Lancashire Teaching Hospitals NHS Foundation Trust

Inspection report

Royal Preston Hospital
Sharoe Green Lane, Fulwood
Preston
PR2 9HT
Tel: 01772716565
www.lancashireteachinghospitals.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our findings

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.
- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Leaders showed adequate experience, knowledge, and skills to run the service. They mostly understood and managed the priorities and issues the service faced, however during some interviews leaders could not clearly or consistently articulate certain business details.

Some staff felt leaders were less visible in services where there were greater pressures.

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks and identified actions to reduce their impact. However, during our inspection of urgent and emergency care we issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly and shows assurance about the actions that were taken to address these issues.

Also, following our inspection of maternity and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The trust supported staff to develop their skills and take on more senior roles. Mandatory training for medical staff needed improvement.

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

The service collected reliable data and analysed it.

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a good understanding of quality improvement methods and the skills to use them.

How we carried out the inspection

Our findings

During our inspection we spoke with a variety of staff including nurses, doctors, therapists, healthcare support workers, pharmacists, patient experience staff, domestic staff, administrators, and the trust's board. During the inspection we also spoke with patients and relatives. We visited clinical areas across the hospital sites. We reviewed patient records, national data and other information provided by the trust.

We held several staff focus groups with representatives from across the trust to enable staff who were not on duty during the inspection to speak to inspectors.

The inspection was overseen by Sarah Dronsfield deputy director and included an operations manager, inspectors, and specialist advisers. An executive reviewer supported our inspection of well-led for the trust overall. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Trust Wide

- The trust had developed and used a team engagement and development tool (TED) to support improvements in levels of team satisfaction and engagement as measured through the trust annual staff survey. The tool was embedded across the trust in leadership development, continuous improvement, and the Star Ward Accreditation programmes. In 2022-2023 the trust completed 175 TEDS, which engaged with 1,523 colleagues. The tool had been recognised by NHSE as an example of excellent practice and the trust was supporting other organisations to do this.
- In November 2022, the trust opened Finney House, a 96 bedded location, which includes 32 residential beds and 64 intermediate care beds. This addresses a long-standing gap in community provision in Central Lancashire and has reduced patients who do not meet criteria to reside from 12% to 5.2%. Since opening, 808 patients have been cared for in Finney House, the home has an average length of stay (LOS) of 10.5 days, ranging from LOS 2.5 to 18 days. To date there has been only one formal complaint, family and patient feedback remains consistently positive.
- The trust was working with the ICS, other trusts and in partnership with the Engineering Design Centre from the University of Cambridge to test their 'Engineering Better Care' model. The trust had adopted this approach and was currently applying the model to 3 programmes, frailty, thrombectomy and complex death notifications.

Maternity

- The service used innovative ways to engage with women, birthing people, families and the wider community to participate in activities outside of the hospital to promote birth choices for women and birthing people. For example, the maternity unit took part and had a stall and float at the local festival promoting birth choices for women and birthing people.

Royal Preston Hospital

Urgent and Emergency Care

Our findings

- The department had been recognised with a Royal College of Emergency Medicine award for work to improve the 'green footprint' of the department.
- The department had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. Data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure staff complete mandatory training in accordance with the relevant schedule and receive sufficient training, supervision, and appraisal to perform their duties competently. (Regulation 18 (2)(a)).

Location/core service

Royal Preston Hospital

Urgent and Emergency Care

- The trust must ensure that medical staff complete all required mandatory training. (Regulation 18 (1)(2)(a).
- The trust must ensure that risk assessments are fully completed for patients attending with mental health needs and mitigating actions to limit identified risks are implemented. (Regulation 12 (1)(2)(a).
- The service must ensure that staff complete patient records accurately and in a timely manner. (Regulation 17(2)(b)).
- The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a)).

Medical Care

- The service must ensure patients receive antimicrobials in line with the national guidelines. (Regulation 12).
- The service must improve compliance for resuscitation training for medical and nursing staff and compliance for sepsis training for medical staff. (Regulation 12).
- The service must ensure that patient records are kept secure. (Regulation 17).
- The service must ensure they have enough medical staff to keep patients safe. (Regulation 18).

Surgery

Our findings

- The trust must continue to take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12(1)).
- The trust must continue to take actions to improve the number of patients receiving a clinical assessment and daily review by a senior decision maker within target timescales. (Regulation 12(1)).

Maternity

- The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training. (Regulation 18(2)(a)).

Chorley and South Ribble Hospital

Urgent and Emergency Care

- The trust must ensure that all staff, including medical staff, complete mandatory training requirements. (Regulation 18(1)(2)(a)).
- The trust must ensure that checks of consumables are completed including integrity of packaging and within expiry dates. (Regulation 12(1)(2)(e)).
- The trust must ensure that patient identifiable information is not visible to visitors to the department (Regulation 10(1)(2)(a)).
- The trust must ensure patients with a mental health concern are cared for in a room that is free from objects that could be used to self-harm (Regulation 12(1)(2)(d)).

Maternity

- The service must ensure staff receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training. (Regulation 18(2)(a)).
- The service must ensure equipment is secure, suitable for the purpose for which it is being used and properly maintained. This includes but is not limited to emergency equipment and firefighting equipment. (Regulation 15(1)(b)(c)(e)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that it continues to monitor pharmacy staffing to support continued improvement in medicines optimisation (Regulation 18).
- The trust should monitor the administration of files for the fit and proper persons checks.

Location/core service

Royal Preston Hospital

Emergency Urgent and Emergency Care

Our findings

- The service should ensure that patient identifiable details are not displayed on public boards. (Regulation 17).
- The service should continue its focus on establishing sufficient numbers of medical staff and managing any risks occurring as a result of staffing lack in medical workforce. (Regulation 18(1)).
- The service should continue its focus on improving local audit (STAR accreditation) outcomes.
- The service should ensure that patients' nutrition and hydration needs continue to be regularly monitored whilst they are waiting for treatment and care.

Medical Care

- The trust should ensure patients receive daily, timely review when not being provided care and treatment on the correct medical speciality ward. (Regulation 12).
- The service should ensure that staff follow infection prevention control principles. (Regulation 12).
- The service should ensure that premises are safe to use for patients. (Regulation 12)
- The service should ensure risk assessments, care plans and intentional rounding is completed regularly for all patients. (Regulation 12).
- The service should continue to monitor the correct recording of NEWS2 observations. (Regulation 12).
- The service should ensure that equipment is properly maintained, including the patient call bells and showering facilities. (Regulation 15).
- The service should ensure that complaints are managed in a timely manner. (Regulation 16).
- The service should continue to improve waiting times for patients accessing neurology cancer treatment.
- The service should improve staff attendance at governance meetings.
- The trust should continue to improve the provision of single sex washing facilities for patients.
- The Trust should continue to recruit allied health professions within medical care.
- The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed.
- The trust should continue to use medicines data to support improvement in medicines safety.

Surgery

- The trust should monitor and review arrangements to ensure that medicines with a minimum dosage interval are administered as prescribed.
- The trust should continue to use medicines data and keep pharmacy staffing under review to support continued improvement in medicines safety, including medicines reconciliation.
- The service should consider how wards and theatre areas can be made more dementia friendly.

Maternity

- The service should ensure the maternity assessment service has the right number of qualified staff and the triage telephone line is answered and monitored by a trained midwife.
- The service should improve the culture where staff feel listened to.

Our findings

- The service should ensure they monitor delays in the induction of labour process and all reasons for the delays are documented.
- The service should ensure there is an accurate overview of risks faced, including the monitoring of delays in induction of labour, monitoring of missed telephone calls and telephone call drop off rates within triage and to rate all 3rd and 4th degree tears and post-partum haemorrhages as incidents.

Chorley and South Ribble Hospital

Urgent and Emergency Care

- The trust should ensure that all conversations with patients, and their families take place in an environment where they are not overheard (Regulation 10).
- The trust should ensure that all noticeboards include current information such as safeguarding. (Regulation 13).
- The trust should ensure that all patients with protected characteristics are supported such as availability of information in formats that patients understand. (Regulation 9).
- The trust should ensure that complaints are managed in a timely manner (Regulation 16).
- The trust should consider including checks of the transfer bag with other daily checks.
- The trust should consider locating paediatric emergency information where children would be treated.
- The trust should consider reviewing the environment where paediatrics are treated to be more child friendly.
- The trust should consider sourcing comfortable chairs appropriate for patients with additional needs such as mobility or bariatric.

Maternity

- The service should review use of patient group directions and storage of aromatherapy oils to assure themselves medicines management is in line with best practice.
- The service should ensure staff carry out newborn observations using track and trigger system in a timely way in line with local guidance.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders showed adequate experience, knowledge, and skills to run the service.

They mostly understood and managed the priorities and issues the service faced, however during some interviews leaders could not clearly or consistently articulate certain business details.

Some staff felt leaders were less visible in services where there were greater pressures.

The trust supported staff to develop their skills and take on more senior roles**.**

Our findings

The executive team spoke of a unitary board, therefore worked to a collective responsibility for aspects such as finance, patient quality, and safety.

Most of the executive directors had been in post since the last inspection in 2019. The chief executive officer joined the trust in 2021. The CEO was experienced in their role with a background in finance and had held various director and chief executive posts. The CEO played a key role in the whole system as chief executive lead for the Lancashire and South Cumbria Provider Collaborative.

Following our inspection, we were informed the CEO was leaving to take up another post. We were cognisant of the potential impact this could have on the stability of the board. The trust appointed an interim Chief Executive Officer (the current COO) on the 1 October 2023 whilst recruitment to the CEO took place. The trust formally announced the appointment of a new CEO on 2nd October 2023.

Executive directors had varied portfolios. The Chief Nurse was supported by a Deputy Chief Nursing Officer, a Chief AHP, two Associate Directors of Governance and Divisional Nurse/Midwifery Directors for each Clinical and Corporate Division. Governance was shared with the medical director. Support for the medical director had been strengthened with 3 deputies soon to be 4. An interim Chief People Officer had been appointed following the retirement of the previous post holder.

The trust's Chief Finance Officer had been in post since August 2019. Prior to this they had held roles at Chief Finance Officer level since 2007 at several hospital trusts.

The Board invested in the establishment of a Director of Strategy and Planning in January 2022 and a planning team in response to the refreshed national approach to planning introduced by NHS England post-pandemic, to ensure that the organisation had the resources required to further strengthen its approach to strategic and operational planning.

We found the leadership team had the knowledge of the main priorities and challenges facing the services, however during some interviews leaders could not clearly or consistently articulate certain business details. For example, the board signed off a cost saving target of £67m without a plan detailing how this would be achieved. Together with the local health economy, the Trust Board accepted a stretch target from the ICS and at the time of the inspection there was little assurance of schemes that supported this. This represents a significant risk to the trust delivery of its financial plan. This was agreed on the assumption that a mitigating 'Memorandum of Understanding' would be put into place, together with a system 'Road Map'. This had yet to be finalised at the time of the inspection.

The ethnic diversity of the board was not representative of the staff as a whole or the local population. Board members acknowledged that the board lacked ethnic diversity with no executive or non-executive members from racially minoritised groups.

The CEO told us until recently, there had been no vacancies to support the Board in addressing this; however, the Board were currently recruiting to a Non-Executive Director position and were aiming to recruit a board member from minority groups.

It was anticipated the trust would make the appointment in August which would address the gap. The Board included a non-executive and an executive director with protected characteristics which added significant value to the representation of the wider community and staff diversity.

Our findings

The current chair was an interim post pending an imminent permanent appointment. They had been acting chair since August 2022 and were a consultant physician with a special interest in elderly care, stroke, and medical education. After the well led inspection, we were informed a substantive appointment had been made to the position of chair starting on 1 August 2023 and the appointment had been ratified by the Nominations Committee and the Governing Body.

There were currently 6 non-executive directors (NEDs) with an advert out to recruit to a vacancy. The NEDs had a diverse range of leadership experience in the sectors of health, local authority, finance, and business. Most of the NEDs had been appointed in the time since our last inspection. The most recent appointments included bringing in expertise as a senior leader from the public sector and commercial environment. The NEDs chaired the trust committees, which reported to the trust board.

The recruitment and induction of non-executive directors was positive. There was a varied mix of skills and experience across directors and a considered approach to the skill set requirements when new directors were recruited.

Non-executive directors reported that relationships with the executives were supportive and there was sufficient challenge and influence to drive improvements. They were clear about their roles and responsibilities and played a large role in chairing committees.

The trust operated through 4 divisions; medicine; surgery; women's and children's and diagnostics and clinical support. Each division was led by a triumvirate of a divisional director, medical director, and a director of nursing or equivalent role. The divisions were supported by service managers.

We spoke with the divisional leads who had a good awareness of the challenges, including quality, workforce, performance, and finance. The leads were positive about the support from the executive team.

There was time set aside for board development which included workshops to review the strategy. The trust had a well organised talent management programme with support for career development and creating a coaching culture for staff who wanted to progress into senior roles.

The trust tried to ensure fairness and equity by working with inclusion leads to provide career opportunities for people from all backgrounds and protected characteristics where necessary. Most staff told us that opportunities for career development had improved but this was dependent on the role and department they worked in.

Some staff groups provided mixed views regarding the visibility of the leadership team, particularly at Chorley Hospital. Also, staff in areas where there were greater pressures, due to challenges recruiting medical staff, financial restraints, and patient demand, felt less supported by the senior leadership. This feedback was like that we received at the last inspection. Some staff also said on some wards there was a culture of silo working.

The Board had a bi-monthly structured walk around where they visited clinical areas and spoke to staff. The Chief Executive worked shifts in different parts of the hospital as part of the 'back to the floor' initiative and was involved in meetings and events with different staff on both sites. The Chief Nursing Officer and Chief Medical Officer also worked shifts in different parts of the trust and carried out visits (with the Chief Medical Officer having a regular clinic on the Chorley site every Tuesday).

As part of our well led inspection, we observed the public and private board meeting on 3 August 2023. The acting chair allowed members to engage and apply scrutiny to agenda items. Those attending were able to seek assurance and there was sufficient challenge on the key areas of risk.

Our findings

The trust had acknowledged the high-level feedback given by the CQC following the recent site inspection visits and informed the board that a specific action plan with regards to concerns we had raised about maternity was to be monitored by the Safety and Quality Committee and would be reported to Board.

Pharmacy Leadership

The executive team had good oversight of the staffing challenges within pharmacy informed through the monitoring of pharmacy KPI's at divisional performance review meetings. New pharmacy team structures were being embedded following staff engagement and formal staff consultation (Q2 2022). There was constant reassessment of deployment and utilisation of pharmacy staffing budget, for example the employment of analysts to strengthen governance.

Similarly, the medicines management associate's team had been expanded to support improved adherence with standards for the safe handling of medicines, whilst releasing technician and pharmacist time to clinical roles. Recruitment and retention plans were being refreshed to help close pharmacy vacancy gaps (~40% band 6/7 pharmacists, 20% technical staff). Recent successful recruitment should reduce pharmacist vacancies from August 2023.

However, we found for example, that limited pharmacy capacity on MAU impacted upon rates of prescription verification, a clinical assessment to ensure safe and optimal use of medicines and medicines reconciliation.

The recent opening of AAU further reduced clinical pharmacy performance on admission wards, due to trust expansion into this area, without increased pharmacy capacity. Similarly, 24h medicine reconciliation rates below trust target were attributed to 'a lack of pharmacy input at early stages in the surgical admission pathway'.

There was also variation between the two hospital sites in performance against key medicine safety metrics on admission wards. Continuous improvement work was underway focussing on expanding the role for pharmacy technicians in completing medicines reconciliation.

Fit and proper persons

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed staff files for members of the board of directors. We found documents such as annual fit and proper persons self-declaration, disclosure and barring service, registration checks were compliant with Regulation 5. However, in 2 files confirmation of qualification checks were missing and in 3 files confirmation of occupational health checks were absent.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and most staff understood and knew how to apply them and monitor progress.

Our findings

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust launched its five-year strategy Our Big Plan in 2019. The divisional business plans were aligned to the Big Plan. The business plans set out the actions, finance and workforce implications and business cases for each of the objectives in the Big Plan

There was a vision, values and focus on people, safety of services and patient experience. There were several enabling strategies which supported the overall strategy. The Director of Strategy acknowledged there was a good range of strategies and signalled that going forward they wanted to build on this strength to make the process for developing them and their contents more consistent.

The trust had a process to monitor progress against the plan. There were a set of metrics which were reviewed annually to consider changing national policy requirements and local circumstances.

Metrics were cascaded through the organisation and reviewed by each divisional improvement forum. Staff were aware of and knowledgeable about the trust's core values and spoke readily of how these related to the work in their services.

There was a greater emphasis for directors to be more outward facing and partnerships were beginning to be embedded and strengthened with the ICS and other national work programmes. Executive and non-executive directors were engaged in wider system developments. Leaders understood the benefits of system wide working to improve patient care for people across the Lancashire and South Cumbria area. Integration had good coverage in the minutes of board meetings we reviewed.

The Big Plan metric was being refreshed in September 2023 with a full review to set the next 3 years taking account of related key developments such as the Integrated Care Board Forward Plan and the development of Place (Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community).

Since the last inspection the trust had launched its clinical services strategy 2022/2025 which was aligned with the system level New Hospitals Programme Framework Model of Care. The key areas included reduction of waiting lists, changes to urgent and emergency care, community integration, health inequalities and workforce and financial challenges.

The trust was also part of longer term and system wide strategies such as the new hospitals programme. As part of a rolling programme of national investment in capital infrastructure beyond 2030 it was announced that a new hospital would be built to replace the Royal Preston Hospital.

A financial strategy had been in place since 2021 with a branding of 'Knowing the Business'. This detailed an action plan to support the overall infrastructure and underpinning strategies to provide the right environment to identify and deliver productivity and reduction in unwarranted variation. It was regularly updated but did not specifically quantify schemes to deliver an underlying breakeven position. The trust has commissioned 2 external reviews to support its work.

The trusts Pharmacy and Medicines Optimisation Strategy, aligned with the trust 'Big Plan' had been redrafted for 2023-2027. There were plans (following sign off) to raise pharmacy and wider awareness and engagement with year 1 priorities. Key deliverables for 2022/23 included the successful roll out EPMA to the emergency department, closing identified risks at the interface between paper and electronic records and implementation of the new pharmacy team structure to support patient flow.

Our findings

Culture

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff felt respected, supported, and valued. Staff were positive about their departments and the local leadership teams; they were able to speak to local leaders about difficult issues when things went wrong.

The 2022 staff survey results showed the trust scored above the benchmark median for each of the areas in the NHS Staff Survey. The trust was placed 13th out of 65 trusts in overall positive scores up from 24th in 2021.

There was a 4% improvement from 2021 in colleagues feeling unwell due to work related stress in the last 12 months. There was no improvement recommending the trust as a place to work and/or care. The most significant fall in satisfaction was around the level of pay. The results were shared with the divisional teams and actions to improve identified.

Colleagues respected one another to achieve the desired outcomes for patients, relatives, and carers. All staff were committed to improving the quality of care and patient experience.

Senior leaders were proud of the transparent culture, which was reflected by staff, at different levels, across the trust, who were honest and open.

Board members and senior leaders were consistent that patient safety was always a priority and had agreed investment to safeguard patient safety despite the difficult financial position of the trust.

Data from the most recent workforce race equality standard (WRES) report showed positive performance. Of the 4 questions asked in the NHS Staff Survey 2022 the trust scored better than, or in line with, the average for all 4.

Action was needed to increase the representation of ethnic minority colleagues in more senior roles alongside the trust's WRES positioning in terms of the likelihood of white staff accessing non–mandatory training and continuing professional development (CPD) compared to staff from ethnic minority groups.

The trust had implemented a plan to identify the cause and implement corrective action where necessary.

In the Workforce Disability Equality Standard (WDES) of the 8 questions asked in the NHS Staff Survey 2022 the trust scored better than, or in line with, the average for all 8. However, the metrics had deteriorated since the previous year.

The trust had an equality diversity, and inclusion (EDI) network with a broad range of representation. Members from the different networks spoke with enthusiasm and positivity about their work and the support offered by the trust. They shared examples of joint working to challenge inequalities and discrimination. As part of every divisional people plan there were dedicated divisional level EDI actions with increased representation from the workforce with specific protected characteristics.

During the inspection we spoke to chairs of the staff network groups including ethnic diversity, LGBTQ+, menopause, disability, and carers. The networks were involved in actions to improve EDI across the trust. The chairs spoke of a positive culture at the trust and felt supported in their roles by trust leaders. The networks were involved in the

development of the EDI strategy and inputted into education and employment management programmes to ensure inclusive recruitment. The CEO was the executive sponsor for the ethnicity council. Several events were planned for the next 12 months by the different networks. The LGBTQ+ network was aiming for the rainbow badge accreditation to monitor how well the trust cared for LGBTQ+ patients. Areas currently under review included declaration rates for a disability and why people did not disclose.

Non-Executive Directors were positive about the culture of the organisation. They had a good working relationship with the CEO and other executive directors.

However, governors gave mixed views about how effective the culture was. Some reported they felt marginalised, and this had been further impacted by the absence of a permanent chair. We found that some relationships between the board and governors was dysfunctional. This had been a long-standing issue. The trust responded to our feedback after the inspection and confirmed that various work streams were underway to address these issues including a recently drafted cultural improvement action plan using the trust's team Engagement and Development Tool, work focusing on the clarity of the role of governors and a review of administrative and wider support around the governing body.

There were formal mechanisms and regular dialogue with staff side representatives and the executive team. Staff reported positive relationships and support for trade union activities.

There was a Freedom to Speak Up (FTSU), Raising Concerns and Whistleblowing Policy. An interim FTSU guardian had been in post for 3 weeks. The guardian had protected time of 3 days a week for the role. There were 30 FTSU champions across the organisation. The Chief People Officer was the executive lead and the guardian had access to the Chief Executive.

The guardian attended a bi-monthly raising concerns meeting chaired by the Chief People Officer. The group identified themes and organisational learning, reporting to the trust's Workforce Committee, which was chaired by a non-executive director and, through the guardian, to the board.

Governance arrangements were strengthened during 2022 with the inclusion of concerns being raised into the divisional improvement forums. An external audit of the FTSU processes showed substantial assurance. The FTSU guardian linked in with regional and national networks to share good practice and learning.

During the inspection staff said they were aware of how to contact FTSU champions and felt they could raise any concerns.

The June 2023, FTSU annual report to the Board showed 204 concerns were raised with the FTSU guardian during 2022-2023. The most frequently stated reasons for contacting FTSU were concerns about patient safety, unfair treatment, bullying and harassment and other professional concerns. Several organisational development programmes to provide staff with opportunities to speak up and address concerns regarding culture, behaviour and leadership had developed across several teams. Although challenges remained in some areas with ongoing concerns about the pace of change. In some cases, concerns raised had led to reviews of medical and nurse staffing levels.

One area for improvement identified by the Workforce Committee chair was closing the loop on concerns raised through FTSU and showing staff the trust had acted on and addressed their concerns.

Our findings

The trust had 8 whistle-blowers in the last 12 months, 4 of which related to the same service within the surgical division, which was the focus of improvement activity. Three concerns related to women and children's health and the other in estates and facilities. Themes included staffing levels, departmental culture, and leadership. The guardian had provided a response to the National Guardians Office and responses and action plans had been shared with CQC.

