

The hospital and clinical areas were accessible by wheelchair and accessible toilets were located throughout the outpatient areas.

Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired. All equipment we looked at, was in date and safety tested.

The environment in the outpatient centre meant that certain areas did not provide full visibility of patients. Managers were aware of the limitations and impact of the environment in relation to patients’ safety. It was recognised within the organisation as a risk and steps were in place to limit the impact of the environment in maintaining the care and support of patients.

**Assessing and responding to patient risk**

Some risks were not identified by the service to fully maintain the safety of patients.

The service had a computer system that would allow risks to patients or from patients to be flagged such as prisoners attending outpatients. However, when we reviewed prisoner records
these flags were not in place either on the electronic records or the temporary records brought to the clinics.

Staff could describe the procedure if a patient became unwell in their department.

**Nurse staffing**

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by care services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From February 2017 to January 2018, Royal Preston Hospital reported a vacancy rate of 12.8% in outpatients. This is worse than the trust’s target of 6%. Vacancy rates at individual sites are as follows:

- Royal Preston Hospital 12.6%
- Chorley and South Ribble Hospital 13.8%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 6.5% for nursing staff in outpatients. This is worse than the trust target for 4.2%. Vacancy rates at individual sites are as follows:

- Royal Preston Hospital 5.9%
- Chorley and South Ribble Hospital 9%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.

We saw the service had a system to determine how many clinics were needed to meet patients’ needs and to ensure these were sufficiently and appropriately staffed.

There was a standard process that was utilised to determine the staff and relevant skill mix needed to make sure there were sufficient staff with the relevant skills available.

Outpatient clinics were staffed by a combination of specialist and outpatient nurses. Staff worked across both the Royal Preston and Chorley and South Ribble Hospital sites.

A review of outpatients staffing was ongoing. None ward based departments were having staffing reviews as part of the wider nursing and midwifery staffing review process. They reviewed staffing levels on an ongoing basis and as part of their governance to make sure that staff with the correct skills were working in the correct clinics.

The service did not use agency staff but relied on extra band three staff and used in house staff working extra hours.

Staff spoken with said they did on occasions work extra hours to accommodate any additional clinics when they were needed to reduce patients waiting times. Overall, staff felt there were enough staff. They also said there was a relatively low staff turnover with staff working in outpatient areas for several years.

Medical staffing

Overall staffing rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information for medical staff in outpatients. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.
Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information for medical staff in outpatients. We are therefore unable to provide commentary on performance.

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

Allied Health Professions
Managers told us they had identified key risks for allied health professions that included staff shortages due to, sickness, maternity leave, unfilled vacancies and capacity demands.

We were informed by staff and managers the service planned to undertake a gap analysis to identify capacity and demand for each area. Additionally, temporary staffing had been approved as a short-term measure to meet patient’s needs.

The establishment of the allied health professions leadership meeting created a focus for taking forward both the operational and strategic issues within allied health professions.

Records
Appropriate records of patients’ care and treatment were not being kept in all outpatient clinics. Some records were not clear, up to date and available to all staff providing care.

Patient records viewed were incomplete, disorganised and were stored on four different computer systems and paper systems. Essential items were not always available. There were no arrangements within the trust to test and improve the quality of patient record keeping as there were no audits being undertaken.

We reviewed 28 records that were both electronic and in paper copies in a variety of clinical areas.

We reviewed the records and systems available and found that there were inconsistencies in their management. We saw records where patients’ specific needs such as mental health or learning disability had not been flagged so that staff could be aware of this need.

12 records reviewed showed missing information such as consultants’ notes written during the patient’s attendance to clinics. We were unable to locate records including consent for procedures
for two patients the service was asked to investigate the missing consent records. We saw that in one instance this was because of delays in the information being scanned in. The service had a target to ensure that all records were scanned in within three days however on this occasion it was 10 days after they attended clinic and the notes were being scanned in that day.

We saw incident records where staff had reported incidents of records scanned in to the wrong patient records and incidents where information was missing.

We were unable to identify an agreed approach to the use of either paper or electronic records in the clinic areas. We spoke with senior managers who informed us there was no auditing arrangements to check the quality and completeness of patient’s records. The inconsistent records and lack of review meant that staff did not have all the information they needed to ensure they were able to deliver patient care safely.

Paper records containing patient identifiable information such as their name and address were not kept securely in any clinic area we visited. We were informed that for main outpatients a secure locking facility to ensure patient confidentiality would be obtained.

We looked at the systems and processes for managing patients’ records and ensuring that medical staff had timely access to patient information and test results. There was a clear system in place to support this. If patient records were unavailable a temporary record was prepared, this meant that clinic appointments were not cancelled due to missing records.

In all clinics we attended we saw that patient records were not kept securely to maintain patient confidentiality. We discussed this with managers and were informed that secure trolleys would be purchased. We did identify this issue at the last inspection.

**Medicines**

The service prescribed, gave, recorded and stored medicines well in general. However, we did find patient group directions that did not reflect the correct versions held electronically and did not record which staff were authorised to use them. Patients received the right medication, at the right dose, at the right time.

The arrangements for staff to provide patients with medicines to take home from clinics (known as TTO) were not sufficient to maintain the safety of patients. Staff competency for TTOs was not sufficiently determined or supported.

We reviewed the arrangements when staff gave patients medicines directly from the clinic areas when the onsite pharmacy was not available. This was mainly at weekends or for clinics that finished after 6pm. There was no standard operating procedure, training or competency available for nursing staff to undertake this task safely. This was raised with the trust at inspection who took immediate steps to rectify and ensure that staff were given the correct support they needed.

We reviewed the arrangements for staff to administer medicines with the authority of a prescriber. For registered health professionals this is known as a patient group direction(PGD). PGDs allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

Patient Group Directions were used in outpatients. These allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The directions we reviewed did not record which staff were authorised to use them and the paper copies were out of date and did not reflect the correct versions on the trust intranet. The trust Medicines Policy did not reference the use of patient group directions.
For staff not, registered health professionals an arrangement known as a patient specific directive (PSD) can be put in place. A PSD is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. The service used two different systems for this; a stamp and a pre-printed record sheet to be completed by the prescriber. The service referred to this arrangement as a clinical agreement. The records we viewed where this system had been utilised were completed correctly. However, the staff we spoke with were unaware of any specific training they had been given to undertake this activity. Staff outlined a process that they were to follow but there was no standard operating procedure available that outlined this process.

Medicines were stored correctly and in a safe manner. Medicines cupboards and fridges were appropriately locked. We did see that single usage eyedrops were left unattended in some consulting rooms.

Prescription records used by prescribers for medicines for patients to obtain from the onsite pharmacy were stored securely and their usage was tracked.

Incidents

Staff members understood and met their responsibilities to raise concerns, report incidents and near misses. When things went wrong arrangements were in place to ensure that patients were told when they were affected, given an apology and informed of any actions taken as a result. However, lessons learnt from incidents were not consistently shared with all staff for them to understand the improvements needed.

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incident classified as a never event for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in outpatients which met the reporting criteria set by NHS England from May 2017 to April 2018.

One of these incidents was categorised as adverse media coverage or public concern about the organisation or the wider NHS.

(Source: Strategic Executive Information System (STEIS))

Lessons learnt from incidents were not consistently shared with staff for them to understand the improvements needed. We saw records and staff confirmed that incidents were discussed at team meetings and news-letters were available that detailed recent incidents. We saw that not all
incidents were discussed or information made available to improve the quality of the service available.

There were five incidents of severe harm relating to patients in the eye clinic. All five were being investigated. On review of the records it was noted for one case the last contact the patient had received was early January and there were no records that the patient had been made aware of an ongoing investigation. Staff assured us that this was not the case and the contacts had not been fully recorded on the trust incident reporting system. There were no records available that immediate learning had been discussed with staff.

There had been an incident earlier in the year in relation to a young child. This had been logged as an incident and investigated. The computer incident log had been closed. We spoke with staff within the area the incident had occurred. Most staff were not aware of this incident or what the actions were to be taken. We spoke with a manager and reviewed the incident information. The manager acknowledged that the learning points identified from the incident were not reflected in the written record and that staff had not been informed of this learning.

Of the twenty-eight incidents we reviewed we saw the majority were reported in a timely manner. However, we saw three incidents where the computer report was not made for over a week after the incident occurred or the review of the incident was not undertaken in 72 hours which was not in line with trust policy.

The service encouraged openness and transparency. Staff understood their responsibilities to raise concerns, report incidents and near misses. All staff spoken with told us they were aware of when and how to raise and log an incident and they were fully supported by managers to do so.

When things go wrong arrangements were in place to ensure that patients were told when they were affected, given an apology and informed of any actions taken as a result. We saw records were appropriate action had been taken to inform patients known as a duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain “notifiable safety incidents” and provide reasonable support to that person.

Is the service effective?

Evidence-based care and treatment

The service made sure that staff provided care and treatment based on national guidance and evidence to achieve positive outcomes for patients.

We spoke with staff, senior managers and reviewed records that showed care and treatment within outpatients was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence.

Audit and staff meetings were held throughout clinics and there were monthly meetings amongst senior managers across all the clinics to promote shared learning.
Nutrition and hydration
There were limited arrangements in place to recognise patients who may have nutritional needs that needed to be met.

We saw there were drinks available for patients.

We spoke with staff and reviewed records where patients were in clinics for a long time. There were limited arrangements to recognise and meet their nutritional needs. For example, if a patient had diabetes there were no arrangements to flag this to staff so they could organise appropriate snacks for patients waiting in clinics.

Pain relief
Staff spoken with and records reflected that patients were prescribed simple pain relief as required. Pain relief medicines were dispensed by the onsite pharmacy, which was located within the outpatient’s reception area. The pharmacy was not in operation over the weekend or after hours. Patients were advised on how to obtain relevant pain relief if a new need was identified.

Records reviewed for those patients attending for pain management did not record how patients’ levels of pain was being monitored to determine their ongoing or newly developed levels of pain.

Records showed that patients could be referred to the pain management clinic by their consultant as needed.

Patient outcomes
Accurate and up-to-date information about the effectiveness of care and treatment was not routinely gathered to be used to improve outcomes for patients.

From February 2017 to January 2018:

- the follow-up to new rate for Royal Preston Hospital was higher than the England average.
- the follow-up to new rate for Chorley and South Ribble Hospital was higher than the England average.

Follow-up to new rate, Lancashire Teaching Hospitals NHS Foundation Trust.

(Source: Hospital Episode Statistics)
We spoke with staff and senior managers regarding how they monitored and managed specific areas such as waiting times for patients before they got an appointment and how long patients waited once they arrived into a clinic before they saw the relevant medic and left the unit. There were no specific arrangements in place to audit or check how long patients were waiting once they arrived in the clinics. The eye clinic had undertaken some sample checking however this was not undertaken in other clinics and there were no actions determined from the results of this monitoring.

Patient Reported Outcome Measures questionnaires were given to all NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery. The questionnaires ask patients about their health and quality of life before and after they had an operation. This helps the NHS to measure and improve the quality of its care. We were informed that these questionnaires could and sometimes were utilised within the clinic areas and this information was made available as needed.

We were informed following our inspection that the service did not participate in national benchmarking programme in relation to outpatients but would explore opportunities to participate.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff members learning needs were identified with training provided to meet their needs. Staff members were supported to maintain, further develop their skills, experience and their competency to undertake their job role.

**Appraisals**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals)

We saw examples where staff received specific training and competency assessments. For example, staff used laser equipment. Trust data showed that 10 doctors were competent to use specific lasers and 22 nurses were competent to assist in lasers. We saw staff had access to training specific to their clinical area of practice. Staff told us they had access to appropriate and job-specific training opportunities.

We saw there had been an increase in the arrangements to provide clinical excellence and support to staff. Some staff told us they had regular morning briefings and managers were accessible.

There had been team meetings at each clinic level and higher within the management structures to provide support and feedback to staff. We saw that these arrangements were not consistent across all clinics as overview of the clinics was across the main three directorates. Managers spoken with were aware of the lack of consistency and were reviewing arrangements to ensure all staff received the correct level of clinical support.
Staff told us and records confirmed that specialist nurses were in post to provide a range of nurse-led clinics. The specialist nurses and therapists had completed extended prescribing courses to expand their skills and improve the quality of service delivery.

Information from the trust showed that new staff were required to complete a full day corporate induction and a local induction before undertaking their role. Staff were positive about the induction process which helped them to orientate to their role.

Staff told us they had received annual appraisals known as personal development reviews. Records showed that personal development reviews had taken place and that staff were supported with their development and educational needs.

**Multidisciplinary working**

Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

We spoke with a variety of staff from differing disciplines. There was a joined-up approach from all staff to plan and meet patients’ individual needs.

The service had reviewed the gaps they identified for therapy support such as physiotherapy and occupational therapy. There was a review to make sure there was sufficient staff to work as part of a team.

All staff spoken with were confident in the support that they received from their divisions.

The service had increased the profile of allied health professions. The management arrangements ensured the deputy director of nursing had an overview of the multidisciplinary approach working closely with the associate director of allied health professions.

**Seven-day services**

Seven-day services could be provided for clinics where needed.

The clinics ran on different days and at different times dependent on the needs of patients and the availability of suitably qualified staff.

**Health promotion**

There was a focus on early identification, prevention and on supporting patients to improve their health and wellbeing.

We saw information was available that detailed how to promote individual health both in general and specific to some medical conditions. However, this was only available in one format and one language. Some information was over a year old and had not been updated.

Staff described how they discussed health promotion with patients who attended clinics including advice and signposting such as smoking cessation.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Not all staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005. Not all staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
Mental Capacity Act and Deprivation of Liberty training completion

From March 2017 to February 2018, the trust reported that 79% of nursing staff in outpatients had completed the Mental Capacity Act Level 2 course. This is worse than the trust’s target of 90%.

The trust has not provided information for Deprivation of Liberty Safeguards (DoLS) training; therefore, it is assumed it was not on offer to staff.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Patients were not consistently supported to make decisions. Where patients’ mental capacity was identified as requiring support the assessment, recording and acting in line with relevant legislation was not consistent and was not consistently understood by staff.

We spoke with staff at different levels and job roles within the outpatient department. There was an inconsistent understanding of how to support patients with mental capacity needs. Some staff could give us clear examples of how they supported capacity and were able to demonstrate how this had been undertaken. Other staff were unable to demonstrate a basic understanding.

Three staff we spoke with confused deprivation of liberty safeguards with the right to carry out treatment in the patient’s best interests.

Records reviewed did not consistently ask or outline where patients may have mental capacity needs. This was because the electronic and paper records whilst having the capacity to flag patients with mental capacity needs the flags were not consistently utilised. As a result, staff would be unaware at the first appointment of patients who required support with their decision making this could result in patients having to attend for another appointment to determine their capacity to make the discussion and hold a best interest’s discussion.

There were no signs that we observed in any of the clinics we attended that provided patients or their relatives about information for advocacy services that could assist them in making informed decisions about their care and treatment.

Some of the staff we spoke with were unaware of Lasting Power of Attorney or how there were orders that granted patient advocates different legal rights. Whilst other staff spoken with were well versed in the orders and how to obtain a copy so they would know what the conditions were. As result there was a risk that some staff would accept a patients’ relatives right to make decisions of a medical nature without checking that the correct legal authority was in place.

There were two patient records whose consent to care and treatment had not been placed in the patient records. Staff were confident that consent had been obtained correctly but there was no record. We asked the service to investigate these two instances and take appropriate action.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The department participated in the Friends and Family Test. Between October and December 2017 89.6% of patients would recommend the hospital to friends and family and between January and March 2018 89.9% of patients would recommend the hospital to friends and family. The
response rate over the six months, across both sites, was 8%. The service tracked the top ten positive and negative themes and words in responses to identify themes.

We found individual examples of compassionate care within the clinics we visited. We observed staff dealing with patients in a very supportive manner.

Patients we spoke with were complimentary regarding the skills of the staff to demonstrate a caring attitude. The friends and family test questionnaires reflected the most positive comments related to staff and how they provided care and support.

Patients and relatives told us and we saw staff introduced themselves and they were treated with kindness and compassion. However, we did see some occasions when staff did not introduce themselves to patients.

We saw in reception areas within the clinics a sigh saying, “my name is …” however, the name on the persons badge was not the same name as the notice this could cause confusion for some patients.

We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.

The trust had a chaperone policy and signs were visible throughout the service informing patients how to request a chaperone.

Some patients told us the outpatient department could be very busy and rather overcrowded which made it difficult to have a private conversation about their medical condition.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Feedback from patients was positive about the way staff treated people. Patients and their relatives were treated with dignity, respect and kindness.

All staff we spoke with talked to patients in a manner that was supportive to their individual needs. All aspects of the care that patients were to receive was discussed with them so they could understand and be involved in how their care was delivered.

Staff at the clinic recognised the impact of a person’s care, treatment or condition had on their wellbeing both emotionally and socially. We saw patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. We saw examples where patients were provided with emotional support to assist them.

The service allowed carers and family members to stay with patients as they wished.

The service had clinical nurse specialists and lead nurses available to support and reassure patients regarding the management of their condition.

There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.

Staff and patients confirmed there was access to both psychiatric and counselling services as and when required. Staff outlined occasions when they had made the appropriate referrals for patients and their relatives to these services.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. All patients were given information verbally and in writing that they could go away with and read to understand their treatment. Written information was not available in a variety of different formats or languages to meet patients’ individual needs.

All patients we spoke with said they understood the treatment they were having and were given realistic expectations of the outcomes of their treatment. Patients were informed following diagnostic investigations when they should contact their GP for the results.

We spoke with patients and those close to them about the care and treatment they received in outpatient services. Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.

Any pre-assessments were carried out in advance of any treatment and pre-operative assessment was carried out before the procedure. We saw staff encouraged patients to ask questions.

The service encouraged patients to have a voice. They proactively sought feedback on improvements the service could make.

We observed staff taking time to clearly and carefully explain instructions to patients and to answer any questions patients had.

Patients we spoke with told us they understood when they would receive their test results and next appointment and how they could contact the service if needed.

Is the service responsive?

Service delivery to meet the needs of local people

Facilities and premises were not always sufficiently adapted to meet the individual needs of patients.

From February 2017 to January 2018:

- the ‘did not attend’ rate for Chorley and South Ribble Hospital was similar to the England average.
- the ‘did not attend’ rate for Royal Preston Hospital was similar to the England average.

The chart below shows the ‘did not attend’ rate over time.
The service sent information following the inspection that showed their ‘did not attend rates’ for 2017-2018 across all the clinics in Royal Preston averaged 9%.

Facilities and premises were not sufficiently adapted to meet the individual needs of patients. Patients who drove themselves to their appointment told us they found car parking difficult because the demand for spaces was high, and they often had a long walk to get to the department. A member of staff in outpatients had reviewed this and had placed a notice board on a corridor outlying a response to assist patients with car parking.

Some people told us they had problems finding a department because of poor signage. Orientation around the outpatient areas was not easy. There were no clear signs to help patients with reduced capacity identify individual clinics. Additionally, signs in clinics were not always specific to meet individual needs such as those who were visually impaired.

Staff and patients told us that waiting areas did not always have sufficient seating available. The outpatient clinics were fragmented throughout the hospital site. Managers told us patients came into main reception where there was a main outpatients’ reception other clinics such as pre-surgery assessments were not easy to quickly identify as they were not part of the main outpatients.

Additional clinics were being held in the evenings or at weekends to reduce waiting times for patients.

**Meeting people’s individual needs**

Waiting times and delays in the department and cancellations of clinics were minimal and managed in a manner that met patients’ needs.

Staff told us and we observed were patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times and reduce the number of
patients who did not attend their appointments. However, this was not a consistent practice throughout the clinics.

Initial appointments were undertaken by the patient booking system from referrals both internal to the hospital and the wider community. Follow up appointments were made in a variety of different ways depending on the clinic the patient had attended. This included booking directly through the clinic receptionist and booking at the outpatients’ main counter at the hospital entrance Patients who had appointments for different clinics told us this could be confusing as they weren’t always sure how they were to make sure they booked a follow up appointments.

We observed in the main outpatient area the proximity of other patients waiting to the person booking in meant that patient confidentiality could not always be assured.

Staff tried to meet the individual needs of patients. We observed that where patients needed to attend different clinics attempts were made to have the patient attend these appointments on the same day.

Translation services and interpreters were available to support patients whose first language was not English. If staff were alerted to a patient’s requirements, face to face translators could be booked in advance. The alert system was not always used we reviewed records where patients did not have English as a primary language but this was not flagging as such staff would not be aware of the need to have a translation service in place.

The service had access to a telephone translation service. However, we saw examples where relatives had been used as a translator or no translator had been used. This was not best practice and would not assist patients to have their needs appropriately meet.

Staff acknowledged the service had been limited for people with hearing impairment but the trust was piloting using skype for sign language. Additionally, there was no signs to indicate that a hearing loop system was in place that would benefit patients with suitable hearing aids. Staff we spoke with were not aware if a loop system was available.

We were told the service was in the process of getting posters translated into the top six languages for the local area.

The same interpretation company had a contract with the trust to provide sign language interpreters for people with hearing impairments. However, the trust had recognised that there was a need for signers who used a northern dialect of sign language for some patients. The trust had made an informative video for patients in sign language and were in the process of developing videos for other services, such as outpatients.

The service had access to an interpreter in the local area for deaf and blind patients. They were focussed on the scarceness of this specialist resource and the need to source additional interpreters in this field for the future. The trust had plans to work with two other NHS trusts to examine individual patient needs and accessibility to information to improve patient experience and share scarce resources and ideas.

We saw the services website had a text to speech facility for visually impaired people to hear what was written on the web pages. The website had clear advice for patients to prepare for an outpatient appointment, what to ask during the appointment and what to do before leaving the appointment.

The trust web site directed patients to an external website where they could view details of access routes into the hospital and each department (including all outpatient clinics) for wheelchair users and persons with restricted mobility. The site included photographs of access ramps, entrances,
reception areas and desks, treatment rooms and accessible toilets and detailed accessibility facts, such as seating and flooring types, access to hearing loops and whether staff had been trained in disability awareness.

The site had been surveyed by an external company to assess that reasonable adjustments which had been made enabled people living with a disability easy access to services.

We saw that nursing and therapy staff liaised with other agencies and families and carers to maintain daily routines and support patients in vulnerable circumstances. However, we noted that whilst there was a system to alert staff in advance to help meet any specific needs such as people living with dementia or learning disabilities this was rarely accurately recorded.

Staff told us of examples where they had put into place systems such as an earlier appointment or longer appointment for patients who may need this. The activity relied on staff memory to put into place and to assist in rebooked appointments due to the lack of this information being consistently recorded in the electronic system.

Additionally, paper records were available in all clinics either as part of the documentation to be scanned in later or as the complete record. None of the records we saw had any systems such as forget me note used for patients living with dementia and recommended by the Alzheimer’s society.

There was a range of information leaflets in clinical areas on topics such as tests and screening, health promotion and other sources of support. However, they were not available for patients whose first language was not English. Staff confirmed the leaflets could be ordered in other languages or alternative formats if required. However, staff did not always know in advance if the patient required information in a different language and were not always able to order it in advance for the patient to have when they attended their appointment.

We spoke with senior managers who were aware of the need to provide materials suitable to patients’ individual requirements. There had been several consultations with patients in the community to adapt and streamline the delivery of services to them as needed. Focus groups had been well attend by patients with ideas from these groups forming action that the service was putting into place to better meet patients’ needs.

Allied health professions had recently reviewed their written information. This was available in all their clinics and in larger print and more pictorialized. Additionally, at the back of the information there was contact details and explanation as to how to request information in the main six languages known to match the needs of patients living in the area.

**Access and flow**

Waiting times from referral to treatment were improving although not all specialities were above the England average.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for February 2018, showed 82.2% of this group of patients were treated within 18 weeks versus the England average of 88.9%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Lancashire Teaching Hospitals NHS Foundation Trust.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Seven specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>98.3%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>96.2%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Other</td>
<td>94.3%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>93.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>93.7%</td>
<td>89.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>90.9%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>87.9%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Nine specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>90.4%</td>
<td>91.7%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>85.8%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>83.2%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>82.9%</td>
<td>87.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>81.9%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>76.9%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60.5%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>52.0%</td>
<td>82.5%</td>
</tr>
</tbody>
</table>
Neurology | 40.9% | 82.0%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From March 2017 to February 2018, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance for the entire reporting period. The latest information we have for February 2018 shows the trust’s referral to treatment time in this category to be 83%, compared to the England average of 88%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Lancashire Teaching Hospitals NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>98.7%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>96.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Other</td>
<td>94.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>92.7%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>87.0%</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

11 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks)

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>87.4%</td>
<td>91.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>87.1%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>86.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.8%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Specialty</td>
<td>2018-19</td>
<td>2017-18</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85.4%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>85.1%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.0%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.6%</td>
<td>90.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>82.9%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>75.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>62.7%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard and the England average for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing similarly to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Lancashire Teaching Hospitals NHS Foundation Trust

(Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment)

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

People could access the service when they needed it.

Patients were kept informed of any disruption to their care or treatment. Patients care and treatment was rearranged most of the time to meet their needs.

The data for outpatients showed that the service met most of their referral to treatment times. However, there were some clinics where patients were not seen in a timely manner. Senior managers were aware of these and had several monitoring programmes, this worked alongside the bookings team. If it was noted that patients waiting times for a specific clinic were extending, arrangements were made for additional clinics to address the waiting times before appointments.

The data showed that the waiting times before patients were seen by oncology had improved. However, oncology waiting times of less than 62 days from urgent GP referral to first definitive
treatment remained below the operational standard placing patients at risk of not receiving timely treatment.

The ophthalmology service had undertaken an audit of the amount of time patients waited once they had attended the clinic until they left the clinic, to determine if patients were waiting in clinic for long periods.

We were informed that if clinics ran late this would mean patients waited but there was no evidence or study as to what the issues may be or how to resolve them. The ophthalmology department had determined that wait times for injections ranged from 1 hour 35 minutes to 3 hours 40 minutes. We asked what action had been taken from this survey the service was unable to provide us with any information as to how this survey would be used.

Additionally, the ophthalmology clinics had determined that 1.6% of patients had waits over an hour, 26.6% had waited between 30-60 minutes and 71.9% of patients waited less than 30 minutes. There was no information available as to any target set or if the service had determined any targets regarding seen within times.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The service produced a newsletter in relation to learning from incidents and complaints. The newsletter of Spring 2018 recorded that complaint responses was improving. In January 2018, 95% of complaints were responded to within 35 working days.

The newsletter detailed that a complaint investigation revealed that there had been a failure to follow the trust’s Documentation policy on a perioperative care plan. Staff were to remember that every page must identify the patient using their name, hospital ID and date. As such staff were given information within the newsletter as to how the service recognised and responded to complaints to improve practice.

We looked around the clinics we visited to see if information was available that supported patients to make a complaint. We could find no information in either leaflets (in suitable formats) or on noticeboards that showed how patients could raise a complaint.

Additionally, a review of the main website for the service did not highlight how patients were to raise a concern or a complaint. There was a link to the patient advice and liaison service (PALS) but this did not state that this was an access point for patients to raise concerns.

Staff we spoke with said that in the first instance complaints could be discussed with them or the manager. We were informed that no log of informal complaints was kept. This was a missed opportunity for the service to determine trends and patterns of low level informal complaints. If the complaint was unresolved at this level, the patient would be assisted to contact PALS to receive support to raise their concerns.

We were unable to determine how many complaints were made for clinics or their trends and themes as this data was kept for three different divisions and could not be easily extracted. We were given told themes included car parking, waiting times, missed appointments and cancelled
clinics. Senior managers spoken with held monthly meetings where general themes for learning was discussed and this was cascaded to staff.

Is the service well-led?

Leadership

Leaders had the experience, capacity, capability and integrity to make sure that a quality service was delivered and risks to performance were addressed.

Leaders at every level demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.

Leaders were not consistently visible and approachable throughout the outpatient services.

The divisional leadership team consisted of a director, nursing director and a medical director.

Staff told us at a local level they were clear about who they reported to. They told us that managers were honest, proactive and they felt confident to approach their direct line manager with any concerns. However, they said that the senior management team above matron level were not always visible. Senior managers we spoke with had developed plans to attend each department on a frequent basis in order that staff could have a greater awareness of the managers and the support available.

We spoke with several senior leaders with input and support to the clinic areas. They were detailed in their discussions that they recognised there were inconsistencies in the practice and understanding of staff throughout the different clinic areas due to three different directorates managing these services.

However, the arrangements for all outpatients' services and their clinics included all three divisions. Senior managers spoken with were aware of the impact of this and were aiming to improve consistency of staff support, communication and training to ensure flexible working over the coming 12 months.

We saw copies of minutes where values and consistency of approach was discussed across the directorates. Leaders discussed risks and areas of improvement.

There was a leadership structure that was designed to support and work in a collaborative manner. Reporting mechanisms and cross directorate support was in place supporting senior managers at monthly meetings.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and key groups representing the local community.

The service had several values that were displayed throughout the patients’ areas these included; caring and compassionate, recognising individuality, seeking to involve, team working and taking personal responsibility.

All staff we spoke with knew what the values and vision of the service were. They were all committed to working towards the objectives. Staff were passionate about patient support and ensuring patients received an excellent standard of care.
The service had a Nursing, Midwifery, Allied Health Professionals’ and Care Givers’ Strategy for 2018 to 2021 which outlined five key commitments and set out plans to improve the patients’ experience of care and treatment.

The service had a comprehensive and realistic strategy, to develop their services further. They had recognised there were areas of the service that still needed development and had identified several strategies to assist. These included developing closer partnership working across directorates to improve consistency and staff support.

Managers spoken with had a clear vision of how they planned to develop the service including moving ophthalmology services from Royal Preston Hospital to Chorley and South Ribble Hospital. The business plan had been submitted to the board and approved and the new pathway for ophthalmology patients designed by the clinical director with input from ophthalmology staff.

Funding was in place to take the strategy for ophthalmology forward and a non-executive sponsor had been identified. Senior staff at Royal Preston Hospital were aware of the plans and had identified opportunities for staff development and improved patient flow through the hospital.

However, some staff told us that though they were aware of plans to move ophthalmology services there had been no consultation with them. Senior managers told us consultation with staff and key stakeholders was planned but it had not taken place at the time of our inspection.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Most staff we spoke with said they felt very supported by their immediate line manager and morale was good. They told us that in general they felt part of the wider hospital trust this was not consistent with all staff spoken with. As examples we found in ophthalmology and ENT that morale although improved from the last inspection was not high this was because staff told us they felt under pressure of workload. Morale was recognised by the service as needing to improve within the core therapy services with staff concerned about frozen posts and an ongoing therapy and nursing workforce review. However, managers we spoke with and confirmed by some staff outlined what actions had been put into place to support staff and believed that this had improved the staff morale.

Staff and senior management reported that there was an open and honest culture across the clinics. Staff explained that they understood the need for openness and transparency and were knowledgeable about their responsibly under the duty of candour regulations.

Senior staff were aware of the NHS staff survey results and had plans to increase inclusivity to promote equal opportunities for staff and promote wellbeing.

We discussed with staff the role of the Freedom to Speak Up Guardian. Freedom to Speak Up Guardians work alongside leadership teams to support staff to raise any concerns they may have. Staff we spoke with had no awareness of the Speak Up Guardian or their role.

Senior managers we spoke with told us they were aware that staff did not have an awareness of the role or availability of the Freedom to Speak Up Guardian. They had taken the decision to have several guardians throughout the organisation to provide staff with alternative means of contact. A training programme for the role was being rolled out and a launch to all staff to raise awareness would be put into place.
In general outpatients we found that staff were committed to trying to work with trust managers to deliver the services. However, we found the “goodwill” of staff was being tested in part due to the increased number of extra clinics in place to meet the demand on the service and further planned changes to the services.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. An environment in which quality of care would flourish was encouraged.

New processes were not yet fully embedded to ensure sustainable improvement as a result there was inconsistent practice throughout the clinics.

The governance team had only been in post for three months. During this time, they had made it a priority to review the risks to the service and people using it. Senior managers acknowledged there was ongoing development of a governance structure and culture.

There were meetings across all the clinics to increase communication and monitor performance. These were at clinic level for staff on an individual basis and at directorate level to achieve a consistent approach to all the clinics such as records and training.

Subcommittees met monthly and reported to divisional governance boards who had responsibility for oversight of priority areas such as safety and quality, workforce, strategy and finance. Clinical governance leads in each speciality attended the governance meetings.

Matrons met regularly with clinical directors ensuring that information flowed from clinics to the divisional leadership and back down. We reviewed minutes of meetings and saw that performance data was presented and discussed across the key domains of safe, effective, caring, responsive and well led and performance dashboards were reviewed and kept up to date.

Changes to clinical practice were discussed and agreed in monthly meetings attended by all consultants and speciality leads. This ensured that changes in operational protocols were adopted by all consultants.

The service had implemented a quality review system known as STAR. The matron in each area received a report once the review had been undertaken with a detailed action plan to determine what improvements were needed and how to take these forwards. The outpatient STAR audit had shown improvements since the programme commenced.

There was a clear appetite and passion from senior managers to bring about improvements and ensure that the service met the needs of patients.

Information and recommendations from patient engagement were part of service planning to improve the service.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. Audit processes to identify risks functioned well in most areas and had a positive impact.
Since the last inspection we saw that the service had been proactive in increasing the quality of the service it provided. These arrangements were still in their infancy and not yet fully embedded in the performance metrics.

We asked for evidence that patient records were audited both electronically and paper we were informed that this was part of the STAR accreditation which included a review of documentation. We saw records in the electronic records that did not belong to patients and saw incidents records were in the wrong patient record had been scanned to the wrong record as such the STAR system did not fully identify these areas or ensure improvements.

There was monitoring of patient clinics and the service was actively increasing clinics to meet patients’ needs had assisted patients to attend clinics. However, this presented logistic issues for the service in making sure that they had the correct staff at all times. On occasions staff told us this had been difficult to manage and ensure that they were able to support additional clinics appropriately.

The service also had a variety of risks on a local and directorate risk level. These were monitored so risks to the service or staff could be recognised and addressed. Senior managers we spoke with were confident that the arrangements although recently fully resourced were having a positive impact. Staff spoken with were unaware of what the governance arrangements were or how they were being monitored. However, we saw some risks listed did not have any details recorded and no actions or control measures.

Senior managers spoken with demonstrated an awareness of the risks and performance issues within their division and had identified actions to address key risks. Risks were owned by each of the divisional subcommittees for safety and quality, workforce, strategy and finance. These committees were chaired by associate divisional directors and reported directly to the divisional leadership team at a monthly performance review forum. The minutes recorded that the divisional risk register was reviewed and discussed by the safety and quality committee and the divisional risk report produced quarterly and presented to the board.

Minutes of the divisional board meeting in January 2018 evidenced that the executive team had oversight of divisional performance and gave feedback to the divisional leadership which was communicated to staff. Issues for escalation were also discussed at this meeting and an action tracking system used to record completed, closed and overdue actions.

Newsletters were sent to staff detailing what lessons learnt were in place. We noted that there were incidents and safety issues where the learning had not been passed to staff. An example included an ongoing investigation for five patients where the learning from the early review had not been passed on to staff.

Throughout our inspection we noted there was a lack of consistency in practice throughout the clinics. This was due to them being managed by three different divisions and as such staff understanding and practice was not consistent. As an example, staff in the eye clinics gave us clear and well-thought-out examples of how the supported patients who need assistance with the mental capacity, in other clinics staff were unaware of their legal responsibilities and the actions they must take.

**Information management**

The service did not always manage and use its information to support all its activities.

The service used different electronic and paper record systems resulting in slow systems affecting service delivery. An example was the delays in scanning of notes after each admission, which affected patients who were re-admitted during this time. The target was for records to be scanned...
within three days of attendance at an appointment but this target was not always achieved. We saw examples were this was over 10 days and the records were not available.

When patients attended most clinics a basic paper file was made available where staff could record the treatment given to the patient and recommendations. All other patient information such as previous attendance or recommended treatment was contained in the electronic system. In other clinics the records were entirely paper based, whilst in others additional paper records were used dependant on the patients’ needs.

The paper records enabled us to track the patient journey and see what care and treatment a patient had received. However, the electronic record did not contain all the information. For example we were aware some outpatients had been given medicines as part of their eye tests. However, the electronic records did not consistently record this authorisation to assist health care assistants undertaking this practice.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service was transparent, collaborative and open with all relevant stakeholders about performance considering the needs of the population to design improvements.

The service has undertaken opportunities to engage with the community who use the services. This involved listening events and opportunities for specific patient groups to be involved and have their say to increase the quality of the service. Over 3000 patients had attended these. As a result, the service had developed the experience and involvement strategy for 2018 to 2021, which had been developed directly from public engagement arrangements. Actions included aspects such as mandatory flagging of service users with specific needs using the current electronic systems and better utilisation of ongoing schemes such as forget me not for patients living with dementia. There was active support from a senior manager to make sure that information was be accessible by patients.

A booklet outlining the strategy had been created this was in a format that had considered how to meet patients needs including pictures, large print and information for the six most common languages in the area on how to obtain a copy on a suitable language. The actions had been agreed by the patient forums.

It was acknowledged by senior managers that these plans were at an early stage and not yet fully in place or monitored as to their effectiveness. However, the plans were ongoing and involved patients in a wide-ranging manner to increase the quality of the service.

**Learning, continuous improvement and innovation**

There was a positive focus on continuous learning and improvement for all staff.

Mortality and morbidity reviews were held following a patient’s death to examine practice and identify areas of improvement. The divisional governance team audited the mortality reviews quarterly and lessons learnt were shared in the clinical governance committee. Outpatients clinics had a small input into these meetings depending on the patients’ journey and needs.

Lessons learnt from incidents and complaints were shared with staff electronically and at daily ward huddles. The monthly team meetings included discussion of learning from performance
trends and ideas for improvements. We identified during the inspection that there were some instances of learning that were included in this system.

The service had taken the approach to combine the responsibility of associated healthcare professionals and nursing staff within the management structure in order that a joined-up approach could be taken towards patient care.

The specialist mobility rehabilitation service had been internationally recognised for its work with war veterans. The specialist mobility rehabilitation service had also been awarded a national customer service award six times.

The patient experience and involvement strategy had a significant number of improvement and innovation approaches. These were taken directly from the expressed views of patients. Examples included, “I told you I have a learning disability and have different needs”, actions included the development and launch of a learning disability symbol that could be used for quick identification and support.

Staff were currently building networks across the North-West region and meeting with system designers to help make sure patients with specific needs might be more easily identified on the systems when accessing care.
Urgent and emergency care services are provided by the trust at the Royal Preston Hospital and at Chorley and South Ribble Hospital. Between 1 February 2017 and 31 January 2018, 91,272 patients attended the trust’s emergency departments, of which 15,790 were children aged 17 years and under. On average, during this time, 250 people per day attended the departments. The emergency department is part of the trust’s acute medicine directorate.

Urgent and Emergency care services are provided at Chorley and South Ribble District General Hospital under the trust’s acute medicine division. The service can accept patients who require a mental health assessment.

Since January 2017 the department has provided emergency care between the hours of 8am and 8pm daily. It previously provided only urgent care. Services are provided to both adults and children for medical / surgical emergencies.

Ambulatory patients are either accepted and registered into the department or referred to the neighbouring on-site urgent care centre depending on the conditions and symptoms they are presenting with. The urgent care centre is operated by another healthcare provider and was not inspected as part of this inspection.

Only certain patients arrive by ambulance via a designated entrance. These patients are triaged in one of two rapid assessment and treatment rooms.

The emergency department is staffed by a combination of consultants, doctors, nurse practitioners, nurses and healthcare assistants.

Following triage, patients receive care and treatment in three main areas: ‘ambulatory’ bays, ‘consulting' rooms or the ‘majors’ area. The ambulatory care service is open from 10am until 6pm.

People with more serious illness or injury are seen and treated in the ‘majors’ area which has six bays. Should patients arrive in the urgent care centre requiring emergency care, they can be treated in one of three resuscitation bays (includes one for children).

In addition to these areas, the centre has one specialist room for treating eye problems, one room (with two trolleys) for plastering limbs, one treatment room and one decontamination room for patients following incidents with hazardous substances.

We visited the emergency department during our inspection. We spoke with 10 patients and 17 carers and staff from different disciplines including clinical directors, medical staff, matrons, nurses, emergency nurse practitioners, health care assistants, reception and domestic staff. We reviewed ten patient records and observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Facts and data about this service

Urgent and emergency care services at the trust are delivered at the following locations:

- Royal Preston Hospital
- Chorley and South Ribble Hospital

(Source: Trust Routine Provider Information Request)
Activity and patient throughput

From April 2016 to March 2017, there were 130,941 urgent and emergency care attendances at the trust. This can be compared to the number of attendances at other trusts in the table below, with this trust being represented by a purple bar.

Total number of urgent and emergency care attendances at Lancashire Teaching Hospitals NHS Foundation Trust compared to all acute trusts in England.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

As can be seen in the chart below, the percentage of A&E attendances at this trust that resulted in an admission decreased from 2015/16 to 2016/17. In both years, the rate was lower than the England average.
In addition to this admission data, a breakdown of attendance by disposal method can be seen in the chart below for the reporting period of January 2017 to December 2017.

**Urgent and emergency care attendances by disposal method, January to December 2017**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,901</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>44,256</td>
</tr>
<tr>
<td>Referred*</td>
<td>17,252</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>542</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Left department #</td>
<td>3,119</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>166</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.
Mandatory training

The service provided mandatory training in key skills to all staff; however, although improving, training completion compliance levels were consistently lower than the trust target of 90%. This meant the service could not assure itself that staff providing care and treatment had the competence, skills and experience to do so safely.

Mandatory training included a range of subjects, it included fire safety (repeated every two years), health and safety (slips, trips and falls), infection prevention level one, and information governance. Additional role specific training was provided and monitored and included medicines management, moving and handling (clinical) adult and paediatric basic life support, and the Prevent Strategy. Training was delivered through a mix of which included e-learning and face to face training.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in urgent and emergency care at Chorley and South Ribble Hospital.

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine Management Training</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 Years</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>116</td>
<td>156</td>
<td>74.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>70</td>
<td>156</td>
<td>44.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>101</td>
<td>237</td>
<td>42.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in urgent and emergency care did not meet the completion rate target for any of the seven courses made available to them. Nursing staff failed to meet the target for training courses classified as ‘other’ with a completion rate of 42.6%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

In July 2018 the trust sent us additional information regarding staff training. Data up to the end of May 2018 showed 72% of nursing and healthcare assistant staff in the service were compliant with the trust’s mandatory training modules. Of the modules 62% of eligible staff were compliant with moving and handling training; and 71% were compliant with Prevent Strategy training. A further 77% of eligible staff were compliant with adult basic life support training but only 44% of eligible staff were compliant with paediatric basic life support training.

Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>46</td>
<td>60</td>
<td>76.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>42</td>
<td>60</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>52</td>
<td>120</td>
<td>43.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the completion rate target for any of the six courses made available to them. As with nursing staff, they also failed to meet the target for courses classified as ‘other’, with a completion rate of 43.3%.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

In addition to the nursing and health care staff training compliance being low, the compliance for medical staff training was below the trust target.

Medical mandatory training figures were held at service level rather than by location. Across both Preston and Chorley, by the end of May 2018, 73% of medical staff in the service were compliant with the trust’s mandatory training modules and 57% were compliant with Prevent Strategy training. A further 47% of eligible staff were compliant with adult basic life support training, which 38% of eligible staff were compliant with paediatric basic life support training.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

We raised our concern with the trust and were told the practice educator’s confirmed actions were in place to improve areas of low compliance. The management team and staff told us that at times they had been unable to be released for some training modules whilst at work. However, staff could complete e-learning during their own time and then take the time back.

We saw evidence that staff were booked onto courses and all staff had been reminded how to access e-learning in the trust and at home. Senior management told us training was discussed during meetings and that compliance should be achieved by the end of September 2018.

At the last inspection in September 2016 we told the trust they must take action concerning the mandatory training, to ensure its compliance reaches and consistently achieves the trust target.

**Safeguarding**

The service provided training to staff on how to recognise abuse and to protect patients from abuse. Staff knew how to report abuse and the service worked well with other agencies to do so. However, there were low training completion rates for nursing and medical staff in safeguarding vulnerable children level three training.

**Safeguarding training completion rates**

While safeguarding training levels were not meeting trust targets, staff knew how to report abuse and the service worked well with other agencies to do so.

The trust has set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff in urgent and emergency care.
**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>49</td>
<td>64</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>105</td>
<td>156</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>50</td>
<td>75</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>36</td>
<td>80</td>
<td>45%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in urgent and emergency care did not meet the completion rate target for any of the four safeguarding training courses made available to them.

At Chorley and South Ribble Hospital, by the end of May 2018, 88% of eligible nursing and healthcare assistant staff were compliant with the trust’s safeguarding vulnerable adults level two training, and 95% were compliant with safeguarding vulnerable adults level three training. By the same time, 91% of eligible nursing and healthcare assistant staff were compliant with safeguarding vulnerable children level two training, while 52% were compliant with safeguarding vulnerable children level three training.

Compliance figures for medical staff were collated across both the Chorley and Preston sites and showed that 46% of medical staff were compliant with level two and level three safeguarding vulnerable adults training, while 78% were compliant with level two safeguarding vulnerable children training and 41% were compliant with level three children’s training.

While not all staff had completed the appropriate training, staff knew how to report abuse and the service worked well with other agencies to do so.

The trust informed us that safeguarding children level three training was a requirement for all clinical staff in the emergency departments.

Senior management in the service acknowledged that safeguarding training levels had not met the trust’s target. High demand had reduced the service’s ability to release staff from clinical shifts to attend training without impacting on patient care and there had been a reliance on staff to undertake training as paid overtime. There had also been a number of changes to the training ‘target audience’ within the department since November 2017 which had impacted on compliance levels. However, the practice educator had agreed an improvement trajectory to achieve compliance with the target by September 2018.

Training covered the ten categories of abuse (including male domestic abuse), stalking and honour based violence (DASH) risk assessment. Training was also provided in the government’s counter-terrorism Prevent Strategy. Referrals for domestic abuse and Prevent were made to and managed through the multi-agency safeguarding hub.

Staff we spoke with were able to describe the types of indicators of abuse or neglect that would lead them to consider reporting a safeguarding concern. Staff were aware of their legal duty to report cases of female genital mutilation and to be vigilant and assess for indicators of child sexual exploitation and domestic violence.

Reception staff checked the child protection information sharing system (CPIS) for any patient aged 18 or under and alerted staff if the child was known to have a child protection plan in place or was a looked-after child. The system which included social workers’ details also automatically flagged a known child’s attendance at the department to the relevant social worker. The service’s...
electronic patient record system flagged if a child was thought to be at risk of child sexual
exploitation.

We asked three staff members to show us how they flagged concerns and they were aware of
how to flag risks. Staff told us they knew how to report a safeguarding incident for both adults and
young people.

Leaders in the department told us this had been identified during a records audit. Actions for
improvement had been planned, including reviewing the questions on the form to become a risk
assessment, and to enable the documentation to travel with the patient into the paediatric
assessment units or paediatric outpatient departments. The leaders also acknowledged further
development of the trust’s IT system was required to enable automatic printing of these sheets for
relevant patients. However, the electronic patient record system flagged up any previous known
safeguarding concerns or referrals on the patient’s records. This meant that staff could identify
patients who were previously considered potentially to be at risk.

The service hosted a multidisciplinary safeguarding meeting once a month to review all relevant
cases in the department. Representatives included the lead consultant, a paediatrician, a child
sexual exploitation lead nurse, a child and adolescent mental health specialist and an approved
mental health practitioner. The service was also represented at the monthly joint Preston and
Skelmersdale multi-agency child sexual exploitation meeting.

The service participated in a quarterly joint safeguarding champions forum with a local
independent healthcare provider.

The trust had a designated safeguarding lead for adults and for children and young people. Staff
were aware of how to find contact details of the trust’s safeguarding team, which were available
Monday to Friday between 8am and 6pm, or the local authority’s safeguarding teams where they
could obtain further advice if needed. Staff had access to 24-hour services if a safeguarding
referral was required out of hours.

Safeguarding policies and procedures were in place for trust staff, which they understood and
knew how to access.

Staff told us an example of a children’s safeguarding case, where staff had not identified that an
adult patient receiving treatment in the department had children, as such the documentation had
not been correctly completed to say they had escalated the case. The trust had safeguarding
champion nurses who were link nurses that staff could approach for specialist advice.

Posters detailing support and advice services to people experiencing domestic violence were
displayed in the toilets, and advice leaflets were given to patients when appropriate.

### Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>20</td>
<td>27</td>
<td>74%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>17</td>
<td>26</td>
<td>65%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>38</td>
<td>60</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>9</td>
<td>33</td>
<td>27%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in urgent and emergency care did not meet the completion rate target for any of the
four safeguarding training courses made available to them.
Medical safeguarding training figures were held at service level rather than by location. Across both Preston and Chorley, by the end of May 2018, 67% of eligible medical staff were compliant with the trust’s safeguarding vulnerable adults level two and level three training. By the same time, 78% of eligible medical staff were compliant with safeguarding vulnerable children level two training, while 41% were compliant with safeguarding vulnerable children level three training.

Cleanliness, infection control and hygiene
The service controlled infection risk well. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection.

The department and equipment used within it were visibly clean and tidy during our visit including reception and waiting areas, triage rooms, treatment bays, clean utility, sluice rooms and corridors.

Clinical areas were kept clean by two staff who also checked the equipment. Domestic cleaning services undertook the environmental and equipment cleaning in each bay and side room in line with a works schedule. The cleaning logs were checked by the provider’s supervisor and reviewed during a joint monthly meeting between the service’s matron and the cleaning provider. We viewed the cleaning logs. All the logs were up to date and completed appropriately.

We noted the log did not include the cleaning of toys in the paediatric waiting room. This was raised with the domestic supervisor and acted upon immediately. Staff on duty were advised of this.

Between June 2017 and May 2018, the department had no reported cases of patients developing methicillin-resistant staphylococcus aureus, methicillin-sensitive staphylococcus aureus or clostridium difficile.

The service undertook a monthly hand hygiene audit in the department. The service’s target for hand hygiene was 100%. Between December 2017 and May 2018, the department in Chorley achieved an average compliance rate of 95% with two months, February and May 2018, achieving 100%. Posters were displayed in the service regarding the importance of hand hygiene.

The service had a department link nurse who carried out weekly hand hygiene audits. The consultant team had also become involved in audits to ensure compliance from the medical staff.

There were sufficient numbers of antibacterial hand gel dispensers located throughout the department and we observed staff using these. Washbasins were appropriately located for staff to use.

We observed staff following infection control and hygiene procedures, including washing hands and having regard to ‘arms bare below the elbow’. There were sufficient quantities of personal protective equipment such as gloves and aprons throughout the department. We observed staff using protective equipment appropriately.

We observed staff managing clinical waste in line with the trust policy. Staff were familiar with the guidance for managing waste and we observed that sharps boxes were dated, had closed lids and staff knew how to dispose of these.

Cleaning equipment was stored appropriately and was accessible if required.
Environment and equipment

Premises were not all suitable for the purpose for which they were being used. The room assigned for monitoring and assessing patients admitted with mental health needs was not fit for this purpose, although the service was opening a new purpose-built room.

The department was located at the front of the hospital. Signage to and within the department was unclear. External signage did not clearly direct patients to the reception and at the reception, which was shared with the urgent care centre, it was unclear which reception patients should go to. We observed patients going to the outpatients’ door in error. This posed a risk of a delay in a patient being assessed and treated.

The department was light and spacious following a refurbishment in 2015. The premises included a modern reception and children’s waiting area. However, the main waiting area was used for patients waiting for the urgent care centre and the emergency department. This waiting area was out of the line of vision of any staff, although had an emergency call button. The paediatric waiting area was in front of reception but not clearly visible for staff. This meant there was a risk that staff would not be able to see if a patient had deteriorated or patients would not be always be able to request assistance from staff.

Senior management told us there were plans in place to merge the reception desks from 12 July 2018 and introduce a new electronic patient identification computer software that the trust believed would help reduce the risk of patient misidentification and record duplication.

Resuscitation trolleys were available in all areas of the department including paediatric resuscitation equipment. Records showed that the trolleys were checked each day in line with trust policy.

We checked a sample of equipment in the department and found it had been safety tested. Stickers indicated equipment had been serviced regularly. All items were within expiry for safety testing, were clean and were ready for use.

Diagnostic imaging equipment such as computerised tomography (CT) and X-ray machines were based next to the department and there was a plaster room with space to treat two patients at any time.

Even though children did not ordinarily attend the centre by ambulance, one resuscitation bay was assigned for children should it be required in the event of a child ‘walking in’ for treatment and requiring resuscitation.

At the last inspection in September 2016 we told the trust they must take action concerning the risks to mental health patients in the room assigned for patients with mental health needs. Managers confirmed at the previous inspection that the room had been risk assessed to help minimise risks to mental health patients. We reviewed the actions to address this and were told the assessment room for mental health patients in use was a temporary arrangement at Chorley. It was located directly opposite the ambulatory bays where the emergency nurse practitioners base themselves. The manager confirmed there was an alternative room awaiting to have work carried out imminently to ensure patients with mental health were assessed or interviewed in an environment that was deemed safe and followed best practice guidance in relation to the safe assessment. We were told by senior management that high-risk mental health patients would be transferred to Preston’s emergency department.
Assessing and responding to patient risk

Risks to patients including children were not always assessed, monitored, managed and responded to in a timely way so that people were supported to stay safe. Compliance with life support training including adult and children’s basic, intermediate and advanced life support, was poor.

Patients who used the department were not always triaged promptly potentially leading to delays in diagnosis and treatment. This was in part due to the department being co-located with an urgent care centre.

The emergency department was co-located with an urgent care centre, operated by another healthcare provider. The centre aimed to provide assessment, care and treatment to patients with conditions that could reasonably be treated by GPs or advanced nurse practitioners. This meant the emergency department reception included staff from both the service and the urgent care centre. Reception staff were not clinically trained.

Patients self-presenting to the emergency department were asked to identify if they were experiencing symptoms from a list of serious or life-threatening conditions displayed on a poster in front of the reception area. A decision was made by reception staff to book the patient into the service’s system or to refer them to book in with the urgent care centre. Patients were subsequently triaged by whichever service they had been registered into. The receptionists told us they would flag all patients presenting with chest pain or deformed limbs, and would direct patients who were visibly unwell to wait in more visible areas of the waiting room. Parents accompanying children were given red flag signs to escalate if they had concerns.

However, there was a risk that patients with serious conditions could be incorrectly directed to the urgent care centre. This could delay assessment and treatment and place patients at unnecessary risk of harm.

Medical staff and nursing staff told us it was not unusual for patients to be transferred from the urgent care centre as they required a level of care or expertise beyond that which could be provided by the urgent care centre. Senior leaders in the service acknowledged this was a known risk, which also impacted on the service’s performance figures. This was because measurement against the targets started at the time a patient was booked into the system irrespective of which provider they were seen by.

Senior leaders told us plans were in place, and due to be implemented in July 2018, to streamline the initial booking and triage process. This included using one patient information system, for both providers and undertaking nurse led triage using the Manchester triage system (an evidence based triage system widely used by emergency providers). Between March and May 2018, the average wait time for triage at the Chorley site was 29 minutes.

Currently, for patients registered into the emergency department, nurse-led initial assessment and triage identified the most appropriate area for patients to be seen and to fast-track relevant patients for pre-emptive investigations. During busy periods, as second nurse (or the service co-ordinator) would be allocated to triage. All nurses had triage training and could request X-rays.

A dedicated band six nurse triaged patients arriving by ambulance. The display screens on the corridor highlighted the patients due for arrival. Triage enabled early identification of patients at risk of developing sepsis, patients with head injuries or other trauma related injuries. The service had two bays for patients. The service had developed an operating procedure with the local NHS ambulance service for the types of patient who could arrive by ambulance which reflected the services at the hospital.
For patients who arrived by ambulance, there was rapid assessment and triage by a registered nurse. These patients were triaged in one of two rapid assessment and treatment rooms. The department did not take major trauma, myocardial infarction (heart attack) or stroke patients. If patients with these conditions self presented they would be seen and then transferred to Royal Preston Hospital. All nursing staff undertaking triage were required to undertake triage training and be signed off as competent.

Risk assessments for pressure ulcer and falls assessments were carried out. High specification mattresses had been provided for all trolleys in the department to reduce the likelihood of pressure ulcers developing. Patients at risk of falls were identified by the use of purple socks. Patients living with dementia were identified by the use of the forget me knot symbol. The service also screened patients for frailty and referred them to the trust’s frailty team.

As there were no inpatient paediatric facilities on site children could not be admitted to the hospital. Children referred to the trust by ambulance were transported directly to Preston and not to the Chorley site. Therefore, any children self-presenting to the department, who were critically ill and required admission, would need to be transferred to Royal Preston Hospital to be admitted to the paediatric ward. The service had a transfer policy, developed with the local ambulance trust, that set out the actions staff should take for children who attended the department. Urgent paediatric transfers from Chorley were logged and monitored on the trust’s incident reporting system.

While the service only received self-presenting children, we had concerns, which we shared with the trust, that the emergency department was not appropriately staffed to assess and treat children self presenting. The service did not have any paediatric nurses working on the shift to triage or treat children awaiting transfer or discharged following treatment.

Although the department had a designated paediatric resuscitation bay with appropriate equipment for children, it did not always have nursing or medical staff on every shift who were trained in advanced paediatric life support.

Compliance levels for life support training were measured against the trust’s target of 90%. Of the eligible nursing staff in each criterion, 82% of staff providing care to adults were compliant with basic life support training, 51% were compliant for intermediate life support, and 72% were compliant for advanced life support. For paediatric basic life support 56% of nursing staff were compliant. The trust did not give data for paediatric intermediate life support or paediatric advanced life support.

Compliance figures for medical staff were collated across both the Chorley and Preston sites and showed that 47% of medical staff were compliant with adult basic life support, while 37% were compliant with paediatric basic life support. The trust reported 100% of medical staff were compliant with paediatric intermediate life support and 46% were compliant with advanced paediatric life support.

Data subsequently provided by the trust for future scheduled shifts showed that, of 236 shifts between 1 May 2018 and 26 August 2018, the Chorley site had advanced paediatric life support trained staff cover on 98 shifts (42% of shifts), partial advanced paediatric life support cover on 40 shifts (17% of shifts) and no advanced paediatric life support cover on 98 shifts (42% of shifts).

Improvement trajectories had been set by the practice educator for compliance with the target for adult basic life support by August 2018, and by October 2018 for paediatric life support.

The service leaders told us that the service had two paediatric emergency medicine trained doctors in the emergency department (across both sites), with each allocated 0.25 clinical care
programmed activities (total of 0.5 programmed activities) per week. This was double the recommended amount of programmed activities. In addition, the service had a consultant lead for paediatric safeguarding who was also allocated 0.25 clinical care programmed activities per week.

The trust had a sepsis nurse specialist team, and the service had systems for recognising sepsis and for initiating early treatment. The team provided cover from 8am to 6pm, seven days a week. The critical care outreach team supported the service, via bleep, when the sepsis nurse specialist team were not on duty.

Sepsis six prompt cards were available for all nursing staff. Sepsis six is a three test and three treatment bundle that has been shown to improve outcomes in septic patients. Posters advertising sepsis awareness, and a sepsis ‘champion day’, were displayed in the department. A trust-wide audit showed 89.3% compliance with sepsis training by staff in admission areas in the trust.

Sepsis screening was undertaken and the sepsis pathway commenced at patient triage, although there did not appear to be any specific sepsis ‘yes/no’ prompt questions on the adult triage card.

The department used a national early warning score system in conjunction with its escalation plan to ensure that deteriorating patients were appropriately escalated to medical staff. This was also used in the ambulatory care unit. Staff used an age-appropriate early warning system for paediatric patients. However, although all staff were given training in the care of the critically ill child, the service at Chorley did not have any specialist paediatric nurses.

Patients presenting with mental illness would be transferred to Preston hospital. Work was due to commence to improve the accommodation so patients could be brought by police to the service as a place of safety.

Only consultants could sign-off patients for discharge from the department. A process was in place for receptionists to check that the relevant doctor had completed patients’ discharge summaries.

**Emergency Department Survey 2016**

The trust’s scored worse than” other trusts for three questions and “about the same” as other trusts for the remaining two questions of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>6.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
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<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>5.6</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
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<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
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<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened</td>
<td>9.6</td>
<td>About the same as other</td>
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<tr>
<td>by other patients or visitors?</td>
<td></td>
<td>trusts</td>
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(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Median time from arrival to initial assessment (emergency ambulance cases only)

From April 2017 to March 2018, the median time from arrival to initial assessment was worse than the overall England median in 11 of the 12 months. The trust is showing a decline in performance over the winter months.

Ambulance – Time to initial assessment from February 2017 and January 2018 at Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Chorley and South Ribble Hospital

From May 2017 to April 2018, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Chorley and South Ribble Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - Chorley and South Ribble Hospital

At the start of the reporting period in May 2017, the percentage of journeys with turnaround time of over 30 minutes was 44%. As can be seen in the graph below, this gradually increased over the reporting period, peaking to 55% in March 2018.
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Chorley and South Ribble Hospital

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A black breach occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From February 2017 to February 2018, the trust reported 4,431 black breaches, with an upward trend over the period. There was a low of 86 in February 2017, with a high of 626 in December 2017.

Black breaches at Lancashire Teaching Hospitals NHS Foundation Trust from February 2017 to February 2018.

There were no black breaches for Chorley emergency department.

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

Nurse staffing

The service had staffing vacancies but it was recruiting to a higher agreed staffing establishment to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The service had agreed and were recruiting to a staffing establishment that ensured it had enough staff with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, the service did not have sufficient paediatric registered nurses to meet national recommendations for a minimum of two paediatric staff during opening hours.

Following the 2016 Inspection the trust carried out a review of emergency department and urgent care nurse staffing. In October 2017 the management team submitted a review of their nursing
establishment to the trust board. They checked their staffing numbers against the Royal College of Nursing Emergency Care Association and Faculty of Emergency Nursing’s baseline emergency staffing tool had indicated a shortfall in the service’s staffing numbers when projected against patient acuity and demand. As a result, the trust had agreed and financed a recruitment programme to increase the establishment for qualified nurses and healthcare assistant staff.

During our inspection, the urgent and emergency services department had sufficient staff available to fulfil the requirements to have four registered nurses, and one health care assistant on the early shift, and four or five registered nurses on the late shift or the ‘middle’ shift (12pm-8pm). Staff told us they would report an incident if they did not have the numbers of staff needed on shift. Staffing gaps were, on occasions filled by staff from the medical assessment unit or the fracture clinic.

Nursing staff sometimes worked across the sites but the system of proper rotation was not in place although was planned to be brought in.

In line with national guidance, published in June 2018, a minimum of two trained children’s nurses should be available at all times. We reviewed the rotas and spoke with the management team who told us they were currently recruiting for children’s nurses or registered nurses with a paediatric course but did not currently have children’s nurses in the rota.

The department also employed emergency and advanced nurse practitioners. These are registered nurses who have extended skills enabling them to see and treat patients without them requiring to see a doctor. The rotas showed the planned number of staff had been achieved on the majority of occasions.

The management team had implemented improvements to the staffing rota and shift patterns as a result of direct feedback from nursing staff. This had arisen as a result of a sustained period of increased demand on the department where nursing staff regularly stayed past the end of their shift at 10pm to care for patients that were awaiting admission and were still in the department.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 25.1% in urgent and emergency care. This is worse than the trust’s target of 6%. The breakdown by site can be seen below:

- Royal Preston Hospital – 31.6%
- Chorley and South Ribble Hospital – 14.9%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Senior leaders acknowledged there had been a high historic level of vacancies in the department. However, following review of demand and patient acuity, the service had been authorised to recruit staff to meet a new establishment. We were told jobs were currently being advertised.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
**Sickness rates**

From February 2017 to January 2018, the trust reported an overall sickness rate of 4.3% for nursing staff in urgent and emergency care. This is similar to the trust target of 4.2%. A breakdown by site can be seen below:

- Royal Preston Hospital – 3.8%
- Chorley and South Ribble Hospital – 5.2%

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*

At Chorley the service regularly used a twilight shift and an agency staff member on nights in case there are delays in closing the unit because patients have not been discharged or admitted when it closes at 8pm. This enabled permanent staff to finish on time, which had not been happening. If it was an agency nurse, they can work until the unit is closed and then be offered to continue their shift on the medical assessment unit.

**Medical staffing**

The service had sufficient consultant staff in post to meet the requirement of consultant cover at Chorley from Monday to Friday 8am to 5pm. However, the service did not always have appropriate paediatric medical and anaesthetist cover in the event of a critically ill child presenting to the department.

The service’s clinical director was in the process of writing a proposal for the board to increase medical staffing establishment to 32 across both sites. This was to support the new developments in the department including the introduction and implementation of a rapid assessment and treatment service model and a move to 24 hours a day seven day a week consultant cover model.

The ambulatory care unit was medically staffed by a consultant supported by a middle-grade doctor during its opening hours between 10am and 6pm.

Although the service used locum staff, leaders told us all locums required a full induction and training on the service’s electronic patient record system before working in the department. The service also preferred, and aimed, to use locum staff that had worked in the department previously.

At Chorley the department had a consultant and junior doctor from 8am. In addition, there were two to three specialist registrars from 9am during rest of the day. At 10pm there is one registrar, a junior doctor and an emergency nurse practitioner.

The day to day consultant finishes at 5pm. The consultant rings over at 6pm from Preston to check they do not have any patients that may prevent them from closing on time.

**Overall staffing rates**
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From February 2017 to January 2018, the trust reported a vacancy rate of 13.5% in urgent and emergency care at Royal Preston Hospital. This is worse than the trust's vacancy target of 6%.

The trust did not provide vacancy data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 1.4% for medical staff in urgent and emergency care. This is better than the trust's sickness target of 4.2%.

The trust did not provide sickness data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As at January 2018, the proportion of consultant staff reported to be working in urgent and emergency care at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 47 whole time equivalent staff working in Urgent and Emergency Care at Lancashire Teaching Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle Career</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior</td>
<td>21%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. The service used both electronic and paper records. Patient records were paper based before being scanned onto an electronic patient information system.

Paper records included pre-printed ‘grab packs’ and the emergency department safety checklist. Grab packs were available for adults, children (separate packs for each age-range), and patients presenting with mental health problems. The packs enabled staff to record the patient’s details, presenting complaint and initial assessment, risk assessments carried out, the patient’s vital signs and observations including national early warning scores, and included space for multidisciplinary team notes, and care and treatment plans.

The safety checklist detailed actions to be undertaken by staff every hour that the patient remained in the department, and was designed to ensure vital actions were not missed.

We reviewed 12 sets of records. Records were dated and signed. The time of triage and when treatment was started was clearly recorded. Two of the records were illegible and did not include the doctor’s General Medical Council registration number in line with the professional standards set by the Royal College of Physicians. Two others did not include any known allergies. We raised these concerns at the time and were made aware they were acted upon. Otherwise records were
clear and recorded patients’ allergies, risk assessments and vital observations, pain score and reason for attendance. Where patients required additional support, or needed a mental capacity assessment because of a learning disability, autism, dementia or mental health, this was recorded. Discharge letters were sent electronically through the system to each patient’s GP within 24 hours of discharge.

The service’s electronic system included alerts for patients that had known safeguarding needs, were known to be at risk of female genital mutilation or child exploitation, or who had previously attended with or were known to have mental health symptoms.

**Medicines**

The service did not always manage records of controlled medicines in line with national guidance. We were unable to locate evidence of staff training or authorisation for the administration of medicines under patient group directions.

There was evidence that signatures, dates and daily checks of the controlled drugs were missed on a number of occasions.

The trust had an up to date medicines management policy which was available to staff on the intranet.

The pharmacist attended the service’s multidisciplinary and governance meetings. Following a pilot study which reduced the services medicines error rates by 60%, an application had been submitted to Health Education England for a pharmacist practitioner for the service.

A pharmacy medicines management assistant reviewed and ‘topped-up’ the departments stocks of medicines twice a week.

Medicines for the majors and minors areas were stored securely in locked cupboards in a key-coded air conditioned room. Ambient room temperatures were recorded by staff.

Medicines requiring storage at low temperatures were kept in fridges. Maximum and minimum temperatures were recorded. Staff were aware of the process to contact the pharmacy team for advice if the temperature exceeded the recommended range for a prolonged period. There was evidence of temperature monitoring however the wrong forms were being used to record this information for fridges so escalation information was not clear. There had been 10 fridge and 13 room temperatures missed in the last three months.

We checked a random sample of medicines in the majors and minors areas which were all found to be within the manufacturer’s recommended expiry dates, including injectables, tablets and ‘to take out’ medications, which were appropriately labelled.

We also reviewed a random sample of the department’s controlled drugs. The register entries were tidy and legible; however, there was a failure to document the date for entries in both department’s Controlled Drugs registers over several pages. It is a legal requirement subject to The Misuse of Drugs Regulations 2001 that indelible entries should be made on the day or within 24hr of the drug being administered.

We shared our concerns immediately with the nurse in charge. The nurse put an alert on the front of the Controlled Drugs register to remind staff of their responsibility to ensure details entered included the date. At the last inspection in September 2016 we told the trust they must take action concerning the records of controlled drug use in registers are kept in line with trust policy.
Nursing staff could administer some medicines by following a patient group direction. A patient group direction, signed by a doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription-only medicines to patients using their own assessment of patient need, without referring back to a doctor for an individual prescription. Patient group directions were used in the department for administration of paracetamol, ibuprofen and co-codamol.

We were shown an electronic copy of the patient group direction which was specifically for the emergency department and had an integral competency assessment. We were told that training had been completed but we were unable to see any evidence of patient group direction training and we were unable to locate evidence of named staff being authorised to use patient group direction. The patient group direction template did not have this as part of its current template and the patient group direction section of the medicines policy did not capture this detail either. We were told by senior management that a new patient group direction policy would be produced to enable this to be reviewed and rectified. The trust had responded to this and we had seen a draft version of this policy during the inspection.

The emergency department did not have FP10 prescriptions (prescriptions that are purchased and distributed free of charge) so patients would be redirected to the urgent care centre if they required a prescription. However, we saw two FP10s locked in the controlled drugs cupboard, which were not on trust stationery and were not recorded in a log book. We raised this with the nurse in charge at the time.

**Incidents**

When things went wrong managers appropriately investigated reported incidents to determine the contributory factors and to identify areas for individual and systemic improvement, and shared learning.

The unit manager and matron within the department reviewed and investigated incidents and complaints and learning from these was shared with staff through a range of ways including written and face-to-face communications. The matron, who had previously been a practice educator, worked in close collaboration with the current practice educator to deliver learning and training to new and existing staff.

The duty of candour is a responsibility that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. We saw evidence that duty of candour had been undertaken across both of the trust’s emergency departments on 29 occasions between March 2017 and February 2018.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

- Commissioning incident meeting SI criteria: 16 incidents.
- Diagnostic incident, including delay meeting SI criteria: four incidents.
- Sub-optimal care of the deteriorating patient meeting SI criteria: one incident.
- Apparent/actual/suspected self-inflicted harm meeting SI criteria: one incident.

(Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)

There were policies to support staff in the event of a major incident or business continuity issues. These included a business continuity plan and individual plans for pandemics, adverse weather, fuel shortages or information system failures. At the last inspection in September 2016 we told the trust they must take action to update the major incident plan to reflect the current use of the service. The major incident plan had been updated and redesigned following the Manchester bombing.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

The noticeboard in the department showed outdated information on falls prevention from 1 July 2017 to 30 September 2017; however, we were told one of the nurses had plans to update this data.
Is the service effective?

Evidence-based care and treatment

The care, treatment and support provided by the service was based on best practice guidance. The service’s policies and pathways reflected current national standards and guidelines.

Staff had access to evidence based care and treatment using national guidelines from the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine clinical standards for emergency departments.

Guidelines formed the basis of local policies and pathways for treating conditions such as paracetamol overdose (using guidance from the National Poisons Information Service).

Guidelines, policies and pathways were accessible via the trust intranet and covered clinical care and treatment, referral to other places of care and equipment use. Nurses told us that when new guidelines or clinical pathways were introduced, information was shared to ensure all staff were aware. We saw the monthly newsletter which was an opportunity for information sharing. In addition, staff meetings were held on a regular basis to share information.

At the last inspection in September 2016 we told the trust they must take action to ensure the version control for policies, procedures and guidance was robust and that these were kept up to date and reviewed regularly. We looked at the pathways for acute kidney injury, child influenza management, sepsis, chronic obstructive pulmonary disease, diabetes, alcoholic liver disease and pneumonia. The version control for these was present and current. We saw the system that had been introduced to monitor the emergency departments clinical guidelines. The Emergency Guidelines and Handbook were linked to a database and governance across both sites. Guidelines were updated in June 2018.

Staff could quickly access policies and procedures for the department, which were held on the trust’s intranet. Departmental guidelines were updated by the clinical lead consultant.

The department participated in the national Royal College of Emergency Medicine audits so it could benchmark its practice against other emergency departments.

The service also participated in the trust-wide programme of influenza screening and treatment for appropriate patients at the point of care in the department. This enabled early identification and assessment by the infection prevention and control team, which ensured that the department provided appropriate management of patients who tested positive for influenza. This work resulted in a reduction in patients’ lengths of stay despite a three-fold increase in the number of cases from the previous year.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. The service made adjustments for patients’ religious, cultural and other preferences.

Housekeepers had responsibility for ensuring patients were offered food and drinks where appropriate via a breakfast and dinner trolley or a sandwich option. One housekeeper covered an early shift and one a late shift. In addition, there was access to on site shops and the well-stocked vending machines were available for people to access while waiting to be seen.

Staff confirmed they could request special diets from the kitchen if needed.
Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was worse than other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse than other trusts.

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<thead>
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<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
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<tbody>
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<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>6.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>5.1</td>
<td>Worse than other trusts</td>
</tr>
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</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Staff gave patients pain relief when required, although not always consistently.

During our inspection two patients told us they had expressed they were in pain but did not receive pain relief in a timely way. We raised our concern regarding one patient whom the doctor then assessed and provided analgesia for.

The service had access to a variety of pain relieving medication. Staff assessed pain using a scoring system between zero (indicating no pain) and ten (indicating significant pain). A visual pain scale, using ‘smiley face’ pictures, was used within the department. This provided an easy way for children to express the level of pain they were experiencing.

Nurses could provide pain relief such as paracetamol, codeine or ibuprofen if necessary during initial assessment, using patient group directions. Patient group directions permit the supply of certain medicines to some patients under strict criteria by healthcare professionals, without individual prescriptions. Other pain relief could be requested from medical staff if required.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service participated in the Royal College of Emergency Medicine audits between 2016 and 2017 but achieved variable results. It failed to meet any of the standards for moderate and severe asthma and consultant sign-off.

The audits against the Royal College’s clinical standards enabled the department to benchmark itself nationally and more locally against the trust’s other emergency departments. Where the audits highlighted areas of concern, the department had taken action to address these. The service had not yet been re-audited by the Royal College, so we are unable to comment on whether or not the service’s performance has improved since the last audit.
In the 2016/17 Moderate and Acute Severe Asthma report, Royal Preston Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for one standard:

- **Standard 5:** If not already given before arrival to the ED, steroids should be given as soon as possible: 5a: Within one hour of arrival (acute severe) and 5b: Within four hours (moderate)

The hospital was in the lower UK quartile for no standards.

The hospital's results for the remaining four metrics were all between the upper and lower UK quartiles.

List of standards in this audit:

- **Standard 1a (fundamental):** O2 should be given on arrival to maintain sats 94-98%. Hospital: 17.3%; UK: 19%.

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 32.1%; UK: 26%.

- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 19.8%; UK: 25%.

- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 77.1%; UK: 77%.

- **Standard 5:** If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

- **Standard 5a (fundamental):** within 60 minutes of arrival (acute severe). Hospital: 50%; UK: 19%.

- **Standard 5b (fundamental):** within 4 hours (moderate). Hospital: 43.3%; UK: 28%.

- **Standard 9 (fundamental):** Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  Hospital: 57.5%; UK: 52%.

(Source: Royal College of Emergency Medicine)

The service’s action plan to improve in this measure included the introduction of an asthma proforma to the grab packs, to ensure staff awareness of the audit results, provide teaching to staff and multidisciplinary teams on the management of asthma, and to regularly include the topic of asthma in important reminders and in handovers of ‘lessons of the week’.
At the time of the inspection, all actions were complete except for the action to introduce the proforma was partially complete with a target of the end of September 2018.

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, Royal Preston Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for two standards:

- **Standard 4** (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 19.6%; UK: 10%.

- **Standard 3** (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 30%; UK: 12%.

The hospital was in the lower UK quartile for no standards.

The hospital’s results for the remaining two standards were all between the upper and lower UK quartiles.

*(Source: Royal College of Emergency Medicine)*

The service’s action plan to improve in this measure included continuing education of staff in the department, inclusion of the standards in shift handover, redevelopment of the clerking pro-forma to include categories that required senior review for adults and children, and the additional of the four standards on the discharge summary.

At the time of the inspection, the majority of actions had been completed. Those that were partially complete had target dates for the end of August 2018.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 severe sepsis and septic shock audit, Royal Preston Hospital was in the upper UK quartile for two standards:

- **Standard 3**: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 92%; UK: 30.4%.

- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 80%; UK: 18.4%.

The hospital was in the lower UK quartile for one standard:

- **Standard 2**: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 46%; UK: 64.6%.

The hospital’s results for the remaining five metrics were all between the upper and lower UK quartiles.

*(Source: Royal College of Emergency Medicine)*
The service’s action plan to improve in this measure again included continuing education of staff in the department, including junior doctors and the multidisciplinary team, including the topic in regular handovers and reminder, and the introduction of a sepsis screening and action tool.

At the time of the inspection, the majority of actions had been completed. The only outstanding action was the introduction of the screening tool which was partially complete with a target date of December 2018.

However, we saw evidence of appropriate review and escalation of patients using the national early warning score system, including the review of children with fever. Sepsis reminder stickers were printed on the children’s grab packs, and the service had developed good links with the acute oncology team to deliver training on neutropaenic sepsis.

**Unplanned re-attendance rate within 7 days**

From April 2017 to September 2017, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% throughout the entire reporting period. The trust performed better than the England average from October 2017 until the end of the reporting period.

**Unplanned re-attendance rate within 7 days - Lancashire Teaching Hospitals NHS Foundation Trust**

(Source: NHS Digital - A&E quality)

**Competent staff**

The service was not compliant against the trust’s target for completion of nursing appraisals or mandatory training. Managers could not assure themselves that nursing staff were competent for their roles.

However, staff we spoke with who had received and appraisal told us their appraisals were effective. This provided them with an opportunity for a conversation with their manager to identify their learning needs, support they required and areas for personal and professional development.

From February 2017 to January 2018, medical staff met the target with an appraisal completion rate of 91.1%, against the trust’s target of 90%. During the same period, 49.4% of nursing staff in urgent and emergency care at the trust had an appraisal. By May 2018 this had improved, with 72% of nursing staff having received an appraisal; however, this was still below the trust’s target.
The service had a full-time supernumerary practice-based educator to support the training needs for staff across both sites, and to oversee the training processes for new and existing nursing staff.

The department had an induction programme for new nursing staff. This was tailored by the practice educator to individual staff needs. Induction included two days face-to-face training, including simulation based exercises on adult and child cardiopulmonary assessment and resuscitation, with the practice educator followed by a supernumerary period.

A paediatric care study day was delivered twice a year to all qualified nurses. This was delivered in conjunction with the hospital’s paediatric team. Registered nurses undertook the ‘care of the sick child course’ delivered by a local university.

The practice educator undertook departmental induction for new bank or agency staff. The department used minimal numbers of agency staff.

Additional training was provided to staff, including awareness of the ionising radiation medical exposure regulations, and the provision of medicines under patient group direction authority.

Staff were encouraged to develop. An example included the trainee emergency nurse practitioners, one had developed a comprehensive training package. The emergency nurse practitioner had attended additional clinical skills training and a prescribing course to achieve their current status.

However, two staff members told us they felt there were limited opportunities to attend study days, and to complete life support courses. They felt the issues were due to a lack of funding and workload pressures.

The clinical director was the directorate’s training lead. Medical staff induction included a half-day training session with a consultant followed by a two-week supernumerary period. The department had developed bespoke pocket-sized induction booklets for medical staff. The “I’m in ED – Get me out of here!” and “The only way is ED” booklets provided a comprehensive range of information about the department, the team, practices, procedures, forms and pathway flowcharts, and the code of conduct. Middle-grade doctors were provided with training every two weeks.

Qualified nursing staff were only able to undertake triage duties following completion of a triage training course. This course was provided to staff once they had gained at least 18 months experience of working in the department.

The service was supporting the regional ambulance service in the development of advance paramedic practice; this included rotating relevant staff to work within the emergency department environment as well as on ambulances.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. The service supported people to live healthier lives.

Staff told us they had positive relationships with other wards and departments within Chorley and South Ribble Hospital.