We met with the guardian for safer working. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian was allocated 2 PAs in their job plan for the role, this was described as manageable. Themes from exception reports were mainly around gaps in the medical and surgical staffing rotas.

There were monthly junior doctors' forums and attendance had improved. All the junior doctors were invited to the meetings which gave them an opportunity to discuss their concerns. A quarterly report was presented to the Medical Workforce Committee and annually to the Board.

The guardian reported good working relationships with the Medical Director and Chief People Officer. The trust had refurbished the doctors mess at the Preston and Chorley sites and provided 6 sleep pods to ensure staff wellbeing. One area of concern was food provision for staff out of hours, this was currently being reviewed.

Cultural ambassadors worked across pharmacy to collectively agree team culture and to embed the cultural behaviours into all aspects of pharmacy work. Following a review of pharmacy internal space, additional staff rest areas and offices for agile working had been established.

The trust offered a range of leadership and management development programmes to support staff at all levels, which was supported by the trust's leadership framework. This included culture and wider leadership programmes, inclusive leadership, clinical director development and divisional action learning programmes.

In 2022 417 members of staff who were identified as 'Rising Stars' (up to band 8a) were offered a place on the talent management programme. This was an increase from 382 (8.4%) in 2021. When reviewing the proportion of staff who were 'Rising Stars' across all bands at an organisational level Band 2 and Band 5 in both clinical and non-clinical roles had the highest proportion of ethnic minority colleagues, however these two groups had the lowest number of Rising Stars identified in the last 12 months.

Band 3, 4 and 7 had the highest proportion of colleagues who had disclosed they had a disability or long-term condition. With Band 7 having 12.3% of colleagues with a disability, this was the highest proportion out of all Bands 1 – 7, equally this was the second lowest proportion of Rising Stars. Further work was being undertaken in these areas.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

The trust had structures, systems, and processes to support the delivery of its strategy including board committees, divisional committees, and team meetings. There was an established set of board committees and arrangements for reporting to the Board. Meetings were replicated and standardised from ward to board.

Our findings

The company secretary had been in post since 2022. They had good oversight of the board assurance framework (BAF) and were responsible for organising the board papers and committees. Management of the BAF sat within the chief nurse's portfolio.

Since the last inspection the trust had reviewed committee papers. Governors now received copies of the Board agendas and chairs reports from the private board meetings. The Chairs Report (Part I) provided an overview of items discussed in the previous Board meeting (Part II). Chairs reports from subcommittees were included in Part I of Board. Since August 2020, the Board Assurance Framework (BAF) had been reported in Part I of the Board. The Board had developed the format in which the BAF was reported, to ensure it was accessible to the public and the governors.

An external risk and assurance review 2022 was positive overall about the trust's governance arrangements with some recommendations to improve the effectiveness of board committees and reporting lines. In response to the review the trust was looking to create a risk management group to strengthen the discussion of risk in the trust.

This would mean escalation of high risks scoring 15+ from divisions into the group and then into committees of the Board instead of through the Senior Leadership Team meeting. The meeting would start in August 2023 in line with the annual review of the Risk Management Policy.

Operational accountability was through the divisional improvement forums chaired by the Chief Operating Officer.

The BAF identified risks to the implementation of the trust's strategy and was linked to relevant corporate risks. The framework was supplemented by a corporate risk register which captured significant risks and reported to the Board. Relevant sections of the BAF were allocated to each of the board committees for review with a focus on gaps and remedial action.

The trust's Risk Appetite Statement for 2022/23 outlined the level of risk the trust was willing to take to achieve its objectives. The risk appetite formed part of the BAF and was used to inform discussions about strategic risk. The Board had agreed the Risk Appetite Statement and Risk Tolerances would remain the same for 2023/24.

Performance against the corporate objectives was reviewed by the board. The objectives were aligned to the trust's strategic aims.

The Audit Committee was chaired by a non-executive director. This committee was responsible for providing assurance to the Board on the trust's system of internal control through independent review of corporate governance and risk management arrangements. The Audit Committee reviewed its effectiveness with input from the trust's internal and external auditors.

The consensus from most staff attending the focus groups held by the CQC following the inspection was that governance structures had improved. Although in some areas with the greatest challenges staff reported that although issues were raised appropriately to senior levels of the trust, there was a perceived lack of priority to focus on the immediate service issues.

To support the governance agenda, in the last 12 months the trust had restructured the department appointing 2 Associate Directors, one of which was the Associate Director of Safety and Learning, with a supporting team.

Our findings

Overall arrangements for financial governance were strong, with opinions from the internal auditors reflecting this position. The Financial Strategy and the Annual Plan (the Big Plan) were overseen at the Finance and Performance Committee and through the full Board in both workshops and formal Board meetings.

The trust has established a Transformation and Recovery board to strengthen the oversight of delivery of the transformation programmes. This reported to the Finance and Performance Committee. Enhanced financial improvement monitoring was in place with bi-weekly meetings to review delivery of financial improvement plan by division. This allowed for any blockages/decisions to be expedited. All meetings were attended by members of the executive team. There was development of a system wide financial recovery plan for September 2023.

The trust medicines governance committee focussed on all aspects of trust medicines safety, including audit, incident reporting and review providing a trust wide oversight of performance. Medicines assurance reporting and learning at directorate and speciality level had been strengthened. Pharmacy Teams aligned with the Divisional Triumvirates provided specialist support around performance and risks associated with medicines in the divisions.

In addition to the monthly medicines' safety reports shared at divisional Always Safety-First meetings, biannual Medicines Assurance Reports were submitted to Divisional Safety and Quality meetings. The trust Acute Pharmacy Team (ED and MAU) was also piloting speciality level medicine assurance reporting to stimulate specialty level data led discussions and gain agreement for improvement actions.

The trust's-controlled drugs accountable officer ensured that the required controlled drugs quarterly reports were submitted to the Local Intelligence Network.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks, but we found risks in the management of mental health patients were not always dealt with appropriately or quicky enough. There were other examples where we saw a breakdown in processes which led us to question the robustness of existing systems and wider organisational learning. Processes for ensuring that learning had been embedded were not always clear.

Not all patient safety incidents were reported to the national reporting and learning system in a timely manner.

The trust had plans to cope with unexpected events.

In interviews with executives and senior leaders, they reported on the trust's top risks. These included finance, long waiting lists; workforce shortages and patient flow particularly its impact on the emergency department. This reflected the risks identified in the BAF.

The trust had significant challenges around elective recovery and performance against the 62- and 31-day cancer treatment targets, this meant the trust was in the lowest 25% of trusts nationally for these metrics. Though the trust had made progress, there was still much to do to achieve the new national targets. The trust had not yet delivered 6 of the 10 requirements set out by the NHS for cancer waiting lists and although they were making improvements with some of the cancer waiting targets, others were lengthy.

Our findings

There were processes for risk stratification of the backlog for elective waiting lists. This included the harm review group which was chaired by the chief nurse and included characteristic based reviews for example patients with learning disabilities. The chief operating officer felt there was good visibility of waiting list numbers and patients. Oversight of priority codes were reviewed in the Performance Recovery Group and Trust Finance and Performance Committee

The trust delivered a financial deficit in 2022/23 following two years of breakeven or better and it was subject to a level of scrutiny through NHS England's Strategic Operating Framework level 3. The breakeven position in 2020/21 and 2021/22 was achieved largely due to the financial regime in operation during the COVID19 pandemic which ensured that provider costs were covered whilst the NHS was in the high levels of escalation. The trust has assessed its underlying financial deficit (before CIP) at c£91.3m.

For 2022/23, the trust's external auditor issued an unqualified opinion on the trust's accounts and for ensuring value for money. One significant risk relating to the trust's arrangements for ensuring financial sustainability had been identified. This was in relation to achievement of the financial plan and the significant levels of savings required in 2023/24. The Head of Internal Audit had issued a substantial assurance opinion for 2022/23.

Following a protracted planning process, the trust set a final plan for 2023/24 at a deficit of £15.3m which was a significant improvement on the initial submission of £65.2m deficit. This plan however assumed a total cost saving of £67m which was significantly higher than levels previously delivered. Whilst in the past, the trust had successfully delivered its cost savings programmes – albeit with significant non recurrent schemes – delivery of this level of savings in a single year was extremely challenging. Within this total was an element of system stretch (£18.5m) for which (at the time of the inspection) there had yet to be any detailed plans developed. The Trust's Financial Improvement Plan was transformational and included £37m savings in Urgent and Emergency Care bed optimisation and the de-escalation of beds opened to support ED pressures.

At the June Finance and Performance Committee FIP (Finance Improvement Plan) update a total saving of £27m was identified as being delivered or at low or medium risk, £17m high risk and £22m remaining unidentified. The financial plan also assumed a net reduction in staffing of c100 WTE.

During our inspection of urgent and emergency care at Preston we issued the trust with a letter seeking immediate assurance following review of 3 patients attending with mental health needs. This was specific to variations in the assessment of mental capacity, risk management plans not being completed, reduction in the risk to self-harm and documentation of routine observations following rapid tranquilisation. Working with the neighbouring mental health trust the trust had sent a response to the concerns raised. This included an action plan to mitigate the risks with fortnightly reports being sent to CQC. Performance showed assurance about the actions that were taken to address these issues.

The trust had an Incident Management policy which was validated in April 2022. It was an interim policy due for review in October 2023 to accommodate the introduction of Patient Safety Incident Review Framework (PSIRF). The trust's proposed implementation date of PSIRF was October 2023.

The trust Safety and Learning Group met weekly and provided oversight and approval of incident investigations including inquests or other external scrutiny. There was good attendance of staff from across the trust at all levels.

However, although the systems for managing incidents and serious incidents was clearly identified and appeared appropriate, we found in maternity the service did not report all patient safety incidents to the National Reporting and Learning System (NRLS), in a timely way. This included 3rd and 4th degree tears and post-partum haemorrhage.

Our findings

However, we saw evidence that each of the cases were reviewed using a thematic review approach and discussed at specialty level governance meetings. The trust acknowledged this and would now report these incidents. The trust provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust had taken action to address this.

We reviewed 3 never events of inadvertent connection to medical air through a flowmeter. The first incident was 18 January 2022; this was not picked up at the time subsequently there were 2 further incidents in January 2023. The trust has taken steps to review and consider where the breakdown in processes occurred and the actions taken as a result. However, this led us to question the robustness of existing systems and wider organisational learning.

We looked at a sample of 6 incident investigation reports from different areas. We found staff support was inconsistent regarding the level of documentation provided in the reports. Organisational and learning across divisions was not always explicit. The process for ensuring that learning had been embedded was not always clear. But there was good involvement of the family in contributing to the terms of reference. The key contributory factors and incidental findings were all well analysed. Actions were generally completed within the timeframe.

A report was commissioned by the medicine division in response to the incidents that had been reported regarding the lack of a seven-day thrombectomy service at the Royal Preston Hospital. The trust was only able to operate the service for 5 days due to insufficient staffing levels over the weekend days.

An expert panel reviewed the impact on patients who presented because of the thrombectomy service not being available at the time of their presentation. 67 patients were reviewed, 8 out of the 22 patients who presented to Preston within the commissioned service hours had sustained severe harm because of the services not being available.

There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7-day week.

The trust had a safety and quality dashboard which was reported to the Safety and Quality Committee. This included positive and negative risk escalation data. It was used as a measure of performance and improvement for different safety metrics including staffing, falls and pressures ulcers. However, during our inspection of services such as medicine trust targets for pressure ulcers, patient moves, falls, stranded patients (14 to 21 days) and super stranded patients (21 days and above) had not been achieved, despite actions taken.

The trust had a learning from deaths policy which was comprehensive and followed the nationally recommended template. It set out the processes for patients with a learning disability, infant or child death and still born or maternal death. The policy set out how to manage the 3 levels of scrutiny, with clear reasoning for each. The trust had achieved 100% scrutiny.

The process of reviewing deaths linked to the Adverse Incident Reporting Management and Investigation policy. The policy set out the reporting expectations both internally and nationally.

An annual mortality report went to the Safety and Quality Committee and up to the Board. The purpose was to provide assurance that governance arrangements were in place for the reporting, review and learning from patient deaths. The report was also considered by the Mortality and End of Life Committee.

Our findings

We reviewed 9 structured judgement mortality reviews (SJRs). The purpose of the SJR is to provide information from which local teams or the organisation can learn. This approach requires reviewers to make safety and quality judgements over phases of care.

The SJRs reviewed used a standard template, using the recognised headings as set out in Royal College of Physicians (2016) Using the Structured Judgement review method Royal College of Physicians. The systems and processes were in line with national guidance and from the sample reviewed the processes were being followed.

There were 12 medical examiners (ME) covering 15 sessions. The ME showed us the learning from deaths process on the 'live' system.

The ME went through 6 reviews, which were completed in line with the trust policy. Examples of raising an incident report and requesting a structured judgement review were noted.

The MEs provided internal reports and reported quarterly to NHS England. Work had started on comparing completed ME reports against SJRs to provide additional assurance.

The trust had an accreditation system to monitor and assess standards in clinical areas across the trust called the safety triangulation accreditation review (STAR) quality assurance framework. The 2022/23 STAR annual report showed of the 126 clinical areas registered there was an increase in silver ratings from 76% to 82% against a target of 75%. There were 54 clinical areas who had achieved gold ratings. The themes identified correlated with CQC inspection findings of inconsistent mental health assessments and infection prevention and control.

The trust had an annual clinical audit and effectiveness plan for the year which incorporated national audits, corporate audits, audits for the trust wide priorities and audit of national guidelines. Audit plans and actions were reviewed by the audit committee.

The chief nurse was the executive director for safeguarding adults and children. There was a clear accountability structure for safeguarding from operational level to the Trust Board. The deputy chief nursing officer was the operational lead for safeguarding and managed the lead for safeguarding children and adults.

There was a named lead for mental health, autism and dementia with practitioners that sat under these. The trust recently appointed an occupational therapy practitioner for people with dementia, the post gave a different perspective and additionality to the team. The head of safeguarding post had been vacant since March, this had been appointed to.

An annual safeguarding report was presented to the Board. The team reported good external overview with partners including collaborative working with system partners such as the police, and other safeguarding teams in the local authority multi agency services.

Safeguarding teams worked across the Preston and Chorley sites. The chief nurse and deputy chief nurse met with clinical leaders each week to share learning and information. There were 20 external safeguarding boards which aligned with the trust, it was acknowledged this was too large and the trust was working with the ICS to review the safeguarding agenda.

Our findings

The director of infection prevention and control (DIPC) was a microbiologist and reported to the deputy chief nurse. The DIPC was supported by a team of senior nurses and doctors. The Associate Director of Infection Prevention Control post was currently vacant. The IPC committee reported to the Safety and Quality Committee, which then reported to the Board.

The prevention of C. difficile infection was a key priority for the trust. In the year 2022/23, the national objective set by NHSE for the trust was no more than 122 hospital associated cases. There was an increase in hospital associated cases during 2022-23 in comparison to previous years with a total of 196 cases. The trust ranked highest of major trusts for C. difficile rates per 100,000 bed days.

All cases were reviewed by the infection prevention control team. Some of the common themes were poor hand-hygiene audit results, delay in isolation and non-compliant antimicrobials. The trust was working with IPC leads in the Northwest to address these areas.

To support continuous improvement mandatory medicines management training was kept under review and refreshed to include learning identified through incident reports and medicines audit.

The risk that essential pharmacy services would 'not be fully provided due to gaps in Pharmacy Staffing Pharmacy' was captured on the trust risk register (Score 15 – High Risk May 2023). In addition to clinical risk-based deployment of staff, the trust was collecting baseline data for example, to demonstrate the impact of pharmacy support as service demand increased for example in AAU.

The antimicrobial stewardship team (AMS) team undertakes quarterly prescription audits to promote good antimicrobial stewardship. The Trust reported good overall compliance with documenting the indication and choice of antimicrobial.

The AMS Team provided feedback to specialities with low compliance and action plans were completed.

The trust achieved the 4.5% reduction in use of antimicrobials which fall into 'Watch' and 'Reserve' categories (as defined by the World Health Organisation) from 2018 baseline (NHS Standard Contract 2022-23). Additionally, the antibiotic guidelines for sepsis of unknown origin had been reviewed to optimise choice of antimicrobials, whilst minimising the use of medicines most associated with increased risk of infection with Clostridium difficile.

The trust scored below average in the CQC adult inpatient survey question: 'If you brought medication with you to hospital, were you able to take it when you needed to'. The trust self-administration policy was under review focusing on medicines where timing was important to ensure most benefit from the medicine.

There were continued challenges around the maintenance of an aging estate and compliance with the latest statutory guidance. There were 26 operational risks on the risk register relating to the estate some of which were from 2017. The Director of Estates reported high levels of backlog maintenance. The trust used a risk-based approach to prioritise high, medium and low risk areas. The largest risk was the main hospital drainage system. The cost of completing all the tasks was estimated to be in the region of £60 million. Resource constraints were evident in the condition of the estate and frustrations were expressed at the lack of capital for renewal of key infrastructure.

Our findings

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had a digital strategy which had been signed off by the Board. Updates were reported to Finance and Performance Committee every six months. The trust worked closely with the ICB digital priorities for the ICS which included programmes the trust was leading on. Each digital project was monitored and included success measures and any risks or issues. The trust was mostly on track for each project.

The management of information was said to be fit for purpose. Operational teams had access to the trust's safety surveillance system which gave a range of information in real time to support them with their management role. This included information on the performance of the service, staffing and patient care.

The format and content of the performance reports had been revised and included the use of statistical process control (SPC) charts in line with good practice.

Then trust made good use of electronic systems and data to support medicines optimisation and was continuing to develop business intelligence reporting to track medicines optimisation activity at ward level.

The use of a web-based audit tool meant that compliance with medicines safety and controlled drugs audits and actions was easily and immediately accessible to clinical areas. Audit findings were also shared at divisional 'Always Safety First' meetings.

The trust made good use of medicines optimisation data from the electronic patient record and prescribing systems. Development of a 'live data' pharmacy clinical prioritisation tool enabled the targeting of clinical pharmacy capacity based on the risk of medicines related harm.

The trust had also successfully delivered a 'safety first' improvement programme to reduce missed doses of critical medicines to ~2%, tracked via EPMA (electronic prescribing and medicines administration) data informing a Business Intelligence App. Continuous improvement methodology had also improved compliance with oxygen prescribing with the roll out of a digital solution.

Electronic prescribing was not yet fully rolled out to maternity, paediatrics, and neonates.

The information governance steering group reviewed incidents on information governance breaches. These were reported to the Finance and Audit Committee. There were 300 incidents reported in the last 12 months, 4 of which were referred to the Information Commissioners Office, no further action was needed.

General Data Protection Regulation arrangements were embedded.

All board members were required to complete Information Governance and Data Security as part of the NHS Data Security and Protection Toolkit (DSPT). As of April 2023, all Board members were compliant with training as reported in the 2022-2023 DSPT.

Our findings

Information technology systems were secure, to prevent unauthorised access to information. Cyber security updates were presented to the Finance and Performance Committee, including the controls, improvements, and challenges.

The Caldicott Guardian worked with the senior information risk owner and processes were in place to ensure data was protected.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had refreshed its Patient Experience and Involvement Strategy 2022-2025 which was developed with patients, relatives, staff, and partner organisations. The strategy aligned to the trust ambition to consistently deliver excellent care to patients. The board received an annual patient experience report.

The new patient experience lead had been in post for 5 months and was driven and focused to deliver the strategy.

Each clinical and several administrative areas had trained patient experience champions. The trust held 2 champions events in partnership with advocacy services, patients, and colleagues. The days were used to emphasise the importance of the patient's voice and 140 champions had signed up.

There were several patient forums which enabled the trust to understand the experience felt by patients and work with them to ensure pathways and services were designed to meet expectations. Examples of improvements through the forums included ward activity boxes, design of the new renal centres and Lancashire eye centre, multi-faith guidebook and patient contribution to the policy for registered assistance dogs.

There was a well-established patient experience and involvement group. The group focus was on the services within the hospital and through working with representatives from departments and external representation. This included, Lancashire Carers Service, Healthwatch, and patient and carer voices.

The trust had a three-year plan to support patients who had a learning disability. The plan was led by patients, family, carer, and staff feedback. The trust held annual 'Our Health Day' events, these were co-produced with people with a learning disability to inform the community about different health needs, and to ensure access and reduction of health inequalities. However, there were some areas which were behind with the Oliver McGowan statutory learning disability and autism training.

The trust had 371 volunteers who worked across both sites. The trust had a recruitment and induction process for volunteers.

The board recognised the importance of partner organisations to support them in providing safe and effective care. Engagement with the integrated care system and integrated care partnership had increased. The integrated care board linked with the trust involvement lead to ensure wider promotion and delivery of engagement and feedback with patients and relatives.

Our findings

The trust worked closely with the local NHS mental health provider and was part of several joint groups and meetings.

The chief pharmacist was engaged with ICB pharmacy and medicines optimisation forums including medicines governance, workforce, and aseptic services. The ICS has taken a collaborative approach to the roll out of the NHS Discharge Medicines Scheme across ICS footprint, with roll out at the trust planned for August 2023.

Staff Engagement

The trust's People Plan 2023-2026 was aligned to the trust's vision, strategy, and objectives and set out 6 strategic aims. One of the key strategic aims of the Workforce and Organisational Development Strategy was to 'engage, retain, reward, and recognise colleagues. The strategy had been developed with staff engagement and feedback from national staff surveys and cultural values assessments. Progress against the strategy was monitored by the Workforce Committee.

The trust had developed and used a team engagement and development tool (TED) to support improvements in levels of team satisfaction and engagement as measured through the trust annual staff survey. The tool was embedded across the trust into a range of areas such as leadership development programme, continuous improvement programmes and the Star Ward Accreditation programme. In 2022-2023 the trust completed 175 TEDS, which engaged with 1,523 colleagues. The tool had been recognised by NHSE as an example of excellent practice and the trust was supporting other organisations to do this.

The trust's staff engagement score was 6.9 which was above the national average. Satisfaction had mostly improved regarding motivation and involvement. The trust performed higher than the average in 3 questions on motivation with a 3% increase from 2021 in response to 'colleagues often/always look forward to going to work' (56%). Staff feeling able to make improvements had also increased by 3% compared to 2021.

Satisfaction had fallen by 2% to 60% (and below the national average (61%)) in response to the question 'if a friend/ relative needed treatment, they would be happy with standard of care provided by organisation'. The trust had identified areas for improvement and developed action plans which were monitored and reported to the Workforce Committee.

There were various engagement channels and activities. Staff had opportunities to meet with the executive team to hear about the latest developments and ask questions. The CEO and senior leadership team visited areas in the trust, and this was reported in the CEO's Monday Message recognising teams and showcasing learning.

The chief pharmacist was engaged with ICB pharmacy and medicines optimisation forums including medicines governance, workforce, and aseptic services. The ICS has taken a collaborative approach to the roll out of the NHS Discharge Medicines Scheme across ICS footprint, with roll out at the trust planned for August 2023.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. The trust had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust showed strong commitment to continuous learning, improvement, and innovation. Continuous improvement programmes were aligned to the trust's Continuous Improvement Strategy.