The urgent and emergency care staff worked with ambulance staff to ensure that, where possible appropriate patients attended the service. Nurses told us that ambulance staff often rang in advance to be sure staff could accept patients based on their clinical condition.
Staff worked with the hospital alcohol liaison service and the proactive elderly care team (PECT) to ensure patients were referred for ongoing care if required. The proactive elderly care team included geriatricians, physiotherapists and occupational therapists who assessed mobility, aid requirements or onward support for elderly patients. The hospital alcohol liaison service included specialist nurses providing assessment, interventions and advice to patients, family, caregivers and staff about alcohol-use. Nurses told us both teams were responsive to the needs of patients.

The trust bereavement team supported patients and their relatives should they be required. They were contactable via the hospital bleep system.

Staff worked with mental health nurses and approved mental health professionals from a local NHS trust to provide care and support for mental health patients.

Nursing shift handover meetings were held at 2pm as the service would not have patients at the start of the shift. The handover was led by the shift co-ordinator with the presence of the consultant. This would detail staff allocations including the area they would work during that shift. At 5pm the consultant gave a handover to the middle grade doctor and the nurse in charge. At 6pm the doctor would call the consultant to share how the service was looking and shift reports would be completed at the end of the shift.

Seven-day services

The emergency department was open seven days a week, from 8am to 8pm.

The proactive elderly care team and hospital alcohol liaison service were available between 8:30am and 4:30pm, seven days a week.

The trust bereavement team worked seven days a week (including bank holidays) between 9am and 5pm, and chaplaincy services were available 24 hours a day, seven days a week.

Health promotion

Staff were aware of how to access health promotion information for patients and they identified and took opportunities to promote health to patients where appropriate.

Staff promoted smoking cessation to patients admitted who smoked. Alcohol consumption was an integral part of the adult assessment tool. With the agreement of patients, staff could refer patients to the trust’s alcohol liaison service or to the local mental health, drug and alcohol charity which supported patients with substance misuse problems.

Staff were encouraged to have a flu vaccination in order to help reduce the spread of flu.

In the waiting area a number of health promotion advice leaflets were readily available for patients to access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from March 2017 to February 2018, Mental Capacity Act (MCA) training
has been completed by 77% of nursing staff and 74% of medical staff. Both staff groups failed to meet the trust's mandatory training completion target of 90%.

(Source: Trust Provider Information Request P14/P49)

The trust had consent policies for adults and children. We observed staff taking consent appropriately. This included both verbal and implied consent (consent implied by way of actions). Staff understood their duties to ensure patients had capacity to consent. Staff told us that where a patient potentially lacked capacity, nursing staff escalated this to the medical team to carry out a formal assessment of the patient’s capacity.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. We observed kind and compassionate interactions between staff and patients and we heard staff introducing themselves to patients by name. Feedback from patients confirmed that staff treated them well and with kindness.

We observed kind and compassionate interactions between staff and patients and we heard staff introducing themselves to patients by name. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 3: “Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.” In addition, a named nurse was allocated to each bay and their names were displayed on a white board within the department.

We observed staff respecting privacy and dignity for patients who were transferred from ambulances trolleys. Patients’ privacy and dignity was maintained with cubicle curtains consistently drawn in clinical areas while patients were receiving care and treatment, or when friends and family were present. This was in line with National Institute for Health and Care Excellence Quality Standard QS15 Statement 1: “Patients are treated with dignity, kindness, compassion, courtesy, response, understanding, and honesty.”

We observed staff mostly responding to patients in a timely way. However, on two occasions because staff were busy or had not fully anticipated the patient’s needs, we saw patients waited longer for attention from the nursing or medical staff.

Staff had access to the specialist bereavement team who provided support for families and could ask them about organ donation. Practical information was provided in the form of a bereavement pack. A protocol was available on the intranet for staff if there was a sudden death in the department. A nurse would be assigned to support the family and carers whilst they were present.

We spoke with eight patients and visitors who all told us they were satisfied with the service they had received. During the inspection a patient who had received treatment a few days earlier returned to express her thanks to the staff. They told us, “I felt very supported and the staff made me feel less frightened”.

We saw staff caring for patients sensitively, taking account of their injuries and responding sympathetically. We observed staff being caring, respectful and reassuring to a patient who was visually impaired. Reception staff sourced details from patients in a polite and respectful manner.

We observed the reception staff leaving their desks to explain and communicate with patients face to face.
Friends and Family test performance

From April 2017 to March 2018, the trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average for 10 of the 12 months. The latest data available shows the trust’s performance at 76.2% compared to the England average of 84.3%.

However, Chorley performed better than the trust average with 93% of patients saying they would recommend the care and treatment provided by the urgent and emergency service at Chorley and South Ribble Hospital.

The department had introduced an electronic system for collecting friends and family feedback. This sent a text message to patients’ mobile telephones to enable them to respond. The system also enabled comments to be made. The nurse lead for the department reviewed all feedback received and highlighted positive feedback on an information board within the department. Negative feedback was reviewed, assessed and learning shared at staff meetings, the safety huddle and by email.

Following negative feedback, the nurse and doctor in charge were dressed in red so they were easily identifiable. In addition, an escalation procedure was in place to ensure patients and relatives who do wait in corridors are provided with care whilst waiting and an opportunity to eat, drink and sit down.

A&E Friends and Family Test performance - Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England Friends and Family Test)

 Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients and relatives told us that staff were approachable and friendly. They told us they could share their worries and concerns with the staff in the department.

The staff could provide a chaperone for anyone who required one in line with the trust’s chaperone policy.
We observed staff providing reassurance in a calm and sensitive manner to patients and relatives as necessary. Staff were aware of the impact on patients and carers as a result of the care and treatment provided. This was in line with National Institute for Health and Care Excellence Quality Statement QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety.

Staff had access to a mental health ‘Grab pack’ (pre-printed assessment cards) that included a risk assessment for patients who were experiencing mental health symptoms. Patients were treated within a designated side-room opposite the ambulatory care bay. Staff referred patients appropriately to the on-site mental health liaison service, who could support patients with psychiatric liaison and assessments. Patients admitted to the department with primarily mental health conditions were transferred to the Preston hospital site due to access to the right treatment and the fact the Chorley department was not open after 8 pm.

The chaplaincy service was available 24 hours a day seven days a week, via the bleep system. It could accommodate requests for support from all religious denominations. Senior staff told us the service was very responsive.

The emergency department could access the palliative care team as required. In line with the Royal College of Emergency Medicine guidance on emergency department care, the department provided a clinical area that was “quiet, private, sensitively designed and readily identifiable as such to approaching staff?”

**Understanding and involvement of patients and those close to them**

Patients and those close to them felt involved in decisions about their care and treatment.

We saw where this was clearly recorded in nine out of 12 patient records.

Care and treatment was provided in line with the National Institute for Health and Care Excellence QS15 statement 4: “Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care”.

We observed where staff spent time with patients and relatives to discuss their care and treatment.

One patient we spoke with told us the medical staff were involving their son in their decisions about their care and treatment because they had requested his involvement. We observed where staff spent time with the parent of a child who was distressed, providing support and involving them where they could.

This was reflected by the responses to CQC’s 2016 emergency department patient survey for the trust. Out of a maximum score of 10 (where a higher score is better), the trust-wide urgent and emergency service scored 8.4 for patients having sufficient time to discuss their condition with a doctor or nurse, and 8.8 for doctors or nurses listening to what patients had to say. Patients scored 7.7 for were you involved as much as you wanted to be in decisions about your care and treatment? Patients scored the department 8.1 for staff explaining the condition or treatment in a way they could understand, and 8.7 for explaining any tests needed. When benchmarked, the scores were about the same as other trusts.
The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. It scored worse for Q40: Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>----------------</td>
</tr>
<tr>
<td>side effects to watch out for?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care and treatment in a way that met the needs of local people. It worked with local commissioners and other healthcare providers to understand current and future demand. It had increased the provision of services since re-opening as an emergency department in January 2017.

The department provides emergency care between the hours of 8am and 8pm daily. The department is staffed until 10pm to allow time to move any patients to an appropriate place for treatment.

People attended the service primarily from the local population in the Chorley area, and staff were familiar with the needs of local people from a range of different backgrounds and cultures.

The service worked with the local clinical commissioning group, and the local mental health commissioning teams. The service’s business manager described the relationship with the commissioners as positive and supportive. The commissioners had agreed winter funding for additional ‘crisis hours’ to enable the mental health liaison team to maintain a presence within the department, and for falls care. Both the commissioners and the service recognised they need to forward plan for next winter.

Oversight of the service, and developments within it, was maintained through the accident and emergency delivery group which reported into the accident and emergency delivery board.

The service worked with the trust’s integrated discharge team, including discharge assessment nurses and discharge facilitators. This service aimed to get people home from the department rather than admitting them overnight, although the leaders recognised this could be challenging after 5pm.

The service monitored patients who reattended to look at whether there were additional plans they could put in place to minimise this.
Leaders in the service planned in advance in conjunction with the local clinical commissioning
groups for local events to ensure sufficient staff were available to manage demands on the
service. Events included a local Caribbean carnival, the world cup, religious festivals, and the local
university’s ‘fresher’s week’.

The separate waiting areas for adults and children had seating, toys, television and magazines.

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Patients who required additional support,
such as those living with dementia, at risk of falls, or who needed assistance with eating were
appropriately identified and care adjustments made accordingly. The service had access to a
learning disability specialist nurse.

A range of patient information leaflets were available within the department. These included a
number of leaflets designed for children, which were identified by pictures of animals. However,
the leaflets displayed were only available in English, as was signage throughout the department.
The practice educator told us that staff could access a limited printout of leaflets in Polish Urdu,
Punjabi and Gujarati; however, the service did not hold routinely hold stocks of leaflets in other
languages. The service was working with its translation providers, and local publishers on a plan
to increase the range of leaflets for other languages.

Staff understood the importance of not relying on patients’ families or carers to interpret important
information and conversations. Interpretation services were available by telephone, and
face-to-face when appropriate; this included British sign language.

Patients living with dementia were identified by the use of a blue wristband and the ‘Forget Me
Not’ flower.

The service had a dementia lead and dementia champions, and encouraged the use of hospital
passports including the John’s Campaign ‘This is me’ approach. The trust had also commissioned
work with a local university on the importance of identity and recognising people living with
dementia as individuals. However, although dementia awareness training was available on-line for
staff, this was not mandatory.

The service also focussed on making carers more visible to staff through the use of carers’
lanyards. Increased visibility meant that staff could involve carers more in the care and treatment
provided to their relative.

The service had access to the specialist skills of band five learning disability nurses, who worked
at Preston and had started on the internal rotation programme. If the patient was a known to the
service, the nurses would meet with the patient on arrival in the department. Stickers within
patients’ notes identified if they had learning disability needs. The service has an advocate on
behalf of patients with a learning disability who use the service, who attended a recent strategy
launch.

Staff undertook risk assessments of patients on admission, including any falls, pressure ulcer or
social history risks. Patients identified with a risk of falling were provided with purple socks to
make them more visible to staff and to enable additional support when required.

The department worked closely with the Lancashire integrated frailty team (LIFT team) to screen
appropriate patients attending the department. Screening was applied to any patient over 65 years
of age, or any patients attending from a nursing or residential care home or community hospital, or
any patients attending from their own home with two or more pre-defined conditions. Early
intervention by the frailty team was aimed at either avoiding the patients’ admission to hospital, or if admitted to ensure daily reviews, therapies and discharge planning were undertaken to minimise the patient’s length of stay.

The service used a book ‘What’s wrong with Jack’ to help young children understand why there were in hospital.

A system was currently in place to redirect patients with mental health needs presenting within the emergency department at Chorley with cooperation from the ambulance service and mental health services at Preston.

If patients with mental health needs were received they would be referred to trained staff who worked in the mental health liaison team, employed by a local mental health healthcare provider. They would undertake mental health assessments of patients in the department and could refer the patient for psychiatric assessment or for assessment under the Mental Health Act. Staff could access the mental health records and care plans for patients who were already known to the team. This enabled staff to identify the support and treatment patients were given by community mental health services to ensure patients received appropriate and continuous treatment, and to provide advice to the medical and nursing team in the department in order to keep the patient safe.

Emergency Department Survey 2016

The trust scored “about the same” as other trusts for the three questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Access and flow

The service’s performance against national targets was mixed. The service performed positively against initial triage and treatment waiting time targets for patients arriving by ambulance, but did not meet national standards for self-presenting patients. Performance against the national four-hour target to admit, transfer or discharge patients was improving and just short of the target. Leaders in the service could describe factors that impacted on performance.

Royal College of Emergency Medicine guidance indicates that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. Average waiting times for self-presenting patients to be seen were displayed in the waiting areas. Times varied depending on demand during the day.

Between June 2017 and May 2018, for all patients, not arriving by ambulance, the average time to initial triage was 37 minutes, and for children specifically the average wait time was 36 minutes. In the same period the average from arrival to initial triage assessment for patients arriving by ambulance was 9 minutes.
During the inspection, we observed the flow of patients and reviewed current information on waiting times. We reviewed waiting times recorded in eleven sets of records. The average waiting time from arrival in the department to initial triage was greater than 15 minutes for six out of 11 patients.

Median waiting times for patient at Chorley from arrival to initial treatment were consistently better the national target of 60 minutes with the service only not achieving this target in March 2018, by two minutes. The average time from arrival to initial treatment between June 2017 and May 2018 was 49 minutes.

Performance against the national target of 95% of patients admitted, transferred or discharged within four hours of arrival showed a downward trajectory. The data we received on this measure was trust-wide and incorporated both the Preston and Chorley sites. Between June 2017 and May 2018, the service did not meet this target with an average of 74% of patients admitted, transferred or discharged within four hours. Performance for children improved but again did not meet the target with 91% of children being admitted within four hours of arrival.

However, between March 2018 to May 2018, the data we received was disaggregated by site and showed that for Chorley an average of 94% of patients were admitted within four hours of arrival. This data was not disaggregated between adults and children.

The percentage of patients waiting for a bed for more than four hours after a decision had been taken to admit them showed an increasing trajectory that was significantly worse than the England average. The trust-wide service had fluctuating performance in the number of patients waiting for more than 12 hours for a bed following the decision to admit. The trust had systems in place to monitor all 12-hour breaches. These were incident reported internally, reported externally to the clinical commissioning group, and discussed with NHS England. None of the 12-hour breaches were at Chorley.

In general, the service performed better than the England average, and against the trust target of 5%, for the percentage of patients leaving the department without being assessed by a clinician. Between June 2017 and May 2018, an average of 1.3% of patients left the department at Chorley and South Ribble Hospital without being seen.

The service was in the process of recruiting to the additional nursing staff vacancies that had been agreed by the trust following the staffing review. The department liaised with the allied health professions to improve flow out of the department.

Chorley department had the service of a medical ambulatory care unit over the last twelve months. Although the unit was not accepting direct GP referrals at the time of our visit, it was taking appropriate patients from the service’s waiting area. These included patients presenting with anaemia, atrial fibrillation, hypotension, diabetes, acute kidney injury, asthma, and patients discharged from the emergency department but who needed blood tests.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for 10 months over the 12-month period from April 2017 to January 2018.

Performance against this standard showed a trend of decline. The trust met the target in April 17 with a median time to treatment of 59 minutes but in March 2018 this was 89 minutes.
Ambulance – Time to treatment from February 2017 to January 2018 at Lancashire Teaching Hospitals NHS Foundation Trust

(Source: Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

The trust did not meet the standard throughout the duration of the reporting period.

The trust breached the standard 12 times from February 2017 to January 2018.

From April 2017 to March 2018, performance against this metric showed a trend of decline. In June 2017 the trust was performing better than the England average but this has deteriorated since from 92% to 73% in March 2018.

Four-hour target performance - Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England - A&E waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average for all month except May, June and July 2017.
From July 2017 onwards, the trust has seen a steep increase in the number of patients waiting more than four hours from the decision to admit until being admitted. There was a drop in November 2017 where performance was similar to the England average, before adopting an upward trend again for the remainder of the reporting period.

Patient flow out of the department at Chorley was less of an issue as there were fewer sick patients as most were sent direct by ambulance to Preston. The trust had employed an emergency nurse practitioner to work overnight to assist with the flow of patients.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Lancashire Teaching Hospitals NHS Foundation Trust

![Graph showing percentage of patients waiting more than four hours from the decision to admit until being admitted.]


Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from February 2017 to January 2018, 20 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in January 2018 with a total of 10 patients waiting.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>276</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>147</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>127</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>234</td>
<td>0</td>
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<tr>
<td>Aug-17</td>
<td>426</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>527</td>
<td>2</td>
</tr>
<tr>
<td>Oct-17</td>
<td>555</td>
<td>0</td>
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<tr>
<td>Nov-17</td>
<td>342</td>
<td>0</td>
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<tr>
<td>Dec-17</td>
<td>662</td>
<td>1</td>
</tr>
<tr>
<td>Jan-18</td>
<td>822</td>
<td>10</td>
</tr>
<tr>
<td>Feb-18</td>
<td>739</td>
<td>0</td>
</tr>
</tbody>
</table>
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2017 to March 2018, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

Percentage of patient that left the trust without being seen - Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England - A&E waiting times)

Median total time in A&E per patient (all patients)

From April 2017 to March 2018, the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric showed a slight improvement in January 2018, however the trust median time was 192 minutes compared to an England average of 153 minutes.

(Source: NHS Digital - A&E quality indicators)
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and used them to improve the quality of care. Lessons learned were shared with all staff. Staff sought feedback from people who used the service.

The trust had a complaints policy which was accessible to staff via the intranet as required.

Between April 2017 and January 2018, the trust received 19 complaints about care and treatment provided by Chorley and South Ribble Hospital urgent and emergency service and relating to the hospitals ambulatory and emergency medical care unit.

Complaints were co-ordinated by the trust’s customer care co-ordinators and sent to the department for investigation. The service’s matron and clinical director had oversight of all complaints received by the department. These leaders could describe the main themes of complaints received to us, which mainly reflected care and treatment issues and poor communication with patients and their carers.

Complaints were subsequently forwarded to the relevant nursing or consultant shift co-ordinator to investigate with the individuals involved.

Informal concerns, arising at the time of the patient’s attendance, were addressed by staff at the time and documented in the patient’s notes. We do not have details of the number of informal concerns received by the service. Staff reported there was a theme regarding patients having to repeat information when they are diverted from urgent care to the emergency department.

Feedback was provided individually to any staff member involved in the complaint in a supportive manner with any relevant training needs identified. Learning from complaints was shared more widely with the team at team meetings, in five-minute briefing sessions, and in the service’s ED Times newsletter (where consent had been provided by the complainant).
We reviewed six complaints about the urgent and emergency service at Chorley and South Ribble Hospital, received in the period between April 2017 and January 2018. All the responses included an explanation of the events that had occurred, provided apologies, and included action plans for improvement where appropriate.

Although action plans were developed, these were not always robust and included no detailed mechanism for the service to assure itself that staff had learnt from the events. For example, plans identified actions for staff to ‘reflect’ on the events or shared learning through the ED Times newsletter, but did not have any mechanism for subsequently checking staff knowledge or competency.

The service collated and shared information on compliments from patients, carers and families. Between May 2017 and June 2018, the service at Chorley and South Ribble Hospital received 21 compliments. One patient wrote, “I am writing to express my thanks to the A&E department. My husband was treated with respect and dignity. I would like to thank the doctors, nurses and the porter for their professionalism and understanding”. Another patient wrote, “Thank you all for your sympathetic, practical and professional help when I was admitted. It is a superb hospital, clean, light and more importantly the staff working there were lovely and brilliant”.

### Is the service well-led?

#### Leadership

The service had managers with the right skills and abilities to run a service providing sustainable care. The service was clinically led by the clinical director, matron and business manager, supported by a unit manager for the site.

The emergency services at Chorley and South Ribble Hospital were provided by the emergency and urgent care directorate within the medicine division. The service was clinically led by the clinical director, matron and business manager. The matron covered both sites. It was supported by a clear governance structure and clear lines of accountability for staff at all levels.

The unit manager for Chorley had been in post for this service since November 2017.

Prior to the inspection, staff had written to the chief executive and director of nursing regarding the late closures at Chorley emergency department. A number of staff had reported to senior managers concerns regarding their late finishes and the impact of this had led to low staff morale within the team. Since then the senior management team had introduced a number of initiatives to ensure the reliable closure of the department to admissions at 8pm which had greatly improved this.

Staff told us they felt more supported currently by their line managers and that communication was improving. Staff described the senior staff as approachable. We saw evidence of staff having a positive relationship with the nursing leads with clinical experience and they had good developing relationships with the management team.

Staff at all levels in the emergency department in Chorley spoke favourably about the local leadership team. They told us all managers very approachable and supportive.

The Preston matrons were working with Chorley to drive the flow and movement of staff between both sites which they told us was working well. Four band sevens were now employed in a rotational position which was having a positive impact on the service.
The departmental and divisional leaders we spoke with understood the challenges facing the service, which included staffing levels and the risk to children using the service. The leaders were also able to clearly describe the actions that had already been taken, or were planned to be taken, to meet these challenges. The leaders for the department were motivated to improve the service provided by the department and worked closely with the trust’s director of continuous improvement.

Leaders told us that a recruitment, appointment and induction process for new staff was ongoing at the time of the inspection, which would bring the department up to full establishment and was expected to help improve performance.

Staff on the unit that we spoke with were aware of who the department and divisional leaders were. Staff spoke positively about their local leaders, who they considered were visible on the unit, approachable and very supportive. Staff told us the chief executive visited the department and was supportive. Although there was a scheduled weekly meeting with consultants and executives, we received mixed views from staff when describing the visibility and supportiveness of senior hospital or executive staff on the unit.

We observed senior leaders within the unit working with the teams in an approachable manner. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standard 14.

Vision and strategy

The service had a vision and strategy for what it wanted to achieve and workable plans to turn it into action which were developed with involvement from key staff, commissioners and other stakeholders.

The strategy for the unit was developed following a service review, which identified six key priorities for 2018-19. These included the improvement of performance against the four-hour target; focus on actions arising from previous CQC reports; planned reduction in agency and locum spending; development of a robust resilient workforce strategy; maximisation of improvement opportunities; continuous improvement in standardisation of process; and, evolution of the department into a best practice clinical business unit. The strategy was underpinned by the divisional business plan, and physical development plans for the department.

Leaders and senior staff within the urgent and emergency service had a clear understanding of the challenges faced by the service, including those where performance was impacted by factors external to the department. They could describe the department’s strategy for improving performance which focused on delivering appropriate staffing levels.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values, and was focussed on providing the best care and treatment for patients.

Staff told us they were feeling more positive from a service who ‘lost’ their team when the emergency department closed in April 2016 and were now rebuilding this. The re-opening of the emergency department in January 2017 and the introduction of internal rotation of the team had led to the staff coming together with their common goal.
Staff were not aware of the option to raise concerns with the freedom to speak up guardian, however, they were aware of the principles of the duty of candour and knew when this would apply.

Managers across the service promoted a positive culture that supported and valued staff, one manager told us, “I am proud of the Chorley staff team, they are working well together and relationships are improving between the two hospitals”.

Nursing and medical staff told us they were motivated, proud and felt supported by their managers to provide good quality care, even though this was sometimes challenging due to demands on the service. One nurse we spoke with told us staff “worked well together and the goal is to have one team” and now there were improvements in the time of the closure of the unit, it had improved staff morale. Another nurse told us they felt that rotation between both sites was a positive experience. A student nurse told us they were finding Chorley a great learning environment with very supportive staff. A junior doctor told us they had received excellent teaching and training opportunities and felt well supported by the medical staff and nursing staff.

The culture encouraged openness and honesty at all levels in the department. Staff were supported to report incidents and feedback to individuals was provided in a positive way. We saw no evidence of a ‘blame culture’ in the department. This was in line with the Royal College of Emergency Medicine’s Emergency Department Care (2017) Quality Standards including QS12, QS18, QS21, and QS50.

Staff told us it was a close and cohesive team who respected and supported each other practically and emotionally. One staff reported, ‘we can even access hugs when we need them’.

Staff had access to a trust psychologist in the last 12 months. Staff could attend ‘debrief’ sessions, even if it has been a challenging shift. Senior staff could also refer staff to these sessions if they were concerned about their welfare.

**Governance**

The service had a governance structure which escalated information to the directorate and then to the trust board.

Staff were clear about their roles within the structure, what they were accountable for, and to whom. There was a clear escalation and governance committee structure in place with clear lines of accountability for staff at all levels that ensured a line of sight from the service to the board. The service had a consultant governance lead.

The service’s consultant governance lead chaired the monthly governance meetings which was attended by the service manager, the matron, two consultants, the practice educator and representatives from reception staff. The governance meeting discussed the service’s high risks every month and cross-linked these with incident reports. Low risks for the service were discussed every quarter. The departmental governance meeting fed into the divisional risk governance meetings which provided a direct route through to the executive board.

The service also undertook a monthly case review meeting. This focused on individual patient cases, highlighting good practice as well as issues arising from incidents and complaints. The meeting also included mortality and morbidity review of deaths in the department. The meeting was open to a wide range of multidisciplinary team staff, including senior and middle-grade medics, nursing staff and other disciplines. Feedback and direct actions from reviews was shared
with individual staff were appropriate, and learning from both meetings was shared with wider staff through emails, alerts, and the department newsletter; the ED Times.

The service was involved in a number of other joint governance meetings with the paediatric team, the mental health partnership, and the urgent care centre.

A monthly department emergency department sister’s meeting was held and minuted. We reviewed the minutes of the last three meetings. The agenda varied with each meeting, but we saw evidence that performance, safety risks and learning from incidents and complaints were discussed and shared at the meeting. A separate departmental staff meeting was also held each month which reflected the agenda and discussions arising from the emergency department sister’s meetings.

### Management of risk, issues and performance

The service had systems for identifying risks, planning to eliminate or reduce them but had not identified all of the risks we identified on the inspection. The risks associated around children using the department did not reflect the concerns we identified.

Service leaders could describe, understood and had oversight of the risks and issues affecting the service. The service had a risk register which identified 25 open risks service-wide across both the Preston and Chorley sites. This included specific risks at Chorley, such as critically ill children presenting to the Chorley department which had limited paediatric facilities.

While there was a risk recorded about critically ill children presenting to the Chorley department it did not reflect concerns about the lack of paediatric staffing or staffing not being trained in appropriate life support training. As a result, there was no evidence of actions taken to mitigate the risks and or oversight by the risk management committee.

The other high risks included those we would expect to see, including delays in triage at the front end and exit block at the back end, and medical staffing. Significant risks reflected a range of issues, including the co-location of the urgent care centre, delays in the mental health pathway and the use of the mental health assessment room, the children’s emergency care pathway, and the risk of misdiagnosis or late diagnosis. Moderate risks included blood transfusion errors, band seven staffing cover, and breaches of confidentiality.

Each open risk identified controls and assurance measures, review dates, actions and action progress fields. The copy of the register provided to us did not include details of the risk owners and inconsistently noted the names of action takers, although the trust subsequently told us this information is held within their local risk recording systems.

Risk and clinical performance was monitored through the departmental governance meetings, the divisional safety and quality committee meetings which met monthly. These fed into the trust’s multidivisional risk management committee which was chaired by the chief executive or deputy chief executive.

Quality and risk management was underpinned by an audit programme within the service. In 2018-19 the program was ongoing and aimed to deliver audits in a range of areas including, although not limited to, sepsis and antibiotic guidelines, radiation awareness, review of patients who had suffered heart attacks, cardiac chest pain, head injury and concussion, and Royal College of Emergency Medicine audit themes for procedural sedation, consultant sign off, venous thromboembolism, feverish child, and vital signs in adults.
Audit meetings were held every three months and were open to all staff. Learning and urgent actions from audits were fed back to staff during handover meetings and through the ED Times newsletter.

A representative from the service attended the trust wide bi-monthly clinical audit and effectiveness group meeting.

The service had a robust training and support mechanism in place for the recognition and management of sepsis. Staff carried Sepsis Six pocket cards and could request review by the trust’s specialist sepsis nurses. This was in line with the National Institute for Health and Care Excellence Guideline NG51 Sepsis: recognition, diagnosis and early management. The Sepsis Six aimed to implement three diagnostic and three therapeutic actions within one hour of a diagnosis of potential sepsis. These included monitoring of oxygen levels, fluids and urine output, measurement of lactate levels and the commencement of blood culture tests and antibiotics.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan and staff were aware of where the plan could be accessed.

**Information management**

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems.

Performance information was collected and analysed by the department and was used to develop and support the services the department offered. This included the collection of data to support national audits and surveys including those by the Royal College of Emergency Medicine, the safety thermometer, the NHS friends and family test, and interactions with the ambulance service.

Performance data was benchmarked against urgent and emergency services in the trust’s other care organisations, against the trust performance, and where appropriate against national standards.

The service had implemented an electronic dashboard system within the department which provided a detailed overview of all patients in the department. This included a range of metrics including the patient’s time of arrival, how long they were in the department, and the time of any decision made to admit the patient to the hospital for further treatment or monitoring. This also enabled performance tracking with the real-time data available to the executive team.

Staff had access to the relevant information needed to care for their patients. The mixed use of paper and electronic records meant the service was reliant on staff remembering to check all the relevant information held, including system flags and notifications, safeguarding information, and existing care plans if patients were known to have one (including frail and vulnerable patients or those presenting with mental health needs).

Patients’ communication needs were noted on the electronic system, and through stickers in the hard-copy paperwork. Hospital passports were also used when needed. This was in line with the accessible information standard; however, there was limited ability for the service to provide information in easy to read or pictorial formats.

**Engagement**

The service engaged well with patients, staff the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
The department participated in the NHS Friends and Family Test scheme. This was primarily driven by text messaging service; reception staff took people's consent when booking a patient in order to meet the requirements of the General Data Protection Regulations. The service's leaders acknowledged that the department served a large elderly population, who did not always use mobile phones. As such, hard-copy feedback cards were also available in the department's reception areas.

The service worked with the education centre to enable work experience for local adolescents. The service held joint meetings with the urgent care centre to review services, to understand how they could work better together, and to develop service improvements.

The clinical director introduced a monthly staff newsletter, the ED Times. This was designed to reflect a range of items of interest to the department including news history, performance, learning, practical information and light-hearted articles.

The matron and clinical director ran drop-in sessions for staff to discuss areas of concern, improvement, or good practice that could be shared.

The services' leaders told us the trust was very responsive in agreeing to additional equipment. The drop-in sessions were also open to ambulance service staff, and as a result an 'ambulance triage lanyard' was introduced so that ambulance staff could more easily identify the ambulance triage nurse.

The service had introduced an encrypted social media group messaging system for staff. This was used to provide staff with updates on training, staffing shortages and shifts available, safety alerts and other relevant changes.

Patient and staff stories had been introduced at divisional, corporate and board level throughout the organisation. A matrons' forum has been created to facilitate discussion about how patient experience can be improved. Patient experience as a subject matter was included in the standard governance meeting agenda and was built into the STAR quality assurance framework.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation and improving patient outcomes.

There was a culture of supportive learning, improvement and development in the department, which was supported by the trust's director of continuous improvement. The practice educator, matron and consultants were pivotal in the development and training of new nursing and medical staff. Shift leaders were involved in reviewing and investigating incidents and complaints.

Staff told us the introduction of the internal rotation of staff made the links with Preston more accessible for learning and development.

Staff were encouraged to take advantage of free educational information via an external website designed by emergency department professionals.

The service participated in the trust's safety triangulation accreditation review (STAR) quality assurance framework. The system measured the quality of care delivered in each department or ward against a set of trust standards that had been developed by staff and triangulated a number of key performance measures to identify and put in place additional support for areas that need it and to recognise and reward areas of good performance.
The emergency department provided an award scheme so staff could nominate teams or staff members for an award in recognition of an achievement, innovation or outstanding care.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment for 15 specialities. There are 482 medical inpatient beds located across 25 wards.

A site breakdown can be found below:

- Royal Preston Hospital - 339 beds across 16 wards
- Chorley and South Ribble - 143 beds across nine wards

(Source: Routine Provider Information Request - Acute-Sites)

The trust had 44,536 medical admissions from November 2016 to October 2017. Emergency admissions accounted for 20,691, 1,346 were elective, and the remaining 22,499 were day case. Admissions for the top three medical specialties were:

- Gastroenterology 10,755
- Respiratory Medicine 7,909
- Geriatric Medicine 4,441

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff, but did not always make sure everyone completed it. Levels of safeguarding training were well below the trust target for nursing and medical staff.

The trust set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in medical care.

Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>20</td>
<td>23</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>361</td>
<td>419</td>
<td>86.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>345</td>
<td>419</td>
<td>82.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>298</td>
<td>415</td>
<td>71.8%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Nursing staff in medical care did not meet the mandatory training completion target for any of the seven training courses made available to them. They failed training courses classified as ‘other’ with a rate of 82.3%; however, the trust has not provided details of what these courses are.

Staff received effective mandatory training in safety systems, processes and practices. During inspection we observed throughout the service, staff compliance with mandatory training was high.

The trust provided updated information at the time of inspection which showed compliance of 92% overall in mandatory training at Chorley and South Ribble Hospital. We saw local records held by managers at ward level which confirmed in many wards this compliance was frequently above 92% and ranged up to 100% compliance.

Mandatory training rates were sufficient to ensure that there were appropriately trained staff across each shift to deliver safe and effective care and treatment.

Managers reviewed staff completion of mandatory training at annual appraisals and staff received email reminders to prompt them when their mandatory training was due.

Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>92</td>
<td>100</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>76</td>
<td>94</td>
<td>80.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>95</td>
<td>200</td>
<td>47.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in medical care at the trust met the target for four of the six training courses made available to them. As with the nursing staff group, they also failed to meet the target for courses classified as other with a rate of 47.5%. The trust did not provide us with information regarding the content of these courses.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Junior medical staff we spoke to told us that there was ample opportunity for training and development beyond mandatory training and that they received support from more senior medical staff in their roles.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff were aware of how to recognise abuse and they knew how to report this. Safeguarding leads were available to support staff when needed and staff were clear about trust safeguarding procedures.

The trust set a target of 90% for mandatory training completion.
From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff in medical care.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>347</td>
<td>417</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>334</td>
<td>417</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>140</td>
<td>176</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in medical care at the trust did not meet the target for any of the three safeguarding training courses made available to them.

During inspection the trust provided updated data for completed safeguarding training and this was 82% across the medical division. This data included both Royal Preston Hospital and Chorley and South Ribble Hospitals, for level two and level three safeguarding adults training. This continued to be below the trust target of 90%.

Staff were aware of safeguarding procedures at ward level and we saw examples of safeguarding concerns which had been followed up appropriately. Staff could access the trust safeguarding lead for support when this was required and safeguarding champions were available on the wards to share safeguarding information and best practice.

Whilst staff were aware of trust processes and how to make safeguarding referrals, we found that the systems at trust level for monitoring incidents in relation to safeguarding were not robust. The trust safeguarding team had implemented a dashboard which showed the numbers of Deprivation of Liberty Safeguard applications which had been submitted and the number of safeguarding alerts against the trust. They also used the online incident reporting system to track the number of incidents reported. This system was not used to identify areas within the service with higher or lower numbers of safeguarding incidents and it did not allow for any theme or trend analysis in relation to incidents. This meant that the trust was not able to identify hotspots within the service or areas for concern to put actions in place to mitigate these risks or concerns. As such, the trust safeguarding team was reliant on ward managers to monitor themes and trends and address these at a local level.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>58</td>
<td>98</td>
<td>59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>54</td>
<td>98</td>
<td>55%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff met the training completion target for one of the three safeguarding courses made available to them. It should be noted that the one course which met the target had only three members of staff eligible to partake.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust provided updated data at the time of inspection for completion of safeguarding training by medical staff. This data was trust wide, including both Chorley and Royal Preston hospitals and was unable to be broken down by hospital site. Training completed for safeguarding level two was 70%; Safeguarding level three training completion was 50%; safeguarding children training completion was 68%. Overall completion of Safeguarding training was 69%. This remained below the trust target of 90%.

Cleanliness, infection control and hygiene

The medical wards we visited was visibly clean and most areas were orderly, although we observed some areas appeared more cluttered.

The trust had an infection prevention and control policy and we observed staff following trust guidance for arms ‘bare below the elbows’ when providing treatment and care to patients. Handwashing facilities, hand gel and protective personal equipment, such as aprons and gloves, were available in all the wards we visited. We saw staff washing their hands and using hand gel in between patient contacts.

We saw patients being nursed in side rooms, in accordance with isolation procedures, to limit the risk of infection to others. We observed staff following additional precautions when providing care for these patients. Notices were displayed on the patients’ rooms to alert staff and visitors prior to entering the room and the door was kept closed in between any patient contacts.

During inspection the trust provided data for cases of infections in medical wards during the past 12 months. There had been six cases of meticillin sensitive Staphylococcus aureus (MSSA) and seven cases of Clostridium difficile at Chorley and South Ribble Hospital during this period. Two of the Clostridium difficile cases had occurred on the respiratory ward and staff described the actions implemented following this to improve performance in managing infection control. Measures included strengthened regimes for handwashing and ensuring staff compliance with trust uniform policy. We saw there had been comprehensive investigation of these cases, with action plans implemented and followed up.

The trust monitored handwashing compliance through regular audits. Information from audit reports showed lowest compliance of 64% for Brindle ward in April 2018, improving to 80% for May 2018. During March to May 2018, audit scores for medical wards showed improvements, with four out of six medical wards demonstrating 100% compliance in handwashing audits during May 2018. Action plans were identified to monitor continued improvements for areas with lower audit scores.

Environmental cleaning schedules were audited and reported to matrons monthly. Reports for March to May 2018 showed ward areas were compliant with environmental cleaning schedules overall, although actions were identified concerning the removal of mattresses from corridors on the wards Rookwood A and B.

Environment and equipment

The service did not always have suitable premises and equipment and looked after them well. The environment in areas was congested, resuscitation trolleys equipment past the manufacturer’s expiry date and hazardous cleaning materials were not always stored appropriately.
We found the environment was appropriate on the wards we visited and the equipment that was provided was mostly suitable for providing care to medical patients. Lifts were available to provide access to the building and treatment areas had suitable entry and exit controls. We saw that some ward areas were more limited in space and this was particularly evident on the medical assessment unit and coronary care unit.

However, when we checked resuscitation equipment on three ward trolleys, we found some items were out of date or missing. On the medical assessment unit, a carbon dioxide detector for an endotracheal tube was out of date on two resuscitation trolleys. On Brindle ward we found the endotracheal tube had ripped packaging, an incorrect ligature cutter and two incorrect sized syringes as detailed on the resuscitation equipment checklist. We saw records of daily checks of resuscitation trolleys were not always secured to resuscitation trolleys. On two of the trolleys we checked, there were loose forms on top of the resuscitation trolley. When we looked at these, we saw they were the latest records of completed daily checks. Whilst these records confirmed the checks had been done as required, there was a risk that the loose papers could have fallen off the trolley, leaving staff unsure if the equipment was safe to use. We raised these concerns to the ward sister who took immediate action.

On the medical assessment unit, we saw in the dirty utility area that the control of substances hazardous to health (CoSHH) cupboard door was ajar, with the keys left in the lock. This cupboard contained various cleaning products and hazardous solutions. The door to another cupboard next to this, containing hand gel stock, was also left open. The dirty utility door was open and this did not have a keypad lock. We raised this issue to the ward manager for attention. Other equipment in this room, including commodes, was labelled with “I am clean stickers”.

We observed throughout the service that waste was disposed of appropriately using separate bins for sharps, clinical and general waste.

During the inspection we checked a sample of equipment including electronic equipment and saw these had undergone electrical safety testing. Items were clean and labelled, with tags attached to confirm appliances had been serviced. The trust had an equipment maintenance database to monitor and ensure different equipment was serviced and maintained appropriately.

Specialist telemetry monitoring equipment was used on the cardiac care unit to monitor patients with heart conditions. The ward sister told us any breakdowns with this equipment were promptly responded to by the trust’s biomedical engineering department, with ongoing servicing arrangements provided by an external company. Any breakdowns were reported as an incident on the trust’s electronic reporting system.

There was a lack of storage space in some ward areas which made it difficult to store equipment safely. On Rookwood A we saw various items of equipment, such as blood pressure monitors, walking aids and syringe drivers packed into a storage room. This room did not have a door to it and the equipment was spilling out onto the corridor. We raised this to the ward sister for attention.

**Assessing and responding to patient risk**

The service had arrangements to recognise and respond appropriately to risks to patients.

The service monitored the condition of patients using a national early warning scores (NEWS) system. This system aims to identify deteriorating patients quickly.

The trust had a procedure for the recognising and responding to deteriorating patients, with guidance for escalating any patients with a national early warning score greater than zero. The procedure also included reference to patients who gave cause for concern without a raised national early warning score and those whose condition did not improve despite intervention. The procedure was based on best available evidence and current national guidelines.
We reviewed eight records in four patient areas and saw that patients’ national early warning scores were recorded and escalated appropriately in these records, following trust guidance. This ensured patients’ needs continued to be closely monitored.

The trust monitored the application of the national early warning scores system on medical wards through audit, with these results used to identify improvements. Data provided by the trust showed appropriate actions were identified, across different performance criteria, to improve performance in application of the national early warning scores system.

There was a sepsis pathway which was in accordance with UK Sepsis Trust guidelines and there were clearly marked sepsis six bundles in each of the wards we visited. Sepsis six is a three test and three treatment bundle that has been shown to improve outcomes in septic patients. The trust provided information around compliance with national targets in relation to the treatment of patients with sepsis. This showed that the trust had met their target against five of the eight measured indicators. Indicators around the screening and monitoring of patients and administration of antibiotics within three hours exceeded the target of 79.7% however; collection of samples for blood cultures within three hours, commencing second litre of intravenous fluids within four hours and senior review or assessment by critical care within four hours were below target.

There was a sepsis lead nurse at the trust whose responsibilities included reviewing education and training for staff and monitoring performance against sepsis targets. There were also sepsis champions throughout the service who disseminated information to other staff members around best practice in relation to sepsis.

Nursing staff completed risk assessments for patients on admission recording these on the trust’s electronic recording system. These documented patient risks for falls, nutrition, pressure ulcers and Venous Thromboembolism (VTE). We reviewed six of these records and saw risk assessments were completed appropriately. Nurse managers told us there had recently been issues with recording risk assessments for pressure ulcers during times of peak admissions over winter, but these had now been resolved. There were no risk assessments about patients’ mental health needs or behaviour. We also saw that restrictions or restrictive practice was not clearly detailed in patients’ care plans, due to a lack of awareness among staff of what may constitute a restraint. This included, for example, the use of sedative or covert medication.

Therapy staff had identified an early mobilisation flow chart for stroke patients. This was used to assess patients’ level of physical function, together with their clinical condition and stage of recovery, to identify the correct manual handling techniques for the individual. Nursing staff used this flowchart for guidance, when assisting patients to move following a stroke.

**Nurse staffing**

The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Numbers of qualified nursing staff were frequently below the required levels planned for shifts.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*
There were not always adequate numbers of suitably qualified staff in place to ensure that people were safe at all times.

The safer staffing tool was used by the service to determine appropriate staffing levels based on the acuity of patients and bed management meetings were held daily to deploy staff to areas of high demand. Where there were shortages in qualified nurse staffing this was often compensated for by increased levels of unqualified nursing staff such as healthcare assistants.

Data provided by the trust at the time of inspection showed that the shift fill rate for qualified nursing staff did not always meet the planned levels identified for wards. This was most apparent for Brindle ward (respiratory), where during January 2018 the fill rate was 71.9%. For the same period, the use of healthcare assistant staff to support ward cover was increased to be 97.8% of shifts filled.

We also observed the staffing for the medical assessment unit was met, with use of over 125% healthcare assistant staffing cover for January 2018. In the medical wards we visited, we saw healthcare assistant staff were often deployed to provide enhanced care for patients with more complex needs, by way of closer observation and one to one care. In times of shorter staffing however, it was not possible to maintain this level of enhanced care, which meant there was an increased risk that patients would not receive care to keep them safe during these times.

During our inspection, the wards we visited displayed information about their staffing levels and we saw these were being met appropriately at the time.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 20.3% in medical care. This is worse than the trust’s target of 6%. The breakdown by site can be seen below:

- Royal Preston Hospital – 22.3%
- Chorley and South Ribble Hospital – 12.4%

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From February 2017 to January 2018, the trust reported an overall sickness rate of 4.2% for nursing staff in urgent and medical care. This is the same as the trust target of 4.2%. A breakdown by site can be seen below:

- Royal Preston Hospital – 4.2%
- Chorley and South Ribble Hospital – 4.3%

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*
Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Medical staffing levels were sufficient to provide safe care and treatment for patients. Doctors reviewed patients in daily ward rounds and were available to see patients at other times during the day or night, whenever this was needed. Nursing staff also had access to medical staff when they needed particular advice about a patient and said doctors responded promptly. Junior ward doctors were appropriately supported by senior and consultant medical staff if further direction was required. We did not hear of any issues of concern, or delays in accessing timely medical advice for patients. Several junior doctors did however reflect on the difficulty in managing effective patient care during recent months, especially during the peak of winter pressures when patient admissions were at a high level. Doctors told us there was no harm to patients at the time arising from this demand.

Middle grade doctors reviewed patients at weekends, with access to a consultant on call who could be contacted for advice if necessary.

The service used long-term agency and locum medical staff to cover gaps in the medical rota and where there were specialist medical vacancies. The service had an action plan to recruit into these vacancies which included overseas recruitment.

Overall staffing rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From February 2017 to January 2018, the trust reported a vacancy rate of 21.9% in medical at Royal Preston Hospital. This is worse than the trust’s vacancy target of 6%.

The trust did not provide vacancy data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates

From February 2017 to January 2018, Royal Preston Hospital reported a sickness rate of 1.1% for medical staff in medical care. This is better than the trust’s sickness target of 4.2%.

The trust did not provide sickness data for medical staff at Chorley and South Ribble Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As at January 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the 207 whole time equivalent staff working in medicine at Lancashire Teaching Hospitals NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff did not always keep appropriate records of patients’ care and treatment. Staff did not always document discussions with families about patients’ care in patient records. Confidential patient records were stored at patients’ bedsides, where information could be easily accessed by the patient, their relatives or other visitors.

The service used both paper based and electronic systems to record patient’s treatment and care. We saw that in general notes were completed to a good standard, with entries legible,
dated and signed by the recording clinician.

Patient records were stored in locked trolleys by the nurses’ station in some wards. However, we saw that on the medical assessment unit, respiratory and cardiac wards that patients’ records were stored at their bedside. These record folders had two sections, one which detailed the patient’s name and general information. The second section was closed to protect the patient’s confidential medical notes; however, this section could be easily opened by medical staff when they needed to access these. We had concerns that equally, this section was available for the patient’s relatives and visitors to open if they chose to do so. Nursing staff told us they sometimes saw relatives and other visitors looking at patients’ confidential medical notes and when they saw this, would ask them to stop doing this. We were told that patients would be asked to confirm their consent for records to be stored at their bedside, however, we did not see completed consent forms for this in any of the notes we reviewed. We also saw patient names displayed on a box outside a side ward on Brindle ward. This did not ensure patients’ personal information was protected.

**Medicines**

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time. Systems were in place to provide safe management of medicines and staff followed these systems.

Medicines were available, stored appropriately and within the manufacturers’ expiry dates, where we checked these in medical wards. Controlled drugs were stored separately with stock checks correctly recorded. Registers for controlled drugs had been signed by two staff members when these medications had been dispensed. Nursing staff completed and recorded daily checks of controlled drugs and records of these checks were correct where we reviewed these.

Intravenous (IV) fluids were stored in locked treatment rooms. The medicines and IV fluids we checked were all within manufacturer’s expiry dates and documented correctly.

Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges. This ensured medicines were safe and effective to be administered to patients. We checked and saw records were complete and up to date for daily fridge temperature checks.

Pharmacy staff were available daily on wards to review medications and ensure that medicines stock levels were maintained. Pharmacists attended daily board rounds to identify any patients who were due for discharge. This assisted in preparing the required medicines for patients to take home and helped avoid any delays for patients waiting for these.

We reviewed five medicine prescription charts and with one exception found that medicines were administered as prescribed and that prescriptions were legible and signed for. Any allergies were clearly documented within the medicines prescription records. For one patient receiving IV antibiotics, the chart indicated the antibiotic should be reviewed after 48 - 72 hours; however, this check was not signed as completed. We saw in the corresponding medical notes an entry was made to confirm continued IV antibiotics.

**Incidents**

Staff recognised when an incident had occurred and reported these appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff could give examples of incidents they had raised and the learning that was shared from these.
Staff in medical services were aware of different types of incidents that could happen and reported these using the trust’s electronic incident reporting system. Staff completed details of incidents fully, together with any initial follow up actions.

Ward managers reviewed incidents and supported members of staff with individual feedback where any immediate learning had been identified. Staff also received feedback from incidents at daily safety huddles, team meetings and by email. Whilst there was a positive culture of incident reporting, we observed that staff did not always consider or identify staffing issues as a reportable incident.

Any unexpected deaths or potentially avoidable deaths that occurred in the medical division were reviewed and discussed at mortality meetings. This meant any patterns and trends could be reviewed and lessons to maintain safety could be identified. The trust had introduced a new mortality review process in January 2018 to review all adult inpatient deaths. The May 2018 mortality report identified there had been a total of 401 adult patient deaths in the medical division between January and March 2018. Of these cases, 150 had been reviewed. The report identified the impact of winter pressures on the time available for all cases to be reviewed.

Incidents resulting in moderate or severe harm to patients were reviewed at monthly governance meetings, attended by the director of nursing, matrons from medical wards and managers from the risk and governance teams. The trust followed a procedure based on root cause analysis principles to investigate serious incidents, which had resulted in harm to patients. We reviewed three investigation reports following serious incidents and saw these had been investigated fully, with appropriate follow-up actions identified and detailed in action plans. We saw evidence of shared learning and reflection following each of these incidents.

Most staff we spoke to were aware of the statutory duty of candour principles and could provide an example of when this would need to be applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Some staff were unfamiliar with this terminology, however could describe examples of how they explained any error to patients, which demonstrated their understanding of principles of openness and transparency. These examples mostly related to delays in medication being administered.

Staff on the respiratory ward described an incident of a patient had sustained a fracture after falling during admission. This had been investigated and the findings were presented at a complaints review meeting. From a review of incident reports, the respiratory governance team had identified trends of patients falling at particular times at night. Following this, the trust’s quality team had worked with ward staff to implement a “falls package”, resulting in a reduction in falls incidents in the ward.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From May 2017 to April 2018, the trust reported no incidents classified as never events for medical care.

*Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)*
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 11 (92% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (8% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff and visitors. The service used information to improve the service. Performance boards on wards displayed information about falls, infection rates and nurse staffing.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 42 new pressure ulcers, 17 falls with harm and 20 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Lancashire Teaching Hospitals NHS Foundation Trust
Total Falls (17)

Total CUTIs (20)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

The pressure ulcer prevalence rate fluctuated between 0.0 (August 2017) and 1.5 (June 2017) from April 2017 and April 2018.

The falls with harm prevalence rate has seen a general downward trend over the reporting period with a particular dip in August and September to a rate of 0.0.

With regard to catheter acquired urinary tract infections in medical care at the trust, the prevalence rate has fluctuated throughout the entire reporting period.

*Source: Safety thermometer - Safety Thermometer*

During the inspection we observed that safety thermometer information was prominently displayed on wards we visited. The information was updated regularly to keep patients and visitors informed about the ward performance. We saw evidence that the information was being used to identify areas for improvement and actions were implemented as appropriate. One ward had been identified with a higher incidence of pressure ulcers and the ward manager told us they had introduced additional measures to try and understand why this was occurring. A pressure ulcer “safety huddle” was introduced, which had helped to reduce the occurrence of pressure ulcers.

Nurses completed patient risk assessments for pressure ulcers and falls as part of the nursing assessment documentation. In records which identified patients who were at risk of developing pressure ulcers, we saw actions were appropriately followed up, such as provision of a pressure care relieving mattress.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance. Staff followed condition-specific care plans when providing care to patients.
Care and treatment was based on national guidelines including National Institute for Health and Care Excellence (NICE) guidelines, however these were not always up to date. At the time of inspection, 60% of NICE compliance statements were out of date.

The service had care pathways which staff followed for different conditions, including sepsis and acute kidney injury. Specialist services also had local care pathways, such as for chronic obstructive pulmonary disease, Crohn’s disease and ulcerative colitis. Patients with alcohol dependency were treated following an alcohol detoxification pathway.

The service had a frailty pathway which identified patients with higher or more complex care needs.

Guidelines, policies and standard operating procedures were discussed at monthly governance meetings. Policies we reviewed were mostly up-to-date and followed national guidelines. However, the trust’s Mental Capacity Act and Deprivation of Liberty Safeguards policy referenced out of date legislation. The legislation regarding death whilst subject to a DoLS has changed following case law and the policy guidance had not been updated to reflect this change.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Patients had a choice of food which they described as good.

Patients we spoke with said they had access to food and drink on request and described the food as good. There was a choice of meals available.

Dieticians were available to support patients with nutritional advice when this was needed. Speech and language therapists undertook swallowing assessments for stroke patients and care plans were provided for patients who required assisted feeding and percutaneous endoscopic gastroscopy (PEG) tube feeding. Records we reviewed showed patients were referred to and reviewed by a dietician and speech therapist when this was needed.

Patients on restricted diets were provided with appropriate food and drink for their needs. However, staff told us this was more limited in terms of choice, with more routine and repetitive menus.

Red plates were used at mealtimes on rehabilitation wards for patients living with dementia. This assisted patients to manage more independently when eating, by identifying the surface of the plate as different from the table. Mealtimes were protected on rehabilitation and elderly care wards. Staff on the coronary care unit told us there were protected meal times for patients, but it was difficult to sustain this alongside open visiting hours between 10am and 8pm.

Water cooler points were available for staff and visitors to use on medical wards.

**Pain relief**

Nursing staff assessed patients’ pain levels and recorded this as part of national early warning scores.

Pain relief, including paracetamol and ibuprofen, was available for patients if needed. Patients said nurses regularly checked they had any pain and responded promptly to requests for any pain relief.

Specialist advice was available from the trust’s pain team, for patients who presented with more complex pain and conditions.
Patient outcomes

Patients’ care and treatment outcomes were monitored and compared with similar services, with results used to assist development. The service had made improvements to the care of patients who experience a stroke and the results of the SSNAP audit had increased from a grade D to B as a result.

Trust level

From January 2017 to December 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology and medical oncology had a higher than expected risk of readmission for elective admissions
- Patients in respiratory medicine had a lower than expected risk of readmission for elective admissions

Elective Admissions – Trust Level

![Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in respiratory medicine, geriatric medicine and diabetic medicine had a lower than expected risk of readmission for non-elective admissions

Non-Elective Admissions – Trust Level

![Non-Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: HES - Readmissions (01/01/2017 - 31/12/2017))

Chorley and South Ribble Hospital

From January 2017 to December 2017, patients at Chorley and South Ribble Hospital had a similar to expected risk of readmission for elective admissions and a lower than expected risk of
readmission for non-elective admissions when compared to the England average.

- Patients in gastroenterology, respiratory medicine and clinical haematology had a lower than expected risk of readmission for elective admissions

**Elective Admissions - Chorley and South Ribble Hospital**

![Graph showing elective admissions for different specialties.](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in diabetic medicine and respiratory medicine had a lower than expected risk of readmission for non-elective admissions

**Non-Elective Admissions - Chorley and South Ribble Hospital**

![Graph showing non-elective admissions for different specialties.](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Sentinel Stroke National Audit Programme (SSNAP)**

Lancashire Teaching Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the both Chorley and South Ribble and Royal Preston hospital achieved grade D in latest audit, April 2017 to June 17. This has remained the same as the previous quarter.

**Chorley and South Ribble Hospital**

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>C</td>
<td>E</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Heart Failure Audit

#### In-hospital Care Scores

Results for Lancashire Teaching Hospitals NHS Foundation Trust in the 2015 Heart Failure Audit were better than the England and Wales average for two of the four of the standards relating to in-hospital care and worse for the remaining two.

#### 2015 Heart Failure Audit results for Lancashire Teaching Hospital, relating to in-hospital care

<table>
<thead>
<tr>
<th></th>
<th>Chorley and South Ribble Hospital</th>
<th>Royal Preston Hospital</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology inpatient (%)</strong></td>
<td>38.5%</td>
<td>45.7%</td>
<td>41.1%</td>
</tr>
<tr>
<td><strong>Input from consultant cardiologist (%)</strong></td>
<td>26.6%</td>
<td>56.9%</td>
<td>41.5%</td>
</tr>
<tr>
<td><strong>Input from specialist (%)</strong></td>
<td></td>
<td>99.8%</td>
<td>79.0%</td>
</tr>
<tr>
<td><strong>Received echo (%)</strong></td>
<td></td>
<td>99.6%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

#### Discharge Scores

Results for Lancashire Teaching Hospitals NHS Foundation Trust results were better than the England and Wales average for all of the seven standards relating to discharge.
2015 Heart Failure Audit results for Lancashire Teaching Hospital, relating to discharge scores

SOURCE: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.

Chorley and South Ribble Hospital

The 2016 National Diabetes Inpatient Audit identified 30 inpatients with diabetes at Chorley and Ribble Valley. Of these 30 patients, 80% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. This is similar to the England average.

Within the 16 metrics, Chorley and South Ribble Hospital was in the top quartile for two metrics and the bottom quartile for three metrics.

(Source: NHS Digital)
Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 37.1% of Chorley and South Ribble Hospital’s nSTEMI patients were admitted to a cardiac unit or ward, compared to an England average of 96.2%.

88.6% of Chorley and South Ribble Hospital’s nSTEMI patients were seen by a cardiologist or member of the team compared to an England average of 55.8%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl. after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorley and South Ribble</td>
<td>84</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>88.6%</td>
<td>37.1%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Royal Preston</td>
<td>85</td>
<td>33</td>
<td>34.3</td>
</tr>
<tr>
<td></td>
<td>89.5%</td>
<td>34.3%</td>
<td>36.1%</td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082 (38099)</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6% (No data)</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit. The proportion of patients seen by a Cancer Nurse Specialist was 84%, which was worse than the audit minimum standard of 90%, but better than the 2016 figure of 57%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 19.5%. This is about the same as the national level.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 65.2%. This is about the same as the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 77.2%. This is the same as the national average.

The one-year relative survival rate for the trust in 2017 is 38%. This is about the same as the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The trust did not have a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 19%. This did not meet the national aspirational standard of 100%.
The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 26%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 95%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The medicine division participated in the trust’s programme of clinical audit, with regular local and national audits being used to benchmark performance against other services. During 2016-2017 the division was involved in 23 mandatory audit programmes, with 74% of these completed with plans. During 2017-2018, the number of completed mandatory audits with plans was 33%. The trust monitored progress in audits at monthly divisional safety & quality meetings, attended by senior clinical staff from medical services. Any delays in action plans, or improvements in service performance, continued to be reviewed at these meetings.

The service had made improvements to the care of patients who experience a stroke and the results of the Sentinel Stroke National Audit Programme (SSAP) audit had increased from a grade D to B as a result.

Sepsis management was regularly audited within the service and measured against commissioning for quality and innovation (CQUIN) national goals. There had been a marked improvement in sepsis performance between quarter one and quarter four against inpatient sepsis screening and timeliness of antibiotics administration in diagnosis of red flag sepsis.

The trust had introduced an accreditation scheme to monitor performance and quality improvement across services. A monthly Safety Triangulation Accreditation Review (STAR) assessed performance at ward level. This included a review of audit results as well as a ward visit at a minimum of six months’ frequency. During ward visits, different measures were assessed, including, for example, documentation and environmental audits. Wards achieved a STAR rating according to these outcomes, which were scored according to a red, amber or green rating. We saw that during February to May 2018, scores in STAR accreditation ranged between 75% and 100% for seven medical wards.

Competent staff

The service made sure staff were competent for their roles. Managers appraised most staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Clinical educators provided ward support to staff for their nursing care practice.

Appraisal rates

From February 2017 to January 2018, 77% of staff within medicine at the trust had received an appraisal compared to a trust target of 90%.

Qualified nursing midwifery staff had a slightly lower rate of 75%, while medical staff achieved 89%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Data provided by the trust at the time of inspection showed staff appraisals continued to be below the trust target of 90% completed in two wards, with remaining medical wards achieving compliance of 90% and above.

Clinical educators provided ward support at ward level for training and development, with monthly updates to ward managers. Newly qualified staff held their own record book of competencies which they completed for different nursing care skills. These competencies included medicines management and administration of IV fluids. Support continued for junior nursing staff throughout the duration of their preceptorship.

A recently qualified nurse told us that they had completed a trust induction as well as an orientation to the ward when they first started in post. This had involved shadowing another member of nursing staff and an introduction to general systems of practice and communications on the ward.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. There was an established multi-disciplinary team approach to support patient needs.

Patients had access to support from a range of different clinical and non-clinical professionals for their treatment and care. This included medical and nursing staff; different allied health professions, such as physiotherapists, occupational therapists, speech and language therapists and dieticians; also, social workers and discharge co-ordinators.

We observed ongoing communications between different members of the multidisciplinary team throughout the inspection and saw there was a positive, comprehensive multidisciplinary approach. Ward rounds involved different members of the multidisciplinary team, depending on the specialism concerned. One example of this was patients on the gastroenterology ward with decompensated liver disease who could access the hospital’s alcohol liaison team for assessment and support. We saw from medical records that patients’ needs were discussed in multidisciplinary team meetings, with regular review of treatment and care plans by the different clinicians involved.

Discharge liaison nurses were available who worked closely with ward staff in planning for patients being discharged from wards. Social workers also participated in discharge planning for any patients where a social or community need was identified.

Mental health liaison practitioners liaised with ward staff and community teams to arrange for continued treatment and access to mental health services in the community. Ward staff told us mental health teams responded promptly to a request for patient advice and support.

The hospital alcohol liaison service worked with all wards and liaised with social services and alcohol services in the community to ensure rapid assessment and support for those patients who had an alcohol dependency.

We spoke with the trust lead for allied health professions who told us of work that had taken place to raise the profile of allied health professions across the service. There had been a recruitment drive to fill vacancies.
Seven-day services

The table below shows the Seven Day Services National Survey 2017 results for Lancashire Teaching Hospitals NHS Foundation Trust. These results could not be broken down by core service.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Seven Day Results</th>
<th>Weekday Results</th>
<th>Weekend Results</th>
<th>National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Consultant Review (within 14 hours of admission)</td>
<td>70%</td>
<td>75%</td>
<td>59%</td>
<td>90%</td>
</tr>
<tr>
<td>Access to Diagnostics</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>90%</td>
</tr>
<tr>
<td>Access to Consultant-Directed Interventions</td>
<td>94%</td>
<td>100%</td>
<td>89%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>On-going Review (Daily or twice daily)</td>
<td>86%</td>
<td>95%</td>
<td>69%</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Source: https://www.england.nhs.uk/publication/survey-results-for-individual-trust-performance-for-7-day-hospital-services/)

The national standard was met for two of the four indicators; access to diagnostics and access to consultant-directed interventions. Time to consultant review was the poorest performing indicator across the trust.

Out of hours 24-hour cover for the stroke service was provided as part of the regional stroke network service, with access to advice and direction for treatment provided via tele link.

Therapy services were not routinely available at weekends, although emergency on call physiotherapy services were provided for respiratory patients. The integrated therapy stroke service was not a seven-day service at the time of inspection, however, positive benefits for stroke patients had been identified in a pilot project of additional shift working by therapists. Arrangements for proposed weekend therapy services were continuing in directorate level discussion, as part of and continuing service improvements.

Discharge liaison nurses informed us there could be difficulties in discharging patients at weekends, particularly to nursing homes. The service was in discussion with different nursing and care homes to address some of the issues that had been identified regarding delayed discharges for patients.

The mental health liaison team facilitated communication with mental health teams based in the community.

Health promotion

Staff completed assessments of patients’ health needs in a holistic way, directing patients to advice and support for promoting healthier lifestyles.

Leaflets and information was available regarding balanced diets, alcohol consumption and smoking cessation. Condition-specific guidance was available, such as for diabetes and heart disease, which included details of related community support groups and national organisations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always understand their roles and responsibilities under the Mental Capacity Act 2005. Patients experiencing mental ill health did not always have risks identified in care plans. There was a generalised lack of awareness of the requirements of the MCA and staff did not follow trust processes for assessing capacity and documenting best interest decisions for patients.
Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training completion

From March 2017 to February 2018, 79.5% of nursing staff at the trust completed mental capacity act training, while 100% of medical staff completed the course.

(Source: Trust Routine Provider Information Request – Training tab)

We found staff had variable knowledge in relation to the implementation of the Mental Capacity Act 2005, for patients who may have lacked capacity to consent to their treatment and care. Whilst we did see staff on one ward had greater awareness of this area, and practice was more embedded, most nurses we spoke with were not confident about assessment processes and were unable to clearly state basic principles of the Act. Staff did not always follow the trust’s policy for assessing and documenting capacity assessment, in line with the Mental Capacity Act 2005. We also saw that ‘care’ had been delivered to patients who may have lacked capacity, without a best interest decision being discussed and documented prior to this care being given.

Training figures provided by the trust showed that 1592 of 1814 eligible members of staff (88%) had completed level one Mental Health Act training this year and 244 of 292 eligible staff members (84%) had completed level two Mental Health Act training across the service. We saw in patient records we reviewed that care plans did not clearly identify the mental health needs of patients, where these were present.

Nursing and other staff did not consider the smaller decisions that may require capacity to be assessed. Records of restrictive practice were not always detailed in patients’ care plans, where this was required. Staff were frequently under the impression that it was the doctors’ responsibility to complete capacity assessments for patients. The trust policy was clear, regarding a two-stage decision making process in assessing and recording patients’ capacity, however we saw this guidance was not routinely followed by staff.

We saw do not attempt cardio pulmonary resuscitation (DNACPR) orders had been placed in some patient notes, where these patients lacked capacity. There was no evidence of their involvement, or a clear record of best interest decisions completed. We reviewed 24 patient records where there was good cause to doubt the capacity of that person and their ability to consent to the treatment they were receiving. Twenty-four patients had a DNACPR in place and in eighteen of these there was no evidence within the records that capacity had been assessed in relation to the DNACPR. Fifteen of the twenty-four records clearly showed that the DNACPR had been discussed with the patient’s family and nine did not. We reviewed one DNACPR record and saw this was put in place without consultation with the patient or relatives. One DNACPR record was a community DNACPR which was also documented on the trust DNACPR form as having been reviewed, however, we saw no record of capacity assessment to support this.

Staff we spoke with understood Deprivation of Liberty Safeguards (DoLS) and we found that for patients who were subject to a deprivation of liberty the relevant application had been submitted. As part of the provider information return the trust had informed us that 191 Deprivation of Liberty Safeguard applications had been made to the local authority between 1 March 2017 and 28 February 2018. Of these applications, only one had been approved. Staff told us that there was a delay in applications approval by the local authority due to high demands. Staff recognised the importance of continuing to complete these applications.
Is the service caring?

Compassionate care

Staff were caring and showed kindness to patients during their hospital admission, respecting the dignity of patients and those who were close to them. They were aware of patients’ care needs and communicated in an appropriate and professional manner. Patients’ privacy and dignity patients was not always protected. In some wards we heard confidential patient details being discussed openly in front of other patients and visitors.

Friends and Family test performance

From April 2017 to March 2018, the Friends and Family Test response rate for medicine at the trust was 25% which was the same as the England average. The table below shows a breakdown of the response rate by site.

Friends and family Test – Response rate from April 2017 to March 2018 by site.

(Source: NHS England Friends and Family Test)

We observed staff interacting positively with patients and those close to them in the different medical wards we visited. Staff encouraged patients to be as independent as they could manage in self-care activities, such as eating and taking medicines.

Staff spoke to patients sensitively and appropriately, with consideration for patients’ individual needs, lowering their voices and closing curtains to protect patients' privacy when providing care. We heard ward staff asking patients’ permission before undertaking their personal care.

Patients were happy with the care they received from staff and said they were treated well. We heard that staff were attentive and spent time with patients. One patient said they would “had 190% praise for nurses, they take care of you and attend to your comfort”.

Another patient felt the care was more individualised and that staff appeared to be happy when delivering care. We saw feedback from patients was displayed in ‘you said, we did’ notices on some wards. Comments here included “the overall level of care provided by staff paid to every aspect of my care went above and beyond”.

(Source: NHS England Friends and Family Test)
During inspection we had concerns about patients’ privacy during ward handovers, where we heard confidential details about patients’ conditions being discussed openly in front of other patients and visitors. We also heard a patient referred to as “the chest pain”. This did not show respect for the patient.

We also heard isolated comments about a poor experience of care from night staff on one ward we visited.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. Staff took time to speak with patients who were upset, providing reassurance.

We observed staff attending to patients when they were distressed or appeared upset, taking time to sit with patients and speaking with them in a calm and reassuring way.

There were specialist staff available, such as nurse specialists and spiritual leaders, to provide for patients’ emotional support needs. This included psychological assessments and advice where this need was identified. Specialist nurses provided information and support to patients who had certain specific medical conditions, such as diabetes, dementia, or for patients following a heart attack.

On rehabilitation and care of the elderly wards soft music was played in ward bays, providing a calming effect for patients, staff and visitors.

**Understanding and involvement of patients and those close to them**

Staff did not always involve patients and those close to them in decisions about their care and treatment particularly with regard to ‘do not attempt cardio pulmonary resuscitation’ decisions.

Patients told us they were involved in decisions about their treatment. These patients said nurses and doctors explained their conditions, treatment and the investigations that may be necessary as part of their care. One patient said the doctors had a good bedside manner.

Patients who lacked capacity to consent to decisions about their care and treatment and those close to them were not always involved in decisions about their care. Whilst patients’ individual needs and preferences may have been communicated to staff by their relatives, the process for identifying, assessing capacity and recording best interest decisions for individual patients who lacked capacity was not consistently applied.

We saw that staff introduced themselves and communicated clearly to ensure patients fully understood. Patients were encouraged to ask questions and were given time to assist their understanding.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service did not always plan and provided services in a way that met the needs of local people. Ward facilities were limited by the ageing environment and this could have an impact on both patients and their visitors.
Average length of stay

Trust Level

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 6.5 days, which is higher than the England average of 5.8 days.

For medical non-elective patients, the average length of stay was 7.0 days, which is higher than the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gynaecological oncology, neurology is higher than the England average.

- Average length of stay for elective patients in nephrology is lower than the England average.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in respiratory medicine is similar to the England average.

- Average length of stay for non-elective patients in geriatric medicine and diabetic medicine is lower than the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Chorley and South Ribble Hospital

From February 2017 to January 2018, the average length of stay for medical elective patients at Chorley and South Ribble Hospital was 2.6 days, which is lower than England average of 5.8
days.

For medical non-elective patients, the average length of stay was 5.7 days, which is lower than England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in nephrology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in respiratory medicine is higher than the England average.

**Elective Average Length of Stay - Chorley and South Ribble Hospital**

![Bar chart showing elective average length of stay for Chorley and South Ribble Hospital.](image)

*Note: Top three specialties for specific site based on count of activity.*

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, diabetic medicine and respiratory medicine is lower than the England average.

**Non-Elective Average Length of Stay - Chorley and South Ribble Hospital**

![Bar chart showing non-elective average length of stay for Chorley and South Ribble Hospital.](image)

*Note: Top three specialties for specific site based on count of activity.*

The medicine division recognised the needs of the local population and used various sources of data such as public engagement and the use of local data and statistics to design and plan the services provided. When new information was known there was a review of service provision.

The facilities and premises within the medicine division were suitable, on the whole, for the services that were being delivered. However, the estate was old and in some areas the accommodation appeared dated, with patient areas more cramped. This was particularly apparent in the medical assessment and coronary care units. This also meant there was more limitation to development of dementia-friendly aspects of some wards.

There was no separate discharge lounge available for medical patients to wait in when they were being discharged. A ward area on the medical assessment unit was designated for patients ready for discharge; this was next to a similar area in the ward provided for GP admissions. During the
inspection, we saw this area was very busy with patients waiting to be admitted. Staff said this had been a particular issue during the winter, with these admissions and discharge areas very congested, when patient admissions were at a higher rate.

On the cardiac care unit, there were no facilities for patients’ relatives. Staff would use whichever different area of the ward was available when they needed to speak with families more privately. We heard this could be a challenge, particularly if doctors needed to share difficult conversations with families about their loved one’s condition.

An ambulatory care unit was available to provide treatment and care for patients referred from the accident and emergency department. Patients with less serious medical conditions, or who required minor procedures, were treated for these in the ambulatory care unit. Patients could go home on the same day, without the need for admission to medical wards.

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Dementia friendly approaches were established, with staff awareness of individual patient needs.

The service responded to people’s individual needs in different ways. Staff were aware of the needs of patients who had dementia and we saw this was routinely considered when providing care. Dementia friendly approaches were established across the service, with use of the forget me not scheme and dementia champions to support this.

The environment on Rookwood A, a medical and elderly care ward, had been improved to meet the needs of patients living with dementia. The bathroom doors were painted a different colour to make this easier for people to locate and use these facilities more easily, with signs bold and clear to make these easier for people to read. The service used red plates to assist patients at mealtimes. The patient lounge was warm, cozy and homely, decorated with a fireplace and other features to make it look more like a sitting room. A sensory garden for patients with dementia had also been created, which provided patients with different comfortable and restful environments on the ward. Patients from Rookwood B medical ward could also access this garden area.

The Trust previously identified a gap in gathering feedback from patients with a learning disability. To more effectively gather feedback from this group of patients and use this information to plan service delivery, service users, carers and organisations were invited to an annual event within the Trust. This provided an opportunity for education and health promotion and activities such as music therapy and singing. The one-day event also provided an opportunity to have a health check following which service users then had a consultation with a clinician regarding the results. The topic for the day was decided by attendees and previously this has been around dealing with death and loss, the next event scheduled was to include information around mindfulness.

Staff on the stroke ward had been encouraged to attend a mental health first aid course, to raise awareness of mental health and stress-related issues, in relation to patients and staff.

Therapy services provided relaxation and “managing emotions” sessions for patients on rehabilitation wards. Patients who experienced symptoms of low mood as an after effect following a stroke had access to mental health practitioners for assessment and advice.

Interpreters were available on request for patients who did not speak English as a first language. All the leaflets we saw were in English, however, these leaflets also stated they were available on request in different languages. We did not see any examples of easy read information.
Staff recognised there could be a gap for patients’ visitors to access drinks making facilities. A drinks station had been set up for patient’ relatives to make their own tea and coffee on the medical assessment unit, gastroenterology and coronary care units.

**Access and flow**

People could not always access the service when they needed it. Referral to treatment times were consistently below the England average. The service had a high number of patient bed moves at night. Staff told us this could happen frequently on a weekly basis.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The referral to treatment time has been worse than the England average for the entire reporting period with the exception of February 2018 where the trust had performance of 88.6% compared to the England average of 88%.

![Graph showing referral to treatment time](image)

*(Source: NHS England)*

**Referral to treatment (percentage within 18 weeks) – by specialty**

All four specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>66.7%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.4%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

*(Source: NHS England)*

People could not always access care and treatment in a timely way. The service had reported referral to treatment times against the 18-week target which were consistently below the England average.

During our inspection, we found that demand for beds on specialist wards and pressures on reducing blockages within the accident and emergency department impacted upon the quality of patient care. The trust told us that between 1 March 2017 and 28 February 2018 there were 1507
moves at night (between 10pm and 6am). During our inspection we spoke with nursing staff who said bed moves frequently occurred at night, particularly in wards providing for more acutely ill patients who were needing higher levels of care. This could happen at least on a weekly basis.

Nurses on day shifts aimed to complete ward admissions documentation for patients being admitted, to reduce the need for patients moves at night. Matrons and managers told us about wider plans to improve patient access and flow through the hospital. This included earlier consideration of discharge planning and improving the rates of patients who were discharged before 11am. The “ten by ten” scheme was another recent initiative, aimed where possible at achieving patient transfers by 10pm. with up to two patients transferring or being discharged from each medical ward vacating beds to be available for new admissions at an earlier stage. Bed managers were available to support this initiative; however, we saw this was still at an early stage in development.

In March, April and May 2018 the hospital had 18,11 and three medical outliers. Medical outliers are patients who are placed on escalation areas or wards outside of the required specialty due to there being no available beds on the relevant specialist ward. We did not request or hear any further details about review arrangements for medical outliers and did not identify if there were any issues for medical staff in providing for timely review of these patients.

During the inspection there were no escalation ward areas in use at Chorley and South Ribble Hospital, although these had still been in use until a few weeks prior to the inspection. Escalation areas were used to accommodate patients due to increased demand at the trust. Therapy staff commented on the impact of having to be redeployed to Royal Preston Hospital during the peak of winter pressures and the effect this had on interrupted service provision to rehabilitation stroke patients at Chorley.

The service had a frailty pathway which was followed for patients with more complex care needs. This assisted in safe discharge planning for this type of patient. Discharge liaison nurses, ward staff and social workers worked together to identify social care referrals and assist in patient discharge processes.

Discharge planning began on admission, for patients who had suffered a stroke, depending on the severity of the stroke. Multidisciplinary discharge planning involved the patient and their family, as well as discharge liaison nurses and social workers. This planning had reduced the average length of patient stay to an average of four weeks. Community ‘discharge to assess’ beds provided patients with a trial discharge facility, prior to their final discharge. The patient’s hospital bed would be kept open for a two-hour period whilst therapist and social workers supported patients in a discharge assessment. If there were any concerns regarding the patient’s safety or other need at this time, the patient could return to hospital for continued rehabilitation, until safe discharge could be achieved.

We heard from staff there could be delays for patients in accessing community services after discharge.

Local GPs had access to a telephone triage system to prioritise patients who required more urgent admission for treatment and care.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. Staff aimed to resolve any concerns directly with
patients or relatives initially and managers informed us that complaints were at a lower level over the past 12 months

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

Numbers and themes of complaints could be clarified during the inspection.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Concerns and complaints were listened to and used to improve the quality of care. Feedback from patients formed part of the Safety Triangulation Accreditation Review (STAR) on each ward. Feedback from complaints and concerns was shared with staff during team meetings and by email.

Ward staff and managers described how they would initially try and resolve any concerns in direct discussions with the patients or relatives who had raised these. During our inspection we heard an example of this from a patient, who described an immediate response from ward staff and a satisfactory outcome of their complaint. Staff told us the most frequent concerns raised were regarding communication issues.

The service responded to complaints and concerns appropriately and in a timely manner. We saw limited information was available on wards about how to raise a complaint or concern, although patients we spoke to told us that they would raise any concerns verbally with a member of staff and that they would feel comfortable to do so. We reviewed detailed responses to three formal complaints. We saw for each of these the complainant was provided with a letter response from the chief executive, a full apology and details of follow up information. This included direction to the parliamentary health service ombudsman, in case of any continuing dissatisfaction.

Senior leaders advised there had been a reduction in the level of complaints over the past 12 months, with new complaints now being responded to within 35 working days.

Is the service well-led?

Leadership

Whilst the service had leaders with the right skills and abilities to deliver services providing high quality sustainable care, senior leadership changes within the division over recent years had impacted on staff confidence in the overall leadership of the medicine division. Many staff we spoke with said they felt the lack of continuous leadership had hampered progress and development in the service. Alongside this, it was acknowledged that in practice, the demand and focus was greater for the acute medical services at Preston hospital and this frequently compromised the ability to sustain a local leadership presence at Chorley.

In general, there was a feeling amongst many staff of being “second in line” to Preston hospital and that issues at Chorley and South Ribble Hospital were not given the same priority. There was no general manager, clinical business manager or specialist business manager for medical services based at Chorley. Many staff also said they had not seen or did not know who the divisional business manager was. Local managers and senior nurses at Chorley felt the lack of leadership over time had impacted on the integrated working approaches overall, particularly between senior medical staff. They expressed the need for a period of stability. However, there
were no concerns raised regarding any impact this may have had on patient safety or quality of care.

Although new in post, senior leaders within the division had taken time to identify key risks and concerns to quality and safety of care across the service and spoke candidly with us about the changes which needed to be implemented to make improvements. The leaders we spoke with conveyed a desire to build momentum and move forward with improvement plans but were conscious it was important to plan and consider these changes and timescales in collaboration with staff.

Staff were consistently positive about the director and deputy director of nursing. Staff had confidence in the nursing leadership and said there had been many positive developments to strengthen the nursing service during the past 12 months. This was particularly in relation to the increased establishment of nursing staffing and the development of quality improvement initiatives. Staff also spoke positively about the medical director, who although still only recently appointed to the role, was recognised for their continuing effort to be a regular presence at the Chorley site.

Junior doctors we spoke with were also enthusiastic about their working experience and the support that was available from senior staff.

The lead for allied health professions had access to trust executive’s and was an established part of the senior leadership team. This had improved the visibility of allied health professions within the division.

**Vision and strategy**

The division of medicine did not have a strategy, although leaders had a vision for what they wanted to achieve and were clear in articulating these. Plans were at an early stage in their implementation, but leaders were aware of and acknowledged the issues facing the service for the future.