Our findings

There was an experienced Director for Continuous Improvement and Transformation and a team of professionals trained in line with the national improvement dosing formula to deliver the organisations improvement strategy at department, pathway, and system level, along with executive sponsors for different work streams.

The trust's approach to continuous improvement aimed to deliver improvements at macro (organisational and system), meso (pathway) and micro (local wards and departments) levels. Each division took part in continuous improvement programmes and activities.

The trust was part of the Health Foundation funded Flow Coaching Academy. Since the last inspection in 2019 the number of coaches had increased from 10 to 60, from different areas and professions with a further 21 coaches in training this year. The trust has also made a submission to this year's Patient Safety awards for the Microsystem Coaching Academy programme.

Training on continuous improvement was delivered as part of all accredited leadership programmes to train leaders in basic improvement skills and raise their awareness of continuous improvement methodology.

There were also two newly created posts for clinical fellows appointed to the continuous improvement team in the last 6 months. This had expanded clinical leadership capacity and capability to support safety improvement work and organisational learning, including the work to improve 'Safety II' learning.

We saw continuous improvement was starting to flourish and embed across the organisation with several programmes and projects already established resulting in positive outcomes.

The trust was working with the ICS, other trusts and in partnership with the Engineering Design Centre from the University of Cambridge to test their 'Engineering Better Care' model. The trust had adopted this approach and was currently applying the model to 3 programmes. Frailty, thrombectomy and complex death notifications.

There was evidence of integrated working across the ICS. For example, medical staff from paediatrics and community paediatrics were involved with the ICS working on a project to introduce a new neurodevelopmental assessment pathway across Lancashire and South Cumbria. There was also a project looking at Physical Neurodisability to establish consistent working across the ICS.

Regular meetings were held with the Northwest Coast clinical research network to look at equity of research access and funding for all patients in the ICS. The trust had a specialty lead for cancer research and site-specific tumour research leads in the network.

The trust had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. Data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

The trust has been participating in a Magnet4Europe research study for 4 years. The aim of the research programme was to gain insight into how hospital care may be improved. Clinical staff from nursing and medical professions were invited to participate in the survey to benchmark against the other 14 trusts taking part from England and organisations from across Europe.

Our findings

The outcomes from both the 2021 and 2022 survey showed the trust was the top scoring UK hospital and third of 67 European hospitals for nurses rating overall safety on their ward or unit. When rating the quality of care delivered nurses rated the trust second of 14 UK hospitals and fifth of sixty 67 European hospitals**.**

Since June 2019 the trust had established 'big rooms'. This programme used an evidence-based quality improvement methodology involving a wide range of staff of different disciplines. Examples included national improvement collaborative for frailty within renal patients, patient flow, and mental health.

To support delivery of the "Our Culture Counts" workplan, the trust had committed to using a culture diagnostic tool to support measuring, reviewing, and acting on its organisational culture. This proactive approach allowed the trust to manage its understanding of its culture, using data driven insights to develop organisational and team culture.

The trust had been awarded the NHS Pastoral Care Quality Award recognising the quality and delivery of pastoral care for 600 internationally educated nurses and midwives.

The trust had processes to ensure managers and leaders at all levels reviewed complaints alongside other forms of feedback. They were responsible for ensuring action was taken on identified learning arising from complaints so that improvements were made to services.

Overall responsibility and accountability for the management of complaints was with the chief nursing officer on behalf of the chief executive. The head of patient experience was responsible for the daily management of complaints and currently triaged all complaints to understand the issues and themes.

The trust held weekly complaints update meetings with each division to monitor progress and support timely completion. The weekly Safety and Learning Group also included an agenda item where updates on complaints and concerns were discussed, and any actions captured and tracked. Learning from complaints was evident and appropriate actions for wider learning taken.

Between 1st May 2022 – 30th April 2023 of 436 complaints identified trust wide 36 complaints were upheld following investigation. There were 6 referrals to the PHSO, of which 5 were still being investigated and 1 was not upheld. The main themes from complaints that ran across all divisions were communication, consent, confidentiality, clinical assessment, and nursing care.

At the time of inspection 24 complaints were breaching timescales to respond. This was being addressed and numbers were to be cleared within 4 months.

We reviewed a sample of complaints from across the trust and saw the trust supported people to make complaints. Themes and trends were identified from complaints and lessons learned were noted and shared with staff. The number of complaints had reduced by 93 when comparing 2021/2022 and 2022/2023.

During 2022/2023 2,664 compliments were received.

There were plans (2023/24 Q2) to bring pharmacy, ward-based nursing teams and matrons together using a Rapid Improvement Cycle' (RIC) approach to drive improvement in performance against key medicines management metrics on the wards including medicines audits, medicines reconciliation, and performance in the pharmacy clinical prioritisation whiteboard.

Our findings

The trust sepsis guidance had been reviewed to adopt new guidance released by the Academy of Medical Royal Colleges in May 2022. The sepsis audit had been updated to reflect new sepsis tool rolled out at the end of November 2023. Although performance against the previous standards was maintained, compliance with the new standards was poor. Then trust was using continuous improvement methodology to better understand the current situation and performance to inform, implement and sustain change.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Chorley and South Ribble Hospital	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023
Royal Preston Hospital	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023
Finney House	Requires improvement Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Requires improvement Aug 2022	Requires improvement Aug 2022
Overall trust	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Chorley and South Ribble Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Nov 2019	Good Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019
Critical care	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
End of life care	Good Nov 2014	Good Nov 2014	Good Nov 2014	Outstanding Nov 2014	Good Nov 2014	Good Nov 2014
Surgery	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Urgent and emergency services	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Good →← Nov 2023
Maternity	Requires Improvement ↓ Nov 2023	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good →← Nov 2023	Good →← Nov 2023
Outpatients	Good Oct 2018	Not rated	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023

Rating for Royal Preston Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good ↑ Nov 2023	Requires Improvement →← Nov 2023
Services for children & young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Critical care	Requires improvement Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
End of life care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Surgery	Good →← Nov 2023	Good ↑ Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Good →← Nov 2023
Urgent and emergency services	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023
Maternity	Requires Improvement ↓ Nov 2023	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good →← Nov 2023	Requires Improvement ↓ Nov 2023
Outpatients	Good Oct 2018	Not rated	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023

Rating for Finney House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Requires improvement Aug 2022	Requires improvement Aug 2022

Chorley and South Ribble Hospital

Trust Offices
Preston Road
Chorley
PR7 1PP
Tel: 01257261222
www.lancsteachinghospitals.nhs.uk

Description of this hospital

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Our findings

- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Leaders showed adequate experience, knowledge, and skills to run the service. They mostly understood and managed the priorities and issues the service faced, however during some, interviews leaders could not clearly or consistently articulate certain business details.

Some staff felt leaders were less visible in services where there were greater pressures.

Leaders and teams used systems to manage performance. There was progress with performance but there was still much to do to address elective recovery and delivery of the financial plan.

The trust had processes to escalate relevant risks and identified actions to reduce their impact. However, during our inspection of urgent and emergency care we issued a letter of concern about the management of mental health patients. The trust responded quickly to the concerns raised and monitoring is continuing to ensure there is continued sustainability in mitigation of ongoing risks. Performance since the inspection has been submitted to the CQC fortnightly and shows assurance about the actions that were taken to address these issues.

Also, following our inspection of maternity and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust who provided the required assurances. No regulatory action was required as a result.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The trust supported staff to develop their skills and take on more senior roles. Mandatory training for medical staff needed improvement.

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the trust and with partner organisations.

Urgent and Emergency Care

This emergency department was classed as a type 1 service.

The department had 16 individual bed areas to care for patients. These were a combination of cubicles with doors and spaces with privacy curtains. These were designated as majors and included a resuscitation area. The service was co-located with an urgent care centre where services were delivered by an independent healthcare provider for adults and children 24 hours a day, seven days a week.

Our findings

At the time of the last inspection, the emergency department treated both adults and children. However, the service is now available for patients over the age of 18 years between 8am and 8pm daily. This included minor injuries. Patients needed to attend the trusts emergency department in Preston when the Chorley department was closed. All children, requiring emergency care and treatment both for illnesses or accidents needed to attend the emergency department at Preston or other hospital that had an emergency department that accepted paediatrics.

We visited the service as part of our unannounced inspection on 26 June 2023. We inspected the urgent and emergency care services at the hospital as part of a trust inspection. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The inspection was carried out by two CQC hospital inspectors, a medicines inspector, and a specialist advisor. We observed care, spoke with eight patients and their relatives, reviewed care records for four patients. We spoke with 18 members of staff of different grades including nurses, doctors, allied health professionals, support staff and senior managers.

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, offered patients food and drink, and gave them pain relief in a timely manner. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week between 8am and 8pm.
- Staff treated patients with compassion and kindness, did not always respect their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it, between 8am and 8pm, and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff generally felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- We found that not all staff, particularly medical staff had completed all mandatory training requirements.
- We found that there were consumables, in the resuscitation area that were passed their expiry dates and the airway drawer in the emergency trollies were overcrowded. The transfer bag, for emergencies, was not included in daily checklists.

Our findings

- We observed consultations with patients and their families that were overheard by other patients. Noticeboards, that were visible to public visitors included patient identifiable information.
- The cubicle identified as the room to support patients with a mental health concern included equipment that could be used to cause self-harm.

Maternity

We inspected the maternity service at Chorley Birth Centre, at Chorley and South Ribble District General Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Chorley and South Ribble District General Hospital is 1 of 2 sites for maternity services for the trust. Chorley Birth Centre is a stand-alone midwifery led unit adjacent to the hospital in Chorley, Lancashire. The birth centre has 3 ensuite birthing rooms with birthing pools and 2 clinic rooms. It is staffed by the continuity of carer team who provide a continuity of carer service to women and birthing people across Lancashire, as well as staffing the birth centre. Between June 2022 and May 2023 there were 186 births at Chorley Birth Centre, which is 4.5% of all births at the trust.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Following our inspection and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust. The letter of intent requested further information around delays within reporting incidents and the grading of incidents. The trust responded quickly to the concerns raised and provided the required assurances.

We also inspected 1 other maternity service run by Lancashire Teaching Hospitals NHS Foundation Trust. Our report is here:

Royal Preston Hospital – https://www.cqc.org.uk/location/RXN02

Our rating of this service stayed the same. We rated it as good because:

- Staff received training in key skills, such as responding to obstetric emergencies.
- Staff understood how to protect women and birthing people from abuse and worked well together for the benefit of women and birthing people.
- The service controlled infection risk well.
- Staff assessed risks to women and birthing people, acted on them and managed safety well. They kept good care records. They managed medicines well.
- The service had enough suitable skilled, trained and competent midwifery staff to keep women, birthing people and babies safe from avoidable harm.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.

Our findings

- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with women and birthing people and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment. All staff were committed to improving services continually.

However:

- Not all staff had training in life support, compliance with life support training was below trust targets.
- Staff did not always ensure all equipment was available, in date and safe for use.
- The service did not consistently report incidents to the National Learning and Reporting System (NRLS) in a timely manner.

Maternity

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, not all staff had completed required life support training.

Staff were up-to-date with mandatory training. Mandatory training compliance for midwifery staff was good across most modules with overall compliance at 91%, against a trust target for training compliance of 90%. However, the service did not split mandatory training compliance data by location, therefore we could not ascertain if areas of lower compliance related to maternity services at Chorley Birth Centre.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph (CTG) competency and skills and drills training. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies. The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Midwifery staff compliance with CTG update was 99%, CTG and fetal monitoring competency was 99% and CTG equipment competency was 99%

The service had a practice development midwife who supported staff to access training and facilitated face to face fetal monitoring, obstetric emergency and public health training days. Staff told us the annual training day included human factors training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff completed regular skills and drills training. Ninety-nine percent of midwifery staff had completed obstetric emergency training.

Staff told us they completed skills and drills in pool evacuation. However, the service did not provide information to show that staff had completed pool evacuation training or compliance rates. Therefore, we could not be assured there would be enough staff trained to evacuate women, birthing people and babies from the birthing pool in an emergency.

However, not all midwifery staff had completed required resuscitation training. For level 2 immediate life support, only 66% of midwives had completed the training and only 64% of midwives had completed paediatric immediate life support training. Newborn life support was included in mandatory multidisciplinary team obstetric emergency training. This meant that staff did not have the appropriate level of training to provide lifesaving treatment to women and birthing people and babies in their care.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Maternity

Staff received training specific for their role on how to recognise and report abuse. Level 3 safeguarding training was provided to staff in line with national intercollegiate guidelines. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training.

Nursing and midwifery staff compliance with training targets was 95% for safeguarding adults and children level 3. This met the trust target.

Support staff/unregistered nursing staff completed level 2 safeguarding adults and level 3 safeguarding children training. The compliance with training targets was 100% and 94%. This met the trust target.

However, the service was not able to split safeguarding training compliance data by location, therefore we could not ascertain exact compliance rates for staff at Chorley Birth Centre.

The service had not yet fully implemented the Oliver McGowan Learning Disability e-learning. This is required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. At the time of the inspection the service had not yet fully implemented the Oliver McGowan or equivalent learning disability eLearning. This was required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The service provided information that showed the training had been agreed by the trust. Following the inspection, the service provided information which showed staff had met the trust target in learning disabilities, autism and neurodiversity training."

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. They told us the Enhanced Support Midwifery Team (ESMT) provided support and were always available for staff to turn to when they had concerns. All staff said the ESMT team were very accessible and contacted the birth centre daily, also attending the daily huddle. Staff could access safeguarding supervision through this team.

The safeguarding team and maternity services had developed and piloted "HOPE" boxes for those women who were separated from their babies either permanently or temporarily. This was being used across local maternity and neonatal systems (LMNS) and nationally to support loss and grief for mother and the child if a long-term separation is the final outcome.

The lead midwife for safeguarding represented the trust at the ICON babies cry, you can cope task and finish group within the local area, which then fed into the national ICON steering group. ICON provided key messages and awareness to women, birthing people and their families to show babies crying is normal and there are methods which could be taken to help parent and families' cope. To educate parents and to reduce head trauma in babies.

The service worked with local partnerships to provide community based simulation training to support midwives to recognise areas of risk and safeguarding concerns during home visits. For example, post-natal follow up care

Care records detailed where safeguarding concerns had been escalated in line with local procedures. Where safeguarding concerns were identified women and birthing people had birth plans with input from the ESMT team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse. This was a mandatory field in the electronic records system and was completed in all 3 records we reviewed.

Maternity

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics, for example by holding additional parent education sessions and workshops for parents who needed additional support.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy. We saw how babies were tagged with an electronic tag which shut down the doors if baby was moved past a certain point. The birth centre was secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The birth centre was visibly clean and had suitable furnishings which were clean and well-maintained. Wards had recently been refurbished to the latest national standards.

The service generally performed well for cleanliness. The birth centre had dedicated domestic staff. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw cleaning checklists were completed in every room.

The service had effective processes in place to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and saw action plans developed to improve compliance with infection prevention and control standards. Actions were monitored through the divisional infection prevention and control meetings.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed ‘bare below the elbows’ guidance. Each birthing room had hand wash sinks with posters displaying correct handwashing technique and alcohol hand gel dispensers. The service had effective processes in place to monitor hand hygiene. We looked at the audit for March to May 2023 which showed 100% compliance in all areas.

Staff cleaned equipment after contact with women and birthing people. Staff completed checklists to show equipment in the birthing room was cleaned after use. They used green ‘I am clean’ stickers to indicate equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities and premises mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment was checked regularly to ensure it was available and safe.

The birth centre was situated in a residential area adjacent to the hospital with a secure entrance and exit. It opened in December 2021 and was specifically designed as a birth centre to meet the needs of women and birthing people. It had 3 birthing rooms with birthing pools, chairs and equipment and 2 clinical rooms. The rooms were large, nicely decorated and well maintained. Birthing rooms had adjustable ambient lighting and built in Bluetooth speakers for women to play their own music during birth.

Access to the unit was through a buzzer, which was monitored by staff. The premises were also monitored by CCTV. Staff told us they never lone worked within the birth centre.

The service had suitable facilities to meet the needs of women and birthing people and their families. The birth partners of women and birthing people were supported to attend the birth and provide support and there was no restriction on the number of birth partners allowed. Each birthing room had a fold away double bed so families could stay overnight. There were kitchen facilities for women, birthing people and their families to use and designated free car parking spaces. Women, birthing people and their families could access a well-kept, secure garden area.

The service had carried out ligature risk assessments of the environment in line with NHS England National Patient Safety Alert/2020/001/NHSPS.

Staff regularly checked birthing pool cleanliness. All water outlets had an automatic flushing system to prevent the spread of legionella and the estates team visited regularly to test the water supply for legionella.

All birthing rooms had piped oxygen and nitrous oxide, as well as portable cylinders which were securely stored. There was a nitrous oxide scavenging system in place in each birthing room. Midwives were tested earlier in the year for nitrous oxide exposure and no high readings were found.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins in an external secure compound while waiting for removal. Porters collected the clinical waste 3 times a day Monday to Friday and daily at the weekend.

Staff carried out daily safety checks of specialist equipment. However, we found out of date and missing equipment and the adult resuscitation trolley was not secure. Though it was stored in line with Resuscitation Council (UK) guidelines with the drawers closed with a tamper evident tag, the tag had been incorrectly attached and the serial number recorded incorrectly. This meant the trolley drawers could be accessed without breaking the tag and there was risk unauthorised people could access the drawer and remove equipment without staff being aware. We informed a senior midwife who took immediate action to ensure the trolley was correctly sealed and the tag number recorded. We found 2 out of date syringes on the emergency trolley and a saturation monitor missing from the neonatal resuscitaire. We informed a senior midwife who removed the out-of-date items and replaced the missing monitor immediately.

The service mostly had enough suitable equipment to help them to safely care for women and birthing people and babies. The service had a system to monitor equipment safety checks completed and due. All new equipment underwent acceptance testing and was placed on an asset database which generated a schedule for preventative maintenance. We reviewed records of portable appliance testing and saw 100% had been completed.

However, we found some out-of-date items including pool evacuation nets and fire extinguishers beyond their service date. The birth centre had 2 pool evacuation nets stored next to the emergency equipment trolleys with labels stating they should be serviced every 6 months by the manufacturer and not used beyond their service date. Both were 6 months overdue the manufacturers service. We informed a senior midwife who removed the nets and the service took immediate action to purchase 3 new nets to arrive that week.

There were 4 fire extinguishers in the birth centre and labels indicated they were last serviced in October 2020. We escalated this immediately to managers. They explained annual checks of fire equipment were carried out by an external contractor and overdue checks monitored by the fire safety officer for the trust. They arranged for the contractor to carry out checks on the extinguishers that week.

Maternity

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Risk was assessed at each maternity contact/appointment. We reviewed 3 maternity care records. In each record, risk factors had been defined and identified at the booking appointment, and risk assessments were completed at each maternity contact. This ensured women and birthing people were allocated to the right pathway so the correct team were involved in leading and planning their care.

The service had clear criteria for staff to assess if women and birthing people would be suitable to give birth at the birth centre. The operational guideline for Chorley Birth Centre gave clear guidance to staff which supported women and birthing people's choice and outlined the risk assessment and planning place of birth processes. There were also clear guidelines for the transfer of care due to maternal condition or an obstetric emergency. All women and birthing people who wished to use the birth centre, but did not meet the guidance, were reviewed by a consultant midwife or obstetrician and a multidisciplinary team plan put in place, which was reviewed regularly with the woman or birthing person and consultant midwife.

The service achieved 100% compliance with provision of one to one care in labour between September 2022 and April 2023.

The service used a nationally recognised tool called Maternal Early Warning Scores (MEWS) in detecting the seriously ill and deteriorating. The MEWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. The audit of MEWS completion and escalation between April and June 2023 did not include Chorley Birth Centre. However, we saw these had been appropriately completed in records we reviewed.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers. Staff used a situation, background, assessment and recommendation (SBAR) tool to hand over care to staff at the obstetric led unit. The service did not provide an audit of compliance with SBAR completion for Chorley Birth Centre.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn observations using track and trigger system (NOTTS) is designed to be used by healthcare professionals working in areas caring for newborns in the early postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NOTTS completion. We looked at the audit for the April to June 2023 and found 29% of observations were not performed on time. Most delays were for observations due to be performed within the first hour of life and at 12 hours. The audit identified 100% compliance with appropriate escalation to the neonatal team. However, it was not clear which maternity service location the audit results related to.

Staff knew about and dealt with any specific risk issues. Midwives used intermittent auscultation to listen to the fetal heart rate during labour. This was peer reviewed every hour by another midwife and if any concerns were identified a telephone consultation held with the obstetric led unit at Royal Preston Hospital.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. The birth centre had remained open at all times since opening in December 2021.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women, birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough midwifery staff to keep women, birthing people and babies safe. The birth centre was staffed by a midwife and maternity support worker from the continuity of carer team, 24 hours a day, 7 days a week. They were overseen by a manager who managed the birth centre and continuity of carer team. A second midwife from the continuity of carer or community team was called in when a woman or birthing person attended in labour.

Managers accurately calculated and reviewed the number and grade of midwives and healthcare assistants needed for each shift in accordance with national guidance. The service had completed a maternity safe staffing review at the end of 2022, which was reported to the trust board in July 2023. This showed the establishment of 8.4 whole time equivalent midwives for Chorley Birth Centre was allocated from within the continuity of carer team and this was in line with the requirements identified through the safe staffing review.

The birth centre manager had the resources to adjust staffing levels daily according to the needs of women and birthing people. There had been only 1 incident where a person was diverted to Preston Birth Centre due to Chorley Birth Centre being full since it opened in December 2021. The manager rostered staff at a monthly team meeting using a self-roster model, which staff reported was working well.

There were no vacancies in the continuity of carer team which staffed the birth centre. The sickness absence rate across all maternity services was 7.9% and the service was working to improve this through strengthened leadership, core roles and reward and recognition activity.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Ninety-one per cent of midwifery staff had received an appraisal. However, the service did not break down compliance rates by location, so it was not possible to ascertain appraisal compliance for this location.

A practice development team supported midwives. Staff told us the practice development midwife regularly visited the birth centre.

Managers made sure staff received any specialist training for their role. For example, 6 midwives had received professional midwifery advocate training with a further 3 being trained.

Maternity

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive and all staff could access them easily. We reviewed 3 records and found records were clear and complete. The service audited records every 3 months. We looked at audits and saw areas of lower compliance related to documentation of postnatal care at Royal Preston Hospital, not Chorley Birth Centre.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. The trust used electronic records which had a 'break glass' system to view electronic records held by other trusts. This system meant if a women or birthing person transferred to another team, even if that team was part of a different provider, the records were available to anyone providing maternity care.

Records were stored securely. Staff locked computers when not in use and had individual computer tablets to use in the birthing rooms.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines administration charts for medicines that needed to be administered during admission were completed in women and birthing people's electronic record. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff mostly stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff checked controlled drug stocks daily. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

However, in the emergency trolley we saw intravenous plasma lyte stored, which had a sticker advising it should not be used as there was not a patient group directive (PGD). PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. We asked managers who told us the fluid was still available in the trolley as it could be used in an emergency via a verbal order from a doctor who would then prescribe after the event.

In the emergency post-partum haemorrhage (PPH) box we found misoprostol, which is a medicine which can be used in the treatment of PPH. However, staff told us midwives could not use this medicine as the PGD had expired and it was unclear why the medicine was still available. We escalated this to managers who told us they would take action to investigate and correct this.