At the time of inspection, the service did not have a clear strategy and staff at all levels were unable to explain how their work aligned to the service strategy.

We spoke with the medicine division’s leaders who were open in discussing the challenges that had been faced within the division. Leaders outlined their plans to progress the future development of a strategy, with a focus on quality improvement across medical services. A central aspect of this focus was to build sustainable seven-day services and improve early supported discharge for patients. The service was working together with the local clinical commissioning groups, and other partners in the wider healthcare system, to resolve some of these shared issues.

The trust had previously identified its approach to collaborative working in its programme Our Health, Our Care covering Preston, Chorley and South Ribble. This focussed on five key challenges to health and social care services: patient experience, clinical challenges, financial challenges, workforce and estates. The trust was working in partnership with other local organisations to develop and deliver the programme. An additional aim through delivery of this programme was to improve the provision of seven-day services.

Although staff at ward level were largely unaware of the detailed strategic developments within the division, there was a sense of optimism and positive direction for the future. Nursing managers said they were “very excited in their role, and this was the start of the acute medicine pathway”
Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with were optimistic about future developments within the service and were committed to improvements in patient care.

We saw there was an open and transparent culture within medical services which was aligned with the trust values. Staff were positive about their work they did and the services they delivered and generally spoke with optimism about future challenges. During the inspection we heard only isolated comments of any exceptions to this.

Staff told us they felt supported by their managers and were clear about their roles and responsibilities. Staff felt encouraged and given appropriate direction for the work they were required to undertake.

There was a positive attitude to development of medical services. The culture encouraged learning from incidents and the promotion of quality care for patients. Staff were motivated to deliver the best care for their patients and actively engaged in quality improvement activities, to achieve better patient outcomes and experiences. Staff had opportunities to develop and take lead roles in different service areas, such as the specialist nurses on respiratory wards who provided expertise, training and support for staff in providing non-invasive ventilation for patients. Divisional leaders actively considered new ways of working to address challenges in consultant staffing, with international advertisements for overseas recruitment. Enhanced roles such as advanced nurse practitioners (ANPs) had been established in different areas to provide tailored support for patients.

We observed throughout the inspection that staff in the service displayed a positive attitude which showed respect and support for their colleagues and patients. We saw many examples of positive interactions, between members of staff in different areas.

Staff reported there was good teamworking and they had a feeling of pride in the work of the service. Staff from different wards said there was “a family approach” for patients and managers in different medical services said they were “absolutely proud” of their staff for the work they achieved.

Staff at all levels were supported by managers and felt they could raise any concerns in an open manner without fear of retribution. However, with the exception of one nurse, staff we spoke with had no knowledge of the trust’s Freedom to Speak Up Guardian, or awareness of the purpose of this role. Since 2016, all NHS trusts are required to have a Freedom to Speak Up Guardian to support staff and promote a culture of speaking up, in situations where they may have identified concerns.

Governance

The trust had not always had effective systems in place for monitoring activity and overall performance to support the delivery of quality care. However, there was new development of clinical governance systems and quality measurement processes at the time of inspection.

Divisional leaders of the service recognised there had not been effective governance systems and on this basis, had decided to make some radical changes to medical leadership structures. The aim was to improve the communications and oversight of quality, performance and risks within the medical division. As such, these changes were at an early stage in their development and therefore it was not possible to assess the effectiveness of the changes to the system overall. We heard from leaders there was a central focus on quality and continuous improvement, which also reflected in the intentions of the planned service strategy.
Leaders identified complaints and timeliness of investigations as priorities for governance. In addition, focus on specific service pathways such as for renal and stroke services was a recognised area for development. Service managers reflected “hard decisions and resource implications” were a necessary aspect of decisions about service configurations. Wherever possible, the aim was to integrate work across directorates and provide a more holistic approach to patient care. An example of this was the work in learning disability and mental health services incorporated in the trust’s “treat as one” approach.

Managers attended meetings across the trust which included input from medical staff, clinical staff and senior managers. Divisional quality, safety and risk meetings and clinical effectiveness meetings were held, with reports from these shared across directorates. There was some evidence that there was sharing of information with and from other committees and groups and into the trust-wide risk meetings.

Ward managers and staff said it was often difficult to arrange face-to-face staff meetings as a group. Key messages for staff were more often shared in safety huddles, noticeboards and staff bulletins.

**Management of risk, issues and performance**

The service did not have an effective system for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The risk register was cumbersome and unclear, with a number of risks remaining open without progress from previous years.

Risks and performance issues were not always effectively managed across the service. Risks were not appropriately escalated when this was needed and timely response to manage risk was not always evident.

The risk register was unnecessarily complex and unclear, with details of risks dating back to 2010. Some of these past risks remained as open risks despite the related actions having been completed, whilst others remained open and had not been progressed. At the time of inspection, there were 74 open risks rated as “moderate” or above detailed on the divisional risk register.

Senior leaders acknowledged the current risk register was not able to be used as an effective tool to identify and monitor divisional risks, due to the number and varying types of risks documented.

We found that systems for performance management required improvement within the service. There were divisional dashboards which monitored performance against key performance indicators in relation to patient experience, safety and referral to treatment times, however, the service provided information which demonstrated there had been a significant decline in completion of clinical audits. At June 2018, 60% of compliance statements for the National Institute for Health and Care Excellence were out of date. This may have been due to the introduction of a new IT reporting system; however, it was not possible for the service to determine whether it was or was not actually meeting compliance with national guidance.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Managers had access to data to monitor performance and identify improvements.

Senior staff had access to the information they needed to monitor performance and to ensure there was sustained or improved standards of care. Information included performance in relation to quality as well as finance information. Clinical staff had access to patients’ investigation results and we did not hear any concerns regarding delays in receiving these.
The division had access to a range of information including audits, performance dashboards, staffing figures, complaints and patient feedback. Leaders of the service used this information to understand, investigate and respond to issues that arose in the division.

Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues. Staff could access relevant information, such as policies and other guidance, via the trust’s intranet.

At the time of our inspection, wards were not using an electronic records system for patients’ notes except for risk assessments which were completed online. This meant that collating information about patients for purposes such as audit was time consuming and unreliable, as it was open to human error. Paper records were scanned onto an online storage system but when we used this to review patient records we found that notes were not always scanned chronologically and it was difficult to locate specific information within the records.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service had engagement activities which had helped inform further development of effective services.

The medical service engaged with patients, the public and staff in different ways.

Clinical staff participated in a regional stroke network, for sharing best practice and latest developments in the speciality. Integrated therapy staff provided stroke education and awareness sessions for patients and carers on stroke rehabilitation wards. The service had created a “my hospital stroke guide” video for patients, which was also available for staff to refer to, via the trust intranet. The stroke association also conducted visits to stroke wards and shared information with staff and patients following these visits.

The service had started to communicate more closely with staff in local nursing homes in a “buddy scheme”, sharing information and identifying joint areas of learning. Staff were planning to extend a similar approach to care homes in the local area.

The coronary care unit had engaged with another local NHS trust in developing services for patients who needed investigative cardiogram.

Staff on Rookwood A promoted a range of activities and social events for patients on the ward, which relatives could also enjoy. This included tea parties and luncheon clubs, with celebrations of other events, such as the royal wedding and Wimbledon. A member of ward staff baked celebration cakes for these different occasions. Volunteers and local community groups, such as girl guides had also attended the ward for such events.

Nursing staff on the medical assessment unit told us they had attended an away day, which one member of staff said was the first of its kind in 14 years. In another ward, in response to concerns about staffing, the matron had met with staff with a “tea and cake with matron” session. During this session, teams had discussed “what would make my working day better”. This had helped to engage staff in identifying their own solutions for improved ways of working and managing day to day work challenges. Staff appreciated this support and said it had helped improve morale on the ward.

Staff on the gastroenterology ward had celebrated the annual nurses’ day with an event commemorating nursing through the generations. Staff dressed in Victorian nurses’ uniforms and invited previous and retired nurses to a buffet celebration to mark the occasion. The director of
nursing had also visited and had acknowledged the work of the ward to promote the event, which was appreciated by patients, visitors and staff.

Staff on Brindle ward had initiated various activities to build staff engagement, including “food Friday” where staff brought in different food to share, based on a theme of the week; the most recent food Friday had been Italian food.

The trust had a staff recognition scheme and areas we visited displayed individual and team achievements in this scheme, such as “star of the month”. Staff we spoke with said they were aware of trust communications and from time-to-time were provided with opportunities to contribute their views and participate in trust wide activities. Staff felt valued as trust employees and several nurses and doctors we spoke with had chosen to apply for a position at the trust, following their positive experience of a training placement.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Staff were positive about their own involvement in service developments and shared examples of initiatives they had introduced.

The coronary care unit had facilitated the establishment of a trust wide resuscitation stock service. The trust had identified that high levels of resuscitation- trolley specific equipment were passing their expiry date before needing to be used. This had caused issues relating to disposal of clinical waste and overall costs. A new standardised and centralised process for stock levels and supply was introduced, with an estimated initial savings in the first two years of approximately £60,000 – £80,000.

The consultant nurse for nutrition had introduced a programme of learning for medical and nursing staff, following a series of Never Events in 2016 - 2017 for misplaced Nasogastric Tubes. This work had improved doctors’ awareness for practising the procedure and reduced the incidence of misplaced NG tubes. The programme also achieved national recognition. The service had also received national award for introduction of a seven-day rapid access nutrition clinic.

The integrated therapy services on Rookwood B (stroke rehabilitation ward) had completed a pilot programme in 2017, where therapy staff worked additional early and late shifts, mirroring those of nursing staff. The aim of the programme was to identify any positive impact of this extended working on the rehabilitation and mobility progress of stroke patients. The programme was positively received by therapists, nursing staff and patients and had a positive impact on numerous aspects of patient care and integrated team working. Results also showed on the days therapists were on shift, there were more stroke patients who could be supported to sit out of bed.

On the stroke rehabilitation ward, we saw posters displayed promoting the ‘end PJ paralysis’ initiative. This encouraged patients to be up and dressed in their own clothing, if they were well enough and able to do so.

Staff from Rookwood B ward had achieved a ‘Britain in Bloom’ award for their development of a sensory garden for patients with dementia.
Chorley and South Ribble Hospital provides a range of surgical services including general surgery and trauma and orthopaedic surgery. There is one inpatient ward, Leyland which provides accommodation for 25 patients and two other wards, Sellers and Rawcliffe that accommodate day case patients. There is also a preoperative assessment unit and Longton Day Case Unit.

The hospital has eight operating theatres for general surgery, including urology and minor vascular surgery, trauma and orthopaedic surgery, breast surgery, laparoscopy, cardio vascular surgery and ear, nose and throat surgery. Patients who need major trauma surgery are transferred to the Royal Preston Hospital.

The trust has 34 main operating theatres covering 11 specialties across two sites;

- Royal Preston Hospital
- Chorley and South Ribble Hospital

The trust has ten surgical wards and 314 inpatient beds.

(Source: Routine Provider Information Request (RPIR) – “Sites-Acute” tab)

The trust had 46,482 surgical admissions from November 2016 to October 2017. Emergency admissions accounted for 11,634, while 28,872 were day cases and the remaining 5,978 were elective.

(Source: Hospital Episode Statistics)

Chorley and South Ribble Hospital had 13,387 surgical admissions from April 2017 to March 2018. Day case admissions accounted for 11,024, 2,197 were elective inpatient admission and the remaining 166 were non-elective inpatient admissions.

During the inspection we visited Leyland, Sellers and Rawcliffe wards, Longton Day Case Unit, all theatres and the pre-operative assessment unit.

We spoke with 30 members of staff including senior managers, ward sisters and managers as well as registered nurses, student nurses and doctors and health care assistants. We also spoke to 11 patients and relatives.

We observed care and treatment and looked at six patient care records and three medication administration charts as well as service performance data.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and compliance rates for nursing staff were above the trust target.

Before the inspection the trust provided data on mandatory training compliance as outlined below. This did not identify compliance rates specifically for surgery staff at Chorley and South Ribble Hospital.

The trust has set a target of 90% for mandatory training completion.

From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in surgery.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>638</td>
<td>725</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>654</td>
<td>921</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>492</td>
<td>722</td>
<td>68.1%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in surgery met the training course completion target for one of the seven courses made available to them. Nursing staff failed to meet the target for training courses classified as ‘other’ with a 71% completion rate, however the trust has not provided a description of what these courses are.

**Medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>257</td>
<td>297</td>
<td>86.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical staff within surgery at the trust met the completion target for none of the six courses made available to them. As with the nursing section above, staff failed to meet the target for courses classified as ‘other’ with a 68.5% completion rate, however the trust has not provided a description of what these courses are.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Mandatory training modules included fire safety, health and safety (slips, trips and falls), infection prevention and information governance. Staff also received mandatory training in moving and handling, advanced basic life support, paediatric basic life support and intermediate life support. The trust provided updated figures for mandatory training compliance for 2017 and 2018 as shown below. The data showed an upward trend in compliance rates in 2018.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Required 2017</th>
<th>Sum of Required 2018</th>
<th>Sum of Compliant 2017</th>
<th>Sum of Compliant 2018</th>
<th>Per. 2017</th>
<th>Per. 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Training overall</td>
<td>911</td>
<td>888</td>
<td>737</td>
<td>786</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>103</td>
<td>90</td>
<td>88</td>
<td>87</td>
<td>85%</td>
<td>97%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>103</td>
<td>90</td>
<td>88</td>
<td>87</td>
<td>85%</td>
<td>97%</td>
</tr>
<tr>
<td>Moving &amp; Handling (Clinical) overall</td>
<td>654</td>
<td>617</td>
<td>393</td>
<td>455</td>
<td>60%</td>
<td>74%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>103</td>
<td>90</td>
<td>60</td>
<td>57</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>103</td>
<td>90</td>
<td>60</td>
<td>57</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>Resus - ABLS overall</td>
<td>843</td>
<td>832</td>
<td>494</td>
<td>659</td>
<td>59%</td>
<td>79%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>103</td>
<td>89</td>
<td>71</td>
<td>78</td>
<td>69%</td>
<td>88%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>103</td>
<td>89</td>
<td>71</td>
<td>78</td>
<td>69%</td>
<td>88%</td>
</tr>
<tr>
<td>Resus - ILS overall</td>
<td>88</td>
<td>56</td>
<td>34</td>
<td>35</td>
<td>50%</td>
<td>63%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Resus - PBLS overall</td>
<td>479</td>
<td>274</td>
<td>206</td>
<td>464</td>
<td>43%</td>
<td>59%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: additional data request)

During the inspection we viewed online records that recorded mandatory training compliance for staff by each module. On Sellers ward only one member of nursing and health care assistant staff
had not completed mandatory training due to sickness absence, 100% of staff had completed falls training and PREVENT training. The PREVENT duty is the duty in the Counter-Terrorism and Security Act 2015 on specified authorities, including the NHS, to have due regard to the need to prevent people from being drawn into terrorism. We saw that training compliance records provided information at speciality level and for individual members of staff compliance.

Staff accessed mandatory training online and face to face. Staff told us they had access to two clinical educators but they were based at Royal Preston Hospital and rarely visited Chorley and South Ribble Hospital. However, ward managers had identified staff as links for different elements of mandatory training such as falls and fire safety. These staff ensured their training was up to date and then trained the other staff on the ward. Staff received email alerts to remind them of any outstanding mandatory training. The training record was reviewed monthly by the ward managers who also sent an email reminder to staff who had any outstanding training.

**Safeguarding**

Staff understood their role in recognising and preventing potential abuse. There were systems to ensure that patients were appropriately protected. Compliance rates for safeguarding training was above trust target. This was an improvement from the previous inspection.

Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to and staff knew how to access them. They were up to date and contained all the necessary information required to support staff to recognise safeguarding concerns and how to respond to them.

On Sellers ward staff could access information on safeguarding from a file in the office. This contained a step by step guide to making a safeguarding referral, useful contact numbers, copies of the trust policy on safeguarding and trust wide documents, a flow chart to help a member of staff assess mental capacity and a guide to making best interest decisions for people with learning disabilities. Ward managers told us they discussed any safeguarding incidents and staff knowledge of safeguarding in annual appraisals.

Staff we spoke to were able to explain when and how they would respond to a safeguarding concern and knew how to access information. They could give us examples of safeguarding concerns they had raised and the outcomes of these.

**Safeguarding training completion rates**

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff in surgery.

The trust has set a completion target of 90%.
Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>218</td>
<td>254</td>
<td>85.8%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>611</td>
<td>718</td>
<td>85.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>604</td>
<td>725</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in surgery at the trust met the 90% training completion target for none of the four safeguarding courses made available to them. However, one of these courses, Safeguarding Children (Level 3), had a much lower number of staff eligible to attend. Therefore, each member of staff eligible represented a higher proportion of the total than those eligible for the other safeguarding courses.

Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>199</td>
<td>293</td>
<td>67.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>190</td>
<td>289</td>
<td>65.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>53</td>
<td>81</td>
<td>65.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in surgery at the trust failed to meet the target for all four safeguarding training courses made available to them. As with the nursing staff section above, Safeguarding Children (Level 3), had a much lower number of staff eligible to attend. Therefore, each member of staff eligible represented a higher proportion of the total than those eligible for the other safeguarding courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The service provided updated data on safeguarding training compliance rates for 2017 and 2018 at Chorley and South Ribble Hospital as shown below.
<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Sum of Required 2017</th>
<th>Sum of Compliant 2017</th>
<th>Sum of Required 2018</th>
<th>Sum of Compliant 2018</th>
<th>Per. 2017</th>
<th>Per. 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>911</td>
<td>588</td>
<td>883</td>
<td>716</td>
<td>65%</td>
<td>81%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>103</td>
<td>92</td>
<td>90</td>
<td>79</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>103</td>
<td>92</td>
<td>90</td>
<td>79</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>274</td>
<td>169</td>
<td>286</td>
<td>227</td>
<td>62%</td>
<td>79%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>29</td>
<td>24</td>
<td>25</td>
<td>24</td>
<td>83%</td>
<td>96%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>29</td>
<td>24</td>
<td>25</td>
<td>24</td>
<td>83%</td>
<td>96%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>903</td>
<td>280</td>
<td>877</td>
<td>731</td>
<td>31%</td>
<td>83%</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>103</td>
<td>38</td>
<td>90</td>
<td>88</td>
<td>37%</td>
<td>98%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>103</td>
<td>38</td>
<td>90</td>
<td>88</td>
<td>37%</td>
<td>98%</td>
</tr>
</tbody>
</table>

(Source: additional data request)

The service did carry out surgery on 16 to 18-year-olds but staff told us this was rare. The nurse leads in preoperative assessment told us they were trained to level three safeguarding children. The updated figures provided by the service did not state if any staff were eligible for or had been trained in level three safeguarding children. Staff raised cases of safeguarding children with the on-call site managers who sought advice from the paediatric on-call team, who were available 24 hours and were all trained to level three safeguarding children.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well and used control measures to prevent the risk of infection. Staff kept themselves, equipment and premises clean. The service had procedures for maintaining the sterility of instrument trays in theatres.

Wards appeared visibly clean and we observed domestic staff carrying out a monthly cleanliness audit of Leyland ward which examined the cleanliness of all areas. We reviewed audit records for Leyland and Sellers wards from April 2018 to June 2018 and saw that all areas including the bays, side rooms, dirty utility room and bathrooms were checked and high standards (scores above 95%) consistently maintained.

Staff on the wards washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed that staff followed ‘bare below the elbows’ guidance. Alcohol hand gel was available at exits and entrances of wards and bays and staff and visitors used these to reduce the spread of infection. The service conducted hand hygiene audits as part of the monthly STAR audit system. STAR is a quality assurance framework used by the trust with monthly reviews undertaken by professional leads looking at key care standards.
Personal protective equipment was available for staff at the entrance of side rooms and bays. We observed staff using personal protective equipment when delivering care and treatment of patients.

There was a Hospital Sterilisation and Decontamination Unit (HDSU) on site. We saw that decontamination of flexible endoscopes took place in the Longton unit in line with decontamination guidance. Staff held weekly decontamination meetings to ensure all equipment had been checked and appropriate actions taken to address any issues and ensure sufficient staff numbers in the decontamination unit. Staff carried out monthly audits of decontamination of equipment.

Staff followed National Institute for Health and Care Excellence infection control guidance during the preoperative phase. Staff completed a preoperative checklist which included removal of jewellery, hair clips, make up and nail varnish and noted if the patient was a known infection risk. However, staff did not ask or note if the patient had showered or if the skin area was clean.

Patients were screened for methicillin resistant staphylococcus aureus (MRSA) as part of the preoperative assessment process. Staff told us that if patient’s MRSA screen result had not been received the patient would be accommodated in a side room.

The service had a process to ensure that National Institute for Health and Care Excellence guidelines on surgical site infections were followed. Staff collected data on surgical site infections in theatre, on the ward and in postoperative follow up appointments. Health care assistants on the wards carried out surgical site infection surveillance on patients prior to their discharge from the ward.

The service had procedures for maintaining the sterility of instrument trays in theatres. They had introduced ‘flat trays’ which protected the outer cover of instrument trays when taking them from the shelf. The service had reviewed the contents of instruments trays and minimised the contents of trays. They had disposed of unused trays and instruments. This had reduced the number of times instrument trays were handled and therefore reduced risk of infection or contamination.

Each operating theatre had a hatch onto the ‘dirty’ corridor, the corridor through which clinical waste was taken. This meant staff did not have to enter the ‘dirty’ corridor to dispose of clinical waste, limiting the risk of contamination.

Environment and equipment

The service did not always have suitable premises and equipment. Some of the theatre environment required maintenance or repair.

We saw that sluice rooms, store cupboards and treatment rooms in the wards were locked. Staff carried out daily room temperature checks in the clean utility room on Leyland ward. We looked at records from January 2018 to May 2018 and saw they were completed daily with one exception in January due to ‘ward pressures’.

Resuscitation trolleys were stored in accordance with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. Staff carried out daily checks of the defibrillator
and weekly checks of drawer contents. We saw oxygen cylinders were secured to walls in line with health and safety best practice.

We found that safety tests were overdue on four compression pumps and one mattress pump on Leyland ward. We brought this to the attention of the ward manager who explained the service was aware of this and there was a plan with an external supplier. We reviewed the planned job list for safety testing at Chorley and South Ribble Hospital and found that annual testing was taking place between 11 June 2018 and 15 June 2018 and quarterly visits were planned for September 2018, December 2018 and March 2019.

The environment in Rivington theatre was displaying signs of wear and tear. There were old, un laminated posters on the walls and cracked flooring. We found cracked flooring in Longton Day Case Unit which had been temporarily repaired with bright tape. This posed a trip hazard and infection control risk. Staff told us this had been reported. We viewed an estate and facilities report that confirmed this was awaiting repair. Staff on the ward said they had to wait a long time to get simple repair and maintenance jobs carried out. They stated this was due to the length of the ordering and procurement process.

The operating theatres had limited storage and stored medical protheses in the ‘dirty’ corridor. A protheses is an implant or small artificial body part. Though the protheses were stored in sealed packaging, this meant there was a risk that protheses could be contaminated by clinical waste.

**Assessing and responding to patient risk**

The service had arrangements to recognise and respond appropriately to risks to patients. The service planned for emergencies and staff understood their roles if one should happen. Risks to patients were assessed to ensure their care and treatment needs were being met.

We reviewed the trust policy for the timely recognition and response to patients at risk of deterioration, which included specific guidelines for wards and theatre and recovery areas. On the wards we saw that the condition of patients was monitored and assessed through intentional rounding. Patient ‘rounding’ is a process of regular nurse checks to ensure patient's fundamental care needs are being met. Records were kept on the electronic patient record and paper records at the end of the bed. Staff told us this was because health care assistants did not have access to electronic records.

The wards and theatres used the national early warning system for staff to recognise and escalate patients in a timely manner if their condition was deteriorating. We reviewed six patient records which indicated the condition of patients was monitored. We reviewed one record for a patient with an increased national early warning system score and saw staff had escalated appropriately and continued monitoring. Timely risk assessment of patients with a deteriorating condition was audited through the monthly STAR audit and the summary report for April 2018 demonstrated a compliance rate of 96%.

The critical care outreach team were available 24 hours a day, seven days a week. The bleep number was clearly displayed on posters throughout the ward and in the office. Staff we spoke to understood how to escalate patients whose condition was deteriorating.
During our inspection we observed theatre processes including implementation of the World Health Organisation (WHO) surgical safety checklist five steps to safer surgery. The WHO checklist was completed at team brief where each patient was discussed, sign in when the patient was taken from the waiting area and at time out, where all activity was stopped prior to surgery to ensure all checks had taken place and everything was in place. The checklist was also used during prosthetic pause, at sign out prior to the patient leaving theatre and at staff debrief after all activity had stopped. The service had introduced the prosthetic pause as an additional pause to check the correct protheses was used as a result of learning from an incident.

We followed two patients through the surgical pathway and observed comprehensive completion of the WHO checklist. One consultant redid the ‘time out’ stage when a new person arrived in the anaesthetic room.

The service audited the use of WHO checklists at each of these stages monthly and reported this using the audit management and tracking system. The service provided WHO checklist audit data as below. The data is from carried out audits at Royal Preston Hospital and Chorley and South Ribble Hospital.
(Source: additional data request)

The service had a plan to provide staff training to ensure all staff were fully aware of the requirements. The service recognised that debrief was an area of concern and safety champions were focussing on this as part of their role.

The service used the red flag sepsis screening and action tool and pathway developed by the UK Sepsis Trust. Sepsis is the reaction to an infection when the body attacks its own organs and tissues and is potentially a life-threatening condition.

We saw that sepsis boxes were available on both wards which contained the pathway documents, the screening and action tool, information leaflets and the checklist for refilling as well as medical supplies. We examined the boxes and found them complete. The storage cupboard in the treatment rooms had clear labels corresponding to the number of the sepsis pathway and a poster displaying the location of the nearest ice machine.

Sepsis training was provided for staff through an e-learning package and through additional study days and simulation. At the end of May 2018 75% of staff on surgical wards and clinics had completed the sepsis e-learning package and 86% of theatre staff.

Any patient with a planned elective surgical procedure routinely attended an appointment for a preoperative assessment. This identified risks prior to surgery and included lifestyle information and assessment of any existing medical conditions as well as preoperative infection screening.

On admission staff completed an elective surgery integrated care pack or a day case/short stay elective pathway document. The pack for elective surgery included information on allergies, infectious disease history, piercings and metal work, anaesthetic history as well as physical health assessments.
For day case or short stay patients staff completed the same preoperative assessment checklist but in addition completed a risk assessment trigger tool. This assessed risk of falls, pressure ulcer care, nutrition and mental status. Staff completed the pathway with patients within 2 hours of admission.

During our inspection we saw that all patients had access to call bells, either on the bed or in their hands. We saw ‘call don’t fall’ leaflets beside the beds on Rawcliffe ward, which asked patients to use the call bell for the first time they wished to get out of bed to prevent falls. Staff on Leyland ward told us that all patients had to be seen by a physiotherapist to assess their risk of falls before nurses could help them out of bed and walk with them.

Patients attending for day case surgery had full skin, falls, nutrition and mental status assessments completed at admission. For elective surgery patients this was done on the ward. Staff on wards assessed patients’ nutritional status and risk using the Malnutrition Universal Screening Tool (MUST). The outcome of the assessments was kept in the electronic patient record for inpatients and in the paper record as part of the pathway document for day case patients.

We viewed six records and saw four where the MUST tool, pressure ulcer screening and falls risk assessment were completed. In one record the patient had been admitted less than six hours previously so had not yet had the assessments completed, in another they were scheduled and took place whilst we were on the ward. We saw an example of a patient with a higher MUST score being referred to the dietitian and a repeat score taken and reviewed.

Staff on Sellers ward told us that following a patient fall an additional form was completed on the incident reporting system which prompted an immediate analysis of the incident with initial lessons learnt and an action plan.

Five of the patient records we reviewed contained VTE assessments. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein.

The service provided scenario training for theatre staff to respond to specific emergency situations as shown below. However, no nursing staff from Chorley and South Ribble Hospital had attended, though the doctors who had attended worked across both sites.
Nurse staffing

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Nursing shifts were filled as planned and the service used bank staff to cover any gaps in shifts.

Overall staffing rates

During the inspection the service provided updated figures for nurse and health care assistant staffing levels from May 2017 to April 2018 as below.

<table>
<thead>
<tr>
<th>Courses</th>
<th>Number of Attendees</th>
<th>Number of theatre Staff</th>
<th>RPH</th>
<th>CDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Critically Ill Transfer Training Course</td>
<td>21</td>
<td>12 Doctors</td>
<td>2 DRs 10 Doctors</td>
<td>Drs work across both sites</td>
</tr>
<tr>
<td>Simulated Trauma Training 30.4.18</td>
<td>16</td>
<td>2 ODP 1 nurse</td>
<td>2 ODP</td>
<td>NIL</td>
</tr>
<tr>
<td>Human Factors and Patient Safety</td>
<td>5</td>
<td>2 Dr 2 Nurses</td>
<td>2 Nurses 2 Dr</td>
<td>Nil Drs work across both sites</td>
</tr>
<tr>
<td>Human Factors and Patient Safety for Anaesthetics 23.1.18</td>
<td>15</td>
<td>13 Anaesthetic North West trainees Doctors 2 Nurses</td>
<td>Unknown The 2 nurses from RPH</td>
<td>Drs across both sites no nurses from CDH</td>
</tr>
<tr>
<td>ST3 Neuro Anaesthetics</td>
<td>10</td>
<td>10 ST3 Neuro Drs</td>
<td>Drs work across both sites</td>
<td>Drs work across both sites</td>
</tr>
<tr>
<td>Anaesthetic Critical Incident Course</td>
<td>12</td>
<td>12 Anaesthetists North West regional Trainees</td>
<td>Drs work across both sites</td>
<td>Drs work across both sites</td>
</tr>
<tr>
<td>National Gastroscopy</td>
<td>16</td>
<td>15 North West Trainees 1 Nurse</td>
<td>Drs work across both sites</td>
<td>Drs work across both sites</td>
</tr>
<tr>
<td>Adult Emergency Airway 23.5.18</td>
<td>15</td>
<td>15 All internal Staff Anaesthetics/nurses/ODPS</td>
<td>6 anaesthetists 5 theatre practitioners 2 ODPs 2 trainee physician assistants</td>
<td>Drs work across both sites No nursing staff from CDH</td>
</tr>
</tbody>
</table>

(Source: additional data request)
### Shift Type and Staffing

<table>
<thead>
<tr>
<th>Month</th>
<th>Ward</th>
<th>% Reg Day</th>
<th>% Unreg Day</th>
<th>% Reg Night</th>
<th>% Unreg Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-17</td>
<td>Leyland</td>
<td>88.14%</td>
<td>128.47%</td>
<td>100.00%</td>
<td>106.82%</td>
</tr>
<tr>
<td>Jun 17</td>
<td>Leyland</td>
<td>93.68%</td>
<td>123.88%</td>
<td>91.67%</td>
<td>97.73%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>Leyland</td>
<td>97.13%</td>
<td>117.65%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>Leyland</td>
<td>82.12%</td>
<td>94.93%</td>
<td>88.71%</td>
<td>80.00%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>Leyland</td>
<td>117.24%</td>
<td>111.28%</td>
<td>98.33%</td>
<td>90.70%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>Leyland</td>
<td>103.35%</td>
<td>112.50%</td>
<td>100.00%</td>
<td>116.28%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>Leyland</td>
<td>108.99%</td>
<td>140.83%</td>
<td>98.33%</td>
<td>120.00%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>Leyland</td>
<td>102.09%</td>
<td>114.60%</td>
<td>96.77%</td>
<td>86.36%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>Leyland</td>
<td>91.67%</td>
<td>108.82%</td>
<td>82.26%</td>
<td>79.07%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>Leyland</td>
<td>93.29%</td>
<td>111.29%</td>
<td>98.21%</td>
<td>87.50%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>Leyland</td>
<td>75.41%</td>
<td>101.45%</td>
<td>100.00%</td>
<td>82.22%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>Leyland</td>
<td>85.06%</td>
<td>91.67%</td>
<td>85.00%</td>
<td>80.95%</td>
</tr>
<tr>
<td>May-17</td>
<td>Rawcliffe</td>
<td>103.40%</td>
<td>74.19%</td>
<td>93.55%</td>
<td>103.23%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>Rawcliffe</td>
<td>105.63%</td>
<td>50.00%</td>
<td>88.33%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>Rawcliffe</td>
<td>94.48%</td>
<td>70.97%</td>
<td>87.10%</td>
<td>135.48%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>Rawcliffe</td>
<td>91.84%</td>
<td>66.94%</td>
<td>67.74%</td>
<td>90.32%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>Rawcliffe</td>
<td>93.92%</td>
<td>68.33%</td>
<td>96.67%</td>
<td>96.67%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>Rawcliffe</td>
<td>90.38%</td>
<td>104.84%</td>
<td>100.00%</td>
<td>122.58%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>Rawcliffe</td>
<td>103.95%</td>
<td>119.38%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>Rawcliffe</td>
<td>111.18%</td>
<td>105.65%</td>
<td>91.94%</td>
<td>106.45%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>Rawcliffe</td>
<td>112.90%</td>
<td>91.94%</td>
<td>83.87%</td>
<td>106.45%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>Rawcliffe</td>
<td>108.04%</td>
<td>74.11%</td>
<td>73.21%</td>
<td>78.57%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>Rawcliffe</td>
<td>126.61%</td>
<td>108.06%</td>
<td>96.77%</td>
<td>177.42%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>Rawcliffe</td>
<td>102.42%</td>
<td>100.00%</td>
<td>105.00%</td>
<td>93.33%</td>
</tr>
</tbody>
</table>

(Source: additional data request)

Nursing staff assigned to Rawcliffe ward also worked on the day case unit (Sellers) and the staffing on each unit was arranged daily based on the surgical list requirements and acuity of patients on the wards. The number of staff on duty Monday to Friday was higher than the number of staff at weekends. During our inspection performance boards on the wards showed that numbers of actual nurses and health care assistants were as planned.

Ward managers told us that they planned to full establishment on all shifts including weekends. If there was then no surgery at weekends staff would be moved to cover any gaps in nursing in the inpatient ward, Leyland, or elsewhere within the hospital.

**Vacancy rates**

From February 2017 to January 2018, Lancashire teaching hospital reported a vacancy rate of 16.5% in surgery;

- Royal Preston Hospital 17.3%
- Chorley and South Ribble Hospital 12.7%
The trust vacancy rate target is 6%, therefore the rate in surgery overall and at each individual site is worse.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

During our inspection staff told us that there was only one band five nursing vacancy and two band three health care assistant vacancies. There were no vacancies in preoperative assessment.

**Turnover rates**

The trust target for turnover rate was 10%. The service provided updated figures showing turnover of qualified nursing staff at Chorley and South Ribble Hospital from April 2017 to March 2018 was 19.8%.

Staff in theatres told us that turnover was highest in non-qualified staff as there were many opportunities for staff to progress in their careers to nurse training or operating department practitioner training.

**Sickness rates**

From February 2017 to January 2018, Lancashire teaching hospital reported a sickness rate of 4.9% in surgery;

- Royal Preston Hospital 4%
- Chorley and South Ribble Hospital 8.8%

The trust has set a sickness target of 4.2%. Therefore, surgery overall and Chorley and South Ribble Hospital performed worse than this while Royal Preston Hospital performed better.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

However, during our inspection ward managers told us that the number of staff off sick was very low. We reviewed electronic records on Sellers ward which showed a sickness rate of 1.32%.

**Bank and agency staff usage**

Ward managers told us that they did not use agency nurses to cover shifts but did occasionally use the NHS nurse staff bank. This was mainly to cover sickness absence. The service provided updated figures for the number of nurse and health care assistant shifts filled by bank staff from April 2017 to March 2018 as below.
<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of ward/unit/team</th>
<th>Staffing type</th>
<th>Total shifts (over the last 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Leyland Ward</td>
<td>Qualified nurses</td>
<td>95</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Leyland Ward</td>
<td>Nursing assistants</td>
<td>299</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Rawcliffe</td>
<td>Qualified nurses</td>
<td>825</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Rawcliffe</td>
<td>Nursing assistants</td>
<td>1146</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Surgical Unit CDH</td>
<td>Qualified nurses</td>
<td>513</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Surgical Unit CDH</td>
<td>Nursing assistants</td>
<td>628</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Theatres Anaesthetics CDH</td>
<td>Qualified nurses</td>
<td>172</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Theatres Anaesthetics CDH</td>
<td>Nursing assistants</td>
<td>15</td>
</tr>
<tr>
<td>Chorley &amp; S Ribble</td>
<td>Theatre Scrub CDH</td>
<td>Qualified nurses</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: additional data request)

Between December 2017 and March 2018 Rawcliffe ward was open as an escalation area accommodating medical inpatients. The 1,971 shifts filled by bank staff were all within this period.

**Medical staffing**

The service was not able to provide data specifically for Chorley and South Ribble Hospital for medical and dental staffing for overall staffing rates, vacancies, turnover and sickness. This is because medical staff worked across both sites.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by care services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Following our inspection, the trust provided the following data for surgery overall.
<table>
<thead>
<tr>
<th>Month (specific date)</th>
<th>Site/ Location</th>
<th>Planned staff – WTE</th>
<th>Actual staff – WTE in month</th>
<th>Actual staff – whole number / headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-17 438 01 Anaesthetics Medical (J35301)</td>
<td>136.65</td>
<td>125.48</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 04 Plastics Medical (J35725)</td>
<td>24.85</td>
<td>23.00</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 06 Breast Medical (J37515)</td>
<td>6.00</td>
<td>6.00</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 06 General Surgery Medical (J35001)</td>
<td>37.78</td>
<td>35.88</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 06 Urology Medical (J35050)</td>
<td>18.95</td>
<td>18.00</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 06 Vascular Medical (J35030)</td>
<td>23.52</td>
<td>18.20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 07 Neurosurgery Medical (J35750)</td>
<td>30.38</td>
<td>25.00</td>
<td>26</td>
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<tr>
<td>Mar-17 438 09 Orthopaedics Medical (J35101)</td>
<td>46.17</td>
<td>38.95</td>
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<tr>
<td>Mar-17 438 14 ENT Medical (J35166)</td>
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<td>14.00</td>
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<tr>
<td>Mar-17 438 14 Ophthalmology Medical (J35153)</td>
<td>14.87</td>
<td>13.50</td>
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<tr>
<td>Mar-17 438 14 Oral Surgery Medical (J35160)</td>
<td>10.44</td>
<td>12.00</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Mar-17 438 14 Orthodontics Medical (J35159)</td>
<td>1.90</td>
<td>0.80</td>
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</tr>
<tr>
<td>Mar-17 438 14 Restorative Dentistry Medical (J35165)</td>
<td>0.72</td>
<td>1.10</td>
<td>5</td>
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</tr>
<tr>
<td>Mar-18 438 01 Anaesthetics Medical (J35301)</td>
<td>137.04</td>
<td>131.38</td>
<td>136</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 04 Plastics Medical (J35725)</td>
<td>26.00</td>
<td>21.80</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 06 Breast Surgery Medical (J37515)</td>
<td>6.95</td>
<td>7.00</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 06 Upper GI &amp; Colorectal Surgery Medical (J35001)</td>
<td>36.93</td>
<td>33.18</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 06 Urology Medical (J35050)</td>
<td>19.00</td>
<td>22.00</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 06 Vascular Surgery Medical (J35030)</td>
<td>23.00</td>
<td>22.20</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 07 Neurosurgery Medical (J35750)</td>
<td>30.28</td>
<td>26.00</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 09 Orthopaedics Medical (J35101)</td>
<td>46.88</td>
<td>45.93</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 14 ENT Medical (J35166)</td>
<td>18.68</td>
<td>15.51</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 14 Ophthalmology Medical (J35153)</td>
<td>15.07</td>
<td>13.58</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 14 Oral Surgery Medical (J35160)</td>
<td>10.54</td>
<td>12.00</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 14 Orthodontics Medical (J35159)</td>
<td>1.90</td>
<td>1.85</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Mar-18 438 14 Restorative Dentistry Medical (J35165)</td>
<td>0.72</td>
<td>1.70</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

(Source: additional data request)

Anaesthetic and ear, nose and throat (ENT) services have the lowest number of actual medical staffing compared to planned staff.

**Vacancy rates**

From February 2017 to January 2018, Royal Preston hospital reported a vacancy rate of 12.0% in surgery. This is worse than the trust’s vacancy target of 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
**Turnover rates**

The service was not able to provide data specifically for Chorley and South Ribble Hospital for medical and dental staffing turnover. However, the overall turnover rate for medical and dental staff in surgery from April 2017 to March 2018 was 11.3%.