We saw aromatherapy oils used during labour were stored in the medicine fridge alongside medicines. This is not in line with Royal Pharmaceutical Society guidance which stated fridges used for the storage of medicines should not be used to store any other items. However, the aromatherapy oils were packaged and segregated appropriately meaning there was little risk of cross-contamination. We escalated this to managers who contacted the trust pharmacy to gain further advice.

Maternity

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly.

The service had no 'never' events.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. The birth centre manager attended key governance meetings such as perinatal mortality reviews to ensure learning from incidents across the trust maternity services was shared. They shared learning from incidents at regular team meetings.

There were no serious incidents in the last 6 months related to Chorley Birth Centre. However, staff could explain how to report serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff described learning from trust wide cardiotocography (CTG) monthly review meetings where any incidents which featured CTG were discussed and learning from those. Staff received a monthly safety briefing which included lessons learnt form incidents and investigations.

However, the service did not consistently report incidents to the National Learning and Reporting System (NRLS) and not all incidents were reported in a timely manner. We reviewed the maternity dashboard and saw the service reported a rate of 3rd and 4th degree tears of 2.7% up to May 2023. However, we reviewed NRLS for January to June 2023 and found only 4, 3rd or 4th degree tears had been reported.

We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measures to ensure all patient safety incidents were reported to NRLS. In the response, the service provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust took immediate action to ensure all staff reported incidents of 3rd and 4th degree tears to the online reporting system and that patient safety incidents were reported to NRLS accurately and in a timely manner in accordance with guidance.

Maternity

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The service was within the women's and children's division. This was led by a divisional director, divisional midwifery and nursing director, divisional medical director and divisional nursing lead for children and young people, also known as the 'quad'. The quad were supported through clear professional arrangements and had professional reporting lines to the medical director and chief nurse. Chorley Birth Centre had a manager who managed the birth centre and continuity of carer team and reported to the matron for midwifery led services.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff. There was a divisional governance group in place which consisted of a divisional governance lead, 2 divisional governance facilitators and 2 band 7 governance risk managers. Relevant information was escalated to the relevant trust quality and safety committees.

Leaders were well respected, approachable, and supportive. There was a maternity leadership team which consisted of a clinical director, associate medical director, deputy divisional midwifery and nursing director, consultant midwife, clinical business manager and clinical governance lead. The leadership team also included the safety and quality matron, lead midwife for safeguarding, matron for midwifery led services, complex care matron and specialty business manager. There were clear lines of reporting from the maternity leadership team to the quad. The maternity leadership team managed a team of band 7 specialist midwives, managers and coordinators.

Leaders were visible and approachable in the service for women and birthing people and staff. The birth centre had a manager based at the centre who also managed the continuity of carer team. They were supported by the midwifery led care matron. Staff told us they were well supported by their line manager and matrons. They told us matrons and senior maternity leaders visited the birth centre regularly.

The service was supported by maternity safety champions and non-executive directors. Maternity safety champions carried out regular visits and walk rounds at Chorley Birth Centre.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy covered 2021 to 2024 and was called 'Our Big Plan'. It had been developed in consultation with key stakeholders and staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies, and we saw infographics about the strategy throughout the unit.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and revised the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity service strategy linked to the overarching trust strategy. Within the strategy the stated aim was to provide choice to women and birthing people by offering 4 places of birth, this included Chorley Birth Centre.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff felt respected, supported, and valued**.** Staff were positive about the birth centre and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. The service provided an overview of the main themes from the most recent staff survey in 2022. They identified the lowest and highest scoring teams and analysed the reasons for those scores. The survey showed the maternity continuity team and specialist midwives were highest scoring teams in the division with high scores for working with colleagues and support from managers.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed people's care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Families we spoke to told us they were treated with dignity and respect by staff at Chorley Birth Centre.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. For example, they had used this data in the annual review of still births to identify any themes or trends for women, birthing people and babies from ethnic minority and disadvantaged groups. The service recently carried out a mapping exercise with the local maternity and neonatal system to look at how they could provide enhanced continuity of carer teams in geographical areas of greater deprivation or greater numbers of women and birthing people from ethnic minority and disadvantaged groups lived.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff could access translation services for women and birthing people when required.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There had been no complaints about the care received at Chorley Birth Centre between April and June 2023. We saw staff and services at the birth centre had been praised within some complaints regarding maternity services we reviewed.

All complaints and concerns were handled fairly, and the service used the approach ,most applicable to deal with complaints and progressed complaints through formal processes where appropriate. The service gave information about how to raise a concern in welcome packs in each birthing room. Staff understood the policy on complaints and knew how to handle them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders operated effective governance processes, throughout the service and with partner organisations. The service had a clear governance structure which outlined how key information and risks flowed from maternity speciality level through divisional committees, boards and improvement forums to the executives, board committees and board of directors. The divisional governance structure reflected the requirements of the Ockenden report. There was a clear structure for escalating higher scoring risks from divisional board to the trust board through the senior leadership team and board committees.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. This included metrics for Chorley Birth Centre. The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff. There were opportunities for managers to meet with the senior management team each month, and key areas including performance, staffing and incidents were discussed in these meetings. Staff and leaders could clearly articulate the governance framework for the division and how information flowed between maternity services and the board.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Policies we reviewed were in date, had clear review dates and referenced relevant national guidance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 safety initiatives. Within 2 safety initiatives there was an exception, 1 relating to one to one care in labour and the other to antenatal corticosteroids. The service had submitted action plans to board to address these areas an ensure they met required compliance levels. This meant they declared fully compliant with the scheme. We saw they provided sufficient evidence of their compliance to the trust board in February 2023.

Maternity

The service provided up to data to the national MBRRACE survey. The service was an outlier for still birth, neonatal mortality and perinatal mortality rates, for data submitted for 2021 and was more than 5% higher than the average for a similar trust in all 3 measures. The stabilised and adjusted still birth rate was 4.5 per 1,000 births, the stabilised and adjusted neonatal mortality rate was 2.09 per 1,000 births and the stabilised and adjuster perinatal mortality rate was 6.57 per 1,000 births. The neonatal mortality rate had worsened over the last 3 years of the MBRRACE report.

We reviewed board papers related to the MBRRACE survey. We saw the service had identified the increased still birth rate prior to the survey publication and carried out a review and identified no themes or trends. They identified the need to make improvements to triage and an action plan was in place for this. The service had a still birth outlier action plan which was monitored and updated regularly, and all still births were reviewed through the perinatal mortality review process.

The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

There was a system for local manager's audits which were recorded on the AMaT system. Managers gave examples of actions taken to improve audit results, for example refresher training with midwives to improve compliance with carbon monoxide monitoring at booking. There was a ward accreditation programme with Chorley Birth Centre currently rated as silver. The service had a action plan to address areas of lower compliance and improve the accreditation score.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. We saw changes following safety champion walk rounds were communicated to staff using a 'you said we did' format.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register in place. We reviewed the risk register and saw it identified 6 high risk, 9 moderate risk and 1 low risk items across both maternity locations, of these 2 risks related to Chorley Birth Centre as well as the rest of maternity services. These were risks relating to staff exposure to nitrous oxide and regular checks of neonatal emergency trolleys. Each risk was clearly defined with controls and assurances and any gaps in these identified. The risks aligned with challenges we found during our inspection and mitigating actions described by staff. Senior managers reviewed risks regularly and each risk had a clear set of actions taken to reduce it, with clear action owners and target dates. The risk register clearly outlined where action had been taken to address identified risks.

Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months and saw they comprehensively covered expected areas of safety and quality. This included clinical effectiveness, audits and performance dashboards, key risks including risk register review and safeguarding, incidents and lessons learnt, staffing and feedback from women, birthing people and their families. The meeting was attended by relevant managers, midwives and stakeholders and the Maternity Voices Partnership chair was invited to each meeting.

Maternity

The maternity and neonatal safety champions met every 2 months. We looked at meeting minutes for the last 6 months and saw they were comprehensive, with a set agenda aligned to the key lines of enquiry. They covered all key safety elements such as incidents, staffing, mortality reviews and equality and diversity. Clear actions were recorded in minutes and the dates for future safety champion walk rounds, which included Chorley Birth Centre.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators, and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

The information systems were integrated and secure**.** The service had a digital midwife to support staff accessing electronic information systems and they visited the birth centre regularly.

Data or notifications were consistently submitted to external organisations as required. The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that required local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity and Neonatal Voice Partnership (MNVP) to contribute to decisions about care in maternity services. The chair of the MNVP had left but the service was involved in the recruitment of a new chair and had engaged with the chair of a neighbouring MNVP to ensure women and birthing people’s voices were still heard in the interim. The MNVP had completed a 15 Steps visit and report and had been involved in the design of Chorley Birth Centre, attending the opening of the new building in 2021. Staff from the continuity of carer team had developed an infographic about latent labour for women and birthing people in collaboration with the MNVP and service users.

Maternity voices partnership engagement meetings were scheduled quarterly and included all key partners from health and the third sector. The service had a Maternity and Neonatal Voice Partnership (MNVP) work plan based on the

principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trusts. We reviewed the plan and saw all actions had deadlines set, were monitored and were fully or partly achieved. The service told us that once the new MNVP lead was appointed that actions would be adjusted to ensure that the plan was co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Leaders understood the needs of the local population. They took opportunities to engage with the local population and promote the centre as a birth option. Staff from the service had taken part in the Leyland festival, to promote birth options and key health promotion messages such as infant feeding. Staff had taken part in the pregnancy circles research project where midwives combined clinical care with antenatal education and peer support. This was done in partnership with local family centres and has shown group antenatal care has a positive impact on women's experiences of antenatal services.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Quality improvement was routinely discussed at team meetings. We saw that what was not working well was discussed at team meetings for midwifery led services and staff engaged in conversation about their ideas and innovations. For example, during the Maternity Summit held in June 2023 the service held a 'Flashes of Brilliance' competition. This was to encourage staff to suggest service improvements or changes to way of working and encouraged staff to submit any ideas no matter how big or small.

Following a response from women, birthing people and their families the maternity service developed the maternity pregnancy schedule. The schedule provided information on the named midwife and consultant for women and birthing people. There were two pathways, one for a standard pregnancy schedule and the other was for women and birthing people who required multiple scans during pregnancy. The schedule provided information as to the pregnancy journey, including routine scans and antenatal checks.

The maternity service had developed and displayed a number of infographic information for women, birthing people and their families. This information was displayed throughout the maternity unit. Information displayed showed information learning posters on neonatal seizures, extreme prematurity, as well as sharing learning with families that had been developed from incidents. For example, aspirin in pregnancy and the importance of routine urine testing.

Leaders encouraged innovation and participation in research. The service was part of the Health Foundation Flow Coaching Academy Big Rooms & Microsystem Coaching Academy and meetings were held weekly. The purpose of the weekly meetings was to coach improvement and design tests of change, review results and plan next steps and action notes were taken to record improvement. A number of staff received training and coaching to lead and facilitate improvement at ward and department level through the microsystem coaching academy. This trained staff to be coaches trained to internal quality expert level (as defined in the NHSI national guidance). We saw examples of improvement projects led by these staff.

Maternity

The service took part in continuous improvement programmes and activities aligned to the trust-wide continuous improvement strategy for 2021 to 2023.

The service took part in wave 1 of the national MatNeo programme on the optimisation and stabilisation of the pre-term infant and shared learning regionally and nationally.

Urgent and emergency services

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however; not all staff had completed it.

Staff completed training as part of mandatory requirements, that were aligned to the core skills framework, with a trust target of 90% with the exception of information governance at 95%. All trust staff were required to complete conflict resolution, equality, diversity and human rights, fire safety, fraud and bribery in the NHS, health, safety and welfare, information governance, patient safety, and speak up - core training.

There were other modules specific to the emergency department (ED). These included moving and handling to level 2 for clinical staff, preventing radicalisation awareness, module for chemical biological radioactive nuclear explosion, consent, aseptic non-touch technique, medicines management, blood transfusion, vital signs scoring and care of the dying modules.

Nursing staff received and kept up to date with their mandatory training. Staff were allocated protected time to complete mandatory modules, although expressed concern that the reduction in the staffing establishment may impact on their ability to complete the training. Nursing staff were compliant with the trust target for all mandatory modules.

Medical staff received mandatory training, however; were only compliant with fire safety and equality, diversity, and human rights. Conflict resolution was 88%, fraud and bribery in the NHS was 68%, moving and handling level 1 was 84% and patient safety was 76%. An additional programme, of ED specific topics, had been prepared, by senior medical staff, and had been scheduled to commence from July 2023. There was a dedicated training room that had been identified where specific training, with necessary equipment, could take place in the department.

The trust had implemented an equivalent course to the Oliver McGowan learning disability e-learning. Compliance was not available at the time of inspection due to the inability to download this, however the trust has since confirmed compliance was 91% in September 2023.All clinical staff were required to complete level 2 adult basic life support (ABLS) and paediatric basic life support (PBLS). Overall compliance was below the trust target of 90% with medical staff at 71% and registered nurses at 83%. These figures were for both hospital ED sites.

Registered nurses completed level 3 immediate life support (ILS) training and level 3 paediatric life support (PILS) training. Compliance was 58% for ILS and 75% for PILS. For level 4 advanced life support (ALS) training and level 4 advanced paediatric life support (APLS) training, compliance for medical staff was 83% for ALS and 84% compliant for APLS. Registered nurses were 60% compliant for ALS and 53% compliant for APLS.

There were staff members on each shift who had competed advanced life support training (ALS) and advanced paediatric life support (APLS) training.

Senior staff told us there had been some delays in training due to the availability of courses. The trust reviewed staffing rotas and confirmed there were no incidents were there was no staff on duty that had not completed appropriate resuscitation training in the 9 months prior to inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. The training co-ordinator was based at the trusts other hospital site but had oversight of both trust hospitals. Staff we spoke with told us that they received email alerts when training refreshers were due.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff received training specific for their role on how to recognise and report abuse in line with intercollegiate guidance for adults and children. Registered clinical staff received safeguarding level 3 training for adults and safeguarding level 3 training for children. Other staff received safeguarding level 2 for adults and level 3 for children.

Registered nurses and other staff were compliant with the trust target for all levels of safeguarding. However, medical staff were 74% compliant with safeguarding level 3 for adults, 88% compliant with safeguarding level 2 for children and 71% compliant for safeguarding level 3 for children. This data was for both ED sites.

Between July 2022 and June 2023 there was a total of 16 safeguarding incidents of which 10 were adults and six were children.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were supported by safeguarding specialists to ensure best practice.

Staff followed safe procedures for children visiting the department. Notice boards included safeguarding information for staff although it was not clear when last updated. Link nurses and champions had been identified for a range of responsibilities included safeguarding and domestic violence.

The trust completed safeguarding audits and reported 100% compliance in safeguarding vulnerable patients across both hospital sites in the six months prior to inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning schedules were in place and demonstrated that all areas were cleaned regularly.

Infection, prevention and control (IPC) level 2 was included in mandatory training requirements for all staff. Registered nurses were compliant with training, however; medical staff were 77% compliant against a trust target of 90%. For aseptic non-touch technique there was a compliance of 68% for medical staff and 91% for registered nurses. A link nurse had been identified to support IPC.

We saw that personal protective equipment (PPE), was readily available in all areas. Staff followed infection control principles including the use of PPE, hand washing and use of hand sanitisers.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed 'I am clean' stickers on equipment.

There were cubicles, with doors, that could be used when patients needed to be isolated.

The privacy curtains were disposable and included recent dates when last changed. Domestic staff told us that curtain changes were included in the deep cleaning of areas following the discharge of patients.

Staff we spoke said that IPC concerns had been included in initial feedback from an inspection visit at the trust's other hospital ED. We observed staff being reminded to maintain standards of hygiene following the handover meeting.

The service generally performed well for cleanliness. Across both ED sites, there was 100% compliance with control of substances hazardous to health (COSHH) audits and an average compliance of 84% for PPE and 80% for environment audits. Between December 2022 and May 2023 there was an average compliance of 97% for hand hygiene audits for this location.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe with the exception of consumables and the area for mental health patients. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The service was co-located with an urgent care centre that was managed by an independent provider.

There was a dedicated area, in the ED, where ambulances were received and another area where patients self-presented. There was one entrance for patients who self-presented, for the ED and the Urgent Care Centre (UCC. The reception area was divided for patients according to need.

There were hospital trolleys available to transfer patients from ambulance stretchers as well as an incubator for any babies in the department.

The service had enough suitable equipment to help them to safely care for patients. Equipment we saw had been maintained and serviced within the 12 months since inspection.

Patients could reach call bells and staff responded quickly when called. Patient call bells and emergency bells were present in patient cubicles.

Staff carried out daily safety checks of specialist equipment and a link nurse had been identified to support resuscitation and checks.

For one of the two emergency trolleys, we observed three omissions of daily checks in six months. We found consumables, in the resus area, that were passed their expiry dates. These included endotracheal tubes, intubation stylets, connector taps and bungs.

We escalated to senior staff, whilst on site. A full check of consumables was completed by trust staff and removed for disposal. Staff disposed of clinical waste safely and appropriately.

For the emergency trollies all equipment was within their date of expiry. There was a drawer that contained airway equipment. We observed that this drawer was difficult to open. We escalated on site and the contents were reviewed by trust staff.

Audits of emergency trolleys had been completed in December 2022, January 2023 and April 2023 with 100% compliance.

We were told that the combined adult and paediatric emergency trolley was under review either to include only essential paediatric emergency equipment or whether a separate trolley should be introduced.

There was a display board, in the resuscitation area, to support staff during a paediatric emergency, however this was positioned in an area where adults were treated rather than children.

There was an emergency grab bag that although was complete, was not included in the daily checks. This was escalated during the inspection.

There were no dedicated mental health suite facilities in the department. There was a cubicle that was nominated for patients identified with a mental health concern. This had two doors that were appropriate, however; there were items in the room that could potentially be used if a patient was at risk of self-harm. This same risk was identified at the Preston site during the inspection in 2022.

At Chorley, the cubicle was located next to the nurse's station and the door was kept open if a patient was present, which allowed staff to observe the patient closely. There were no toilet facilities in the cubicle meaning patients had to use the public toilets where there were potential self-harm risks.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Patients who self-presented were triaged by the urgent care staff that was managed by an independent health provider. There was a separate rapid assessment and treatment (RAT) area, where ambulances were triaged by department staff. There was prompt handover of patients who were transferred into the department.

The trusts patient safety surveillance dashboard for the ED's displayed data about patients and capacity in the departments. They included numbers in the department, patients who had a decision to admit, status of ambulances, nurse staffing, any patients identified with a mental health concern and patients that were potentially deteriorating using NEWS scores. The service could also view the whiteboard for Preston and for the urgent care centre.

Urgent and emergency services

Staff used the nationally recognised national early warning score tool (NEWS2) to identify deteriorating patients and escalated them appropriately. The NEWS score is a system for scoring the vital signs that are routinely recorded at the patient's bedside.

Staff completed training for NEWS2; with a compliance of 81% for registered nurses. For blood transfusion training, there was a compliance of 59% for medical staff and 81% for registered nurses. There was a compliance of 93% for staff who had completed sepsis training in the ED.

The trust monitored compliance with administration of antibiotics within an hour. There was an improving trend over the year with the latest quarterly results of 89% compliance.

The trust completed quarterly audits of NEWS2. Between April 2022 and March 2023, there was an average compliance of 87% for the emergency observations and fluid balance element and 82% for the critical care outreach team (CCOT) escalation element. Action plans to improve compliance where being monitored trust wide.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues including reporting sepsis, VTE, falls and pressure ulcers. We observed that, in the records we reviewed, risk assessments had been completed. There were yellow wristbands available for patients identified as a potential risk of falling as well as identification of an enhanced level of care.

There were link nurses that had been identified for sepsis and pressure area care. There were public noticeboards that displayed a variety of information including NEWS, pressure ulcers, blood transfusion, always safety first and mental health care.

The emergency nurse practitioners (ENP's) were available to support any junior members of staff in the event of an emergency. The ENP's saw, treated, and discharged all minor injuries for patients over 18 years old. Paediatric minor injuries were treated at Preston. Children with minor illnesses were seen in the urgent care centre. For maternity patients, there was a GP-led facility at Chorley; any obstetric emergency needed to attend in Preston.

There was an on-site intubation team who could be contacted if needed as well as the CCOT, based at the trust's other hospital.

The CCOT could either verbally review or provide support to the department if needed. There was a process in place for the safe transfer of patients both, adults, and children for acute physical or mental health concerns and actions to take dependent on acuity of the patient.

Senior leaders told us that children who self-presented at the department was one of their top risks for the department. The ED reviewed approximately 150 children a year that needed to be transferred to an alternative appropriate hospital location. Transfers were either self-presenting with family or by ambulance dependent on the assessed condition of the child.

Critically ill children continuing to present at this ED where there were inadequate paediatric facilities was included as a moderate risk in the ED risk register. There were staff, with appropriate skills, who were trained in the care, stabilisation and transfer of children if needed.

Urgent and emergency services

There were pathways, agreed with the local NHS ambulance service where patients identified with certain conditions, such as stroke or cardiac, were transported directly to the acute centre in the region. This could be the trust's other hospital location, a hospital within the integrated care system or wider in the North West. Patients presenting with stroke symptoms, for example, being conveyed by ambulance were directed to the trust's other hospital. Any patient self-presenting with stroke symptoms was urgently transferred by ambulance to Preston hospital.

There was a policy in place to transfer medical patients across the two locations as well as a standard operating procedure for handover of patients to the ED and urgent care centre whether self-presenting or arrival by ambulance.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed training in the mental health risk identification and management tool. There was 90% compliance for registered nurses. The mental health team were based at Preston. This meant that patients who required specialised assessment needed either to be transferred to the other hospital ED or be reviewed virtually on the trusts 'attend anywhere' service.

Following the inspection of the trust's other hospital ED, concerns were raised with the trust about the care and treatment of patients with mental health symptoms. Staff we spoke with at Chorley were aware of the concerns and had been shared the feedback verbally and written.

Senior managers told us that access to and delays in the mental health pathway were one of the ED's top risks.

The ED was supported by security staff when open. They completed enhanced training in control and restraint techniques, conflict resolution and breakaway techniques. Staff had either completed necessary refresher course or were booked to attend in July 2023.

Between June 2022 and May 2023, there were no incidents identified where there were insufficient numbers of staff to undertake restraint if required in the ED at Chorley.

Staff shared key information to keep patients safe when handing over their care to others.

Handovers included all necessary key information to keep patients safe. We observed the daily multi-disciplinary handover where all patients and any concerns were discussed.

Staff we spoke with told us that they tended to have a surge of patients in the early evening. There had been incidents where patients were in the department after 8pm meaning delays in patients being seen and treated as well as staff working longer than their planned shift. These were reported on daily shift forms completed by the nurse in charge and incident reported. Following the opening of the Williams triage facility, we were told that the incidences had reduced mainly for medical patients. Staff from the triage facility came to the department from 7pm and transferred patients if needed to in-patient beds.

The trusts had a full capacity protocol including how, when, and where to escalate patients and covered both hospital locations.

Urgent and emergency services

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The establishment had been reviewed and the number of registered nurses and healthcare assistants had been reduced to 8 registered nurses and 4 healthcare assistants on each shift. Senior leaders told us that this was to align to pre-COVID staffing levels.

Between November 2022 and April 2023, registered nurse fill rates were between 110% and 129% and unregistered nurse fill rates were between 87% and 116%.

For the same period turnover figures for both ED's for the trust were low. For allied health professionals (AHP's) this was 0% and for medical staff and registered nurses' turnover was 0.9%.

Between May 2022 and April 2023 sickness rates were an average of 4.3% for AHP's, 2% for medical staff and 6.3% for registered nurses across both ED's.

The ED's, across both locations were funded for 131 registered nurses and had 15 vacancies. For unregistered staff, funding was for 63 but there were 31 vacancies.

Substantive staff worked either 7.30am until 8pm or 9.30am until 10pm.

The service was supported by regular bank staff and agency if needed. Agency staff could be booked to start at 2pm although it had been agreed they could start now at 12 midday as there had been concerns about late cancellation of shift.

All staff received an induction and staff we spoke with told us they were supported during that time. Link nurses and champions had been identified to support student nurses in the department.

There had been rotation of registered nurses, band 6 and 7 levels, across the two locations to ensure competencies and skills were maintained as well as integration of the staff across both locations. Senior leaders had received mixed feedback from staff regarding rotation and this was under review.

Between January 2023 and June 2023 there were six incidents reported for staffing concerns in the ED; five were graded as no harm and one incident as low harm.

There were plans in place to manage any shortfalls in staffing numbers. Staff could be redeployed across the two ED's dependent on need. Senior managers could support staff as necessary. Meetings were held throughout the day where staffing levels were discussed. Bank and agency could be utilised if needed.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Staffing was planned across both hospital ED's. The services were funded for 106 medical staff; there were 23 vacancies.

Managers could access locums when they needed additional medical staff. There was support from advanced clinical practitioners (ACP's) that worked in the department as well as ACP's who in-reached to support alternative pathways for patients.

Managers made sure locums had a full induction to the service before they started work and were monitored to ensure they had the appropriate skill set for the department.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We were told that there were challenges in middle grade doctors at this hospital as there were more learning opportunities at the trust's other hospital where patients, following trauma or presenting with a surgical speciality were routinely treated.

Senior leaders told us that staffing was one of the main risks in the department. The potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies was included in the ED risk register.

The service had consultants on duty Monday to Friday. At weekends, and after 5pm during the week, there was senior leadership from associate specialist doctors.

There was a cohort of doctors who worked mainly in the department, but most doctors worked at both locations. Doctors in training roles were based at the other hospital ED although GPs in training worked in the department.

Doctors worked closely across locations to ensure patients were in the right place and receiving appropriate care. Doctors we spoke with felt supported by senior clinicians for the service.

As part of the people strategy there were plans increase the numbers of advanced practitioners and non- medical consultant positions across urgent and emergency care to support the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, notice boards displayed confidential information.

Patient records were a combination of paper and electronic. Patient notes, at the location were comprehensive, to a good standard and all staff could access them easily. We observed that, for the four records we reviewed, these were completed in a timely manner.

When patients transferred to a new team, there were no delays in staff accessing their records. We observed that paper care records were transported with patients so available to continue care.

The trust completed audits of risk assessment and care plan completion and reported an average of 78.8% compliance across both hospital ED locations.

Records were stored securely. Between December 2022 and April 2023 there was an average 96% audit compliance for storage in the ED. We observed, however; that patient identifiable information was visible, on patient boards to visitors as well as staff. This was highlighted at the last published inspection of the other ED location.

Medicines

The service used systems and processes to safely prescribe and administer medicines but compliance with trust standards for the safe handling of medicines, including Controlled Drugs were not met. There were plans for Rapid Improvement Cycles to help support improvement in this area. Capacity within the pharmacy team to provide clinical support to the department was limited, but several vacant positions had been successfully recruited to.

Staff followed systems and processes to prescribe and administer medicines safely.

Doctors had access to the local care record to view patient's current medicines when patients were clerked in. The senior pharmacist aligned to the acute medical team visited ED to provide proactive clinical pharmacist review, when possible, limited by pharmacy team capacity. There were plans to increase pharmacy presence following the recent successful recruitment to several vacancies in the pharmacy team.

Since our previous inspection, the trust's electronic prescribing and medicine administration (ePMA) system had been rolled out to the adult emergency department. A trust improvement programme had resulted in rapid improvement and continued good compliance with oxygen prescribing.

Trust sepsis policy had been updated in line with the Academy of Medical Royal Colleges sepsis guidance (May 2022), supporting the appropriate use of antimicrobials in sepsis. The sepsis audit had been updated to reflect these changes and the sepsis group was focussed on supporting improved compliance with this.

Staff generally stored and managed medicines and prescribing documents safely.

Performance with the trust's own quarterly controlled drugs (CD) audit (70% 12 months to date) and monthly safe medicines storage audit (81% 12 months to date) was below the trust 90% standard. Recent action to improve this included a review of stock management process, and fitting of additional stock cupboards. Staff had been reminded to alert pharmacy to any CD concerns. Discussions had started to explore piloting an electronic controlled drug register in Q3 2023-24.

Staff learned from safety alerts and incidents to improve practice.

The trust's Medicines Safety Team provided oversight of medicines incidents across the trust. We saw that appropriate action was taken to learn from medicines incidents in ED, reducing the risk of reoccurrence.

The trust had policies to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. The trust had taken prompt action to review these across the trust in response to concerns we shared with the trust at other locations.

Medicines management was included in mandatory training requirements. Compliance was 81% for registered nurses against a trust target of 90%. We were told that there had been an updated module with a strengthened internal mandate since May 2023.

Link nurses and champions had been allocated to support medicines management.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust had an electronic incident reporting system. Incidents were identified on daily shift reports and reported on the electronic system.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Between July 2022 and June 2023 there was a total of 643 incidents across both the ED and the urgent care centre, that was managed by an independent provider, of which one was reported as a serious incident. There were no never events reported for this location.

Staff told us that incidents where the department was open past the closing time were reported on the trusts incident reporting system. Between July 2022 and June 2023 there were 28 incidents reported in relation to the late closure of the ED. There were 24 of these incidents graded as no harm, three were low harm and one was moderate harm. The moderate harm incident was in relation to a patient referred late to the department from the urgent care centre (UCC). The incident was assigned to the UCC for investigation.

Incidents where security staff were involved that included any patients who presented with mental health concerns were reported across the ED's. Between December 2022 and May 2023, there was a total of 70 restraint incidents of which eight related to the Mental Health Act and 45 related to the Mental Capacity Act. In the six months prior to inspection there were no incidents relating to patients with a mental health concern that were graded as moderate or above. As incidents were recorded across the location it was difficult to review the incidents for this location.

The department monitored incidents reported for pressure ulcers, falls and venous thromboembolism (VTE). Between July 2022 and June 2023 there were 11 pressure ulcers incidents reported. There were 2 that were not present on admission, three that were present on admission and six that were recorded as unknown whether present on admission. All incidents were recorded as no or low harm and investigated by the unit manager.

There were eight falls incidents reported; four were recorded as no harm, three were low harm and one was reported as moderate harm. The moderate harm incident related to a patient who slipped on ice when leaving the hospital grounds following discharge and was brought to the ED for treatment. Risk of falls was included in the ED risk register.

There were no VTE incidents reported.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. Senior leaders told us that following a late closure incident, when a patient was delayed in transfer, there was a concern that staff allocated from the hospital did

not have the required skills to allow the emergency nurse to leave the shift while the patient was in the department. The late closure standard operating procedure was reviewed to ensure the right skills and competencies. Late closure was included as significant in the ED risk register. Learning was shared at staff meetings, by emails, memos and social media groups. Matrons and ward managers had been shared information at leaders forums.

We spoke with staff regarding the inspection of Preston ED. Staff we spoke with had been shared the initial feedback from the inspection and aware of proposed changes in processes.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Of the copies of policies and procedures that we were provided with all were within their date of review. The department had a booklet that included any updates in protocols for staff to access.

Any changes in national guidance, such as the National Institute for Health and Care Excellence (NICE), were discussed at monthly governance meetings that covered both ED locations.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At the handover meeting, staff referred to the psychological and emotional needs of patients, their relatives and carers.

The department was included in the trust's safety triangulation accreditation review (STAR) process. This system monitored performance in all areas of the trust and reported results monthly. There were two elements. The first included monthly reviews undertaken by peer review matrons. The second element were accreditation visits by the quality assurance team.

Quality metrics were reviewed including infection prevention and control, medicines safety, record keeping, emergency equipment, safeguarding vulnerable adults and children, and safe storage of equipment including control of substances hazardous to health (COSHH). STAR information was stored in the trusts electronic audit management and tracking system. Dependent on the outcome of visits, improvement action plans were implemented and monitored by the local teams.

Compliance in STAR audits at the location had varied in the six months prior to inspection from 73% to 96%. However, staff had achieved silver status prior to the inspection visit.

Urgent and emergency services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff provided drinks and sandwiches to patients who were waiting for treatment plans in the department. Vending machines were available for public use in the waiting room.

Staff completed training in food safety level 1. There was a compliance of 92% for registered nurses.

We observed in patient records, that staff fully and accurately completed patients' fluid and nutrition charts where needed.

The trust risk assessments included the calculation of a malnutrition universal screening tool (MUST) score. The MUST score was triggered once patients were admitted to the hospital and therefore compliance with MUST completion was not audited in the ED. However, a system was in place to allow the nursing team in the ED to make electronic referrals for patients to see a dietitian.

The ED carried out monthly audits on completion of fluid balance documentation that included vital signs recording, completion of fluid balance charts, totalling of the fluid balance every four hours and urine output being included on the vital signs. Between July 2022 and June 2023 there was an average monthly compliance of 85%. An action plan that included transferring documentation to electronic and re-audits was in place to improve compliance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Patients we spoke with told us they had been offered and received pain relief in a timely manner. The trusts STAR quality assurance framework included pain management audit. Between July 2023 and June 2022 there was 100% compliance when patients were asked if their pain had been managed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust had an electronic audit tracking system that monitored the audits for the service. This included both national and local audits as well as re-audits that were either active or closed and the audit forward plans.

Between April 2022 and May 2023 there were 18 audits registered under the Emergency Department speciality in the trusts electronic audit tracking system (AMaT).

Urgent and emergency services

The trust's clinical audit and effectiveness department facilitated the programme of national and clinical multidisciplinary audit activity. The service participated in national mandatory clinical audits. These included the Royal College of Emergency Medicine (RCEM) audits and the Trauma Audit and Research Network (TARN) audit. The data was across both hospital ED locations.

The latest TARN results showed the trust was above the national average for both data accreditation and case ascertainment.

For 2022 to 2023 the service participated in two RCEM audits. These were RCEM 2022: Mental health self-harm audit and RCEM 2022: Consultant sign-off audit.

For the period 2022 to 2023, the RCEM audits that were reported on were: Fractured neck of femur (NOF), pain in children and infection, prevention and control.

For fractured NOF, the trust performed better than the national average for three of the four standards. There was no national result for the fourth standard. For standard 1: Pain is assessed immediately upon presentation at hospital, the trust average result was 72% compared to the national mean result of 48%. For standard 2: Patients in moderate or severe pain (e.g., pain score 4 to 10) should receive appropriate analgesia within 30 minutes (or accordance with local guidelines) unless there is a documented reason not to, the trust scored an average of 56% compared to the national mean of 15%. For standard 3: Patients should have an x-ray at the earliest opportunity (within 90 minutes), the trust scored an average of 61% compared to a national mean of 56%. There was an action plan aligned to the report recommendations, that showed the progress with the implementation of changes.

For pain in children, the trust performed better than the national average in all three standards. This hospital did not routinely see children in the ED.

For infection prevention and control, the trust performed worse than the national average for the first two standards but better for the third standard. Standard 1: Patients should have documented evidence of infection screening for: 1. Symptoms of Covid 19 2. For conditions considered to make them extremely vulnerable (and who will have been shielding themselves at home) 3. For other infectious diseases requiring isolation, the trust average was 9% compared to the national mean of 25%. For Standard 2: Patients with an identified vulnerability isolated in a side room, the trust average was 17% compared to the national mean of 23%. For Standard 3: Patients identified as potentially infectious moved to an appropriate area, the trust average was 81% compared to the national mean of 80%.

We did not observe any concerns with IPC at this location.

The physiotherapy service completed audits in the ED. These had highlighted that therapy provision assisted in admission avoidance. Patients could be seen in the therapy trauma clinic. Out of the 571 patients that were seen by physiotherapists over a third were referred on for further therapy. Just over half of the patients seen were discharged directly.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support in development.

Managers gave all new staff a full induction tailored to their role before they started work.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The clinical educators supported the learning and development needs of staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We were told that bank nursing staff completed mandatory training. Any role specific competencies were agreed locally with the mangers at Chorley.

The service ensured staff with certain competencies were on each shift in case a patient needed stabilising prior to transfer.

Staff participated in monthly child and adult resuscitation simulation exercises as well as regular resuscitation skills training provided by the ED clinical educator. These were multi-disciplinary and either classroom or department based.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. In the staff induction checklist, all staff were advised not to use any medical device which they did not feel competent to use.

Managers made sure staff received any specialist training for their role. There was a range of competencies that were required to work in the ED including telemetry (monitoring of the heart remotely), non-invasive ventilation (NIV), tracheostomy and electrocardiographs (ECG).

For telemetry, nursing staff from band 3 to 7 were required to complete this competency. At the end of June 2023, there was 82% compliance.

For NIV nursing staff from band 5 to 7 were required to complete this competency. At the end of June 2023, there was 66% compliance. Of the 109 staff, 68 were compliant. Staff attended resuscitation skills study days provided by the ED clinical educator. These included NIV policy, pathways and ongoing care of patients during NIV.

There were sufficient staff with NIV competency to ensure there was cover on each shift. Support was also available from the cardiac unit which had staff with NIV competency. There was seven-day consultant on call provision for the respiratory team who also provided support.

For tracheostomy, all band 6 and band 7 staff in the ED completed advanced life support (ALS) training which included advanced emergency airway management including tracheostomy. Band 6 and band 7 nurses were 83% compliant. ED consultants had emergency airway management skills meaning that there was always a staff member on duty with the ability to maintain a patent tracheostomy.

Nursing staff within the ED also attend a tracheostomy awareness study day, which had been developed by the ED clinical educator, the critical care outreach team and simulation services. Band 6 and 7 nurses had attended the course. There was at least one band 7 and 2 band 6 nurses in the ED at all times who had these skills. Patients with tracheostomy were admitted to three designated speciality wards or the critical care unit if needed.

For ECG, training was provided for band 3 -7 nurses on recording an ECG. A total of 139 staff in ED had completed ECG training.

For taking blood samples, all registered nurses and doctors completed training and competency assessments for taking blood during their initial professional training. On commencing at the trust staff were competency assessed utilising aseptic non-touch technique (ANTT). Compliance with ANTT competency was at 84% for the ED.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance rates for both medical staff and registered nurses was 89% across both hospital ED's. However, bank nursing staff we spoke with told us that they had not had an appraisal.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed the staff meeting that was held daily, including at weekend, to discuss all patients in the department. This meeting included doctors and the nurse shift manager. Any concerns or plans were shared.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us that there was a good working relationship with the independent provider for the urgent care services that were co-located.

Staff referred patients for mental health assessments when they showed signs of mental ill health.

Seven-day services

Key services were available seven days a week, from 8am until 8pm, to support timely patient care.

The service was open seven days a week but not available overnight. The department was open to patients from 8am until 8pm. There were no patients who had arrived by ambulance after 6pm; The service accepted patients who self-presented between 6pm and 8pm. Staff remained in the department until 10pm.

There was physiotherapy support in the department Monday to Friday but also supported some weekends.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle.

Emergency nurse practitioners (ENP's) signposted patients they saw as appropriate to smoking cessation or the trust alcohol team. There were identified link nurses and champions to support triage, minor injuries and wound management.

For minor injuries, there were leaflets available to support verbal advice given.

Physiotherapists worked closely with the ENP's to support appropriate treatment pathways. Leaflets were available to access exercises or self-referrals to physiotherapy.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Training for Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoL's) was included as part of mandatory safeguarding training requirements.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining verbal consent during care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

The trust completed audits for Do not attempt cardiopulmonary resuscitation (DNACPR) decision and reported 100% compliance across both hospital ED locations.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, took account of their individual needs but did not always respect their privacy and dignity.

Urgent and emergency services

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients and their relatives described staff as amazing, brilliant, calm and provided care that was above and beyond.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We observed discussions about individual care took place in a cubicle where other patients and relatives were waiting. This meant that confidential patient information could be overheard by others.

The trust participated in the NHS Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Between May 2022 and April 2023 there was an average of 73% positive response for patients attending the emergency department. There was no response rate provided and data was presented across both hospital locations.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. There was a chaplaincy and spiritual care department that was accessible 24 hours a day available across the trust including a chapel and multi faith room and representatives from faiths including Islam and Christianity including volunteers.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Urgent and emergency services

Staff supported patients to make informed decisions about their care. We observed that families were involved in the care and treatment of the patient.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Between April 2022 and April 2023 there were approximately 28650 attendances for the Chorley emergency department with an average of 2000 per month. This excludes Chorley urgent care centre attendances.. Managers planned and organised services, so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered.

The service was available for patients over the age of 18 years between 8am and 8pm for patients who self-presented. The last ambulance to the service was at 6pm daily. Any paediatric patients were transferred or signposted to either the other ED or a paediatric facility, dependent on the acuity of the child. The service was co-located with an urgent care service that was managed by an independent health provider that was available for all age groups 24 hours a day, 7 days a week.

The signage was not clear when approaching the department, although there was no feedback from patients that they were unable to locate the department.

The trust website outlined for patients where to access treatment dependent on their individual medical condition, injury or age group signposting either to an ED or urgent care centre (UCC).

Reception staff who took patients' details on entry to the hospital departments had allocated reception desk areas. The patient waiting area was shared between the ED and UCC services. This had seating and vending machines for patients and their relatives waiting to be seen.

For patients who we saw were taken to wait into a cubicle in the department, with other patients, there was only waiting room chairs rather than more comfortable patient armchairs.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were no mixed sex breaches reported for the ED.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access emergency mental health support, when open, 7 days a week for patients with mental health problems, learning disabilities and dementia. Patients with mental health needs needed to be transferred to the other ED location to be assessed by colleagues from the mental health team there.

The service relieved pressure on other departments when they could treat patients in a day. The minor injuries service could signpost patients to alternative outpatient services or therapies.

Meeting people's individual needs

The service was inclusive but did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a trustwide strategy and a process to support patients with enhanced care needs.

The toilet facilities, close to the waiting room were spacious, wheelchair accessible, dementia friendly and non-gender specific.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There was a box that included items to support patients identified with cognitive impairment, however the contents were being reviewed by the dementia champion to ensure these were appropriate.

Link nurses and champions had been identified to support patients with dementia, learning difficulties and mental health needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We observed staff speaking with patients and their relatives in caring and appropriate ways. However, we did not see any hearing loop in the department.

The service displayed information leaflets that were written in English. We did not see leaflets written in languages other than English, alternative formats or the inclusion of how to access them.

The trusts website had a range of accessibility features to meet patient needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a trust wide service for accessing interpreters as well as staff members who were available to support on site if needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences if they needed to wait in the department.

There was a process to support patients deemed as high intensity users (HIU). The core principles of the HIU service were to identify, personalise, de-escalate, discharge and manage relapse. The team worked with patients, their families and other professionals to identify needs and implement a care plan to help reduce the need to attend the ED.

There was an area in the department where any children that needed to be treated or stabilised prior to transfer to a hospital with paediatric facilities were cared for. This was a re-purposed area that did not include any décor that was child-friendly or an area where the family could wait.

Urgent and emergency services

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were below and better than national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Triage of patients who self-presented were triaged by the urgent care centre staff. This was managed by an independent health provider. The trust monitored ambulance attendances and handover times. Between February 2023 and June 2023 there was a total of 41022 attendances of which 2552 were ambulance attendances. These varied from four to 38 attendances daily. The hospital was consistently below the England average for handover that took over 30 minutes and the best performing with the region. Between March 2023 and June 2023 between 80% and 93% of patients spent less than four hours in the ED that was consistently above the region and England times. There were no children routinely seen in the ED. However, children that attended were transferred to the appropriate department dependent on condition.

Staff we spoke with told us that in addition to patients, from the locality, they had seen an increase in numbers of patients from out of the area. Between July 2022 and June 2023, there were approximately 2390 patients who attended that did not have a local postcode. This meant that staff did not have access to all information recorded on electronic systems by community staff including GP's.

Managers and staff worked to make sure patients did not stay longer than they needed to. There was a standard operating procedure for closure of the department. There had been incidences when patients remained in the department after the closure time. This meant that staff were delayed in finishing their shifts.

Between April 2022 and April 2023 there were 173 patients who were in the department after closure at 10pm. The trust had identified the two main reasons for late closure were patients who self-presented near to the 8pm cut off time with outstanding areas of their assessment or treatment by 10pm and delays with patients being transferred to inpatient beds at both hospital locations. When patient flow was under pressure the ED was used overnight as an escalation area as per the trust wide escalation plan.

Since the opening of the Williams triage facility, staff we spoke with told us there had been improvements for patients with a medical condition. There had been some concerns that patients presented for surgical specialities could still be delayed. Plans were in place for escalation if needed.

The clinical site team visited the department to speak with the department leaders. There were bed meetings that occurred at regular times throughout the day where any concerns could be raised. The trust had introduced the trust operational officer team to support access and flow. We were shared an example of where this team had supported the service to promptly action the transfer of a surgical patient, out of the ED, that had been delayed. Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Urgent and emergency services

Between July 2022 and June 2023 there were patients transferred from the department either to the trusts other hospital ED or to an appropriate healthcare setting to meet their care and treatment needs. There were 240 patients with acute needs and 91 patients with mental health concerns transferred to the other ED. For the same time period there were 52 patients with acute needs and seven patients with mental health concerns transferred to an alternative healthcare setting.

Between April 2022 and April 2023 there were a total of 389 acute adult patients and 30 adult patients with a mental health concern who left the department before being seen. Following the inspection of the trusts other ED location a letter of concern was sent to the trust regarding patients with a mental health concern resulting in an action plan to address concerns.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. A link nurse had been identified to support patient experience.

Compliments were displayed on the patient experience notice board.

The service clearly displayed information about how to raise a concern in patient areas. There were patient leaflets that included details of the patient advice and liaison service (PALS).

Between July 2022 and June 2023, there was a total of 10 complaints for the service, two of which were upheld and two were partially upheld. There were no complaints referred to the Parliamentary and Health Service Ombudsman (PHSO).

The list of complaints provided did not include the length of time taken to manage the complaints. Three complaint responses were provided; two took seven and nine months to complete. This was outside of the trusts complaint policy of a maximum of 60 days for complex complaints.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. There was a governance board where feedback could be shared.

Is the service well-led?

Good 

Urgent and emergency services

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was senior leader presence at the hospital at least once a week.

Staff we spoke with told us that they were supported by their managers at the hospital, however they told us that senior managers were not visible and visited only ad hoc times.

Shift leaders were skilled and focused on the priorities in the department. They were sighted on the particular risks in the department as well as the other hospital ED.