**Sickness rates**

From February 2017 to January 2018, Royal Preston hospital reported a sickness rate of 1.3% in surgery. This is better than the trust’s sickness target of 4.2%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

The service provided updated figures for bank medical staff usage from April 2017 to March 2018 as below.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of ward/unit/team</th>
<th>Staffing type (consultant, middle grade, doctor in training)</th>
<th>Total Shifts Filled by Bank Staff (over the last 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorley and South Ribble</td>
<td>J35301 - Anaesthetics</td>
<td>Middle Grade</td>
<td>10</td>
</tr>
<tr>
<td>Chorley and South Ribble</td>
<td>J37515 - Breast Surgery</td>
<td>Doctor in Training</td>
<td>1</td>
</tr>
<tr>
<td>Chorley and South Ribble</td>
<td>J35001 - Upper GI and Colorectal Surgery</td>
<td>Doctor in Training</td>
<td>1</td>
</tr>
<tr>
<td>Chorley and South Ribble</td>
<td>J35001 - Upper GI and Colorectal Surgery</td>
<td>Middle Grade</td>
<td>5</td>
</tr>
</tbody>
</table>

The service provided updated figures for agency staff usage for medical and dental staff as below from April 2017 to March 2018 as below.
Staffing skill mix

As at October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the whole time equivalent staff working at Lancashire Teaching Hospitals NHS Foundation Trust

(Source: additional data request)

The service had sufficient suitably qualified staff. We reviewed medical rotas and saw that consultant cover was available Monday to Friday. Out of hours there were processes for medical cover through registered medical officers. All consultants were contactable if not on site and out of hours. The online rota displayed details of their on call and private work.

Consultants gave junior doctors and ward managers and sisters contact numbers to be contacted out of hours and staff reported they had used this and consultants always responded. There were non-resident consultants on call overnight and weekends at the Royal Preston Hospital site who
could also be contacted.

**Records**

Though staff kept appropriate records of patient’s care and treatment these were both electronic and paper and not all staff had access to electronic records. We found paper records stored in an unlocked room meaning that confidential personal information could potentially be accessed by people not authorised to look at it.

The service used a mix of electronic and paper patient records. We were told that paper records were kept for ‘intentional rounding’ and risk assessments and were told this was because healthcare assistants did not have access to the electronic patient record.

During our inspection we reviewed six records and found that they were contemporaneous, comprehensive and accurate.

We reviewed one Do Not Attempt Cardiopulmonary Resuscitation form and found that it was fully completed and had been reviewed daily throughout the patient’s stay on the ward.

We look at six sets of patient records, electronic and paper. We saw risk assessments using the Malnutrition Universal Screening Tool (MUST), venous thromboembolism (VTE) assessment and National Early Warning Scores (NEWS) were completed in four of the records. One record did not have the assessments completed as the patient had only been admitted in the last six hours. We saw that one patient record showed the assessments as ‘scheduled’ and we observed a nurse doing these whilst we were on the ward.

The elective surgery care pack and day case/short stay elective pathway documents were kept in the paper record. The records contained appropriate details of patient needs and treatment including two care plans, one which identified social circumstances and holistic needs and another which focussed on clinical care and treatment. Care plans were reviewed and signed weekly.

World Health Organisation (WHO) safer surgery checklists were kept in the paper patient record and recorded electronically.

Paper patient records were stored in a locked notes room on Leyland ward. There was a desk outside the room used by staff and senior staff told us that the room was locked when there was no one at the desk. However, during our inspection we found the room unlocked when no one was using the desk meaning that records containing confidential personal information could potentially be accessed by visitors and others not authorised to look at them.

**Medicines**

Medicines were stored correctly and in a safe manner. Staff members kept accurate records of medicines.

Medication was stored securely, the treatment rooms were temperature controlled, brightly lit and tidy. There was evidence of appropriate temperature monitoring for the room and the refrigerator.
Controlled drugs checks were regularly carried out and a random check of stock found balances correct. Fluids were stored securely and potassium fluids were segregated.

Temperature readings of refrigerators that store medication and vaccines should be between two and eight degrees and any deviations and corrective action should be recorded. We reviewed checklists on Leyland and Sellers wards from March 2018 to May 2018 that demonstrated that maximum and minimum refrigerator temperatures had been recorded daily and all were found to be within range. The thermometer was clearly displayed on the front of the refrigerator.

On Sellers ward we saw that the controlled drug stock check had been completed daily from March 2018 to May 2018. Where a discrepancy had occurred, this had been noted and recalculation and signed for by a member of staff.

Daily pharmacy support was available on Leyland ward. This supported medicines reconciliation, clinical checks, requisitioning of medicines, top up of stock and facilitating To Take Out prescriptions.

A paper medication administration record was being used. We looked at three charts and saw that patient details were completed on each page, this is important as the nurse can see the patient’s name on the same page as the prescription being administered to reduce the potential for mistakes.

Antimicrobial stewardship was reviewed. Doctors told us they reviewed patients’ C-reactive protein (CRP) test results weekly. CRP results are important as they indicate inflammation which can be a sign of infection. They told us they liaised with the microbial specialist and consultant to review care and treatment based on these results.

Incidents

Staff recognised incidents and knew how to report them. Managers investigated incidents quickly and shared lessons learnt and changes in practice with staff through monthly team meetings and daily safety huddles. Staff attended harm free care meetings to share learning from incidents across the service.

Staff reported incidents using an electronic system and were aware of the types of incidents they would report. Staff gave examples of incidents they had reported such as patient falls and pressure ulcers.

Following an incident staff involved held an immediate ‘safety huddle’. At this they identified any immediate lessons learnt and actions to be implemented. If appropriate, staff also completed a personal reflection and discussed the incident in a meeting with managers.

Ward managers and sisters and matron attended monthly harm free care meetings where lessons learnt across the whole division were shared. Ward managers told us that staff were offered the opportunity to attend these meetings with them to share the learning with their team.
Lessons learnt from incidents were also shared with staff in monthly team meetings. The minutes of meetings were emailed to all staff and a paper copy was kept in the ward office for staff who could not access a computer.

We reviewed minutes of the monthly meetings for Leyland and Sellers wards from March 2018 to May 2018. We saw evidence that incidents and lessons learnt were discussed at every meeting and were a standard agenda item. Staff we spoke to were able to describe changes made as a response to lessons learnt from incidents. They told us that skin assessments are now discussed at board rounds and audited regularly following an incident where a patient acquired an avoidable pressure ulcer and there was no risk assessment.

Theatre staff told us that they discussed information about incidents and lessons learnt in the morning safety huddle before surgery starts. They gave us an example of changing practice and reviewing the World Health Organisation safety surgery checklist to include a cannula flush and pressure ulcer check before the patient leaves theatre following an incident.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke to were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported two incidents classified as never events for surgery. Both incidents were classified as surgical/invasive procedure incidents.

(Source: Strategic Executive Information System (STEIS))

We reviewed the root cause analysis reports and action plans for both never events and found that a comprehensive investigation had taken place involving the relevant people and lessons learnt identified and an appropriate action plan put in place. We saw that both action plans had been completed and there was evidence of lessons learnt shared with the wider team. We also saw that Duty of Candour had been applied both verbally immediately following the incidents and formally in writing.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 21 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were:
• Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 13 (62% of total incidents).
• Slips/trips/falls meeting SI criteria with three (14% of total incidents).
• Surgical/invasive procedure incident meeting SI criteria with three (14% of total incidents).
• Treatment delay meeting SI criteria with one (5% of total incidents).
• Sub-optimal care of the deteriorating patient meeting SI criteria with one (5% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Of the 13 diagnostic incidents reported to STEIS one was at Chorley and South Ribble Hospital.

Safety thermometer

The service collected safety information and shared this with staff, patients and visitors on white boards in the wards. Safety performance was audited monthly and recorded using an electronic tracking tool.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 44 new pressure ulcers, 14 falls with harm and 12 new catheter urinary tract infections from April 2017 to April 2018 for surgery.
The service provided updated figures for pressure ulcers at Chorley and South Ribble Hospital between January 2018 and May 2018 as below.

### Pressure Ulcer incidence - Surgery CDH, January 2018 –May 2018.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Avoidable</th>
<th>Unavoidable</th>
<th>Awaiting Validation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>February</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>April</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: additional data request)

The service provided updated figures for the number of falls on surgical ward at Chorley and South Ribble Hospital between January 2018 and May 2018 as below.

(Source: NHS Digital)
<table>
<thead>
<tr>
<th>Ward</th>
<th>Jan 2018</th>
<th>Feb 2018</th>
<th>March 2018</th>
<th>April 2018</th>
<th>May 2018</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leyland</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sellers</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Winstanley</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

(Source: additional data request)

There were no catheter acquired urinary tract infections between January 2018 and May 2018 at Chorley and South Ribble Hospital.

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Sellers and Leyland wards displayed up to date performance information on a white board. On Leyland ward the board showed there had been no pressure ulcers or catheter acquired urinary tract infections in June and there had been four falls. On Sellers ward the performance data displayed for June 2018 showed there had been no pressure ulcers, falls or catheter acquired urinary tract infections. Both performance boards stated there had been no case of Clostridium difficile or methicillin-resistant Staphylococcus aureus (MRSA) between April 2017 and June 2018.

In theatres performance information was displayed on a ‘How are we doing?’ board. We observed an effective postoperative debrief which included discussion on what had gone well and challenges that arose. The debrief was recorded on the World Health Organisation safer surgery checklist.

The service monitored performance through the monthly STAR audited which was recorded using the audit management and tracking electronic tool. The outcome of the STAR audit was shared with staff in monthly team meetings and presented to the divisional nursing director and through the safety and governance group.

**Is the service effective?**

**Evidence-based care and treatment**

The service made sure that staff provided care and treatment based on national guidance and evidence in order to achieve positive outcomes for people. Staff used a sepsis red flag system to monitor patients and identify sepsis.

The service managed sepsis through a sepsis pathway that was in line with National Institute for Health and Care Excellence guidance. Staff used national early warning scores to screen patients and identify sepsis. A sepsis red flag system was in place and a sepsis box available in treatment rooms.

Staff ensured that thrombo-embolic deterrent stockings were used by patients and the correct application of thrombo-embolic deterrent stockings was recorded in a ‘stocking care plan’.
Thrombo-embolic deterrent stockings are used to help prevent the occurrence of blood clots developing in the leg after surgery.

We reviewed a clinical governance committee report which demonstrated that the service had well developed workstreams to implement National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIPs are national standards which include the use of the World Health Organisation safer surgery checklists and the need for multidisciplinary teams to work together. The service had a Local Safety Standards for Invasive Procedures (LocSSIP) template for use in some invasive procedures and a task and finish group were developing it for use in other areas.

Staff in theatres used the WHO surgical safety checklist five steps to safer surgery and this was recorded electronically as well as a paper copy kept in patient notes.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. Patients were assessed using the malnutrition universal screening tool and referred to dietitians where appropriate.

Staff assessed patients’ nutritional needs using the malnutrition universal screening tool. We reviewed six patient records and saw that the malnutrition universal screening tool assessment had been completed for four patients. One patient had not yet had a malnutrition universal screening tool assessment as they had been admitted less than six hours before. One patient had an assessment scheduled and it took place whilst we were visiting the ward. We saw an example of a patient with a high malnutrition universal screening tool score being referred to a dietitian for further support and advice and the malnutrition universal screening tool assessment repeated regularly.

We observed a mealtime on Leyland ward. We saw that patients were offered a choice of hot meals, cold meals and salads, hot and cold puddings, sandwiches and fruit from a hot trolley on the ward. Staff served the meals to the patients with a choice of hot or cold drink. Staff used blue trays to indicate a patient who needed assistance eating and red trays for patients with dementia.

We looked at examples of menu cards and saw that choices included options for vegetarians, patients who required higher calories, soft and textured foods and food for renal patients. Patients we spoke to told us the food was sufficient and tasty, ‘the food is excellent’.

Water was available on patients’ tables and patients told us this was regularly refreshed.

Staff on Sellers ward told us they encouraged day case patients to eat as soon as possible following surgery. They could access hot meals for patients and had a kitchen where they made toast and hot drinks for patients. Staff contacted the kitchen department daily to order sufficient bread and sandwiches for the number of expected patients. Nutritional guidelines were included on menu cards and on posters in the kitchen area.

The trust policy on ‘peri-operative fasting’ contained clear guidelines for staff on what food and drink adults could have before and after surgery.
Pain relief

Patients pain was monitored and recorded regularly.

The ward manager on Leyland ward did a pain round twice daily to check if patients required any pain relief. Intentional rounding was undertaken which included regular assessment of pain. The service has access to a specialist pain management nurse who was based at Chorley and South Ribble Hospital two days a week and could be contacted by bleep at other times.

We saw that a pain assessment was completed as part of the discharge checklist for day case patients.

The service had reviewed the enhanced recovery pathway for orthopaedic patients and introduced a new system of pain relief. All orthopaedic patients returning from surgery were given paracetamol, liquid pain relief medicine and medicine to prevent nausea and vomiting.

Patient outcomes

Patients care and treatment outcomes were routinely collected and monitored and the information used to improve care. Staff carried out monthly audits of patient outcomes using a quality assurance tool.

Patient outcomes were reviewed in monthly mortality and morbidity meetings and at clinical governance meetings. The internal STAR audit programme was in place and monitored and reported to divisional leadership using the audit management and tracking system. The STAR audit produced a ward based action plan which was also recorded on the audit management and tracking system.

The lower limb, spinal, foot and ankle and upper limb teams had a weekly meeting to review all the previous week’s cases and review all metal work implanted and any trauma to patients.

Relative risk of readmission

Trust level

From January 2017 to December 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery and general surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. Top three specialties for specific trust based on count of activity

From January 2017 to December 2017, all patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and trauma & orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/11/2016 - 31/10/2017))

A breakdown by site can be seen below:

**Chorley and South Ribble Hospital**

From January 2017 to December 2017, all patients at Chorley and South Ribble Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

- Urology, upper gastrointestinal surgery and trauma & orthopaedic patients at Chorley and South Ribble Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

**Elective Admissions - Chorley and South Ribble Hospital**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. Top three specialties for specific trust based on count of activity

From January 2017 to December 2017, all patients at Chorley and South Ribble Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and urology patients at Chorley and South Ribble Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average
- Vascular surgery patients at Chorley and South Ribble Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective Admissions - Chorley and South Ribble Hospital**

Senior managers recognised the need to address higher than expected risk of readmission for non-elective patients and were working with the continuous improvement group to find solutions. They told us the high rate was due to the number of centralised specialist services which created an increase in demand from patients who lived in other areas.

**Hip Fracture Audit**

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.7% which was within the expected range. The 2016 figure was 8%.

The proportion of patients having surgery on the day of or day after admission was 67%, which was worse than the national standard of 85%. The 2016 figure was 66.4%.

The perioperative medical assessment rate was 80.5%, which failed to meet the national standard of 100%. The 2016 figure was 79.1%.
The proportion of patients not developing pressure ulcers was 97.7%, which falls in the middle 50% of trusts. The 2016 figure was 96.9%.

The length of stay was 21.6 days, which falls in the middle 50% of trusts. The 2016 figure was 19.5 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 77.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 77.8%.

The risk-adjusted 90-day post-operative mortality rate was 1.8% which was within the expected range. The 2016 figure was 7.2%.

The risk-adjusted 2-year post-operative mortality rate was 20.3% which was within the expected range. The 2015 figure was 20.8%.

The risk-adjusted 30-day unplanned readmission rate was 6.1 which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 72.3% which was a negative outlier. The 2016 figure was 74.4%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.4% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range. The 2016 figure was 3.5%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 11 days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 2.7% which was in the expected range. The 2016 figure was 2%.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency
admission. This indicates that more than 15% of records had the referral source missing.

The 90-day post-operative mortality rate was 2.7%, which is within the expected range. The 2015 rate was 2.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9% which was within the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), the Royal Preston Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 148 cases.

The Royal Preston Hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 143 cases.

The Royal Preston Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 82 cases.

The Royal Preston Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 68 cases.

The risk-adjusted 30-day mortality for the Royal Preston Hospital was within expectations, based on 148 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed.
In 2016/17 performance on groin hernias was worse than the England average.

For Varicose Veins, performance was better than the England average.

For hip replacements, performance was about the same as the England average.

For Knee replacements was about the same as the England average.

(Source: NHS Digital)

Senior staff told us that the local clinical commissioning group had changed the criteria for patients who could access surgery for groin hernia repair. This meant that patients having surgery on groin hernias had more complex operations and potentially less successful outcomes.

Competent staff

Staff members were supported to maintain and further develop their skills and experience. Staff members' competency to undertake their job role was monitored through annual appraisal and most staff had received their appraisal at the time of our inspection.

The service provided updated figures for appraisals for nursing staff in surgery at Chorley and South Ribble Hospital as below which demonstrates an upward trend in number of completed appraisals in 2018.
From February 2017 to January 2018, 75.4% of nursing staff in surgery completed an appraisal which worse than the trust target of 90%. However, medical staff achieved an appraisal rate of 91.7%, meeting the target.

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals)

Ward managers monitored appraisal completion on an electronic spreadsheet which they updated monthly. We reviewed the spreadsheet and saw it held details of revalidation dates for all qualified staff and there were no staff overdue for revalidation.

Preceptorship was in place for newly qualified staff and staff told us they had been supernumerary on the ward for six weeks and this time had been protected. They told us health care assistants were given three weeks supernumerary time.

The service had a clinical educator for orthopaedics based part time at Chorley and South Ribble Hospital who provided additional training to staff on Sellers and Leyland wards. Staff could access additional role specific training such as spinal deformity training. The service provided data on compliance with the number of training events for spinal deformity. At the end of May 2018 compliance was 67%, however the service told us additional training was being held in June which would increase compliance to 80%.

The service used the Collaborative Learning in Practice training model to support student nurses. The ward manager told us she used coaching to encourage student nurses to take a lead in their own practice and to problem solve.

Multidisciplinary working

We saw positive examples of team working between staff of different disciplines, staff worked well together to meet the range and complexity of patients’ needs. Patients’ care and treatment was discussed at daily multidisciplinary team board rounds.

Leyland ward had multidisciplinary board round every day which was attended by nurses, junior doctors, physiotherapy and occupational therapy staff. During our inspection we observed a multidisciplinary board round and saw that each patient was discussed in turn. Staff shared information on current care and treatment, predicted date of discharge, next steps for therapy, any
referrals to other services that had taken place or which were needed and progress of therapy. We saw that staff discussed feedback from the mental health team about a patient they had referred.

Staff described a positive working relationship between nursing and medical staff. We observed a consultant led ward round and saw that the consultant saw all the patients on the ward as well as his own.

We saw positive examples of positive team working between staff of different disciplines. For example, we observed an effective handover from a nurse on the ward to an anaesthetic practitioner and then later back to ward staff. At each stage the practitioner gave a comprehensive overview of the patient’s current situation and care and treatment received. Ward managers and sisters attended the daily theatre safety huddle to aid coordination and information sharing between the teams.

The lower limb, foot and ankle, upper limb and spinal teams had a weekly multidisciplinary team meeting which included radiology services, trainee doctors, surgeons and consultants. Every patient was discussed at this meeting and all surgical site infections reviewed.

Records we reviewed contained evidence of multidisciplinary team working where appropriate.

**Seven-day services**

Medical cover was available seven days a week, out of hours and at weekends this was provided by registered medical officers. Staff told us consultants could be contacted out of hours and consultant cover was accessed from Royal Preston Hospital if needed. Staff reported they had never had a problem contacting a consultant out of hours.

Physiotherapy services were available on Leyland ward seven days a week and occupational therapy was available Monday to Friday. Multidisciplinary board rounds were held seven days a week and medic led ward rounds took place daily. Pharmacy service staff were available on the ward every day.

The service could access diagnostic services such as x ray department and blood tests seven days a week. Staff told us if an issue occurred which needed more complex diagnostic equipment the patient would be transferred to Royal Preston Hospital.

A site manager was available seven days a week over 24 hours and there was on call cover for airways management in theatres 24/7.

The service provided some general surgery and urology operations on a Saturday.

**Health promotion**

Staff made sure that they provided patients with support and information to live healthier lives. Lifestyle questions were asked at preoperative assessment and admission and staff made referrals to relevant support services where appropriate.

Lifestyle information was discussed with patients who attended for preoperative assessment and also at admission. This included an assessment of alcohol intake, smoking levels, physical activity
levels and weight management. The pathway documents contained triggers for referral to other services and contact details of services and how to make a referral. It told staff which leaflets patients should be given if they wanted further advice.

Staff told us that alcohol and smoking intake assessments were also recorded on the electronic patient record and this contained a flag and a referral form on the system to smoking cessation and alcohol services.

We saw that health promotion leaflets were included with the preoperative pack sent to patients before their surgery.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Patients’ consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. The service had appropriate systems and policies to support patients to make decisions and for assessing patients’ mental capacity, where appropriate. Staff could describe the process and knew where to seek additional support if needed.

Planned surgical procedures were discussed and consent obtained during outpatient clinic consultations and again at preoperative assessment. Consent was then confirmed by staff on the day of the procedure when the patient was admitted to the ward or unit. We reviewed six records and saw that consent had been obtained and the consent form signed by patient and staff.

The Mental Capacity Act 2005 allows restraint and restriction to be used if they are in a person’s best interest. Extra safeguards, Deprivation of Liberty Safeguards (DoLS), are needed if the restriction and restraint used will deprive a person of their liberty. During our inspection there were no patients subject to a DoLS on the wards. However, staff could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity.

The service had appropriate policies and systems for assessing capacity and copies of these were available for staff in a file in the ward office. The ward manager told us they had only made three DoLS applications in the last year. Staff told us if concerns were raised regarding a patient’s capacity they would seek support from the trust’s mental capacity lead.

We spoke to senior staff in the preoperative assessment unit who told us that they would carry out a mental capacity assessment at preoperative stage if there were concerns. The capacity assessment would be kept in the patient record and be recorded in the care plan and written on the list form which was sent to theatres.

Staff gave two examples of involvement in best interest meetings with patients, their families, doctors, nurses and independent advocates. They told us about a patient with lasting power of attorney in place that attended for knee surgery. The trust safeguarding team had supported the patient to attend a best interests meeting with everyone involved in their care.

From March 2017 to February 2018, the trust reported that 86% of nursing staff in surgery had completed the Mental Capacity Act Level 2 course. This is worse than the trust target of 90%.
The trust has not provided information for Deprivation of Liberty Safeguards (DoLS) training. The inspectors may want to check if this course was made available to staff.
(Source: Routine Provider Information Request – Training tab)

The service provided updated figures for 2017 and 2018 for completion of Mental Capacity Act training for Chorley and South Ribble Hospital. These showed that in 2017, 89% of nursing staff completed Mental Capacity Act Level One training and 83% of eligible nursing staff completed Mental Capacity Act Level Two training. To date in 2018, 88% have completed Level One training and 96% of eligible nursing staff have completed Level Two. DoLS training was included within the adult safeguarding training for staff.

The service was not able to provide separate figures for medical staff at Chorley and South Ribble Hospital as they work across both sites. However, compliance rates for medical staff in 2017, were 48% for Level One training and 62% for Level Two. This had improved in 2018 to 67% completing Level One and 63% completing Level Two.

**Is the service caring?**

**Compassionate care**

Feedback was positive about the way staff treat people. Patients and relatives, we spoke with told us they were treated with dignity, respect and kindness. Staff responded compassionately when patients required help and responded quickly when patients called for support to meet their personal needs.

We spoke to patients and relatives on Leyland ward and observed care and treatment on the wards and in theatres. Patients reported that staff demonstrated a caring approach. Comments such as ‘everybody has been very nice’ and ‘brilliant, great here’ were received from patients we spoke with. One patient told us that staff always greeted him warmly.

We observed that staff interacted with patients in a respectful and considerate way. We saw staff accompanying a patient with a learning difficulty back to the ward from theatre. Staff offered reassurance that was appropriate to the needs of the patient.

We observed staff demonstrating an awareness of patients wider social needs and arranging hospital transport and referring to other appropriate community services such as dietitians.

The wards had Friends and Family Test performance cards and boxes at the entrances and displayed patient feedback scores on the performance board. We saw that the performance board stated that in May 2018 91% of patients had said they would recommend the ward.

**Friends and Family test performance**

The Friends and Family Test response rate for surgery was 27% which was similar to the England average of 29% from December 2016 to November 2017.
Friends and family test response rate at Lancashire Teaching Hospitals NHS Foundation Trust, by site.

Chorley and South Ribble Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlington DC</td>
<td>117</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Leyland</td>
<td>426</td>
<td>29%</td>
<td>95%</td>
</tr>
<tr>
<td>Rawcwin</td>
<td>738</td>
<td>28%</td>
<td>87%</td>
</tr>
<tr>
<td>Sellers</td>
<td>808</td>
<td>25%</td>
<td>93%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

The response rate for surgery at Chorley and South Ribble Hospital from December 2016 to November 2017 was 24% which is below the England average.

We saw the service respected patient’s privacy and dignity needs. Patients reported that staff respected their privacy during examinations and when offering support. We observed staff closing curtains when assisting patients to get in and out of bed. We saw notices displayed in wards advising patients that a chaperone was available for consultations on request.

We saw reception staff greeting day case patients warmly and with respect and giving clear directions to the wards.

Emotional support

We saw that staff provided information to patients in a way they could understand and provided support to minimise their distress.

We saw that the family of a patient with learning difficulties were encouraged to stay with them throughout their admission for day case surgery and accompanied them to the theatre to provide emotional support.

Reception staff told us they noted a patient’s level of anxiety and emotional distress when they presented for admission. They gave us examples of actions they had taken with patients who were anxious such as accompanying them to a quiet area and alerting nurses to a nervous patient.

Volunteers visited the ward three times a week, offering support to patients by listening to them and supporting them to complete patient feedback cards. We spoke to one volunteer who had experience of undergoing surgery and staff told us that patients spoke positively about the empathy and support they gave.
Staff offered appropriate support to people with dementia to help them cope with their treatment. Patients were given a cloth wallet made of material or felt which opened and had items such as buttons and pockets to twiddle or manipulate. Patients were given these to reduce agitation and they could be taken home by patients or washed for re-use.

**Understanding and involvement of patients and those close to them**

Patient’s relatives were involved and encouraged to make decisions about the care and support they received. We saw staff spending time with patients’ relatives to explain their care and treatment.

Staff involved patients and those close to them in decisions about their care and treatment. The service provided open visiting hours from 10am to 8pm and carers were encouraged to visit throughout the day and assist their loved ones at mealtimes.

The service had a carers charter and leaflets were available on the wards telling what support and involvement they should expect from staff and the service. The leaflet told them how to contact Patient Advice Liaison Service (PALS) if they had concerns.

We saw staff talking to carers in a sensitive manner to resolve an issue involving another patient and carers on the ward and staff responding quickly and respectfully to one carer’s request for further information on their relative’s progress.

We spoke to two relatives who told us they were happy with the care and treatment their loved ones had received and with the involvement they were given in that care and treatment. There was evidence in four patient records of family and carers being involved in care and treatment through discussion and feedback.

Patients we spoke to felt they had been given appropriate information about their treatment and been kept informed of their care plan. However, one patient told us she felt that she had not been listened to by the doctor prior to her surgery when expressing concerns about certain elements of her treatment.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Patients’ needs and preferences were considered and acted on to ensure that services were delivered in a way that met their needs.

At the time of our inspection the service had introduced open visiting hours from 10am to 8pm and provided free television between 8am and 12pm in response to feedback from patients and carers.

Staff told us the service had changed the opening hours of preoperative assessment to accommodate appointments early and late in the day. They had done this as patients with young
families had told them it was difficult to attend preoperative assessment appointments due to childcare commitments and the times appointments were offered.

The service had submitted a business plan to move ophthalmology services to Chorley and South Ribble Hospital to improve the patient experience and make the service sustainable. The service told us this had been approved and a project plan was in place and they had planned consultation with staff, patients and other key stakeholders.

Staff on Longton Day Case unit told us that they had recognised that patients attending the unit who were admitted at reception on Sellers ward sometimes found it difficult and anxiety provoking to find the unit. They had developed plans to admit patients at a reception desk on Longton Day Case Unit to address this and improve the patient pathway, hopefully saving time and increasing the number of spaces on the theatre list.

**Average length of stay**

**Trust Level – elective patients**

From February 2017 to January 2018, the average length of stay for all elective patients at the trust was 5.3 days, which was higher than the England average of 3.9 days.

Trauma & orthopaedics elective patient at the trust were 4.2 days, which was higher than the England average of 3.9 days.

Neurosurgery elective patients at the trust were 5.3 days, which was as expected, compared to the England average of 5.0 days.

Urology elective patients at the trust were 3.5 days, which was higher than the England average of 2.5 days.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for different specialties](image)

*Note: Top three specialties for specific trust based on count of activity.*

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 6.6 days, which is higher than expected, compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at the trust was 4.4 days,
which is as expected, compared to the England average of 3.8 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 12.2 days, which is higher than expected, compared to the England average of 8.7 days.

The average length of stay for Urology non-elective patients at the trust was 2.9 days, which is the same as the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay for different specialties at the trust and England average.]

*Note: Top three specialties for specific trust based on count of activity.*

**Chorley and South Ribble Hospital - elective patients**

From February 2017 to January 2018, the average length of stay for all elective patients at Chorley and South Ribble Hospital was 4.4 days, which is higher than the England average of 3.9 days.

The average length of stay for trauma & orthopaedics elective patients at Chorley and South Ribble Hospital was 4.2 days, which is higher than the England average of 3.9 days.

The average length of stay for urology elective patients at Chorley and South Ribble Hospital was 1.7 days, which is lower than the England average of 2.5 days.

The average length of stay for upper gastrointestinal surgery elective patients at Chorley and South Ribble Hospital was 4.5 days, which is the same as the England average of 4.5 days.

**Elective Average Length of Stay - Chorley and South Ribble Hospital**

![Bar chart showing average length of stay for different specialties at Chorley and South Ribble Hospital and England average.]

*Note: Top three specialties for specific trust based on count of activity.*
Chorley and South Ribble Hospital - non-elective patients

The average length of stay for all non-elective patients at Chorley and South Ribble Hospital was 6.4 days, which is higher than the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at Chorley and South Ribble Hospital was 3.7 days, which is as expected, compared to the England average of 3.8 days.

The average length of stay for vascular surgery non-elective patients at Chorley and South Ribble Hospital was 11.2 days, which is higher than the England average of 10.7 days.

The average length of stay for Urology non-elective patients at Chorley and South Ribble Hospital was 2.8 days, which is as expected, compared to the England average of 2.9 days.

Non-Elective Average Length of Stay - Chorley and South Ribble Hospital

(Source: Hospital Episode Statistics)

Staff told us that above average length of stays were attributed primarily to difficulties transferring or discharging patients who were from a different borough or area.

Meeting people’s individual needs

Staff took account of patients’ individual needs, particularly for patients with dementia, learning disabilities and sensory impairments. Wards used a picture book called ‘The Hospital Communication Book’ to communicate with patients with learning or communication difficulties or who did not speak English.

The service holistically assessed patient’s needs. We reviewed the care plan and care pathway documents for elective and day case patients and saw they included a review of the patient’s social circumstances, mental health needs and caring responsibilities. Care plans also included questions that triggered the need for additional input from smoking cessation, alcohol or weight management services.

The service focused on meeting the needs of patients living with dementia. The service used a flower shape hole punched into the patient’s hospital wristband to discreetly identify patients with...
dementia. Staff could access equipment from a dementia box which contained equipment designed for patients with dementia such as the cloth wallets which they could play with and take home to reduce anxiety. The box also contained useful contact and information for staff on caring for people with dementia.

The service had pledged to follow ‘Johns Campaign’ for patients with dementia. Johns Campaign states that in hospitals carers of dementia patients should not just be allowed but should be welcomed, and that collaboration between patients and all connected with them is crucial to their health and wellbeing. The wards displayed ‘carers welcome’ posters and the service provided fold up beds and a reclining chair for carers to stay with patients. Carers were given special lanyards and badges to wear so that staff on ward would recognise them and include them in discussions about and activities with their loved ones.

Wards used a picture book called ‘The Hospital Communication Book’ for patients with learning or communication difficulties or who did not speak English. The picture book was used to help patients communicate their needs and explain their symptoms. It contained sections on personal care, degree of pain, foods, people, body parts, drinks, personal things, symptoms and medical procedures. It also contained hints and tips for staff to communicate with patients with visual impairment or hearing loss and basic Makaton signs. Makaton is a language programme using signs and symbols to help people communicate. Staff could also access a specialist learning disability nurse for support and advice.

The service provided interpreters for patients who did not speak English. Staff booked interpreters from The Big Word, an interpretation service that the trust had a service level agreement with. Staff told us they could also access interpretation over the telephone if they needed it immediately for a patient who did not speak English and where an interpreter had not been booked. Staff in the preoperative assessment unit stated they would add information regarding the patient’s interpretation and communication needs to the preoperative assessment forms which went to theatre staff.

Staff made adjustments to processes to accommodate the needs of patients with learning disabilities or who were very anxious. They told us about a patient with learning difficulties who had been taken directly to the theatre with their family to be admitted and then discharged from theatre, as they became very anxious in unfamiliar environments. They informed us that the families of people with learning disabilities could accompany their loved ones to theatre to provide support and reassurance. We observed a multidisciplinary team meeting where staff discussed moving a patient to a different bed to help reduce the symptoms of claustrophobia.

The service had extended visiting hours from 10 am to 8 pm and during our inspection we saw that relatives and visitors could stay with patients up to the point they went to theatre and during mealtimes.

Patients having knee or hip surgery attended physiotherapy led group sessions prior to admission for their operation. The sessions taught patients how to use equipment such as crutches and Zimmer frames correctly and gave patients exercise to do before and after their surgery. We spoke to one patient who told us how helpful this had been.
Access and flow

The average length of stay from February 2017 to January 2018 for all non-elective and all elective patients was higher than the England average.

Referral to treatment (percentage within 18 weeks) - admitted performance

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery the trust has been similar to the England average for the entire reporting period.

The latest information available shows that as at March 2018, 80% of this group of patients were treated within 18 weeks compared to an England average of 68%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Two specialties were above the England average and three of specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>78%</td>
<td>61%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>Urology</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>65%</td>
<td>72%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>37%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

In Q1 2017/18, this trust cancelled 276 surgeries. Of the 276 cancellations, 25% weren’t treated
within 28 days. This has improved through to Q3 2017/18 where we can see, of the 311 cancellations, 12% weren’t treated within 28 days.

Over the two years, the percentage of cancelled operations at the trust has been higher than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Lancashire Teaching Hospitals NHS Foundation Trust**

[Graph showing percentage of patients cancelled and not treated within 28 days]

Over the two years, the percentage of cancelled operations at the trust has been similar to the England average.

*(Source: NHS England)*

The service provided updated figures for quarter one 2017/18 which demonstrated that of the 276 cancelled operations 41 were cancelled at Chorley and South Ribble Hospital.

Elective orthopaedic surgery at Chorley and South Ribble Hospital was cancelled for two weeks in April 2018 due to the pressure of admissions from the emergency department and the need for medical inpatient beds.

The service carried out general surgery and urology operations on Saturday to address the backlog from cancellations.
The service provided updated figures for delayed transfer of care for the surgical division at Chorley and South Ribble Hospital which showed that on 21 June 2018 there were six patients who were delayed in their discharge arrangements, four of which were for social reasons.

Leyland ward had a named admission and discharge nurse for three days a week and assistant practitioners did this work on the other four days. They liaised with the integrated discharge team who were based on the ward. The named discharge nurse completed a checklist for every patient due to be discharged which included making referrals to other agencies as appropriate.

We reviewed the standard operating procedure for reviewing stranded patients and saw that appropriate processes were in place to review stranded patients and escalate issues to a stranded patient team. A stranded patient is a patient with a length of stay of seven days or more.

The service used the Clinical Utilisation Review (CUR) tool, an electronic bed management system, to track the number of patients, identify stranded patients and aid patient flow through the department. Staff completed the CUR twice a day following the ward round updating the number of beds based on the number of patients and their acuity and this was reviewed daily by the matron.

Patients were tracked daily using the Five SAFER Actions for Patient Flow tracking tool to ensure they were reviewed, they had an expected date of discharge and if being discharged that morning they were transferred to the discharge lounge by 10am.

An anaesthetic practitioner collected all patients going for surgery from the ward. The same anaesthetic practitioner supported them through recovery and back to the ward or through to discharge. This improved the patient journey through the department as it reduced the number of handovers between staff.

The service had recruited an arthroplasty nurse as an enhanced recovery practitioner for six months to offer additional support to patients having hip and knee surgery from admission through to discharge. At the time of our inspection the new post had not started but the practitioner was due to start the next week.

Day case patients were admitted and assessed on Rawcliffe or Sellers ward. They attended at 7.30am or 12.30 pm dependant on the time of their operation. Some patients were discharged following review by a staff nurse and the service had introduced nurse led discharge for some breast surgery cases to improve the patient journey through the department.

The service held weekly theatre list meetings to discuss the planned operations for the following week and ensure the correct staffing was in place. Following this the ward managers and matrons met to discuss any flags and equipment issues to ensure everything needed to support the patient was in place.

The service used the ‘golden patient’ system. These were patients who were identified the day before surgery as the first to go to theatre and would be appropriately prepared to go to theatre by 8.30am. This system enabled theatre lists to start on time and the team knew which patients had to be admitted and prepared by 8.30am.
However, staff in theatres told us they did not always have timely access to theatre lists and there had been occasions they had received the list at 3pm the day before the planned surgery. We reviewed the general departmental standards and saw that guidelines stated that no changes should be made to theatre lists for two weeks before the planned surgery. Staff also told us that they did not always receive the patient notes the day before surgery and they had reported this through the online incident reporting system.

Learning from complaints and concerns

Staff members were aware of how to support patients to make a complaint or raise a concern. Complaints were taken seriously and treated compassionately. Learning from complaints was discussed with staff at monthly team meetings.

The service provided data that demonstrated they received 12 complaints between December 2017 and May 2018. We reviewed the complaints and saw they related to issues such as staff attitude, communication issues and delayed treatments, appointments or diagnosis. The service had investigated complaints and provided a written response.

Staff told us they attempted to resolve complaints immediately and used verbal de-escalation to help solve concerns quickly. Complaints and lessons learnt were shared in the monthly team meetings and at safety huddles. We reviewed minutes of the monthly team meetings and saw that complaints were discussed at every meeting.

Staff we spoke to told us they would direct patients to the Patient Advice Liaison Service (PALS) based at Royal Preston Hospital if they were not able to resolve the complaint immediately. Posters with information on how to contact PALS were displayed around the hospital.

At the time of our inspection the surgical division was 100% compliant with complaint response times across Royal Preston Hospital and Chorley and South Ribble Hospital. The trust had appointed a Head of Customer Care in February 2018 to ensure appropriate leadership for complaints handling. The service used a ‘stop the clock’ system to extend the deadline for response to complaints in exceptional circumstances. This process had clearly defined criteria for use and had to be agreed with the Head of Customer Care and recorded on the incident reporting system.

Is the service well-led?

Leadership

Leaders at every level were visible and approachable. The leadership was knowledgeable about the issues and priorities for the quality and sustainability of services. The matron at Chorley and South Ribble Hospital worked across the surgery and diagnostic and clinical support divisions providing cohesive leadership and support to ward and theatre staff.

The divisional leadership team consisted of a divisional director, a divisional nursing director and a divisional medical director. Theatres sat under the diagnostics and clinical support division which also had a divisional clinical director of anaesthetics. They were supported at Chorley and South
Ribble Hospital by a matron from the surgical division who worked across the diagnostic and clinical support division to also manage theatres.

Staff reported that the matron and divisional leadership were visible and approachable. We observed positive interactions between staff and managers. The head of nursing walked around the site and wards every Wednesday and staff told us they saw her regularly.

The matron was supported by ward and theatre managers and ward sisters and they met on a weekly basis. The matron met weekly with the divisional leadership team weekly and fortnightly the theatres business manager joined the meeting to discuss improving the flow of patients through theatres.

Staff on the surgical wards and in theatres commented positively on the impact that having one matron managing across the wards and theatres had made on team working and integrating patient pathways. The matron held daily board rounds with ward managers or sisters to ensure any issues such as patient care and treatment, incidents, stranded patients, bed numbers and complex discharges were addressed.

Staff told us that ward managers and sisters were supportive and accessible and they felt comfortable raising issues with them and the matron.

The matron conducted monthly audits using the STAR quality assurance system supported by a manager from a different ward or area and every six months conducted a full audit also accompanied by a non-executive director.

**Vision and strategy**

The service had a clear vision for what it wanted to achieve and workable plans to turn it into action. Plans to move ophthalmology surgery to Chorley and South Ribble District Hospital were well developed and funding was agreed.

Staff we spoke with were aware of the trust values of being caring and compassionate, recognising individuality, seeking to involve, building team spirit and taking personal responsibility. We saw booklets outlining the trust values were available across the site. The trust vision to deliver ‘excellent care with compassion’ was displayed on leaflets and posters throughout the wards and site.

Managers had a clear vision of how they planned to develop the service including moving ophthalmology services from Royal Preston Hospital to Chorley and South Ribble Hospital. The business plan had been submitted to the board and approved and the new pathway for ophthalmology patients designed by the clinical director with input from ophthalmology staff. Funding was in place to take the strategy for ophthalmology forward and a non-executive sponsor had been identified. Senior staff at Chorley and South Ribble Hospital were aware of the plans and had identified opportunities for staff development and improved patient flow through the hospital.

However, some staff told us that although they were aware of plans to move ophthalmology surgery, there had been no consultation with them. Senior managers told us consultation with staff and key stakeholders was planned but it had not taken place at the time of our inspection.
Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with described the culture within the service as open and positive and told us they were proud to work there.

Staff told us that morale was good and had improved since our last inspection. Staff were proud to work for the service. They spoke positively about the culture within the service calling Chorley and South Ribble Hospital a ‘happy hospital’.

We spoke to staff who experienced care from the service either personally or through their loved ones and all of them stated the standards of care they or their loved ones had received made them feel proud to work in the service.

There were mechanisms to provide staff with the development they needed and 96% of nursing staff had received an appraisal. Appraisals are important as they provide the opportunity to acknowledge the work staff have done and offer encouragement for them to strive to high levels of achievement as well as manage their performance.

Staff were aware of the role of the Freedom to Speak Up Guardian and knew where to find further information if they needed to contact someone to raise concerns about patient care and treatment. However, not all staff we spoke to knew who the Freedom to Speak Up Guardian was or how to contact them. A Freedom to Speak Up Guardian works alongside the trust’s senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care. The service used a quality assurance system to regularly audit the quality of services and produced action plans to improve services based on the outcomes of the audit.

The service had a clear governance structure and defined lines of accountability from ward to board that supported the delivery of good quality sustainable services and had recently introduced a new governance structure in surgery and diagnostics and clinical support divisions.

Subcommittees met monthly and reported to divisional governance board and had responsibility for oversight of key areas such as safety and quality, workforce, strategy and finance. Clinical governance leads in each speciality attended the governance meetings. Matrons met regularly with ward managers, theatre managers and with clinical directors ensuring that information flowed from ward to the divisional leadership and back down to staff on the wards and in theatres.

Changes to clinical practice were discussed and agreed in monthly enhanced recovery meetings attended by all consultants and speciality leads. This ensured that changes in operational protocols were adopted by all consultants, for example changes to preoperative ‘prep and drape’
procedures prior to surgery had been adopted by all consultants and surgeons following agreement at an enhanced recovery meeting.

One consultant we spoke to told us he was proud of the governance structures the service used and he had replicated these systems in his work in the private sector as he felt they ensured high quality, safe care was provided.

Management of risk, issues and performance

The service had effective systems for identifying risks and staff were involved in the recognition and reduction of risks. Staff we spoke to were aware of the key risks in their area and had escalated these.

We reviewed the risk registers for both surgery and diagnostics and clinical support divisions and saw that it contained details including a rating of the risk, control measures in place, review dates, action plan, action due and completed dates and a review of actions. However, we saw some risks listed which did not have any details recorded and no actions or control measures. For example, we saw risks listed against Chorley and South Ribble Hospital with regards to environmental issues and storage of medicines which had no action recorded or controls listed.

Risks were owned by each of the divisional subcommittees for safety and quality, workforce, strategy and finance. These committees were chaired by associate divisional directors and reported directly to the divisional leadership team at a monthly performance review forum. The divisional risk register was reviewed and discussed by the safety and quality committee and the divisional risk report produced quarterly and presented to the board.

Senior leadership demonstrated an awareness of the risks and performance issues within their division and had identified actions to address key risks. For example, due to the impact of winter pressures meaning surgical beds were used for medical inpatients elective surgery was cancelled in April 2018. The leadership team were working with the continuous improvement group to design a model for bed allocation that identified ring fenced beds for elective surgery patients to avoid future cancellations.

Managers knew the risks and mitigating actions within their departments and communicated these to staff. We saw that risks were displayed on the ‘How are we doing’ board in theatres.

We reviewed the agenda and minutes of the performance review forums for the diagnostic and clinical support division for March, April and May 2018 and for the surgery division for March 2018. We saw that performance data was presented and discussed across the key domains of safe, effective, caring, responsive and well led and performance dashboards were reviewed.

Minutes of the divisional board meeting in January 2018 evidenced that the executive team has oversight of divisional performance and gave feedback to the divisional leadership which was communicated to staff. Issues for escalation were also discussed at this meeting and an action tracking system used to record completed, closed and overdue actions.

The matron carried out monthly audits using the STAR quality assurance system to monitor compliance and performance against several areas including environment, medicines safety,
safeguarding, display of performance information, infection control, incident reporting, responding to deteriorating patients and information provided to patients. Divisional monthly harm free care meetings were attended by the matron and ward and theatre managers and information shared with staff at team meetings. The matron held a board round daily in each area to ensure she was aware of any performance and risk issues arising each day.

Information management

The service collected information and monitored performance information through monthly integrated performance reports. Performance information was shared with staff through team meetings and displayed on the wards and in theatres.

The service collected information and monitored performance information through monthly integrated performance reports. The matron conducted monthly audits of performance in all areas and recorded this using the audit management and tracking tool which was reviewed by ward and theatre managers. We saw that information from the integrated performance report and audit management and tracking tool was displayed at ward level.

Staff had access to the information they needed to undertake their role. However, not all patient records were electronic, wards were using a dual system of electronic and paper based records and not all staff had access to electronic records. This could increase the risk of errors or information being lost and meant staff had to look in different places for different information. The service was introducing a PACS (picture archiving communication system) in June and had developed staff training but this was not in place at the time of our inspection.

Policies and procedures were available and accessible via the trust’s intranet facility. Important information such as safety alerts was shared in ward huddles and monthly team meetings to help keep staff up to date and aware of issues.

Engagement

The service actively engaged with local groups and the public.

The trust had a patient experience and involvement strategy for 2018 to 2021, which had been developed following engagement with patients, local groups and partner organisations through discussion and listening events. Performance boards in wards and theatres included patient feedback and feedback from the patient advice and liaison service (PALS).

There were systems to support improvement and innovative work by staff through staff recognition schemes, 100 Reasons to be Proud’ and the ‘Thank You’ scheme. Staff achievements were also recognised at the annual quality awards. Staff told us that they felt they could provide feedback directly to managers and the matron and were encouraged to share ideas in the monthly team meetings.

The matron held a quarterly meeting that was open to all staff to attend to encourage engagement and share learning, ideas for improvement and celebrate achievement. In theatres staff were encouraged to share ideas on the ‘ideas’ white board. They told us they had taken part in a ‘Fab Week’ in September 2017 where they had the opportunity to discuss improvements and share
ideas. Staff told us that non-executive directors visited the wards and theatres to find out about their work.

The service actively engaged with local groups and the public. Once a quarter the local scout group visited the theatre in the evening after all operations. They were shown around and shown instruments and other equipment such as airways management equipment and hip replacements. They used laparoscopic equipment to pick up sweets and were given information about the importance of antibiotic guardianship. Staff reported that these visits were very successful and engaged future generations in the work of the hospital and addressed common myths about hospitals and surgery.

During our inspection the theatres held a coffee morning for people with dementia and their carers and relatives and the service had planned a theatre open day for July 2018.

**Learning, continuous improvement and innovation**

There were systems to support improvement and innovation work including staff reward and recognition schemes, data systems and ways of sharing information. Learning from incidents was shared with staff electronically.

Mortality and morbidity reviews were held following a patient’s death to examine practice and identify areas of improvement and the outcomes recorded in the audit management and tracking system. The divisional governance team audited the mortality reviews quarterly and lessons learnt were shared in the clinical governance committee.

Lessons learnt from incidents and complaints were shared with staff electronically in ‘making it better’ memorandums which were also shared at daily ward huddles. The diagnostics and clinical support division produced a clinical governance newsletter quarterly which was shared electronically with all staff and shared lessons learnt from complaints and incidents. The monthly team meetings included discussion of learning from performance trends and ideas for improvements.

In theatres, there was a board titled ‘Inspiring Continuous Improvement’ which displayed details of changes made following ideas shared by staff. Staff were encouraged to share lessons learnt and ideas using the STAR acronym, which stood for situation, task, action and result. We saw that changes had been made following ideas shared by staff such as streamlining of instrumentation in theatres.

The service had trained staff to be patient safety champions in theatres as a resource for all staff and to cascade safety information and training to the teams. Safety champions received additional training including human factors training and critical thinking and decision making, to undertake this role.
Facts and data about this service

Chorley Birth Centre is a midwifery led free standing birth centre. It provides a homely environment with one-to-one midwifery care, and is suitable for women with low-risk pregnancies. Chorley birth centre has a core team of staff but staff from Royal Preston Hospital and community teams also work here. The team was managed through the maternity services for the trust.

The birth centre had a triage room, two delivery rooms with built in birthing pools and en-suite bathrooms and a further two delivery suites. There are two postnatal rooms, five clinic rooms and a large clinic room used for support group meetings.

Between May 2017 and May 2018, Chorley birth centre delivered 154 babies. The home birth rate for the same period was 2.5%.

During this inspection we spoke with two patients and their relatives and 16 members of staff.

Number of babies delivered at Lancashire Teaching Hospitals NHS Foundation Trust – Comparison with other trusts in England.

A profile of all deliveries from January 2017 to December 2017 can be viewed below.
The percentages of single and multiple births at the trust are the same as the England birth profile. With regard to mother age comparisons, the trust has more births to mothers under the age of 34 than the England rate and fewer births to mothers over the age of 35.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at Lancashire Teaching Hospitals NHS Foundation Trust by quarter.

2016/17 quarter one saw the highest number of births at the trust with 1,123, whereas 2017/18 quarter one saw the lowest number with 953.

SOURCE: HES - Deliveries (October 2016 - September 2017)
Is the service safe?

Mandatory training

Staff compliance with annual mandatory training had improved. The trust had plans in place to improve compliance with training where it did not meet the target they had set.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from March 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>167</td>
<td>176</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>159</td>
<td>176</td>
<td>90.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>176</td>
<td>37.5%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity have met the 90% completion rate target for six of the seven courses made available to them.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Staff had to complete red and blue mandatory training days which included PREVENT (introductory training around the risks of radicalisation and roles involved in supporting those at risk), clinical governance, bladder care, saving babies lives, cardiotocograph, intermittent auscultation, safeguarding and antenatal screening. The obstetric emergency training was mandatory and separate to this training.

Managers told us that between March 2017 to April 2018 all midwifery staff had completed the resuscitation training appropriate for their role.

The trust provided us with figures for PROMPT (Practical Obstetric Multi-Professional Training), evidence based multi-professional training package for obstetric emergencies, which showed 65% of midwifery staff had completed this in the last 12 months.

Staff told us they regularly complete simulation training for emergency situations such as management of a haemorrhage.

The trust had an up to date policy for the management of sepsis. Staff told us they were familiar with the guidance within the policy.
Safeguarding

Staff were trained to the appropriate level for adult and children’s safeguarding.

The trust set a target of 90% for completion of mandatory safeguarding training.

A breakdown of compliance for safeguarding courses from March 2017 to February 2018 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>162</td>
<td>176</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>160</td>
<td>176</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>147</td>
<td>175</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff in maternity met the safeguard training target for three of four courses made available to them.

(Source: Trust Provider Information Request P18)

The service had safeguarding systems and processes which staff used to safeguard women and babies from abuse. The trust had an up to date baby abduction policy which staff we spoke with were familiar with. All babies we observed during our inspection were security tagged when in the postnatal suites.

During our inspection we found the door to the rear entrance of the birth centre unit propped open. While there were no women using the birthing centre at the time this could pose a security risk if any women were admitted. This was immediately closed during our site visit. Following our inspection this incident has been added to the birth centre risk register to highlight a potential increased abduction risk.

Ninety two percent of midwifery staff had completed adult safeguarding level three training. 100% of midwifery staff had completed children’s safeguarding level two training. Eighty four percent of midwifery staff had completed children’s safeguarding level three. The trusts target for completion by qualified midwives was 90%.

The trust had a system for recording safeguarding concerns such as a child protection plan. Safeguarding risk assessments were completed at patient booking appointments and reviewed regularly.

Safeguarding information was kept within women’s records and a colour coding system for notes was used to highlight women at risk.

The safeguarding leads regularly attended multidisciplinary meetings to discuss safeguarding concerns and share good practice. All staff we spoke with felt supported by the safeguarding team to manage safeguarding concerns.
From May 2017 to May 2018, Chorley birth centre staff had made 268 referrals to the safeguarding team. The trust had a female genital mutilation policy. Female genital mutilation is a routine enquiry in midwifery and the trust was compliant with Department of Health reporting. Cases of female genital mutilation identified by the trust were reported monthly to the safeguarding board.

Eighty three percent of staff at Chorley birth unit had completed female genital mutilation safeguarding training between April 2017 to June 2018 against a trust set target of 90%.

Cleanliness, infection control and hygiene

The birth centre was clean and well maintained and infection control rates were good. We saw a programme of cleaning for the birth centre environment and evidence that individual pieces of equipment were cleaned regularly.

During this inspection we found all areas to be clean, tidy and well stocked with personal protective equipment such as gloves and aprons. The birth centre had hand gel widely available for staff and visitors.

We observed all staff to be arms bare below the elbows, using gloves and observing handwashing practices.

We saw well stocked home birth boxes which provided personal protective equipment for community midwives.

Equipment appeared clean and had recent labels attached to show when last cleaned. Staff provided us with the cleaning rota for the birth centre which was up to date.

There were no cases of Methicillin-resistant Staphylococcus aureus in the last 12 months at Chorley birth centre.

The service provided hand hygiene audits for the last 12 months. Staff compliance with the audit was 100% for 10 out of the 12 months. May 2017 compliance fell to 70% and in October 2017 to 91%. The trust highlighted in their action plan that this drop in compliance was due to staffing problems that month.

Environment and equipment

Chorley birth centre was based in an older part of the main hospital building which was dated and tired. However, the birth centre environment was bright, homely and all areas were spacious and clean.

We observed the contents of three portable resuscitation kits used by the community midwife teams. Records showed the boxes were checked after each use only. We saw each box contained out of date stock some items being up to 12 months out of date. Out of date items included tongue depressors and resuscitation masks. The items were highlighted at the time of the inspection to the ward matron and replaced immediately.
Hazardous cleaning products, toilet cleaner and sterilising tablets, were kept in a cupboard in the sluice area. The sluice and cupboard doors did not have locks fitted. Staff told us they were waiting for a lock to be fitted to the cupboard. Staff moved the hazardous cleaning tablets and toilet cleaner during our inspection to a locked cupboard until a lock could be fitted the next day. The trust provided us with an up to date policy regarding the control of substances hazardous to health which required hazardous substances to be stored in a locked cupboard.

The birth centre had clinic rooms available for glucose tolerance testing women, breast feeding support and baby hearing screening.

The triage room was cleaned to a high standard with equipment displaying servicing and cleaning labels.

Clinical waste was stored correctly. Sharps boxes we saw were kept appropriately in the dirty utility area and were closed and labelled.

The birth centre had a resuscitation trolley for adults and neonates, both of which were easily accessible to all rooms. We saw evidence that the trolley was checked daily to ensure that it was ready to use.

**Assessing and responding to patient risk**

The service had good systems in place to ensure safe transfer of deteriorating patients to Royal Preston Hospital.

The service had a standard operating procedure which detailed how to manage the deteriorating patient at Chorley birth centre. All staff we spoke with knew the process for transferring a deteriorating patient to the Royal Preston Hospital by calling 999. Staff told us this had happened 30 times during the last 12 months out of a possible 154 women.

Staff told us that a nurse would accompany the patient to Preston, a handover to staff would be completed using a situational, background, assessment recommendation (SBAR) handover tool. This tool is designed to make patient handover more efficient between areas and improve safety. Midwives told us after completing handover, they would return to Chorley birth centre to ensure safe staffing levels were maintained.

All staff we spoke with knew how to assess, monitor and respond to a deteriorating patient. We saw evidence of in depth risk assessments for women with low and medium risk pregnancies. If a woman was identified at their booking appointment as being medium to high risk they would be offered an obstetrician review to complete this assessment.

During the last 12 months the percentage of women who received a booking appointment before 10 weeks and 6 days of their pregnancy was 48% and by 12 weeks and six days was 88% compared with a trust target of 50% for both.

On admission to the birth centre women were assessed in the triage area. We observed six women telephoning the triage helpline at Chorley birth centre. They were given appropriate triage advice by the midwife and where necessary directed for assessment at Preston triage centre.
Staff used a modified early obstetric warning score to monitor women during labour and a paediatric early warning score to monitor babies in the post-natal period. During our inspection we reviewed nine patient records and saw the modified early obstetric warning score completed in all records.

Staff knew what to do in a medical emergency such as a postpartum haemorrhage and they could explain how they would access the Chorley and South Ribble Hospital emergency crash team while also calling 999. The birth centre operational policy which gave clear guidance on the threshold for managing a postpartum haemorrhage at the birth centre.

The trust had retrospectively audited compliance with the post-partum haemorrhage local policy between October 2016 to March 2017. Compliance with local policy was found to be 34% with the reasons for this being given as poor documentation of care and treatment rather than the care women received. For example, staff had not documented in 17 of the 118 cases that they had called for the emergency resuscitation team but the team had documented their attendance. The trust also highlighted actions and learning points from this audit as a need for improving incident reporting by staff as this had not been completed for 40 of the 118 cases reviewed.

**Nursing and midwifery staff**

Staffing was highlighted during our last inspection in September 2016 as a concern. Although managers had taken steps to manage staff challenges vacancy rates remained above trust targets.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

During our last inspection in September 2016 staffing was highlighted as a concern.

Chorley birth centre is managed by two band seven midwifery team leaders who use an electronic rostering system to plan staffing. There were core staff who worked at Chorley birth centre with staff rotating or covering shifts from the community teams and Royal Preston hospital.

Staff told us about current staff shortages due to sickness, 18 staff on maternity leave and 23 vacant midwife posts (across both locations). All staff told us that day to day staffing was a “challenge”.

Managers told us the 23 vacant posts had been filled (across both locations) by newly qualified midwives due to start in September 2018.

Managers had been reliant on existing staff but were aware this may have contributed to team sickness levels. They had recently advertised for bank staff as agency staff did not always have the necessary training to work with neonates.
Staff and managers did not feel that patient safety was compromised by staffing challenges. Managers had put measures in place to mitigate risk. However, staff did feel that postnatal appointments were often postponed due to poor staffing rates.

Safe staffing was discussed at the safety huddle each day and staff were reallocated based on pre-determined staffing ratios for the midwifery led unit.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 16.9% in maternity. This is worse than the trust’s target of 6%. The breakdown by site can be seen below:

- Royal Preston Hospital – 16.7%
- Chorley and South Ribble Hospital – 57.1% (based on four members of staff)

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

**Sickness rates**

From February 2017 to January 2018, the trust reported an overall sickness rate of 4.2% for nursing staff in maternity. This is the same as the trust target of 4.2%. A breakdown by site can be seen below:

- Royal Preston Hospital – 4.2%
- Chorley and South Ribble Hospital – 9.4%

Maternity staff numbers at Chorley and South Ribble Hospital is lower than at Royal Preston Hospital. The figure of 9.4% is based on 35 permanent staff sickness days compared to the 2,258 sick days at Royal Preston Hospital.

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*
**Midwife to birth ratio**

As of September 2017, the trust had a ratio of one midwife to every 27 women which is the same as the England average.

(Source: Electronic Staff Records – EST Data Warehouse)

**Medical staffing**

This location did not have any medical staffing as all obstetric deliveries were planned for Royal Preston Hospital.

**Records**

Records were not always stored safely which meant patient confidentiality was at risk.

During our inspection we reviewed nine sets of patient records and five medicines charts. All documentation was clear, legible, signed and dated correctly.

We saw that records were not always stored securely in locked cupboards to maintain patient confidentiality.

We found postnatal handheld patient records stored on the floor in the liaison office at the birth centre. The room did not have a lock fitted and there was no lockable filling cabinet available.

Staff told us the notes had been stored this way while the department administrator was on sick leave and that managers were aware patient records were being kept in an unsecure way. We raised this with managers during our inspection and a lock was fitted to the office door immediately and records moved to a secure filling cabinet.

Chorley birth centre documented women’s care and treatment in handheld patient records which were later scanned onto the hospital computer system.

We saw evidence of risk assessments, care plans and multidisciplinary team notes within all the patient records we reviewed.

**Medicines**

We observed the safe storage of medicines and good procedures for checking stock, ordering and disposing of medication.

Medicines that needed to be stored at a lower temperature were stored in fridges. We saw fridge temperature checks were completed daily and medicines were stored within safe temperature limits.

Community midwives checked controlled drugs such as pethidine, a drug used for pain relief during child birth, from the Chorley birth centre medicines store. We saw this was accurately recorded and any breakages were documented correctly.

The trust had a standard operating procedure for storing and transporting medical gases.
We observed that medical gases were stored in an appropriate lockable cupboard which was labelled correctly for storage of medical gases. Cylinders were stored correctly and there were appropriate carrying bags available. Staff told us how they would order new cylinders and report faults.

Community midwives could safely access this cupboard 24 hours a day. Community midwives used the carrying bags to transport and store cylinders safely within their cars.

**Incidents**

There was a clear system for reporting incidents and learning from events.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Of these, the most common types of incident reported were

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with one (50% of total incidents)
- Slips/trips/falls meeting SI criteria with one (50% of total incidents).

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents in maternity which met the reporting criteria set by NHS England from May 2017 to April 2018.

Both incidents had occurred within the maternity service but at the Royal Preston Hospital site. The trust provided details that both incidents had been investigated and any lessons learned had been passed onto staff appropriately.

All staff and managers we spoke with had a good understanding of duty of candour. Staff could give examples where the duty of candour policy and process had been applied.
Safety thermometer

The service displayed safety thermometer information on the “How are we doing” boards. The birth centre board displayed the results of hand hygiene audits, optimal cord clamping, water birth, breastfeeding initiation, comments from the friends and family test and thank you cards.

Is the service effective?

Evidence-based care and treatment

Some trust policies were outside of their review date. We saw that policies remained relevant but the content had not been reviewed at the time the trust had advised.

During our inspection we reviewed 15 trust policies relevant to midwifery, five of which had not been reviewed at their specified review date. The content of the policies remained relevant but the process for completing the review and documenting this had not been followed and completed in a timely way.

All staff we spoke with could locate policies and procedures. The service had a mobile phone application with the documents which made them easier to access, particularly for community staff.

The trust provided the Chorley birth centre standard operating procedure which gave details on managing obstetric emergencies and transfer process.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs. Staff supported women with breastfeeding. Breastfeeding initiation rates for the service were 69.7% compared with a national average of 81%.

The birth centre provided hot and cold food, drinks and snacks for women between 7am-6pm.

Women and their relatives were encouraged to bring additional food, drinks and snacks and a kitchen was available for their use. Women we spoke with were happy with the food and the choice on offer.

Average breastfeeding initiation rates from May 2017 to May 2018 were 69.7% compared with 84.5% in the previous 12 months. Women were supported to breastfeed both in the birth centre and during the postnatal period. This was sometimes provided by midwifery support workers in the community.

Pain relief

The birth centre monitored and provided women with pain relief. The birth centre offered medication as pain relief for low risk births and alternative pain relief such as water birth, aromatherapy and music.

Staff told us most women chose to use the birthing pool to manage their pain often in combination with nitrous oxide.
The trust provided information that out of 154 births between July 2017 and June 2018, 131 women gave birth in water.

Aromatherapy was also available to women and the trust provided a policy for staff providing aromatherapy to women.

Women who required an epidural would need to be transferred to Royal Preston Hospital. This was discussed with women during their antenatal appointments.

**Patient outcomes**

The service completed regular clinical audits to monitor patient outcomes.

**Standardised Caesarean section rates and modes of delivery**

From January 2017 to December 2017, the total number of caesarean sections was as expected. The standardised caesarean section rates for both elective sections and emergency sections were also as expected.

![Standardised caesarean section rates (January 2017 to December 2017)](image)

**Patient outcomes**

The service completed regular clinical audits to monitor patient outcomes.

**Standardised Caesarean section rates and modes of delivery**

From January 2017 to December 2017, the total number of caesarean sections was as expected. The standardised caesarean section rates for both elective sections and emergency sections were also as expected.

![Standardised caesarean section rates (January 2017 to December 2017)](image)

In relation to other modes of delivery from January 2017 to December 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

![Proportions of deliveries by recorded delivery method (January 2017 to December 2017)](image)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)**

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended
The perinatal mortality rate (per 1,000 births) was 6.08. The comparator group was 6.44 this was up to 10% lower than the average for comparator group.

(Source: MBRRACE UK)

The trust provided data from the maternity dashboard on patient outcomes from June 2017 to May 2018. During this period there were 65 home births in the Chorley and South Ribble area, 44 of which were attended by a midwife.

During the last 12 months, 30 women out of 154 were transferred to Royal Preston Hospital from Chorley birth centre in an emergency as defined in the standard operating procedure. None of these women had waited longer than eight minutes for an emergency ambulance.

The trust provided details within their risk register of the potential for delays in transfer time from Chorley to Preston in an emergency as an emergency ambulance response time could not be guaranteed within eight minutes.

We spoke with medical staff who told us about a recent audit on the management of antenatal anaemia. The results of this audit had led staff to change the patient pathway for managing anaemia for women.

Between July 2017 and June 2018, no women who gave birth at Chorley birth centre experienced a 3rd or 4th degree perineal tear.

Competent staff

Staff received their annual appraisal performance review to discuss and evaluate job performance and career development.

From February 2017 to January 2018, 59.1% of nursing staff within medicine at the trust had received an appraisal, which is worse than the trust target of 90%.

The trust did not supply appraisal information regarding medical staff for maternity.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Managers told us that despite staffing shortages and pressures they could complete staff appraisals. However, from May 2016 to May 2017 74% of all staff and from May 2017 to May 2018 74% of all staff received an appraisal at Chorley birth centre compared with the trust target of 90%.

The trust provided information that from June 2017 to May 2018 monthly figures for compliance with medical devices training was between 41 % and 49% each month. This increased in June 2018 to 59% of staff had completed medical devices training compared with the trust target of 90%.

The trust provided annual taught sessions on the practical obstetric multi-professional training (PROMPT) programme which covered cardiotocography training. This was mandatory for all midwives. This day also included management of shoulder dystocia, perineal mental health, neonatal resuscitation, breech birth and post-partum haemorrhage. Staff are also required to
complete a separate online competency assessment via the K2 perinatal training package as part of the mandatory training.

Between April 2018 to July 2018, 94% of staff had attended the taught session with 71% of staff completing the online training.

Managers provided us with an action plan for increasing compliance with online training after our inspection towards their own target of 90% by October 2018.

The role of midwife supervisors has been discontinued nationally and replaced with the A-EQUIP midwifery supervision model. The A-EQUIP model uses midwifery advocates to empower and develop midwives in their workplace to deliver high quality patient care. Managers told us that Chorley birth centre was currently training five advocates who would be available to roll out the A-EQUIP model in September 2018.

The trust was taking part in the four elements of the ‘Saving Babies Lives’ (Department of Health 2016) programme, which included smoking cessation intervention, fetal movement monitoring, better CTG understanding, and improved detection of growth restricted babies (GROW package). This provided standardised procedures, training and tools for assessment of fetal growth and birthweight.

GROW training was delivered by the trust as part of mandatory training for midwives. Current compliance for Chorley birth centre staff was 64%.

**Multidisciplinary working**

Staff communicated effectively with the wider multidisciplinary team at daily huddles and when handing over women’s care to Royal Preston Hospital.

During our inspection we observed a staff handover at the Chorley birth centre from the night to daytime shift. Staff communicated effectively relevant patient information.

Staff at Chorley birth centre also passed information to the Royal Preston hospital safety huddle each shift to enable good multidisciplinary team working.

We saw good examples of multidisciplinary team working between clinics, support groups and medical teams. Staff told us they had good working relationships with social care services, safeguarding and enhanced care teams and mental health teams.

**Seven-day services**

Midwifery led services at Chorley birth centre were provided 24 hours a day, seven days per week.

The telephone triage service at the birth centre was available 24 hours a day, seven days a week.

Obstetrician clinics were held weekly at the birth centre for higher risk women to discuss their care and birth options with the obstetrician.

**Health promotion**

Women were offered health promotion advice on smoking cessation, alcohol consumption, carbon monoxide monitoring and vaccinations.

Chorley birth centre staff ran a monthly breast-feeding support group from their clinic rooms and supported women to breastfeed during postnatal home visits.
Staff told us they had changed the date of the new-born hearing screening clinic so that babies could receive there screening in a timely way.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

All staff had a good understanding of their roles and responsibilities regarding the Mental Health Act and Mental Capacity Act.

**Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training completion**

From February 2017 to March 2018, 92% of nursing staff at the trust completed the Mental Capacity Act level two training.

*(Source: Trust Provider Information Request – Training tab)*

During our inspection we observed patient consent being obtained, both written and verbally. We saw evidence of obtaining consent prior to care and treatment within women’s notes.

Staff attended Mental Capacity Act training as part of their mandatory training course. 89% of midwifery staff had attended this training in the previous 12 months. Staff could give examples where they had supported women who lacked capacity to make decisions about their care.

Staff that we spoke with understood their roles and responsibilities within the Mental Health Act to support women experiencing mental ill health. The service had clear pathways for identifying women with mental health conditions.

**Is the service caring?**

**Compassionate care**

Women received patient centred, kind and compassionate care from staff at Chorley birth centre.

Women we spoke with told us that staff were kind and caring during their labour and birth. They felt staff treated them with respect and dignity at all times and made them feel relaxed.

**Friends and Family test performance**

**Friends and family test performance (antenatal), Lancashire Teaching Hospitals NHS Foundation Trust**

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average, with one particular dip in performance in September 2017 where the trust scored 81% compared to the England
average of 97%.

Friends and family test performance (birth), Lancashire Teaching Hospitals NHS Foundation Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally similar to the England average.

Friends and family test performance (postnatal ward), Lancashire Teaching Hospitals NHS Foundation Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average for the duration of the reporting period.

Friends and family test performance (postnatal community), Lancashire Teaching Hospitals NHS Foundation Trust

From March 2017 to March 2018, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)
The trust performed about the same as other trusts for all of the questions it completed in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.01</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.54</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.79</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.10</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.25</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.51</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.45</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.65</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.96</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.50</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.24</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.68</td>
<td>About the same</td>
</tr>
<tr>
<td>birth</td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.10</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.44</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.88</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)
Emotional support

Staff we spoke with told us that they regularly provided emotional support for women. We saw evidence in women’s notes of anxiety and depression screening.

Staff told us they would refer to the enhanced support team who worked closely to support women and supported staff to care for women with enhanced care needs. The team supported women with safeguarding, mental health and drug and alcohol needs.

Clinic rooms were quiet and able to provide women with dignity and privacy during sensitive conversations.

The birth centre was taking part in a postnatal screening trial to offer emotional support for women following a traumatic birth. Staff offered women who had experienced trauma during labour emotional and practical advice on how to manage this.

Understanding and involvement of patients and those close to them

Data from the CQC Survey of women’s experiences of maternity services 2017 showed most women felt they were involved enough in decisions about their care. Results also showed their partner or someone else close to them was involved in their care during labour and birth, as much as they wanted.

During our inspection we observed relatives and partners being encouraged to stay with women during their labour.

Is the service responsive?

Service delivery to meet the needs of local people

Care provided at Chorley birth centre was responsive and personalised to meet women’s needs and choices. Services reflected the needs of the local population such as translation services for women whose first language was not English.

Bed Occupancy

From Q2 2016/17 to Q3 2017/18 the bed occupancy levels for maternity were generally similar to the England average, with the trust having 60% occupancy in Quarter Q3 2017/18 compared to the England average of 60%.
Bed occupancy levels compared to the England average from Q2 2016/17 to Q3 2017/18

(Source: NHS England)

We saw that the service provided personalised care that was responsive to patient’s needs. The trust had a Chorley birth centre standard operating procedure which gave details on providing continuity of care between Chorley and Preston midwifery units.

Staff told us they provided continuity of care by using a situation, background, assessment, recommendation (SBAR) tool when transferring women in labour to the Preston site.

Patient information on service delivery was available in the waiting rooms and delivery suits at the birth centre. Chorley birth centre also provided a patient information leaflet on their website which could be accessed online or printed in English and other languages on request.

Delivery rooms were all en-suite and equipped with couches for women to promote active labour. Two rooms had birthing pools and projectors so that music and images could be projected onto the wall during birth. There were drop down beds for postnatal care or for partners to use.

Women who wanted a home birth had access to birthing pools provided by the midwifery service at the birth centre.

Women with multiple pregnancies were offered a discussion with the obstetrician before 32 weeks about a plan for birth which considered risks and patient preferences and choices. Staff supported women with developing their own birth plans and delivering in their preferred place of birth.
Meeting people’s individual needs

All staff including managers took a flexible, patient centred approach to care and considered individual’s needs. The service provided additional support for women who required this such as those experiencing mental health concerns or drug and alcohol needs.

The service took account of individual patient needs and choices. Staff told us that they regularly accessed translation line services for women whose first language was not English.

Staff gave us examples where women with learning disabilities had been encouraged to have their support worker present during labour and birth.

Staff told us that they would refer women with additional support needs, such as mental health needs or drug and alcohol dependency to the enhanced support team.

The community midwifery team had been working alongside the Deaf Society to produce information videos for deaf women and their relatives with accompanying sign language.

Access and flow

Women were triaged appropriately and directed to the service best suited to their individual situation. Access to the midwifery led service was 24 hours a day. This meant women could access face to face and telephone triage services as and when they needed to.

On admission to the birth centre women were triaged in a separate triage room by the midwife.

Staff told us that women who used the telephone triage service would be directed to the most appropriate service. We observed higher risk women being advised to attend triage at Royal Preston hospital.

Triage information was written in the women’s paper records at the birth centre which was transferred to the electronic notes or made available to community midwives.

The trust had a missed appointments guideline for staff if a woman missed an appointment with the midwifery or clinic services at Chorley birth unit. Staff told us about how they would follow up missed appointments in line with this guidance.

The midwifery led birth centre and home birth service have not been cancelled during the previous 12 months.

Staff told us about an antenatal project they are working on as part of a maternal and neonatal health and safety collaborative to look at improved access to midwifery services for patients.

Learning from complaints and concerns

In the period between March 2017 and April 2018 there were 17 complaints about maternity, this was a reduction from 20 in the previous time period. Themes were women/family experience, communication, delays in clinical service provision and staff attitude.

The service was learning from these complaints in a variety of different ways such as with the antenatal care project to reduce waiting times in clinics, the Better Births training project, working...
with two nearby maternity units and training midwives, obstetricians and anaesthetists in dealing with obstetric emergencies in a standardised way. The service had also included human factors training and been involved in the enhanced elective caesarean section project that provided continuity of care with information in podcast and leaflet format.

**Is the service well-led?**

**Leadership**

The service had made improvements to the management and leadership structure since our last inspection in September 2016. Staff spoke positively about the new team leaders at Chorley birth centre and felt supported in their professional development by these team leaders.

Chorley birth centre had two band seven midwifery team leaders who were recently in post and staff were split into teams across all three care settings, Chorley, Preston and the community. Band seven team leaders were allocated protected management time and were delegated tasks by the matron, such as ensuring staff received appraisals and were booked onto mandatory training. A midwifery matron worked across all three services, they attended Chorley birth centre approximately once a week.

Staff told us that the matron and team leaders were visible, approachable and had a good understanding of the day to day pressures staff faced.

Staff felt that the leadership within the service had improved since our last inspection in September 2016. Band seven staff felt that the head of midwifery was visible and approachable. However, not all staff found the Head of Midwifery had a visible presence at Chorley birth centre.

**Vision and strategy**

The service demonstrated a clear vision and service development strategy. Staff spoke positively about the values of the trust and had a common sense of purpose.

The trust had implemented a staff engagement strategy to support team development and change management.

Senior managers told us about a transformation group which considered the wider strategy and vision for the midwifery service.

Vision and strategy was discussed within monthly staff meetings and staff feedback was encouraged through direct feedback or staff survey routes.

**Culture**

All staff we spoke with were passionate about their work and were proud of the care they delivered to patients.

Staff told us they would speak with their team leaders or matron if they had any concerns and felt able to do this freely.

Staff at all levels had a good understanding of duty of candour and felt able to report clinical incidents in a free from blame culture.

None of the staff we spoke with were aware that the trust had freedom to speak up guardians and they were not familiar with what that role meant.
Staff we spoke with felt respected and valued as part of the midwifery team. Senior staff told us they had worked hard to promote an integrated and fair culture between all the midwifery teams. Senior staff reported challenges getting staff to engage with team meetings and changes to rotas and staffing they had made to improve equity.

Midwifery team meeting notes reflected some of the challenges the team had faced in working more collaboratively and they had drafted a letter to senior managers highlighting their concerns. Staff had been positive about how they had been supported and managed.

Staff told us there were currently a high number of staff off work with sickness and on maternity leave. Managers told us the reasons for this sickness were not work related. Staffing and burn out was a concern to most of the staff we spoke with.

**Governance**

The trust employed a clinical governance and risk lead for neonates and women’s health and a consultant obstetric lead for governance. They facilitated weekly risk meetings within the maternity department.

Staff have monthly meetings where governance is discussed and there are clear lines managing risk and for escalating concerns.

The trust held a weekly case review of incidents reported across all divisions.

Senior managers told us they have an improved system for managing incidents with good oversight from the trust board.

**Management of risk, issues and performance**

The service had a robust audit programme which identified risks and managed them well. The service had a risk register in place which they used to monitor risk and work towards improvements.

The department had a risk register which listed the risks that affected the department, what the likelihood and impact of those risks were and the mitigation and controls in place. If risks scored over a certain score they were escalated to the medicine division’s risk register or the corporate risk register.

The risk register for the birth centre clearly identified the risks within the service. Current significant risks highlighted on the risk register included delays in transfer time to Royal Preston hospital from Chorley birth centre.

Managers had put measures in place to mitigate this risk and staff were aware of how they could manage the identified risks.

Managers provided staff with a “lesson of the week” bulletin on incidents which had occurred and the lessons that could be learnt from them.

**Information management**

The service collected, analysed, managed and used information to support all its activities.
The service used a maternity dashboard which covered key clinical, quality and staff related targets. The trust provided information following our inspection and could compare with last year's performance in key areas.

We observed staff information and safety huddles daily at the Chorley birth centre where information on safety, staffing and risk was shared with Preston midwifery unit.

Engagement

The service held maternity voices partnership meetings, that were well attended by maternity staff, service users and external agencies and charities. People’s views were sought to help shape the service of the future.

The unit had signed up to the Royal College of Midwives caring for you campaign which is an initiative set up to promote maternity services to care for and look after their staff.

The weekend before our inspection the department held an engagement event at the trust named bumps, birth and babies, which had been advertised within the unit and on their social media page. We were told that there were between four and five hundred previous and potential service users in attendance throughout the day.

The department held a celebrating transformation in maternity event in February 2018 with speakers ranging from midwives, obstetricians, student midwives and service users. The event was attended by approximately 80 people consisting of midwives, obstetricians, maternity support workers, women and their families. This event was held to showcase the work being undertaken within the department to improve maternity care for women and their families.

The service published a monthly staff magazine named Womenzone. This included a written message from the head of midwifery, friends and family feedback, maternity incidents, root cause analysis, learning points and areas for improvement.

The department held quarterly birth forum meetings. Staff members that are invited include the head of midwifery, varying levels of midwifery staff, theatre staff, obstetricians, anaesthetists and neonatologists. These purpose of these meetings is to discuss pertinent issues regarding the labour ward and the birth centre. Areas discussed include staffing issues and their effect on access and flow and improving the birth environments such as soundproofing the labour ward rooms following finances being raised by service users. The March 2018 meeting did not occur due to low attendance and this is on the risk register and is being reviewed.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The maternity department had been selected as a beacon site for their midwife led birth centre by being one of three trusts in the country to achieve the gold standard of offering women the choice of four places of birth for their baby. They were selected for this by the midwifery unit network which is a leading initiative to support women with positive birth experiences.