Staff worked well as a multidisciplinary team and supported each other. Local clinical leads were available and accessible in the emergency department and provided support to junior team members.

Leaders were aware of staff competencies and assigned tasks appropriately. Staff we spoke with told us their managers recognised their skills and helped them with development needs.

The trust's people plan had a focus on career structures throughout the ED pathway so that staff could move between specialist and advanced practice and leadership careers across each part of the pathway.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Senior leaders told us that the strategy for the emergency department covered both hospital sites. There was an urgent and emergency care strategy, dated 2023 to 2025. This outlined the plans for delivering and the recovery of the services. There was also the emergency services clinical service strategy, dated 2021 to 2024 that was aligned to the divisional and trust strategies.

For the ED's the vision was "… for patients to receive the right pathway first time, from pre-hospital to in hospital. For the Emergency Department to resuscitate, treat the trauma and acutely unwell, save lives through outstanding timely patient-centred care that is driven by educational innovation, high performing teams and practice-changing research. This will be supported by system care delivery closer to home."

Urgent and emergency care was one of the trust and divisions strategic priorities that included:

- Providing the right pathway.
- Delivering high quality safe and effective care.
- Reducing mental health delays.

- Obtaining a right sizing of estate to improve patient flow.
- Being responsive to surges in demand.
- The development of a workforce that enabled front end assessments, with a clear roadmap of development opportunity for nursing, medics and allied health professionals.
- Providing a well-defined wellbeing strategy.

The divisional strategic objectives for the ED's included the provision of outstanding and sustainable healthcare to the local communities, offering high-quality specialist services to patients in the integrated care system (ICS) region and to drive health innovation through world class education, training and research. There was a recognition for the need for safe levels of appropriately trained and skilled staff, particularly as a trauma centre, and to ensure that patients were streamed to the most appropriate pathway so the most acutely ill were seen in the ED.

The strategy followed the same principles as the trusts big plan of consistently delivering excellent care, being a great place to work, delivering value for money and being fit for the future. There was a recognition that a two location ED model had challenges. However, there were more strengths than weaknesses identified such as teamwork, delivery of pathways and streaming, ambulance handovers, zero corridor care and wellbeing of staff.

Leaders measured the strategy against key health outcomes. These included the monitoring of clinical outcomes, life expectancy, mortality and morbidity and reduction in health inequalities between regions, improvement of health and well-being of the local population and positive experiences both for patients and staff as well as measuring financial sustainability.

The ED recovery strategy outlined the trusts transformation plans. There was a recognition of the unprecedented challenges particularly since the COVID pandemic but also identified that there is a need for a system -wide approach to improving the service. The strategy outlined the ambitions to improve waiting times and continue to participate in the ambulance collaborative programme. The plan focused on key areas including:

- Increasing capacity by reviewing models of care including participating in NHS England's new improvement programme to support standardisation of care, working with clinical leadership to set out common principles for providers.
- Growing the workforce by supporting career progression, increasing the numbers of advanced practitioners positions, skills to support patients with mental health needs, and use of allied health professional (AHP) skills.
- Improving discharge by working collaboratively with system partners and use of digital systems.
- Expanding and better joining up health and care outside hospital by supporting social care and virtual ward expansions and working with the community.
- Making it easier for our population to access the right care such as urgent care services or alternate pathway.

There was a delivery plan on a page that summarised the strategy and included key performance indicators used to monitor outcomes.

The department had a noticeboard that included the services goals alongside the trust goals and values. However, this was dated for 2022 to 2023. We were told that the departmental goals were under review for the upcoming year.

Urgent and emergency services

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive culture in the department. Staff we spoke with told us they enjoyed working in the department with good team working. They told us that there was a friendly atmosphere, and they were well supported by their local managers. Staff worked in a department where they were valued and respected by their line managers.

We observed a diverse team of staff who worked together to meet the needs of the patients in the community. All staff we spoke with were encouraged to develop and expand their skills. The trust had an equality, diversity and inclusion strategy group that had management representation from the medical division. Updates of plans were shared at monthly meetings as well as the presentation of patient stories. The trust also had forums for ethnicity, LGBTQ Plus Ambassadors and living with disabilities.

Most of the doctors worked at both ED's and reported good working relationships. Some of the nurses we spoke with reported they felt isolated at times as the other hospital ED had a dedicated trauma centre and was open 24 hours a day. Registered nurses had been asked to work across both hospitals. This meant there was a sharing of skills across locations and staff could maintain their competencies. It was hoped that the cross cover would help staff to feel integrated across the trust.

Senior managers told us there had been some communication concerns regarding the initial co-location of the urgent care service, that was managed by a different provider, particularly triage issues. However, staff on-site told us there were now good working relationships with the service.

Speak up core training was included from 1 May 2023 following an external requirement from the Office of the National Guardian. Compliance was recorded across both hospital ED's. For medical staff compliance was at 29%, registered nurse compliance was 35% and other staff was 44%. This was an average of 37%. Staff had been given a three-month grace period for this module (Until 31st July) to achieve the 90% trust target.

In the staff survey, for 2022, responses for the ED's were for the ED's at both sites. There were 85% of the 240 staff, who had responded, that reported their last experience of physical violence. There were 58% of staff who had reported their last experience of harassment, bullying or abuse. There were 35% of staff who said relationships at work were unstrained and 39% who said they didn't often think about leaving the organisation.

Governance

Local leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework was across both EDs with representation from both locations. The senior leaders covered both locations including medical and nursing leads in order to have oversight of the whole service and support the integration of the departments.

The department participated in the trusts safety triangulation accreditation review (STAR) process that monitored a number of quality metrics on a monthly basis. Patient areas were awarded a rating dependent on performance. The department had achieved silver status.

Urgent and emergency services

The clinical audit and effectiveness team monitored the performance of national and local clinical audits that were indicated in relation to governance requirements. They provided reports to the trust's safety and quality committee.

The ED's held monthly minuted governance meetings. We were provided copies for February 2023, March 2023 and April 2023. There was a standardised agenda that covered both ED's. Leaders discussed audit progress, any guideline changes, complaints, patient experience, reviewed risks, any medicine concerns, performance including the dashboard, improvement work, training needs and lessons learned and shared.

There were monthly divisional board meetings. These had standardised agenda items that included feedback reports from divisional safety and quality, workforce and finance and performance committees. Any key issues for escalation both positive and negative were discussed as well as items for information or approval.

There were monthly divisional always safety first meetings. These had agenda items for patient story, discharge processes, safeguarding, medicines and incidents.

The service worked closely with the co-located urgent care centre that was manged by an independent provider. They collaborated to ensure the most appropriate pathways for patients.

The trust linked in with the other trusts in the integrated care system (ICS) through the provider collaboration board. In these meetings there were discussions about activities that could assist in reducing the demands on the ED's across the region.

Management of risk, issues and performance

Local leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust maintained a risk register that included the divisional and departmental risks. The ED risk register included risks from both hospital locations. There were six risks graded as high, 15 as significant and two that were graded moderate. The copy of the risk register, that we were provided with included the target scoring for each of the risks, showed that they had been reviewed within the 6 months prior to inspection. tThe risk register included the controls and mitigations for the risks.

The ED's risks graded as high included falls, the lack of available beds and delays for patients with mental health concerns and the potential risk to patient safety due to medical staff vacancies.

Risks graded as significant included late closures, stabilisation and transfer of critically ill patients to a receiving hospital and the risk that critically ill children continue to present at the hospital where there are inadequate paediatric facilities.

Risks were discussed at monthly ED governance meetings that were for both locations.

Senior leaders were well sighted on their top risks and articulated processes in place to mitigate risks including escalation and transfer protocols and arrangements.

The urgent and emergency transformation programme board monitored the delivery of the ED strategy and monitored outcomes under the aims to consistently deliver excellent care, a great place to work, delivery of value for money and fit for the future. This board reported to the board of directors through the finance and performance committee.

Urgent and emergency services

The organisation monitored progress through its safety triangulation accreditation review (STAR) process. This STAR process was a quality assurance framework that commenced in June 2017 that provided an evidence based approach in demonstrating the standard of care delivered. It identified what worked well and where further improvements were required. There were monthly reviews that were undertaken by matrons, in divisions, who peer reviewed their departments. There were also accreditation visits that were undertaken by the quality assurance team supported by governors and other staff in the trust.

The results of the STAR monthly audits were used to monitor safety standards within each clinical area. The outcomes formed part of the monthly assurance report completed by the Matron. These were monitored at both divisional committee and board level, as part of the safety and quality dashboard. The aim was to provide ward to board assurance on a monthly basis. The results were also included in the monthly divisional improvement forums and in divisional meetings.

The unannounced comprehensive accreditation gave additional assurances by providing a report based on the outcome and findings of the visit. The STAR comprehensive accreditation visits frequency was based on a risk profile, linked to the previous score. The accreditation visits included monitoring of quality metrics such as infection prevention and control, medicines safety, record keeping, emergency equipment, safeguarding, and patient call bells. The ED had achieved silver status. Environment was one of the metrics covered, including storage checks. However, the star policy did not include expiry date checks. We had e identified consumables that were passed their expiry dates.

Results from STAR were recorded in the trust's audit management and tracking (AMaT) system. This issued a monthly STAR report that was presented at the divisional safety and quality meeting, the divisional always safety first meetings and the nursing, midwifery and allied health professionals board. The monthly and accreditation visit outcomes were reported through the divisional improvement forums and to safety and quality committee. Staff were able to access results on the trust intranet.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

There were dashboards for the trust that showed live information about patient numbers and any concerns. These could be viewed for both departments meaning that support could be given as appropriate. This meant there was continuous oversight of the department as well as an awareness of the other hospital ED.

For patients who attended from out of area, the service could not access any previous records including GP information.

Information management was included in mandatory training requirements with a trust target of 95%.

National and local audit data was submitted to the trusts electronic audit tracking system and monitored both locally and trust wide.

Engagement

Leaders and staff actively and openly engaged with staff to plan and manage services.

Staff we spoke with told us they received feedback from managers via different platforms including team meetings, governance board that included 'you said, we did,' a booklet with any updates to be aware of and by social media groups. We requested copies of team meetings, however; did not receive any to review.

The trust issued a monthly newsletter, the best version of us, to leaders in the organisation and the chief executive sent his Monday message newsletter to all staff. Staff have been contacted regarding plans to build a new hospital and were invited to attend summit events. Staff also received a bi-weekly bulletin of health matters.

Engagement with public groups, with the exception of the NHS Friends and Families Test, had been stopped prior to the COVID pandemic although there had been a day dedicated to learning disabilities. An event had been held, in the local area for patients with kidney disease with a presentation and information available.

A revised patient experience and involvement strategy was launched in 2022 with contributions from patients, relatives and carers as well as staff, governors, and partner organisations. Following feedback from patients changes had taken place such as a remembrance garden at the hospital that could provide a quiet, reflective space.

Of the 4440 responses in the 2022 staff survey, there were 240 responses from the ED and acute medicine division. The responses were rag rated in comparison to the whole organisation. There were six responses rated green, 42 that were amber and 49 that were red. There were 80% of staff who thought there were opportunities to show initiative frequently in their role. There were 65% who said that team members often meet to discuss the team's effectiveness. There were 62% of staff who responded that said the organisation acts fairly with career progression and 57% said they were involved in deciding changes that affected their work. However, of the responses that were worse than the average for the organisation, there were 14% who said that they are never or rarely worn out at the end of work, 20% who said they were satisfied with their pay and there was 32% who said their appraisal left them feeling that the organisation valued their work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

There was a collaborative approach to research and innovation and staff we spoke with told us that continuous improvement was in place across the departments and up to trust level. One of the ED strategic objectives was to drive health innovation through world class education, training and research. The trust was committed to quality improvement, throughout the departments, divisions, trust level and the integrated care system. The trusts big plan objectives were to provide safe and reliable care with good and improving outcomes for patients by continuous improvement programmes. These were at system and department level with divisional priorities. There was a range of programmes in the ED's such as weekly meetings with the NHS ambulance provider, working groups for frailty and mental health and big room work. There were local department level improvements through he trusts microsystem coaching academy programme. They had shared work with external providers and stakeholders to share best practice.

The trust's always safety first was embedded in the department. The trust's big room programme included topics such as sepsis. The department supported the other hospital ED particularly when escalation was needed and to support the ambulance collaborative to improve ambulance handover times across the ED's. The service supported the other trust ED by seeing and treating patients in the local community that helped with capacity and flow.

Therapy provision had been shown to help with admission avoidance and there were plans to expand this service.

Royal Preston Hospital

Sharoe Green Lane
Fulwood
Preston
PR2 9HT
Tel: 01772716565
www.lancsteachinghospitals.nhs.uk

Description of this hospital

Lancashire Teaching Hospitals NHS Foundation Trust is an acute trust providing services to the Preston and Chorley areas and a range of specialist services to people in Lancashire and South Cumbria. The trust delivers services from three core sites, Royal Preston Hospital, Chorley & South Ribble Hospital and the Specialist Mobility and Rehabilitation Centre. It is also a major trauma centre. The trust serves a population of 395,000 people and provides regional specialist care to 1.8 million people.

The trust is situated in an area where 20% of the population are 10% most deprived nationally, up to 25% of children and 20% of over 65s are living in poverty. There are high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia. By 2035 the over 75s will double. 17% of people in Pennine Lancashire are from a black minority ethnic background.

The trust employs over 8,800 staff and has 900 beds across 2 sites. It has an income of 738 million.

We carried out this unannounced inspection as part of our continual checks on the safety and quality of healthcare services at the trust. We inspected urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital.

A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions.

We also inspected the well-led key question for the trust overall.

Where we did not inspect services, using our rating principles the ratings for these services have been aggregated from the inspection in 2019.

No Use of Resources review was undertaken as part of the 2023 inspection.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.

Our findings

- We rated surgery at Preston and urgent and emergency care and maternity at Chorley as good. We rated urgent and emergency care, medicine and maternity at Preston as requires improvement. In rating the trust, we took into account the current ratings of the 9 services not inspected this time.

Urgent and Emergency Care

At the Royal Preston Hospital, the urgent and emergency service operates 24 hours a day, seven days a week. The emergency department is also a major trauma centre, accepting adult patients with more serious injuries. The service also has a separate children's emergency department for children in need of urgent care. Patients are triaged in designated assessment areas and in cubicles or rooms for more seriously unwell patients. An urgent care centre was co-located in the department, with services delivered by an independent healthcare provider for adults and children, 24 hours a day, seven days a week. Following triage, patients are treated in one of four main areas: the minor injury/illness unit, the ambulatory care unit, A&E majors, or A&E resuscitation.

We visited the service as part of our unannounced inspection on 31 May & 1 June 2023. We inspected the urgent and emergency care services at the hospital as part of a trust inspection. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The inspection was carried out by two CQC hospital inspectors, a medicines inspector, and two specialist advisors. We observed care, spoke with ten patients and their relatives, reviewed care records for 13 patients. We spoke with 26 staff of all grades including senior leaders, medical staff, nurses, domestics, allied health professionals, practice educators, children's nurses, and pharmacists. We attended a range of meetings including, bed management meetings, ward handover meetings and senior leadership interviews.

Our rating of this location stayed the same. We rated it as requires improvement because:

- Compliance for some areas of mandatory training was low for medical staff; the design, of the department made it difficult to keep people safe; Staff did not always assess risks to patients, act on them or keep care records updated. Staff did not always complete medicines records accurately or kept them up to date although they managed medicines well.
- Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff did not always follow up if patients had enough food and drink whilst waiting for treatment.
- People could not always access the service when they needed it and patients often had long waiting times for treatment.
- The service did not always take account of patients' individual needs.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical Care

Medical care services at Preston Royal Hospital are provided by Lancashire Teaching Hospitals NHS Trust.

We visited Royal Preston Hospital as part of our unannounced inspection from 31 May to 1 June 2023. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Medical care services are part of the division of specialist medicine at Lancashire Teaching Hospital.

The inspection was carried out by 2 CQC hospital inspectors, a medicines inspector and 2 specialist advisors. We observed care, spoke with 15 patients and their relatives and reviewed care records for 15 patients. We spoke with staff of all grades including senior leaders, medical staff, nurses, allied health professionals and practice educators. We attended a range of meetings including, bed management meetings, ward handover meetings and senior leadership interviews.

During our inspection we visited and inspected the acute assessment unit, the acute medical unit, the frailty assessment unit, respiratory, the coronary care unit, the discharge lounge, Fell View, a general medical ward, and the stroke unit. We visited Finney House to review how patients move from the hospital to the step-down rehabilitation centre .

We previously inspected the medical division at Preston Royal Hospital in 2019.

Our rating of this location stayed the same. We rated it as requires improvement because:

- The service did not always control infection risk well. The environment did not always keep people safe. Staff did not always identify and quickly act upon patients at risk of deterioration and did not always have the resources available to them to support patient's needs. The service did not have enough established medical staff to keep patients safe from avoidable harm.
- The service did not always achieve good outcomes for patients. Not all services were available 7 days a week.
- The services facilities and premises were not always appropriate for the services being delivered.
- The service did not always meet the needs of local people and the communities served.
- People could not always access the service when they needed it and sometimes had to wait longer than national targets for treatment.

However:

Our findings

- Staff completed their mandatory training in a timely manner. Staff understood how to protect patients from abuse, and managed safety well. The service had enough nursing staff to keep patients safe from avoidable harm. Staff kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and supported patients to make informed decisions about their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service took account of patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service identified relevant risks and issues and implemented timely actions to reduce their impact. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

We inspected the service with two inspectors, a medicines inspector and a specialist advisor.

During our inspection we visited the main theatres; a specialist plastics theatre; pre-operative assessments; the surgical assessment unit and 13 wards, including those with specialities in major trauma, vascular surgery, orthopaedics, general surgery and neurosurgery.

We spoke with 68 staff from a range of roles, including nurses, support workers, medical staff, ward managers, matrons, governance staff and senior leaders. A further interview with the senior leadership team was conducted off site following the inspection.

We also spoke with 9 patients and 2 relatives. We reviewed 5 patient records and attended a team handover/safety huddle and a bed meeting.

We reviewed policies and procedures and a range of data and other documents.

We previously inspected the surgery division at Preston Royal Hospital in 2019.

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They mainly managed medicines well. The service managed safety incidents well and learned lessons from them.

Our findings

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not always ensure that medicines with a minimum dosage interval were administered as prescribed.
- People could not always access the service when they needed it and waiting times for treatment were above the England average.

Maternity

We inspected the maternity service at Royal Preston Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions. We last carried out a comprehensive inspection of the maternity service in October 2018.

Royal Preston Hospital provides maternity services to the population of central Lancashire.

Royal Preston Hospital is 1 of 2 sites for maternity services for the trust. On site there was both an obstetric led unit as well as a midwifery led birthing unit. The obstetric led service had a delivery suite and two wards, ward A (antenatal care) and ward B (postnatal care), maternity theatres, antenatal clinic, maternity assessment suite which incorporated maternity triage and maternity day unit. The trust had approximately 4,125 deliveries per year across both sites.

Following our inspection and a review of trust data, we issued a letter of intent under section 31 of the Health and Social care Act 2008 to the trust. The letter of intent requested further information around waiting times and staffing within the maternity triage, delays within the induction of labour, as well as delays within reporting incidents and the grading of incidents. The trust responded quickly to the concerns raised and provided the required assurances.

We also inspected 1 other Maternity service run by Lancashire Teaching Hospitals NHS Foundation Trust. Our report is here:

Our findings

Chorley and South Ribble District General Hospital - https://www.cqc.org.uk/location/RXN01

The team that inspected the service comprised a CQC lead inspector, 2 other CQC inspectors and 4 specialist advisors including midwives and an obstetrician. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

We provided the service with 2 working days' notice of our inspection.

We visited the delivery suite, midwifery led birthing unit, maternity theatres, antenatal ward, postnatal ward and maternity assessment unit.

The inspection was carried out using a pre-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

During the inspection we spoke with staff including the divisional nursing and midwifery director, deputy director, and midwives. We reviewed records and spoke with women, birthing people and their families.

We received over 100 give feedback on care forms through our website. Feedback received indicated women and birthing people had mixed views about their experience. Feedback included about concerns about communication.

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

Our rating of this service went down. We rated it as requires improvement because:

- Staff training compliance for life support, compliance with life support training was below trust targets and medical staff was below the trust target for all training other than Cardiotocography (CTG) training.
- The service did not consistently report incidents to the National Learning and Reporting System (NRLS) in a timely manner.
- Not all staff felt that were listened to by senior leaders when highlighting concerns around staffing.
- The service reported women had experience long delays in the induction of labour and not all reasons for the delays were documented.
- Audits showed compliance with hourly CTG reviews continued to not meet the trust target of 85%.
- From November 2022 to May 2023 data showed there was a declining performance in relation to the time taken from making the decision to carry out a category 1 (urgent) caesarean section to delivery in line with clinical guidance.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment. and all staff were committed to improving services continually.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills. Staff met the compliance rates for mandatory training but did not always complete the training specific to their roles in a timely manner.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules consisted of the following:

- Conflict resolution
- Equality, diversity, and human rights
- Fire safety
- Fraud and bribery in the NHS
- Health, safety, and welfare
- Infection prevention control (level 1 and level 2)
- Moving and handling (level 1 and level 2)
- Patient safety for all staff
- Patient safety board and senior leadership teams

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were accountable for keeping up to date with mandatory training and any gaps would be reviewed during their yearly appraisals.

The trust target for the mandatory training modules listed above was 90%, nursing staff had a completion rate of 97%, 'other staff' including support staff had a completion rate of 97% and 89% of medical staff had completed the training.

The trust had updated the medicines management module and included another training module called 'Speak Up' in May 2023. A 3-month grace period had been provided for staff to build compliance.

Non mandatory training was offered to staff on the division. This included training for end-of-life care, blood transfusions and the aseptic non touch technique.

Although staff told us they did not have time to complete training during scheduled shifts, the trust provided the opportunity for training to be completed as overtime.

The division had practice-based educators who had good insight into the challenges staff faced and had plans to resolve them. They provided development opportunities for international nurses and other nurses wishing to progress their career. They had also arranged additional training courses for some staff on the Acute Assessment Unit (AAU) who had recently moved from another area of the hospital and lacked acute experience.

The trust was unable to provide data for the Oliver McGowan Learning Disability E – learning as this was not yet available to staff but there were plans to provide this. The Oliver McGowan Learning Disability E Learning training should have been available to staff sooner, as from 1 July 2022, all CQC-registered health and social care providers had to make sure their staff received training on learning disabilities and autism appropriate to their role.

Nursing and medical staff did not always keep up with the resuscitation training. Medical staff on the division had a compliance rate of 78% for level 2 adult basic life support and paediatric basic life support whilst nursing staff had a 65% compliance rate for intermediate life support training.

Nurse and medical staff completed training in the recognition and treatment of sepsis. The trust target of 90% compliance was exceeded by the nursing staff (92%) but not achieved by medical staff (54%).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Medical staff did not always meet the compliance target for safeguarding training.

The trust had safeguarding policies for safeguarding children and young people and safeguarding adults which incorporated the PREVENT procedure (government counter terrorism strategy which aims to stop people becoming terrorists or supporting terrorism). The policy had arrangements in place to safeguard women or children with, or at risk of Female Genital Mutilation (FGM). The policies included information to support staff to protect patients from abuse. These were available on the trust intranet.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of the safeguarding leads within the service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us they could speak with the ward manager, the co-ordinator, the safeguarding lead, or the matron for support. They knew how to access the reporting system and report safeguarding incidents when they arose.

The trust had an established safeguarding team, with named doctors and named nurses as safeguarding leads for children and adults. Staff told us the safeguarding team were visible and accessible.

Safeguarding training on how to recognise and report abuse was mandatory for all staff. There was an expectation that staff in clinical areas would have level 1 and 2 for safeguarding adults and children. The courses included some classroom-based training. Managers above ward manager level were expected to undertake safeguarding courses to level 3. Safeguarding training covered the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS).

Nursing staff exceeded the trust's target compliance rate of 90% for the training. Safeguarding training compliance for level 2 safeguarding adults training was 99% and for level 3, 98%. Nursing staff's compliance for level 2 safeguarding children was 99%. However, medical staff did not always achieve the 90% target, 82% of medical staff had completed level 3 safeguarding adults training and 89% had completed level 2 safeguarding children training.

The trust provided 'PREVENT duty training' (a course that teaches about radicalisation, extremism and terrorism and concerning behaviours to look out for) as a stand-alone course. The overall compliance for staff on the division of medicine was 98% for the basic awareness module and 96% for the follow up module.

Safeguarding information was displayed on notice boards throughout the hospital.

Staff followed safety procedures for children who may be situated on the division or visiting the wards. Matrons completed daily reviews of 16- and 17-year-old patients who were based on the adult medical wards. The safeguarding leads had daily reviews with these patients and escalated concerns appropriately.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Leaders did not always equip staff with the equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

The leaders did not always support staff to follow infection control procedures. We did not see the 5 stages of hand washing posters situated above hand wash sinks. These posters act as a reminder to staff to wash their hands in line with the world health organisation's (WHO) guidance. The trust's infection prevention control (IPC) team had identified that there were not enough hand sanitising stations located on the Acute Assessment Unit (AAU) but had plans to resolve this. Despite this, the division were audited monthly for hand hygiene compliance and had achieved above the target of 94.4% between February and May 2023.

All wards had privacy curtains around patient bed spaces. At Fell View (a step-down facility on the Preston site), we found curtains that were labelled with a date from last year (9/11/22). This was not in line with the provider's policy and best practice guidelines.

We saw out of date information posters on ward 19 telling patients what to wear regarding COVID – 19. We raised this with staff who told us this information was out of date and removed it soon afterwards.

The trust had an internal accreditation process for wards/divisions called the safety triangulation accreditation review (STAR). The division achieved 83% compliance for the environmental STAR assurance audit for May 2023 against the trust target of 95%. Actions were identified and included daily spot checks for hand hygiene and personal protective equipment (PPE) compliance, maintaining a clutter free environment and regular infection control education sessions.

Following our inspection, the service provided information around infection rates. We received data from April 2022 to May 2023 which showed the division had reported 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA). However, In February 2023, the trust was ranked highest of the major trusts in the Northwest in terms of Clostridium difficile (a bacterium in the gut that can cause mild to severe diarrhoea) incidences. The medical division had 110 cases of healthcare associated Clostridium difficile between 2022 and 2023. Patients with Clostridium difficile were reviewed on a case-by-case basis. The infection prevention and control committee identified lapses in care were the cause of 75% of the cases identified. The infection prevention and control annual report highlighted how the lapses in care will be

reviewed in the trust's Antimicrobial Management Group, the divisional infection prevention and control meetings and a review is due to be undertaken during meetings with the Clinical Commissioning Group (CCG). An action plan had been agreed. Actions included business cases for equipment to rapidly decontaminate the environment, more domestic resource and to maintain and potentially increase isolation capacity.

However, the trust monitored outbreaks of infections and had policies and procedures for staff to follow when patients tested positive. We reviewed the outbreak procedure which had adequate preventative measures and information for staff to follow to escalate patient cases.

All patients were screened for infectious diseases, such as MRSA when they arrived on the wards. Infectious patients were provided with individual side rooms to reduce the chance of transmission to other patients. We witnessed that the doors to the side rooms were closed on the wards we inspected.

Medical wards were visibly clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were housekeepers assigned to most wards.

We checked 10 pieces of equipment on various medical wards, and 8 had been labelled with 'I am clean' stickers to show they had been cleaned.

The endoscopy unit was compliant with the management and decontamination of flexible endoscopes standards. The unit's monthly decontamination audits had been completed.

Staff followed infection control principles including the use of PPE. We observed staff wearing the correct PPE and washing their hands between patient contact. There were adequate amounts of PPE available. An audit of PPE compliance was completed monthly. The division scored above 90% compliance between January and April but were between 80% and 85% for May 2023.

The trust completed surveillance of their water treatment system. An external audit took place in January 2023 which tested the water treatment system and they passed with 100% compliance.

Nursing staff had a 96% compliance rate for level 2 infection prevention and control training. Medical staff had a 94% compliance rate for level 1 infection prevention and control training and 83% were compliant for level 2. The trust target was 90%.

Environment and equipment

The design of the premises and the environment did not always keep people safe. However, staff were trained to use equipment, it was maintained well, and they managed clinical waste effectively.

The design of the environment did not always follow national guidance. There was 1 shower situated on the Acute Frailty Unit (AFU)) and Acute Assessment Unit (AAU). The 2 wards were mixed gender wards. Patients using services should have access to segregated showering facilities to maintain their dignity and respect. The AAU did not have any side rooms for patients with infectious diseases and therefore tents were used when a patient had an infectious disease to reduce the chance of transmission. On 2 of the bays, this was not possible as they were too small and therefore patients were moved to larger bays or different wards. Several wards had bays and side rooms which were not visible from the nurse's station. Staff told us that bay nursing was used for increased observations of patients and some of the wards such as the hyper acute stroke unit and respiratory unit had specialist equipment that allowed for remote monitoring.

On the AAU there was no door to the ward which meant patients could potentially abscond. The flooring on the AAU was damaged in patient areas including on entry to the patient toilet and on entry to the bay. Senior staff explained that one of the main risks for the AAU was falls and the environmental issues were a contributing factor. The AAU was in its infancy and a business plan had been approved for improvements to be made to the estate. In July 2023, following the inspection, substantive floor repairs to the AAU were completed.

We observed a corridor between the medical assessment unit (MAU) and the stroke unit that had been blocked with chairs and a metal cage with laundry in. In the case of an emergency, this posed an evacuation risk.

Staff told us the shower on the AAU department flooded each time it was used and a shower on ward 17 had not been working for the last 2 weeks. There was not a patient toilet on the coronary care unit, however the CCU was in the middle of a larger ward which had a patient toilet. . We observed poor maintenance of wheelchairs on the stroke unit.

Medical staff told us that the department had leaks in the roof which was causing hot water to pour into certain areas, although we did not see this on the inspection.

Patients could reach call bells and staff responded quickly when called. Between April 2023 and May 2023, the medicine division was 91% compliant with nurse call systems. However, 2 call bells on the stroke unit were not working and the call bells on the AAU were temporary and not fixed into the wall. The system had not been embedded due to the ward being newly established and was still connected to the urgent and emergency care department (previously COVID resus). Staff were therefore responsible for responding to urgent and emergency care call bells which took time away from caring for patients on the AAU. The call bell in the shower on the AFU was broken which restricted the use of the shower unless the patient was supported by a member of staff. Environmental risks were identified on the divisions risk register meaning that leaders had oversight of them.

The service did not always have facilities to meet the needs of patients' families. Some wards that we visited did not have rooms for relatives or for breaking bad news to patients.

The medical wards had a clean and dirty utility room. The clean utility rooms were used to store medicines and medical equipment and had a lockable door which had a pass code. The dirty utility was used for the disposal of clinical waste, almost every dirty utility was clean and well organised.

There were clearly signposted fire exits on all the wards we inspected. The wards had evacuation slides and chairs to move patients in an emergency. Each ward had fire extinguishers which had been serviced in the last 12 months.

Staff carried out daily safety checks of specialist equipment. There were resuscitation trolleys on all the medical wards we visited. Each trolley had a suction unit and a defibrillator which had been serviced within the last 12 months. We observed that oxygen cylinders on each trolley were full. However, on ward 19 we found forceps that had passed their expiry date. This was escalated and replaced at the time of our inspection. Emergency trolleys were securely tagged so that staff knew when the trolley had been last opened and if it had been replenished correctly. We reviewed audits for emergency equipment for the division and found they had met or exceeded 90% between February and May 2023.

The division had over a 90% compliance rate between February and May 2023 for completing daily checks of clean utility temperatures, fridge temperatures and intravenous (IV) fluid storage temperatures.

The service had enough suitable equipment to help them to safely care for patients. When new equipment was introduced, medical engineers trained staff before them being able to use it. We saw that there was adequate stock, and a process of regular review was in place to ensure that patient consumable equipment was within their expiry date.

We checked 10 items of equipment, and all had been safety checked. This had been completed by the estates department.

We observed that items with the potential to be hazardous to health (COSHH) were locked away securely. The division had scored an average of 87.5% for COSHH compliance between April 2022 and March 2023.

We observed that waste was managed appropriately by staff. Audits for appropriate management of waste had been 100% for the division between January and April 2023, however in May was 82%.

Assessing and responding to patient risk

Staff did not always identify and quickly act upon patients at risk of deterioration. Staff did not always have the resources to support patient's needs. Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff did not always identify and quickly respond to patients at risk of deterioration. Staff used the nationally recognised early warning scoring (NEWS2) tool to identify deteriorating patients. Despite staff having a good knowledge of the NEWS2 tool and 89% of nurses having completed the NEWS2 optional training module we reviewed an audit completed between January and March 2023 that showed that 12 out of 32 sets of observations had been recorded incorrectly.

The trust had a sepsis pathway which was in accordance with the United Kingdom's Sepsis Trust guidelines. There was a sepsis lead nurse and a consultant for the organisation who provided training to the "sepsis champions" on the division. The sepsis leads and champions shared information around best practice about sepsis. We reviewed data from the last quarter of 2022. Staff provided antimicrobials within 1 hour of a suspected sepsis diagnosis to 78% of patients and 82% of patients within 90 minutes. New national guidance which now takes into consideration the time a patient deteriorates, instead of a suspected sepsis diagnosis has been introduced meaning the data from the last quarter of 2022 now shows that 58% of patients received antimicrobials within an hour. The trust had identified this fall in performance and had implemented actions including an electronic dashboard with the aim of identifying and escalating patients quicker based on their NEWS2 score and further sepsis education delivered by the sepsis lead nurse.

Staff did not always have the resources to support patients when they were at risk of deteriorating. Staff were not able to support patients who required thrombectomies (a type of surgery to remove a blood clot from inside an artery or vein) at weekends, despite being commissioned to do so, which had led to 8 incidents of severe harm between March 2021 and December 2022. There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7 – day week.

Patients were not always reviewed by senior decision makers in a timely manner. We saw evidence from the Same Day Emergency Care (SDEC) Unit which showed between December 2022 and February 2023 that an average of 42% of patients had been reviewed every 24 hours by a senior decision maker compared to the trusts 90% target. In the same time period, an average of 82% of patients had a clinical assessment by a consultant within 14 hours compared to the trust's target of 90%. However, staff did have access to out of hours consultants, registrars, and junior doctors if they had urgent concerns regarding patients.

Medical care (including older people's care)

Enhanced patient observations or 1 to 1 nursing was used for patients who were at risk of falls but were being cared for in side rooms, however staff told us that due to health care assistant shortages 1 to 1 nursing could not always be guaranteed.

Some staff told us they had concerns regarding the competency of staff on the AAU. They explained that many of the staff had been redeployed from a general medical unit and did not have experience in acute medicine. Four training days had been arranged by the practice educator for the division including acute internal medicine training (AIMS) and intermediate life support (ILS).

Staff told us how they felt unequipped to manage certain patients' mental health needs and the number of patients with mental health needs and eating disorders entering the division was causing staff to feel "burned out." These risks were identified on the divisions risk register. Leaders for the division acknowledged that some patients with mental health needs were not being assessed daily by psychiatrists due to the demand and lack of resources but were assured there was appropriate support available from the safeguarding team and mental health leads. The trust had provided a training package so staff could complete a mental health risk scoring tool with patients before they were assessed by the mental health liaison service. The completion rate for the mental health risk identification and management tool for the division was 92%. The trust was working closely with the mental health trust through improvement groups to manage these risks.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Updates to risk assessments due for each patient were detailed on the handover document for each patient. Risk assessments carried out included risk of pressure ulcers, malnutrition, and falls. There were nursing assessments for each patient that included hygiene, cannulas, and physiological observations. During the inspection, we reviewed patients' risk assessment processes and management. The care provided was safe and appropriate with most documentation being detailed, and outcomes recorded in a timely manner.

Stroke clinical nurse specialists provided 24-hour cover for the emergency department. They administered thrombolysis (a clot busting drug) to patients who had suffered ischemic strokes. The imaging department kept 4 transient ischemic attack slots for magnetic resonance imaging (MRI) and 2 doppler ultrasound scan slots open for emergencies.

The division had access to the critical outreach team 24 hours per day should a patient suddenly require emergency intervention.

On the endoscopy unit, staff had a gastrointestinal endoscopy checklist that they followed when the patient signed in, before them being administered medication and when the patient was leaving the procedural area.

Staff were able to inform us of patients on the ward with identified risks, such as vulnerability and existing pressure sores.

Staff had a good understanding of how to resolve conflicts and the compliance rate for conflict resolution training was 90%.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Medical care (including older people's care)

The overall staffing fill rate for adult inpatient wards in April 2023 was 92%. We reviewed the staff fill rate for 10 of the wards on the medical division. We found that 9 out of the 10 wards had a fill rate of over 80%. For example, the AFU had a 98% fill rate for registered and unregistered staff for the day shift. The fill rate was 90% for registered nurses and 101% for unregistered staff for the night shift. Ward 24 had over a 100% fill rate for registered and unregistered staff on the night shift. The AAU was the only outlier from the 10 wards we reviewed. The fill rate was 74% for unregistered nurses for day shifts and 77% for both registered and unregistered staff for the night shift.

The leaders of the division told us they were fully established for registered nurses due to an international recruitment programme which had reduced nurse vacancies from 350 whole time equivalent to 0 whole time equivalent on the division.

The trust had a 12.3% vacancy rate for band 2 and band 3 health care assistants (HCA). According to leaders, the medical division had 120 health care assistant positions that were vacant. 45 of these positions had been recruited to and staff were currently in training. This vacancy rate had improved since March 2023 when there were 250 vacancies. Staff on ward 17 (elderly ward) expressed concern about enhanced care being difficult to maintain due to the shortage of HCA's. However, leaders told us that the HCA vacancy rate was mitigated by an over establishment of registered nurses, who whilst in training and awaiting registration would support 1 to 1 care provision. This was evidenced by 14 of the 24 medical wards being over established. The leaders of the division were recruiting more HCA's as part of their workforce plan (people plan).

Managers attempted to accurately calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used an electronic system called "safe care." The system reviewed electronic rosters, staff working on that day and the acuity of patient's and was able to indicate "red flags" which included when there were less than 2 registered nurses on a ward during any shift.

Matrons reviewed the staffing levels at staffing meetings which occurred twice daily, in the morning and late afternoon.

Specialist areas such as the coronary care unit, the respiratory high care ward and stroke unit had the appropriate levels of staffing planned for patients. Leaders had changed staffing assessments to ensure these areas always had 2 senior nurses on shift.

Managers gave all new staff a full induction tailored to their role before they started work. The induction programme included the mandatory training staff needed to complete within the first month of working for the trust and key policies and procedures that staff had to familiarise themselves with.

We held focus groups following the inspection with clinical and non-clinical staff. Staff told us nurse staffing had become more robust, there was good cross divisional working and regular workforce reviews. However, they felt the skill mix on the medical wards needed resolving and agency and bank staff were used too regularly.

The medical division had a low but variable turnover rate for nursing staff between November 2022 and April 2023. It ranged from 0.84% (full time equivalent) to 0.33% (FTE). In April 2023, the turnover rate for nursing staff was 0.55%.

Shift changes and handovers included all necessary key information to keep patients safe. We attended nursing and medical handovers and observed them being well attended by staff, that all patients were discussed in detail (including their psychological needs) and the purpose and outcomes were clear.

The division had 2 occupational therapists and 4 physiotherapists. At the time of our inspection there were approximately 220 patients on the medical division. Leaders told us that there would be 2 further occupational therapists joining the team in due course.

Core therapy services were provided by the diagnostic support division. The physiotherapy vacancy rate was small. There were some challenges including the recruitment of occupational therapists, but the chief allied health professional was looking at innovative ways to resolve issues including proposals for different models of care which had gone to the board for approval.

The trust had an absence rate of 6.3% for March 2023 which was higher than the sector average (5.3%). The main reason for absence from work was anxiety, stress, depression, or other psychological symptoms. In April 2023, nursing staff had a 5.16% (FTE) absence rate, whilst AHP's had a 1.49% absence rate for the medical division.

Medical staffing

The service did not always have enough registered medical staff but used locum staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The leaders for the medical division told us one of their biggest risks was the shortage of medical staff on the division. They told us there were gaps in medical cover for the respiratory service and an insufficient amount of consultant cardiologists and registrars to meet the demands of the service. In the April 2023 workforce committee meeting minutes for the medicine division, it was reported there were 'almost 84' whole time equivalent medical vacancies for the division. The risk was reported on the risk register and the leaders were discussing with executives how they could change job plans and look to increase resources.

The division did not have enough neuro interventional radiographers to provide a 7-day thrombectomy service which had led to 8 severe incidents directly related. The division had recently employed 1 member of staff and were awaiting another to return to work following parental leave. The division had plans to offer a 7-day thrombectomy service from September 2023.

The vacancy rates in March 2023 for junior clinical fellows was 29%, senior clinical fellows 26%, consultants 14% and Speciality and Specialist (SAS) doctors 16%. We were told there was 7 vacancies on the elderly medical ward and 5 vacancies on the respiratory ward which included 3 consultants and 2 senior clinical fellows.

The division had low turnover rates for medical staff. In March 2023, the turnover rate was 1.04% and in April 2023 it was 1.31%.

The division had low and reducing rates of sickness rates for medical staff. In April 2023, the sickness rate was 1.96%.

Managers made sure locums had a full induction to the service before they started work.

Staff told us that trainee doctors working on the MAU were missing valuable training opportunities as they were covering the MAU and AAU.

Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment and records and were clear, easily available to all staff providing care and up to date. Records were not always stored securely.

Patients' notes were updated by nursing staff through an electronic patient record (EPR). Staff we spoke to told us the system was easy to use, and they had been sufficiently trained.

The EPR system was username and password protected. We observed staff locking computers when they were not being used.

Most patient records were stored online. On most wards, sophisticated systems were in place which ensured data was easily accessible for staff. However, on the AAU, staff told us they used paper-based assessments which they said was time consuming as they had to be scanned onto the EPR system.

Patients' observational charts and intentional rounding tools were completed in line with trust policy.

Patients identified with a dementia, a learning disability, autism, or a physical disability were identified in the clinical electronic records using a flag. The flag indicated that reasonable adjustments were needed which ensured that the patient's care was not compromised due to their cognitive or functioning impairment.

We reviewed the records of 15 patients across the medical inpatient wards. Records were completed appropriately and included the relevant assessments and observations. Staff recorded risk assessments that had been completed when a patient was admitted to a ward and the EPR system would then alert them when they needed to be repeated. However, audit results for the division from both sites for risk assessments and care plans being completed was under 80% between February and May 2023 and below 70% for intentional rounding documentation (process that nurses follow to carry out regular checks) in the same time period.

Patient records were not always stored securely, we saw 2 patient records outside side rooms on ward 20 and a letter containing confidential details regarding a patient at an unmanned reception desk on ward 23. The division was audited for storing notes safely and had scored 83.2% for April 2023 and May 2023 compared to the trusts target of 90%.

Medicines

Staff did not always follow systems and processes to prescribe and administer medicines safely.

Staff followed systems and processes to prescribe and administer medicines safely. The service had electronic prescribing and medicine administration (ePMA). We found medicines were prescribed safely. The trusts medicine safety improvement work had resulted in a reduction in the number of missed doses of critical medicines.

Audit results showed the missed doses had reduced from 4.20% December 2022 to 2% in April 2023. However, we saw evidence of medicines not always being administered as prescribed. We found 1 person was prescribed antimicrobials for an infection however they did not receive the first dose of their medicine for 4 hours. We saw another person did not get their once weekly medicine for osteoporosis. We also found a person who was prescribed a medicine with a minimum time interval between repeated doses, was given repeated doses of their medicine too close together. This placed the person at risk of unnecessary overdose.

We raised this with the nursing staff during the inspection so steps could be taken to address this. The trust had a self-administration policy, however the medicines included in the policy were limited and did not promote and support people to self-administer their medicines. We found one person was self-administering one of their medicines that was not included in the trust's policy.

We found people's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine they had previously reacted to. Information provided by the trust showed staff reported medicine related incidents and near misses. The Medication Safety Team review and monitor types, trends, and rates of errors.

Staff stored and managed all medicines and prescribing documents safely. We found medicines were stored safely and securely. Medicines were available to staff out of hours and an on-call rota for pharmacy staff was in place to provide pharmacy support. The pharmacy team attended the wards at regular intervals to ensure stock was appropriately managed and checked medicine expiry dates. We randomly checked expiry dates of medicines and found no issues. However, information provided by the trust showed poor compliance with the trust's medication safety audit at 79.4% in March 2023 identifying as red, with the green target at 90.1%. The service had been within the red or amber results in the previous 4 months. The trust pharmacy had plans to roll out rapid improvement cycles focuses on medicines safety, targeted toward areas with poor compliance.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff were present on several wards to review and reconcile people's medicines to ensure the medicines they were prescribed were correct (50% Medicines Histories, 34% Medicines Reconciliation completed in 24hours, trust data May 2023). This meant there was a risk people may not be prescribed all their medicines as they had not had a medicines reconciliation within 24 hours of admission (National Institute for Care Excellence Guidance NG5). This was linked to pressures within the pharmacy department, with the trust confirming they had an approximate 40% vacancy rate of some pharmacist roles and approximately 30% of pharmacy technician roles in the year to March 2023. A number of these vacancies had been recruited to, commencing in Q2/Q3 2023.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We found 2 people on the medical wards were prescribed a medicine to control their behaviour. We found the documentation to support the reasoning for doses being administered were not always thorough and clear. However, clinical staff had requested the support of the mental health team for 1 person.

The trust was developing a policy to support staff to safely prescribe, administer medicines and monitor people with acute and severe agitation. Staff will receive training following the development and implementation of the new policy.

Incidents

The service mainly managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had an incident reporting policy which was up to date at the time of the inspection. Most staff knew what incidents to report and how to report them. When staff completed an incident report on the trusts electronic reporting system it was then reviewed by the ward manager or sister. However, on the inspection we became aware of a medication incident in which a patient had not been provided with vital medication for a condition and was self-administering it instead. This incident was not reported, we raised this with the matron for the ward who quickly resolved this.

Medical care (including older people's care)

The medical division had reported 8906 incidents between 1 June 2022 and 30 May 2023. From those incidents 42 were reported as serious incidents. The 3 highest ranking categories for serious incidents were pressure ulcers (8), slips, trips, and falls (7) and sub optimal care of a deteriorating patient (6).