The trust provided staff with our journey to outstanding care document each month which gave details of recommendations from the report of our September 2016 inspection and the changes the trust and staff had made in working towards these.

The community midwifery team had been working alongside the Deaf Society to produce information videos for deaf patients with accompanying sign language.
Team leaders were involved with the better births by design initiative sharing models of good practice across trusts.

The service had a maternal and neonatal health safety collaborative group which met to discuss the improvement plan for the midwifery service.
Facts and data about this service

The acute outpatients service at the trust is delivered at Royal Preston Hospital and Chorley and South Ribble Hospital.

Although this appendix relates to our inspection of the outpatients’ departments in Chorley and South Ribble Hospital, the data contained within also includes trust wide data. The data included in the appendix relates to the main outpatients’ departments only. The service had a main outpatients’ department but also had outpatient clinics for the departments of surgery and medicine. The service does not centralise this data and we were unable to get full and accurate data. The service is aware of this and is working on a methodology to ensure that this information can be retrieved in the future.

Total number of first and follow up appointments compared to England

The trust had 547,861 first and follow up outpatient appointments from February 2017 to January 2018. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from February 2017 to January 2018.
<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Preston Hospital</td>
<td>408,119</td>
</tr>
<tr>
<td>Chorley and South Ribble Hospital</td>
<td>184,734</td>
</tr>
<tr>
<td>This Trust</td>
<td>594,280</td>
</tr>
<tr>
<td>England</td>
<td>105,531,002</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**Type of appointments**

The chart below shows the percentage breakdown of the type of outpatient appointments from February 2017 to January 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at Lancashire Teaching Hospitals NHS Foundation Trust from February 2017 to January 2018 by site and type of appointment.

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff and most courses had a completion rate in line with trust targets.

The trust has set a target of 90% for mandatory training completion.
From March 2017 to February 2018, the trust reported the following compliance for nursing staff and medical/dental staff in outpatients.

**Nursing staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>113</td>
<td>122</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>133</td>
<td>186</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>73</td>
<td>120</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in outpatients at the trust met the completion target for five of the eight mandatory training courses made available to them. They did not meet the target for courses categorised as ‘other’ by the trust, however the trust has not provided any details about what these courses entail.

It should also be noted that medicine management training and manual handling – object training had very low numbers of eligible staff, therefore each staff member represents a higher percentage than those on other courses.

**Medical Staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in outpatients at the trust met the training completion target for five of the six courses made available to them. However, the five courses have only two eligible members of staff assigned to each of them with the course classified as ‘other’ having four eligible members of staff. Therefore, each member of medical staff represents a higher proportion of the total than nursing staff for the same training course.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Managers and staff, we spoke with confirmed the service had core mandatory training which was undertaken on a rolling basis this included areas such as health and safety and fire. In addition, other training was compulsory, such as resuscitation. Training uptake was reported and monitored across the divisions.
Staff told us they were encouraged to complete their mandatory training; however, this was difficult on occasions due to workload. Managers were aware of these concerns and were undertaking an approach to support staff to attend training as necessary.

## Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

### Safeguarding training completion rates

From March 2017 to February 2018, the trust reported the following safeguarding training completion rates for nursing and medical staff within outpatients.

#### Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>115</td>
<td>122</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>110</td>
<td>122</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>22</td>
<td>28</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in outpatients met the completion target for three of four safeguarding courses made available to them.

#### Medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical staff in outpatients met the completion target for one of the safeguarding courses made available to them. However, as with the above training section, there is a very low number of medical staff eligible for each of these courses, therefore they represent a higher proportion of the total than nursing staff for the same courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The department had a clear system and process for the identification and management of adults and children at risk of abuse (including domestic violence). An alert could be added to the IT system to highlight if patients had previous safeguarding concerns.

The department had good links with the services safeguarding lead. There was accessible support available to staff and managers for advice 24 hours a day, seven days a week.

Nursing, medical and administration staff we spoke with could explain the process of safeguarding a patient and provided us with specific examples when they would do this. We observed staff
accessing the trust safeguarding guidelines, which were readily available. This provided information of how to make referrals when staff had concerns about a child or adults’ safety.

Staff were aware of the assessment for child exploitation and female genital mutilation. This was covered in safeguarding training.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection in most areas.

We saw all clinic areas were visibly clean environments. Cleaning schedules were in place and kept up to date to show when cleaning had taken place and what areas had been cleaned. The service had in place “I am clean” stickers to identify equipment that had been cleaned.

Staff told us and we saw that they could access infection control and hand hygiene policies on the services central computer system.

Staff told us and we observed that it was not always possible to separate patients and reduce the risk of infection for some specialities. All patients were in the same waiting area.

We observed good hand washing and infection control practices throughout. This included the use of personal protective equipment where appropriate, for example, disposable gloves and plastic aprons.

There was a suitable supply of alcohol hand gel dispensers and hand washing facilities which were readily accessible by all staff as needed, to reduce the potential spread of infection.

The service carried out internal audits and checks for hand hygiene. Data provided by the service showed compliance was 100% in most areas.

In the main outpatient area, we saw one clinic room that was used to apply dressings. There were two couches in the room, separated by a curtain. We were told that it was regularly used to treat two patients at the same time. This was a lack of infection control and a risk to patient safety as two patients with open wounds could be treated at the same time within the room. We raised our concerns with managers during our inspection so they could carry out a risk assessment of the room.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

The environment in the general outpatient area was well maintained.

Most of the emergency trolleys we looked at were stocked correctly and located in an area which was easy to access in the event of an emergency.

All trolleys sampled contained consumables which were within the expiry date and the relevant equipment was checked daily. We found one emergency trolley where the oxygen cylinder was nearly empty. We alerted the manager and they arranged for the oxygen cylinder to be changed.

The hospital and clinical areas were accessible by wheelchair and accessible toilets were in outpatient areas.

Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired. All equipment we looked at was in date and safety tested.
The layout of the department meant that patients who had attended a clinic and were waiting for patient transport services to take them home, waited in a corridor next to the main outpatient area. This area was not overlooked by hospital staff who may not be seen if they became unwell.

**Assessing and responding to patient risk**

Some risks were not identified by the service to fully maintain the safety of patients always. The service had a computer system that flagged any risks to patients or from patients such as prisoners attending outpatients. However, when we reviewed prisoner records these flags were not in place either on the electronic records or the temporary records brought to the clinic.

Staff could describe the procedure if a patient became unwell in their department. For example, if a patient was having a suspected cardiac arrest staff would call the resuscitation team in the hospital to attend to the patient immediately.

**Nurse staffing**

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe always. Any staff shortages were responded to quickly and adequately.

**Overall staffing rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by care services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Any staff shortages were responded to quickly and adequately.

We saw the service had a system to determine how many clinics were needed to meet patients’ needs and to ensure these were sufficiently and appropriately staffed.

Outpatient clinics were staffed by specialist and outpatient nurses. Staff worked across Royal Preston and Chorley and South Ribble Hospital sites.

A review of outpatients staffing was ongoing. None ward based departments were also having staffing reviews as part of the wider nursing and midwifery staffing review process. They reviewed staffing levels on an ongoing basis and as part of their governance to make sure that staff with the correct skills were working in the correct clinics.

The service did not use agency staff but relied on extra band three staff and the use of in-house staff working extra hours.

Staff said they worked extra hours to accommodate any additional clinics when they were needed to reduce patient waiting lists. Overall, staff said there were sufficient staff.
Vacancy rates

From February 2017 to January 2018, the trust reported a vacancy rate of 12.8% in outpatients. This is worse than the trust’s target of 6%. Vacancy rates at individual sites are as follows:

- Royal Preston Hospital 12.6%
- Chorley and South Ribble Hospital 13.8%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From February 2017 to January 2018, the trust reported a sickness rate of 6.5% for nursing staff in outpatients. This is worse than the trust target for 4.2%. Vacancy rates at individual sites are as follows:

- Royal Preston Hospital 5.9%
- Chorley and South Ribble Hospital 9%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Overall staffing rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has provided this information at a provider-wide level and not provided a breakdown by core services. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided...
this information for medical staff in outpatients. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information for medical staff in outpatients. We are therefore unable to provide commentary on performance.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

We saw the service had a system to determine how many clinics were needed to meet patients’ needs and to ensure these were sufficiently and appropriately staffed.

There was a standard process that was utilised to determine the medical staff and relevant skills mix needed to make sure there was sufficient staff with the relevant skills available.

**Allied Health Professions**

Managers told us they had identified key risks for allied health professions that included staff shortages due to sickness, maternity leave, unfilled vacancies and capacity demands.

We were informed by staff and managers that the service planned to undertake a gap analysis to identify capacity and demand for each allied health profession. Additionally, temporary staffing had been approved as a short-term measure to meet patient’s needs.

The allied health professional leadership meeting had created a focus for taking forward the operational and strategic issues within allied health professions.

**Records**

Appropriate records of patients’ care and treatment were not being kept in all outpatient clinics. Some records were not clear, up to date and available to all staff providing care.

We reviewed 12 patient records in a variety of clinic areas.
We found in the main outpatients' department records were incomplete and essential information had not been recorded or was not available. For example, most records had not been signed and dated or the signature was illegible. In nine records there were no allergies reported and in four records information about, follow-up appointments were not documented. In three records the risk assessments were not completed.

We saw records where patients' specific needs such as mental health or learning disability had not been flagged on the electronic patient record system to alert staff of this need. A manager told us this was being reviewed to ensure improvement in this area.

In other clinic areas including physiotherapy services the records were completed appropriately. Notes were legible, signed and dated, pain scores had been assessed; there had been a review of prescribed medicines and allergies were recorded on the records.

We were unable to identify an agreed approach to the use of either paper or electronic records in the clinic areas. We spoke with senior managers who informed us there were no auditing arrangements to check the quality and completeness of patient’s records. The inconsistent records and lack of review meant that staff did not always have all the information they needed to ensure they were able to deliver patient care safely.

There was a clear system to ensure that doctors had access to patient information and test results. For example, if patient records were unavailable a temporary record was prepared, which meant clinic appointments were not cancelled due to missing records.

**Medicines**

The service prescribed, gave, recorded and stored medicines well in general. However, we did find some medicines stored in a non-medical grade fridge and patient group directions that did not reflect the correct versions held electronically and did not record which staff were authorised to use them. Patients received the right medication, at the right dose, at the right time.

Medicines were stored securely in general but we did find a cupboard in one treatment room that was not secure. The main outpatient department medicines cupboard contained a variety of items that would be single patient use. Some were labelled, for example, Naspetin cream, which would enable the item to be supplied to take home if prescribed. Other single use items were not labelled, for example, Otomize ear spray and chloramphenicol eye ointment 1%. We identified a box of eye drops that had been a patient’s own drugs that was stored with the main clinic stock. This was removed immediately and destroyed.

Some medicines required refrigeration. The fridge in the main outpatient department that was being used to store the items was a food grade fridge with a freezer compartment which had a high component of ice. Medicines should be stored in an appropriate medical grade fridge. This was brought to the attention of the team. The medication that had been at risk was immediately destroyed and the fridge was replaced with a medical grade fridge.

Prescriptions in the outpatient department were stored in a locked cupboard but access was not restricted and there was no audit trail within the department to track this controlled stationery.

We reviewed the arrangements for staff to administer medicines with the authority of a prescriber. For registered health professionals this is known as a patient group direction. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription.
Patient Group Directions were used in outpatients. These allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. The directions we reviewed did not record which staff were authorised to use them and the paper copies were out of date and did not reflect the correct versions on the trust intranet. The trust Medicines Policy did not reference the use of patient group directions.

Incidents
Staff members understood and met their responsibilities to raise concerns, report incidents and near misses. When things went wrong arrangements were in place to ensure that patients were told when they were affected, given an apology and informed of any actions taken as a result.

Never events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From May 2017 to April 2018, the trust reported no incidents classified as a never event for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from May 2017 to April 2018.

One of these incidents was categorised as adverse media coverage or public concern about the organisation or the wider NHS.

(Source: Strategic Executive Information System (STEIS))

The service encouraged openness and transparency. Staff understood their responsibilities to raise concerns, report incidents and near misses. All staff said they were aware of when and how to raise and log an incident and they were fully supported by managers to do so.

Lessons learnt from incidents were not consistently shared with staff for them to understand the improvements needed. We saw records and staff confirmed that incidents were discussed at team meetings and news letters were available that detailed recent incidents.

When things go wrong arrangements were in place to ensure that patients were told when they were affected, given an apology and informed of any actions taken as a result.

We saw records where action was taken to contact and inform patients, known as a duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain “notifiable safety incidents” and provide reasonable support to that person.
Is the service effective?

Evidence-based care and treatment

The trust made sure that staff provided care and treatment based on national guidance and evidence to achieve positive outcomes for patients.

We spoke with staff, senior managers and reviewed records that showed care and treatment was delivered in line with evidence-based practice.

Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).

Audit and staff meetings were held throughout clinics and there were monthly meetings amongst senior managers across all the clinics to promote shared learning.

Nutrition and hydration

There were limited arrangements in place to recognise patients who may have nutritional needs that needed to be met.

There were drinks and snack vending machines available for patients in the main outpatient department.

There were limited arrangements in place to recognise patients who may have nutritional needs that needed to be met, for example patients with diabetes who may have waited in a clinic for some time. However, staff told us if a patient had nutritional needs they could arrange to provide a sandwich and a drink for them.

The Winstanley Ward delivered chemotherapy treatment to outpatients who were required to attend the service for several hours to receive their treatment. The service provided food and drink to meet their needs.

Pain relief

Staff spoken with and records reflected that patients were prescribed simple pain relief as required. Pain relief medicines were dispensed by the onsite pharmacy. The pharmacy was not in operation over the weekend or after hours. Patients were advised on how to obtain relevant pain relief if a new need was identified.

Records reviewed including those from patients attending for pain management did not record how patients’ levels of pain was being monitored to determine their ongoing levels of pain.

Patients could be referred to the pain management clinic by their consultant if required.

Patient outcomes

From February 2017 to January 2018:

- the follow-up to new rate for Royal Preston Hospital was higher than the England average.
- the follow-up to new rate for Chorley and South Ribble Hospital was higher than the England average.
Follow-up to new rate, Lancashire Teaching Hospitals NHS Foundation Trust.

(Source: Hospital Episode Statistics)

Accurate and up-to-date information about the effectiveness of care and treatment was not routinely gathered to be used to improve outcomes for patients.

We spoke with staff and senior managers regarding how they monitored and managed specific areas, such as, waiting times for patients before they got an appointment, how long patients waited once they arrived into a clinic before they saw the relevant medic and when they left the unit.

There were no specific arrangements to audit or check how long patients were waiting once they arrived in the clinics. The eye clinic had undertaken some sample checking however this was not undertaken in other clinics and there were no actions determined from the results of this monitoring.

Patient Reported Outcome Measures questionnaires are given to all NHS patients having hip or knee replacements, varicose vein surgery or groin hernia surgery. The questionnaires ask patients about their health and quality of life before and after they have an operation. This helps the NHS to measure and improve the quality of its care. We were informed that these questionnaires could and sometimes were utilised within the clinic areas and this information was made available as needed.

Senior managers outlined how they monitored individual patient outcomes. They described how they discussed overall effectiveness of the service based on overall outcomes for patients at clinical and management meetings. There were a variety of plans to monitor and benchmark the service outcomes against other similar providers though these were in the early stages.

We were informed following our inspection that the service did not participate in any national benchmarking programmes in relation to outpatients but would explore opportunities to participate.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
Staff told us they had received annual appraisals known as personal development reviews. Records showed that personal development reviews had taken place and staff were supported with their development and educational needs.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

(Source: Routine Provider Information Request (RPIR) – P43 Appraisals)

The service made sure staff were competent for their roles.

Staff were supported to maintain, further develop their skills, experience and their competency to undertake their job role.

We saw examples where staff received specific training and competency assessments. For example, staff used laser equipment. Trust data showed that 10 doctors and 22 nurses were competent to use and assist in using lasers.

We saw staff had access to training specific to their clinical area of practice. Staff told us they had access to appropriate and job-specific training opportunities.

Managers told us that band 3 nurses had been sent on assistant practitioner courses and that nursing sisters had undertaken degree courses.

We saw there had been an increase in arrangements to provide clinical excellence and support to staff. Some staff told us they had regular morning briefings and managers were accessible.

There had been team meetings at each clinic level and higher within the management structures to provide support and feedback to staff. We saw that these arrangements were not consistent across all clinics as overview of the clinics was across the main three directorates. Managers spoken with were aware of the lack of consistency and were reviewing arrangements to ensure all staff received the correct level of clinical support.

Specialist nurses were in post to provide a range of nurse-led clinics. The specialist nurses and therapists had completed extended prescribing courses to expand their skills and improve the quality of service delivery.

Information from the trust showed that new staff were required to complete a full day corporate induction and a local induction before undertaking their role. Staff were positive about the induction process which helped them to undertake their role.

**Multidisciplinary working**

Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

We spoke with a variety of staff from differing disciplines. There was a significant joined up approach from all staff to plan and meet patients’ individual needs.

The service had reviewed the gaps they identified for therapy support such as physiotherapy and occupational therapy. There was an ongoing review to make sure that there was sufficient staff to work as part of a team.

All staff spoken with were confident in the support they had received from their divisions.
The service had increased the profile of allied health professions. The management arrangements ensured the deputy director of nursing had an overview of the multidisciplinary approach, working closely with the associate director of allied health professions.

**Seven-day services**

Seven-day services could be run for different clinics as needed.

The clinics ran on different days and at different times dependent on the needs of patients and the availability of suitably qualified staff. However, there were still some services where clinics were not held outside Monday to Friday working hours.

**Health promotion**

There was a focus on early identification, prevention and on supporting patients to improve their health and wellbeing.

There were general health promotion leaflets available in clinic areas.

Staff described how they discussed health promotion with patients who attended clinics including advice and signposting such as smoking cessation.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Patients were not consistently supported to make decisions. Where patients’ mental capacity was identified as requiring support the assessment, recording and acting in line with relevant legislation was not consistent and was not consistently understood by staff.

We spoke with staff at different levels and job roles within the outpatient departments. Staff awareness of how to support patients who lacked capacity was variable. Some staff were unable to demonstrate a basic understanding of mental capacity and mentioned that it was to do with safeguarding. Managers told us that training on the Mental Capacity Act 2005 was included in the safeguarding course.

There was a lack of information provided to patients or their relatives about advocacy services that could assist them in making informed decisions about their care and treatment.

Some staff we spoke with were unaware of Lasting Powers of Attorney or how there were orders that granted patient advocates different legal rights. As a result, there was a risk that some staff would accept a patients’ relatives right to make decisions of a medical nature without checking that the correct legal authority was in place.

**Mental Capacity Act and Deprivation of Liberty training completion**

From March 2017 to February 2018, the trust reported that 79% of nursing staff in outpatients had completed the Mental Capacity Act Level 2 course. This was worse than the trust’s target of 90%.

The trust has not provided information for Deprivation of Liberty Safeguards (DoLS) training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion and treated them with kindness and respect. Feedback from patients confirmed that staff treated them well and with kindness.
The department participated in the Friends and Family Test. Between October and December 2017 90.1% of patients would recommend the hospital to friends and family and between January and March 2018 91.6% of patients would recommend the hospital to friends and family. The response rate over the six months across both sites was 8%. The service tracked the top ten positive and negative themes and words in responses to identify themes.

We found individual examples of compassionate care within the clinics we visited. We observed staff dealing with patients in a very supportive manner.

Patients we spoke with told us staff were helpful and kind and demonstrated a caring attitude. The NHS Friends and Family test questionnaires reflected that the most positive comments related to staff and how they implemented care and support.

We observed staff introduced themselves to patients and relatives. confirmed. However, we did see some occasions when staff did not introduce themselves to patients.

We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.

The trust had a chaperone policy and signs were visible throughout the service informing patients how to request a chaperone.

Some patients told us that the outpatient department could be very busy and overcrowded which made it difficult to have a private conversation about their medical condition.

The treatment room in the main outpatient department where there were two beds separated by a curtain did not offer the expected level of privacy if two patients were being treated at the same time.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

We saw that staff talked to patients in a manner that was supportive to their individual needs. All aspects of the care that patients were to receive was discussed with them so they could understand and be involved in how their care was delivered.

Staff at the clinic recognised the impact of a person’s care, treatment or condition had on their wellbeing both emotionally and socially. We saw patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.

The service allowed carers and family members to stay with patients as they wished.

The service had clinical nurse specialists and lead nurses available to support and reassure patients regarding the management of their condition.

There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.

Staff confirmed there was access to both psychiatric and counselling services for patients if required.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. However, patients’ personal, cultural, social and religious needs were not always consistently determined with arrangements in place to meet their individual needs.
Patients were given information verbally and in writing so they could understand their treatment. All patients we spoke with said they understood the treatment they were having and were given realistic expectations of the outcomes of their treatment. Patients were informed following diagnostic investigations when they should contact their GP for the results.

Patients we spoke with were clear about what appointment they were attending, what they were to expect and who they were going to see.

We saw staff encouraged patients to ask questions. This was reflected on the trust website where patients were encouraged to prepare for an appointment and to bring any questions or concerns that they wanted further explanation on or which were worrying them.

We observed staff taking time to clearly and carefully explain instructions to patients and to answer any questions patients had.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned services in a way that assisted them to meet the needs of local people.

From February 2017 to January 2018:

- the ‘did not attend’ rate for Chorley and South Ribble Hospital was similar to the England average.
- the ‘did not attend’ rate for Royal Preston Hospital was similar to the England average.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Lancashire Teaching Hospitals NHS Foundation Trust.

(Source: Hospital Episode Statistics)

The data above relates to the main outpatients only.

Since our inspection, the trust provided “did not attend” rates across all the outpatient clinics at Chorley and South Ribble Hospital. These showed that the average rate for non-attendance at
an appointment across all the clinics was 8.1%. The highest rates of non-attendance were found in the dietetics clinic (14.9%); anaesthetics (14.3%); elderly care (13.8%); physiotherapy (13.6%) and oral surgery (13%).

The service had introduced a text reminder service for patients and a reminder was sent to the patient both a week and a day before the patient’s appointment. Senior managers told us introducing the reminder the day before the appointment had reduced ‘did not attend rates’.

One patient who drove themselves to their appointment told us they thought the car park spaces were not wide enough. We noted that the hospital car parks were very full during our inspection and this may have delayed patients in finding a suitable parking space close to the hospital main entrance where the main outpatient department was located.

Patients reported that signage was adequate and that it was easy to find the appropriate department. They also reported that the hospital was convenient to get to. We noted there was a shuttle bus available to transport patients between the two hospital sites should this be required.

Patients told us the clinic seating areas were busy but comfortable although one patient told us the chairs in the waiting areas were too low for people of reduced mobility.

There were volunteers available in the outpatient department to support patients in finding the right clinic.

Meeting people’s individual needs

The service took account of patients’ individual needs in general but systems designed to flag patients needing extra support were not consistently used and information for patients was not always made available in formats that met their needs.

The outpatients’ department had translation services and interpreters to assist and support patients whose first language was not English. There was an Interpreter Policy to support staff on ensuring that the right service was given to patients. There were 65 identified different languages across the trust catchment area and the trust had a contract with an external company to provide face to face and telephone interpretation services.

Patients were asked to inform the service in advance if they required an interpreter and a face to face interpreter was generally booked for the first appointment. A decision was then made as to whether telephone interpretation was appropriate for follow-up appointments or whether a face to face interpreter would still be required. Telephone interpretation was not used for patients with known learning disabilities.

The service measured the success of obtaining interpreters who were fluent in specific dialects and had a 97% success rate.

We saw there was a range of information leaflets in clinical areas on topics such as tests and screening, health promotion and other sources of support. However, they were not readily available in any languages other than English. Staff said they could be ordered in other languages or alternative formats, if required but were not always able to order these in advance of the patient attending the hospital and their individual needs becoming known.

Allied health professions in outpatients had recently reviewed their written patient information and this was available in all their clinic areas. The information was in larger print with pictures. On the
The trust was in the process of getting several posters translated into the top six languages for the local area.

The service could access sign language interpreters for people with hearing impairments. The service had recognised there was a need for signers who used a northern dialect for some patients. The trust had made an informative video for patients in sign language and were considering making further videos for other services, such as outpatients.

A pilot system using Skype for sign language was used in outpatient services where a face to face signer was not available. Hearing loop systems were available in some outpatient areas but not all and there were no signs in place to indicate that a loop system was available to support those patients with hearing aids.

The service had access to an interpreter for deaf and blind patients. They were focussed on the scarceness of this specialist resource and the need to source additional interpreters in this field for the future. The trust had plans to work with two other NHS trusts to examine individual patient needs and accessibility to information to improve patient experience and share scarce resources and ideas.

During our inspection, the service recognised that friends and family test cards were too small in the ophthalmology clinics and other outpatient services where visually impaired patients attended. They had ordered the cards in a larger A4 size and printed on yellow card to better enable visually impaired patients to read them and respond.

The trust website had a text-to-speech facility for visually impaired people to hear what was written on the web pages.

The main outpatient department in the hospital was on the ground floor and was accessible to patients requiring wheelchair access or those with restricted movement. Other outpatient services on higher floors were accessible by patient lift.

The trust web site directed patients to an external website where they could view details of access routes into the hospital and each department (including all outpatient clinics) for wheelchair users and persons with restricted mobility. The site had been fully surveyed by the external company to assess that reasonable adjustments had been made to enable people living with a disability easy access to services.

Patients requiring transfer home by patient transport services were asked to wait at a seating area in the main corridor outside the main outpatient department. However, many of these patients were vulnerable and had to wait for some time for their transport to arrive. The seating area was not directly overlooked by any hospital staff. We spoke with one patient and their spouse who had been waiting almost two hours for their transport home. They had not been checked by any staff and had not been offered any refreshments.

The main outpatient department employed volunteers to assist patients in finding the right clinic and to support patients in the waiting area although there were none there at the time of our inspection. There were plans in place to teach the volunteers basic sign language to greet deaf patients.

The outpatient medical record systems had a facility to alert staff of patients who had specific needs, though this was not consistently being used, other than to record patient allergies. The
Head of Customer Care had developed a proposal to ensure that information for additional support needs was added to the medical records system and that this was mandatory.

Staff could give examples of where they had liaised with other agencies, families and carers to maintain daily routines and support patients in vulnerable circumstances, such as patients living with dementia or learning difficulties.

Adjustments included, reducing waiting times for an appointment, making earlier appointments to avoid the patient waiting in the clinic and seating patients in a quiet area. We were given examples of very specific patient needs where staff had put things in place in advance of the appointment to keep the patient calm and relaxed whilst attending a clinic.

Senior managers we spoke to were focussed on the need to meet the Accessible Information Standard. The standard was introduced by NHS England and require all organisations that provide NHS care to follow the standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Patients with learning disabilities or specific needs had access to a “patient passport”, on which important information about the patient’s needs, likes, dislikes and carer details could be given.

**Access and flow**

Waiting times from referral to treatment were improving although not all specialities were above the England average.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From March 2017 to February 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for February 2018, showed 82.2% of this group of patients were treated within 18 weeks versus the England average of 88.9%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Lancashire Teaching Hospitals NHS Foundation Trust.**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Seven specialties were above the England average for non-admitted RTT (percentage within 18 weeks).
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>98.3%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>96.2%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Other</td>
<td>94.3%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>93.8%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>93.7%</td>
<td>89.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>90.9%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>87.9%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Nine specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>90.4%</td>
<td>91.7%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>85.8%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>83.2%</td>
<td>89.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>82.9%</td>
<td>87.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>81.9%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>76.9%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>60.5%</td>
<td>85.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>52.0%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Neurology</td>
<td>40.9%</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From March 2017 to February 2018, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance for the entire reporting period. The latest information we have for February 2018 shows the trust’s referral to treatment time in this category to be 83%, compared to the England average of 88%.

**Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Lancashire Teaching Hospitals NHS Foundation Trust.**

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty**

Five specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>98.7%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>96.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>Other</td>
<td>94.9%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>92.7%</td>
<td>83.6%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>87.0%</td>
<td>84.9%</td>
</tr>
</tbody>
</table>

11 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks)

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>87.4%</td>
<td>91.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>87.1%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>86.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td>General surgery</td>
<td>85.8%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>85.4%</td>
<td>89.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>85.1%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.0%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.6%</td>
<td>90.6%</td>
</tr>
<tr>
<td>General medicine</td>
<td>82.9%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>75.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>62.7%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard and the England average for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from
Diagnosis to first definitive treatment (All cancers)

The trust is performing similarly to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Lancashire Teaching Hospitals NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Patients were kept informed about any disruption to their appointments which could be rearranged if required.

We observed that patients had a choice of appointments and in many instances, additional clinics were held in the evenings or at weekends to reduce waiting times However, there were still some services where clinics were not held outside Monday to Friday working hours.
Initial appointments for patients were arranged by the patient booking centre that was housed in an off-site facility in a business park in Preston. Referrals were received from GPs and internally from within the trust. Follow-up appointments were generally made with the outpatient reception staff before the patient left the clinic.

Data supplied by the trust showed, between April 2017 to March 2018 all outpatient clinics across Chorley and South Ribble Hospital had cancelled 13,082 patient appointments, 21,313 appointments were cancelled by patients.

The cancellations by the hospital included those patients whose appointments had been brought forward and those given a later appointment date. This equated to 34,395 total cancelled appointments and was approximately 19% of all patient appointments annually. Only five of the total cancellations had been recorded as incidents by the trust.

Senior managers were aware of meeting referral to treatment times and had several monitoring programmes in place. Where waiting times for a first appointment began to increase, arrangements were made for additional clinics to reduce waiting lists.

The ongoing monitoring of patient clinics and actively increasing the number of clinics to meet patients’ needs had assisted patients to attend clinics. However, this presented logistic issues for the service in making sure they had the correct staff at all times. On occasions staff told us this had been difficult to manage and ensure they were able to support additional clinics appropriately.

The outpatient services did not routinely audit or collect data about in-clinic waiting times so were unable to monitor how long, on average, patients were waiting to be seen when they arrived at a clinic and how waiting times could be improved. Similarly, there was no monitoring of late starting clinics. There were no targets in place for maximum wait times in clinics to improve the patient experience.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided this information in a format which allows analysis by staff group or core service.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

The trust used an electronic reporting system to record incidents and complaints. Complaints were identified and uploaded onto the system along with actions taken. At the end of the complaints process the complaint was sent to the governance team to cascade downwards to relevant teams for discussion in team meetings and with individuals concerned.

There was a standard trust template for team meetings that included an agenda item on learning from complaints and concerns.

The service produced a newsletter in relation to learning from incidents and complaints. The newsletter of Spring 2018 detailed that a complaint investigation revealed that there had been a failure to follow the trust’s documentation policy on a perioperative care plan. Staff were to remember that every page must identify the patient using their name, hospital ID and date. As such staff were given information within the newsletter as to how the service recognised and responded to complaints to improve practice.
The Head of Customer Care had been overseeing the Complaints and Patient Advice and Liaison services since February 2018. They reported that in February only 30% of complaints were responded to within the trust target of 35 days. By March 2018, 100% of complaints were responded to within the target timescale.

They reported that communication with the patient was started as soon as possible and the complaints policy had been re-written to enable the resolution of complaints in as timely a way as possible. A new process for dealing with complaints had been piloted with a view to rolling it out to all services when a robust evaluation had taken place.

If the complaint could not be resolved informally, patients and relatives could be assisted in contacting the Patient Advice and Liaison Team to receive support in making a formal complaint.

The trust website had a page that advised patients how to raise a complaint and there was a link to an electronic complaint form. There was also advice on receiving advocacy during the complaints process.

Managers told us there were plans in place to reintroduce a patient facing Patient Advice and Liaison Service (PALS) team to the hospital. This had been discontinued over four years ago and the Preston PALS team had been providing an outreach service to Chorley and South Ribble Hospital for two and a half days per week. The new team would be the PALS/Patient Experience Team and part of their role would be to resolve any issues on site and provide information to patients who had these additional requirements.

The outpatient services displayed “How Are We Doing” posters that contained information about how to complain. There was a code on the posters that patients could use with their mobile phone to direct them to the complaints page on the website. The posters were also aimed at people with learning disabilities and had patient experience emojis with sad or smiley faces to assist in patients indicating how their experience had been.

We were unable to determine how many complaints were made for clinics or their trends and themes as this data was kept for three different divisions and could not be easily extracted. We were told themes included car parking, waiting times, missed appointments and cancelled clinics. Senior managers spoken with held monthly meetings where general themes for learning was discussed and this was cascaded to staff.

Is the service well-led?

Leadership

Leaders had the experience, capacity, capability and integrity to make sure that a quality service was delivered and risks to performance were addressed.

Leaders demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.

The divisional leadership team consisted of a director, nursing director and a medical director.

Staff told us they were clear about who they reported to. They said managers were honest, proactive and they felt confident to approach their direct line manager with any concerns. However, they said the senior management team above matron level were not always visible. Senior managers we spoke with had developed plans to attend each department on a frequent basis so staff could have a greater awareness of managers and the support available.
Managers were aware of the challenges to support staff from different divisions working in the clinics and were improving communication and training.

We saw meeting minutes where values and consistency of approach was discussed across the directorates. Leaders discussed risks and areas of improvement.

There was a leadership structure that was designed to support and work in a collaborative manner. Reporting mechanisms and cross directorate support was in place supporting senior managers at monthly meetings.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and key groups representing the local community.

The service had several values that were displayed in patient areas these included; caring and compassionate, recognising individuality, seeking to involve, team working and taking personal responsibility.

All staff we spoke with knew what the vision and values of the service were. They were all committed to working towards the objectives. Staff were passionate about patient support and ensuring patients received an excellent standard of care.

The service had a Nursing, Midwifery, Allied Health Professionals’ and Care Givers’ Strategy for 2018 to 2021 which outlined five key commitments and set out plans to improve the patients’ experience of care and treatment.

The service had a comprehensive and realistic strategy, to develop their services further. They had recognised there were areas of the service that still needed development and had identified several strategies to assist. These included developing closer partnership working across directorates to improve consistency and staff support.

Managers had a clear vision of how they planned to develop the service including moving ophthalmology services from Royal Preston Hospital to Chorley and South Ribble Hospital. The business plan had been submitted to the board and approved.

The new pathway for ophthalmology patients was designed by the clinical director with input from ophthalmology staff. Funding was in place to take the strategy for ophthalmology forward and a non-executive sponsor had been identified. Senior staff at Chorley and South Ribble Hospital were aware of the plans and had identified opportunities for staff development and improved patient flow through the hospital.

**Culture**

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Most staff we spoke with said they felt very supported by their immediate line manager and morale was good.

The service recognised that morale in the core therapy services needed improvement because staff were concerned about the ongoing therapy and nursing workforce review. There were actions in place to support staff which had improved staff morale.

Staff and senior managers reported there was an open and honest culture across the clinics. Staff said they understood the need for openness and transparency and were knowledgeable about their responsibly under the duty of candour regulations.
Senior staff were aware of the NHS staff survey results and had plans to increase inclusivity to promote equal opportunities for staff and promote wellbeing.

We discussed with staff the role of the Freedom to Speak Up Guardian. Freedom to Speak Up Guardians work alongside leadership teams to support staff to raise any concerns they may have.

Staff we spoke with were not aware of the role of the Freedom to Speak Up Guardian. Senior managers had taken the decision to have several guardians throughout the organisation to provide staff with an alternative means of contact. A training programme for the role was being rolled out and a launch to all staff to raise awareness would be put into place.

In general outpatients we found that staff were committed to trying to work with trust managers to deliver the services.

Staff were also included in health promotion. There had been a 75% take-up of flu jabs offered to staff. They were supported in smoking cessation. There were also walking, running and social groups for staff.

**Governance**

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. An environment in which quality of care would flourish was encouraged.

However, new processes were not yet fully embedded to ensure there was consistent practice throughout outpatient clinics.

The governance team had only been in post for three months. During this time, they had made it a priority to review the risks to the service and people using it. There was an acknowledgement from senior managers that the priority was the development of a robust governance structure and culture.

There were meetings across all the clinics to increase communication and monitor performance. These were at clinic level for staff on an individual basis and at directorate level to achieve a consistent approach across all clinics.

Subcommittees met monthly and reported to divisional governance boards who had responsibility for oversight of priority areas such as safety and quality, workforce, strategy and finance. Clinical governance leads in each speciality attended the governance meetings.

Matrons met regularly with clinical directors ensuring that information flowed from clinics to the divisional leadership and back down. We reviewed minutes of meetings and saw that performance data was presented and discussed across the key domains of safe, effective, caring, responsive and well led and performance dashboards were reviewed and kept up to date.

Changes to clinical practice were discussed and agreed in monthly meetings attended by all consultants and speciality leads. This ensured that changes in operational protocols were adopted by all consultants.

The service had implemented a quality review system known as STAR. This was conducted at clinic level. The matron in each area received a report once the review had been undertaken with a detailed action plan to determine what improvements were needed and how to take this forward. The outpatient STAR audit had shown improvements since the programme commenced.

There was a clear appetite and passion from senior managers to bring about improvements and ensure that the service met the needs of patients.
Information and recommendations from patient engagement events were part of the services planning to improve the service.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. Audit processes to identify risks functioned well and had a positive impact.

Since the last inspection we saw the service had been proactive in improving the management of risk but these arrangements were still in their infancy and not yet fully embedded in the performance metrics.

The service had various risks on a local and directorate risk register. These were monitored so that risks to the service or staff could be recognised and addressed. Senior managers we spoke with were confident the arrangements, although only recently fully resourced, were having a positive impact. However, some staff were unaware of what the governance arrangements were and how they were being monitored.

Senior managers demonstrated an awareness of the risks and performance issues within their division and had identified actions to address key risks.

Risks were owned by each of the divisional subcommittees for safety and quality, workforce, strategy and finance. These committees were chaired by associate divisional directors and reported directly to the divisional leadership team at a monthly performance review forum. The minutes showed the divisional risk register was reviewed and discussed by the Safety and Quality Committee and the divisional risk report produced quarterly and presented to the board.

Minutes of the divisional board meeting in January 2018, evidenced the executive team had oversight of divisional performance and gave feedback to the divisional leadership team which was communicated to staff. Issues for escalation were discussed at this meeting and an action tracking system was used to record completed, and overdue actions.

Newsletters were sent to staff detailing the learning from incidents. However, we noted there were some incidents and safety issues where the learning had not shared with staff. An example included an ongoing investigation for five patients where the learning from an earlier review had not been passed on to staff.

**Information management**

The service collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.

Information was kept securely and maintained the confidentiality of patients.

The service used different electronic and paper record systems resulting in slow systems affecting service delivery. An example was the delays in scanning of notes after each admission, which affected patients who were re-admitted during this time. The target was for records to be scanned within three days of attendance at an appointment but this target was not always achieved. Medical staff could voice record the records made in clinic that were later transcribed.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
The service was transparent, collaborative and open with all relevant stakeholders about performance considering the needs of the population to design improvements.

The service had been involved in extensive engagement with the community and patients who were using the services. There had been engagement with around 3000 patients from a wide range of organisations during public engagement events, such as, health days, annual members events and listening events.

The outcome of the public, staff and stakeholder engagement was the development of the Patient Experience and Involvement Strategy 2018-2021. The actions in the strategy were as a direct result of listening to what patients, staff and stakeholders said mattered to them. There were four main aims within the strategy: to deliver a positive patient experience; to improve outcomes and reduce harm; to create a good care environment and to improve capacity and patient flow.

We saw that all staff were committed to delivering the improvements outlined in the strategy and patients and the community remained involved in designing and agreeing the improvements so that they met their expectations.

The actions included an increased availability of information in different languages; more British sign language interpreters and volunteers who could use sign language; staff consistency in the way they introduced themselves; improving the experience of patients with mental health and learning disabilities and improved ways for patients to raise concerns without making a formal complaint.

Consultation with the public was ongoing and Chorley and South Ribble Hospital had arranged a learning disability event day and had worked with a national children’s charity to organise a children’s event where children were being asked to suggest improvements, including what they would like to see in outpatient clinics for children.

A senior manager, who had worked at the trust for over 20 years, told us they had never seen the organisation so patient focussed before.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation

Mortality and morbidity reviews were held following a patient’s death to examine practice and identify areas of improvement. The divisional governance team audited the mortality reviews quarterly and lessons learnt were shared in the clinical governance committee. Outpatients clinics had a small input into these meetings, depending on the patients’ journey and needs.

Lessons learnt from incidents and complaints were shared with staff electronically and at daily huddles. The monthly team meetings included discussion of learning from performance trends and ideas for improvements.

The service combined the responsibility of associated healthcare professionals and nursing staff within the management structure so that a joined-up approach could be taken towards patient care.