We saw evidence of incidents being discussed in committees and being escalated. The medical division reported 46 incidents of violence and aggression towards staff in May 2023. This was reviewed in the safety and quality committee in May 2023. Actions to identify the categories of abuser was suggested and the theme would be escalated to the health and safety governance committee.

We found an increased number of severe harm cases between 1 January and 31 March 2023. This was due to an incident panel review which had identified 8 cases of severe harm which related to the thrombectomy service not being available out of hours. We reviewed the investigation and found detailed explanations of the incidents, causes and proposed actions.

The medical division (including ED) had reported 3 'Never Events' in the last 12 months. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. These incidents were related to the emergency department, please see the emergency department report for more details.

The medical division reported 53 incidents relating to 'insufficient numbers of healthcare professionals' or 'insufficient numbers of support staff' between 1 December 2022 and 31 May 2023.

Ward managers shared incidents and findings with their staff through team meetings, team huddles and via group communication routes. Patient safety bulletins were published twice a week in line with the trust's 'Always Safety First' strategy and contained learning identified through the safety and learning group and updated staff on urgent safety bulletins. We reviewed the safety and quality committee meeting minutes from May 2023 which showed that lessons learned from the Never Events was discussed in a presentation format and shared on the trusts intranet page for staff to review.

Each ward had a governance board which staff, patients and visitors could observe on entering the ward or unit. Incidents was one of the topics on the board. Some areas such as the stroke unit had up to date incident information including patient falls, medication incidents and violence and aggression. In contrast, the AAU displayed 0 incidents despite the ward manager reporting there had been approximately 10 falls in May 2023.

On wards that had an increased number of hospital acquired pressure ulcers or falls we observed information boards specific to those areas that acted as a reminder for staff.

Staff understood the duty of candour. They were open and transparent and gave families a full explanation when things went wrong. Clinical meetings were held regularly to discuss incidents triggering duty of candour. Evidence from the trust showed that the medical division was over 90% compliant with the duty of candour for moderate and above incidents in February 2023. We reviewed evidence of letters apologising for treatment that patients had received whilst in hospital.

Most staff on the division had completed non mandatory training for serious investigations (83% medical staff, 82% nursing staff and 85% nurse support staff).

Medical care (including older people's care)

The trusts mortality meetings had been replaced by another process called a Structured Judgment Review (SJR). Reviews of SJR's were carried out monthly. We received data from April 2022 to March 2023 and saw the medical division had exceeded the trust target of completing 20% of reviews for deaths that had occurred.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed a list of current policies, procedures, and clinical guidelines that the trust sent us following our inspection and all the documents were in date. The trust had a process for renewing policies in line with their review date. The author and relevant manager were alerted 6 months before the review date and asked to review the content which ensured the document remained valid.

Staff had access to a range of evidence based clinical care pathways with relevant conditions. These included sepsis, atrial fibrillation, stroke, frailty, and inflammatory bowel disease. Patients with alcohol dependency were treated on the alcohol detoxification pathway. The service had a frailty pathway and a virtual ward facility for patients with complex care needs, this pathway reduced the length of stay of frail patients.

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

There was a sepsis standard operating procedure and flowcharts for staff to follow in case of suspected sepsis.

Patients receiving acute non-invasive ventilation (NIV) were treated in a designated respiratory ward in line with British Thoracic Society (BTS) quality standards for acute non-invasive ventilation in adults.

Nurses on the acute stroke unit, had been trained to use the National Institute of Health Stroke Score (NIHSS) which was used to evaluate the neurological status of acute stroke patients.

Specialist stroke consultants assessed patients who were thought to be having a stroke. Following the assessment, if a stroke had been confirmed they were put on to the stroke pathway.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

The division took part in national audits. See patient outcomes section of the report.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required. Staff asked for support from mental health liaison specialists when providing care and treatment for patients with mental ill health.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs. However, the Speech and Language Therapy service was not available 7 days a week.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection, we saw staff providing patients with food and drinks.

Staff fully and accurately completed patients' fluid charts when needed. A learning improvement group, which met monthly had been put in place following substandard fluid balance compliance scores in 2021. Since then, actions had been taken, such as updating the patients' electronic record to include a cumulative running total of fluid balance for staff to see. Since these actions had been embedded, records reporting patient output had been more accurate and between 85 to 90% for April and May 2023. Audits for eVital signs and fluid audits had also improved and were between 80 and 90% between February and May 2023.

Nutritional status boards were situated on the wards we visited. This included information about patients' dietary requirements including if they required soft food or were 'nil by mouth.'

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST). The MUST was a five-step screening tool which identified adults who were malnourished, at risk of malnourishment or at risk of obesity. If patients scored highly on the MUST they were referred to a dietician or the nutritional support team.

Patients had a good choice of food, including optional menus for patients who had specific dietetic or religious requirements. The division operated protected mealtimes to encourage patients to eat without interruption. We observed patients had access to water at their bed side. We observed patients being assisted to an upright sitting position to eat their meal during lunchtimes. Patients were helped to feed themselves or assisted appropriately if needed.

Specialist support from staff such as speech and language therapists were not always available. The speech and language team operated a 5-day service and did not work on Bank Holidays.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed and monitored patients regularly to see if they were in pain. Pain was assessed as part of the NEWS2 score. We reviewed 15 patient records and found that pain scores were recorded for all patients and that pain relief had been administered timely and appropriately.

Patients told us they were regularly asked whether they required pain relief and received it soon after requesting it.

The trust had pain assessment tools on the trust intranet for patients who could not communicate verbally.

The hospital had an inpatient pain team which included 4 specialist nurses and was led by a consultant with a special interest in acute pain.

Patient outcomes

Relevant national and local audits did not always show good outcomes for patients. However, the service did use the findings to make improvements and had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national and local audits. Out of 113 audits, 18 were classed as national mandatory audits, 6 national audits and 88 local audits. 28% of the audits had been completed. The audit results for the service were mixed and some had been impacted upon by the COVID – 19 pandemic. We did see evidence that managers used the results to improve patient outcomes.

The trust took part in the Myocardial Ischaemia National Audit Programme (MINAP) between 2020 and 2021. MINAP contains information about the care provided to patients who are admitted to hospital with acute coronary syndromes. The trust scored 64% which was below the national aggregate of 102% for case ascertainment (a metric which shows the proportion of eligible cases submitted to the audit), 73% for the proportion of patients receiving appropriate secondary prevention medications against the national standard of 80% and the national aggregate of 90% and 84% for the rate of referral to a cardiac rehabilitation programme following discharge compared to a national aggregate of 81% and a national target of 85%.

The care organisation had exceeded 3 out of 6 metrics for the 2021 National Heart Failure Audit but were below national targets for the other 3. The trust had implemented actions such as maintaining some of the heart failure nursing team who were redeployed during the Covid 19 pandemic to increase the number of patients who can be reviewed.

The respiratory department met 1 out of 5 (25%) of the key standards set out in the national adult asthma audit between 2020 and 2021. The administration of systemic steroids within 1 hour of arrival at hospital was 24% and respiratory reviews within 24 hours of arrival at hospital was 21%. One of the standards, regarding peak flow recordings was at 0%, this was due to it being stopped for IPC reasons during the COVID-19 pandemic. The division had ensured that peak flow rate was now available in the electronic recording system and there was a respiratory inreach team who reviewed the administration of steroids within 1 hour of arrival. The respiratory department also scored 98.6% regarding the prescription of oxygen on ward 23 and 100% for a DNACPR audit that was completed on 19 patient records.

The general medicine department were audited for blood culture collection in the treatment of sepsis patients. From 25 patients, 11 had ‘Blood culture’ in their initial medical plan (44%), 15 from the 25 had their blood cultures taken (60%) and 5 from 25 (20%) had their blood cultures taken before the first dose of antibiotics administration. The findings were presented at meetings across the relevant wards to raise awareness of the importance of blood cultures being completed.

The areas on the medical division were audited monthly, as part of the safety triangulation accreditation review (STAR). Within the division, 30 out of 35 clinical areas submitted their review for April 2023 and demonstrated 87% compliance for April 2023. Between February 2022 and February 2023, the division had not achieved the trusts target of 95% and had scored under 80% on 4 occasions. The MAU and the cardiac catheterisation laboratory required escalation to divisional leadership as they had scored under the expected range for 3 consecutive months.

Medical care (including older people's care)

The wards also took part in a ward accreditation scheme which was unannounced and undertaken by a member of the quality assurance team, governors, volunteers, and colleagues. The wards were assessed in various areas including the environment, documentation, infection prevention and control and listening to patients. Wards were graded from red, amber, or green depending on the level of assurance gained. Those rated red or amber achieved a bronze star, those who had achieved green were awarded a silver star and a gold star was given when there were 3 consecutive green ratings. In April 2023, 6 medical wards from the Royal Preston Hospital took part in the accreditation scheme and either maintained their score or improved it. Between April 2022 and February 2023, the division had an average of 58% of its wards and units rated silver or above, compared to the trust target of 75%.

Patient falls had been worse than the monthly target for the division for 17 of the past 20 months between October 2021 and May 2023. A falls 'Big Room' had commenced to look at ways to reduce incidents. Progress was monitored via the Divisional Always Safety-First meetings.

Pressure ulcers had been worse than the monthly target for the division for the last 18 months between December 2022 and May 2023. The division had a plan to reduce pressure ulcers by 10%. The target between April 2022 and April 2023 was 343. We reviewed data between April 2022 and February 2023 and found there had been 541. Pressure ulcer reduction and improvement was included as part of the Always Safety-First Improvement Programme.

The Sentinel Stroke National Audit Programme (SSNAP) data showed that, overall, The Royal Preston Hospital achieved grade B between Jan and March 2023 which had improved from April 2022 when they had an overall rating of D. SSNAP scores range from A (best) to E (worst).

The stroke team had implemented several initiatives which improved the rating including recruitment to core therapy services, speech, and language therapy and to nurse consultants. They had implemented an internal SSNAP dashboard which allowed the team to monitor progress in real time and a daily multi – disciplinary board round which included the community team on the acute stroke unit. These improvements had positively impacted upon some of the individual SSNAP domains including thrombolysis, occupational therapy, physiotherapy, speech and language therapy and multi-disciplinary team working.

The care organisation recognised that the 'stroke unit' domain was consistently scored as E. This domain showed how 38% of patients were directly admitted to the stroke unit within 4 hours, that the median time for a patient to arrive on the stroke unit after the clock had started was 6 and a half hours and that 76% of patients spent 90% of their stay on the stroke unit. Although the care organisation had made improvements from April 2022 to March 2023, they consistently achieved an E rating for this domain. The division and trusts risk register had the SSNAP data recorded as a risk and actions were in place.

The endoscopy service had completed monthly audits which ensured they were compliant with 6 World Health Organisation (WHO) checklists including when the patient signed in and signed out. They scored a mean average of 97.88% for compliance with the checklists and actions had been identified to improve performance.

The trust had introduced an initiative which had reduced waiting times on gastroenterology from 72 hours to 33 hours (a 54% reduction).

Venous Thromboembolism (VTE) Prophylaxis prescribing for out of hours acute admissions was at 100%.

Medical care (including older people's care)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. From the division, 96% of medical staff, 91% of nursing staff and 89% of the supporting staff had completed their appraisal. The overall compliance rate was 90%. During our focus groups, following the inspection, most staff groups spoke positively about the appraisal process.

Managers provided examples of instances in which they had identified poor staff performance promptly and supported staff to improve. They told us they would involve their matrons, seek support from human resources when required and look to support the member of staff through various means including increasing the period of supernumerary status (not counted as part of the workforce whilst they are learning or on placement in a clinical setting) for those who were training.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. For example, the band 5 and band 6 nurses had monthly 1:1's with their matron and the nurses on the stroke ward received clinical supervision twice a month. However, from the focus groups completed following the inspection, staff had mixed responses regarding whether they felt supported to develop in their roles. They told us how it was dependent on the ward manager and the areas of the medicine division that they worked on.

Managers made sure that temporary staff, including bank and agency staff had access to an information pack on every ward which provided them with the appropriate processes to complete their roles competently.

Managers ensured that staff received specialist training for their role. All 9 stroke clinical nurse specialists, who provided 24-hour cover to administer thrombolysis, had completed an advanced thrombolysis module within their supernumerary period. All band 3 to band 7 nurses and care assistants had completed face to face or e learning for recording electrocardiograms (ECG's). The sepsis pathway, including the "sepsis six" was included as part of the newly qualified nurse's preceptorship (a structured period for newly qualified staff when they start their employment in the NHS).

However, the overall compliance rate for non-invasive ventilation (NIV) competency assessments was 41%. We were told that this was due to an increased number of new starters, including internationally recruited nurses who were about to complete their preceptorship period. The unit had been provided with 2 ward managers to help increase the compliance rate by October 2023. Band 6 nurses, who were 88% compliant for the NIV competency assessments were rostered on to each shift.

The clinical educators were available for staff to support them in achieving competencies or training goals. They maintained records of role specific training for staff, for example, dementia awareness training, pressure ulcer training and diabetes training. Staff we spoke with said they had good access to the clinical educators and felt supported.

We saw there was a wide range of specialist nurses, for example the pain management team, infection control team, palliative care team, diabetes nurses, safeguarding and dementia leads, who supported staff in ensuring they were delivering competent care. Staff told us they valued the input of these teams who were proactive at team meetings and on the wards.

Medical care (including older people's care)

Some doctors from the focus groups that we completed told us there was a lack of support for junior doctors within the medicine division. They explained this was due to consultants being asked to do more than expected and them not getting the training opportunities due to overcrowding and service demand.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked closely with social care organisations and community healthcare services when planning discharges of patients with complex needs. Staff could refer to a dedicated discharge team if required. We reviewed discharge letters which contained appropriate clinical information about patients' hospital stay, which were shared with the general practitioner.

We were told about and saw various example of staff working well as a team across the division. We saw positive interactions between staff, including senior staff and students. Doctors told us that microbiology and the infectious disease team supported them well regarding the sepsis pathway and the in-reach service was excellent. The stroke unit told us how they worked closely with the local ambulance trust to provide timely care to stroke patients. The enhanced high care unit worked closely with non-medical consultant practitioners from the trust specialist ventilation team.

Staff had regular multidisciplinary meetings to discuss patients. Board rounds took place daily which included all members of the multidisciplinary team (MDT) such as occupational therapists, physiotherapists, nursing, and medical staff. On the medical assessment unit handovers occurred at key points during the day. These included nursing to nursing team handovers, pre-ward round handover, a post ward round multidisciplinary handover and an afternoon wrap around handover focusing on any cases of concern. We observed handovers of patients and found them to be well attended, clear and concise, with appropriate discussion of the holistic needs of each patient.

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. Leaders recognised the mental health service was under pressure currently and as such were working with the mental health trust to improve processes. The trust had recently provided the local mental health trust access to the electronic patient record system which allowed them better access to assessments, risks, and plans for medication and supported the delivery of timely patient care.

Consultants reviewed patients to ensure their care and treatment was effective. Records showed that patients treatment plans were co-ordinated to support their individual needs.

Some staff voiced concerns regarding the medical outlier teams not always sharing the outcomes from consultations with patients on their wards. Staff explained that they would be expected to read the patients notes for updates instead of being given a summary verbally.

Seven-day services

Not all key services were available 7 days a week.

The division had systems to help care for patients in need of additional support or specialist intervention, but these services were not always available 7 days a week. The trust provided a dedicated stroke service to patients for Lancashire and South Cumbria and saw on average between 3 – 5 suspected or confirmed acute stroke admissions per

day, however the Thrombectomy service which was commissioned to be delivered over 7 days from 8am – 6pm was only available from Monday to Friday between those times due to workforce limitations. There were plans in place to be able to operate the fully commissioned hours from September 2023. A business case was being undertaken to extend the service to 11.00pm over the 7 – day week.

Consultants led daily ward rounds on all wards, but this did not include the weekends, meaning they did not meet the NHS services, 7-day services clinical priority standards for time to first consultant review. A consultant review could be requested for patients that required one via an electronic system which staff had access to. Out of hours, staff could contact a senior house officer (junior doctor) or a registrar (a doctor in the middle of their training) if they needed support. There was also a consultant on call 24 hours a day.

On the stroke unit, telemedicine was in place so that patients could be reviewed out of hours, additionally consultants could access patient scans remotely out of hours.

Staff could call for support from mental health services, discharge facilitators and diagnostic tests, 24 hours a day, seven days a week.

The physiotherapy team worked 6 days a week and the speech and language and palliative care team worked 5 days a week. The occupational therapy team had a limited service at the weekend and prioritised discharges.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The division had information promoting healthy lifestyles and support on the wards/units including information leaflets on smoking cessation, diabetes, and coronary heart disease.

Staff assessed patients' health when admitted and gave support to them to live healthier lifestyles.

Patients with a history of drug or alcohol abuse were referred to the alcohol and drug liaison team, which provided support to the patient and liaised with community services regarding ongoing support on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients were risk assessed with regards to their mental capacity and deprivation of liberty safeguards (DoLS). Staff who assessed patients as lacking capacity would then make a referral to the safeguarding team who carried out a more detailed mental capacity assessment.

We reviewed 3 do not attempt cardiopulmonary resuscitation (DNACPR) forms during our inspection. The forms included why the DNACPR had been put in place, whether a discussion had been held with the patient and the clinician and if this had been communicated with a family member. All were completed correctly, apart from 1 which had not recorded the discussion held with the patient which indicated whether they were aware of the decision. We reviewed an audit which reviewed the DNACPR decisions and found that staff on the medical division had achieved or exceeded the target of 90.3% between February 2023 and May 2023.

Medical care (including older people's care)

We observed several patients on the medical wards under a DoLS order. We found that the documentation had been completed correctly in all patient records that we reviewed.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They told us that they would speak with the safeguarding leads for the division if they needed support.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mandatory training for staff covered consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. MCA and DoLS was included in the safeguarding adults' modules that staff completed. See the safeguarding section of the report for compliance rates.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and took account of their individual needs.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw numerous examples of staff having positive interactions with staff, including a matron taking time out from a busy schedule to speak with a patient living with dementia.

We spoke with 15 patients who told us that staff treated them with kindness and respect. One patient said that staff were 'caring, friendly, devoted and attentive.'

During consultations with nursing or medical staff, curtains and doors were closed which ensured privacy for patients.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw examples of staff assisting patients who were distressed in an open setting. Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

Medical care (including older people's care)

We observed an interaction between a matron and a patient living with dementia. The matron, who was busy, ensured she took time out of her day to speak to the patient and attend to their needs.

Staff demonstrated empathy when having difficult conversations with patients and told us they would utilise private rooms (such as the relatives' rooms) when delivering bad news to patients or their relatives. The relative's room on ward 20 (care of the elderly) was also used for family to stay overnight if patients were receiving palliative care.

Patients or their relatives could be referred for access to psychological support if required. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement. The care organisation had a multi-faith chaplaincy service which was available for spiritual or religious support to patients of all faiths and beliefs.

We observed a 'treatment dog' on ward 20. We spoke with staff who told us they arranged regular visits as it was associated with a reduced state of anxiety for patients.

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their families shared their experience of the hospital via the friends and family test. Patients and families gave positive feedback about the service. between January and May 2023, the inpatient wards had consistently achieved over 85% which is the trusts expected percentage.

Staff supported patients to make informed decisions about their care. We spoke with 15 patients. Most patients, 12 out of 15 said that nursing and medical staff fully explained the care and treatment options which allowed them to make informed decisions. However, the further 3 patients told us they had to continuously ask for updates and when they were communicated with the information was provided too quickly.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people.

The services facilities and premises were not always appropriate for the services being delivered. The service did not always meet the needs of local people and the communities served.

The premises and facilities were not always appropriate for the services being delivered. There was pressure for beds on the division which included cardiorespiratory services were the demand was higher than the capacity that facilities could provide. This caused some patients to be based on nonmedical wards as outliers which meant that care was not

always being delivered to patients by the right ward speciality. The trust provided us with data which showed that medical reviews for medical outliers were not always completed, in May 2023, 23% of medical outlier reviews for the trust had not been completed. The risks regarding bed capacity were identified on the divisional and trust wide risk registers and the leaders were aware when we spoke with them.

The stroke unit no longer had a hyper acute stroke unit (a unit dedicated to monitoring and stabilising a patient newly diagnosed with a stroke), although there were plans to open this in June 2023, or a gymnasium for physiotherapy.

The showering facilities on the AAU, AFU and Ward 17 were either not in good working order or breached the mixed sex standard.

The division's ability to discharge patients was impacted upon due to challenges for the provision of care in the community. Wards had discharge coordinators whose role was to plan discharges and liaise with other bodies to ensure safe discharge. The trust also attempted to lessen the impact of the external difficulties with flow by introducing an acute assessment unit and by utilising the acute frailty unit and the same day emergency care (SDEC) unit. The SDEC had 20 beds which relieved pressure on other departments such as the emergency department when they could treat patients in a day. The division also had access to a 7 day discharge lounge.

Virtual wards across frailty, respiratory and SDEC focused on using digital support for patients at home during their recovery were in place.

The division had a step-down unit on site called Fell View for patients who were medically optimised but required support before them returning into the community. The trust had also opened a community health care hub at 'Finney House' for patients who no longer met the criteria to reside in an acute hospital but required support such as rehabilitation or a package of care before them returning into the community. Finney House offered individual rooms which were finely decorated for 64 patients. Finney House offered a library, cinema room and hairdressers which was available for patients.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Patient's individual needs were identified through comprehensive admission assessments which took into consideration patients physical needs, mental health needs and social needs.

Automatic doors were in place throughout the hospital which ensured access for patients and visitors using wheelchairs. There were enough lifts to all medical areas.

Staff did what they could to make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Patients with learning disabilities were supported by the learning disability lead nurse if required. Staff told us that patients with learning disabilities could also be supported more frequently by carers and loved ones under 'John's Campaign.' (This is a nationally recognised campaign which promotes the rights of people in hospital, who are living with dementia to be supported by their family carers).

The trust had dementia champions based on the divisions and offered dementia conferences for staff to attend. Patients living with dementia were highlighted on the medical wards via a blue forget me not flower next to their name on the main patient details board. We observed pledges by staff on different wards of how they would improve care for people living with a dementia diagnosis and artwork which encouraged people to see the person behind the diagnosis of dementia. China tea sets were available for some patients with dementia to make them feel more comfortable and there were open visiting times so they could be supported appropriately.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports which highlighted to staff any impairments and reasonable adjustments required to support them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a sensory loss. The division had activity boxes for partially sighted or blind patients.

The service had information leaflets available in languages spoken by the patients and local community and access to British Sign Language interpreters if needed.

Patients told us they were given a choice of food and drink to meet their cultural and religious preferences.

Chaplaincy facilities were available within the hospital to meet the needs of people with different faiths. These facilities were open to patients and visitors 24 hours a day and located near the entrance to the hospital for ease of access.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were sometimes worse than national standards.

Managers and staff worked to make sure patients did not stay longer than they needed to. The division had opened a 20 bedded acute assessment unit which had been running since March 2023. The unit was designed to reduce long waits in the urgent and emergency department and staff told us that this had helped. The unit was run by advanced clinical practitioners and had a different admission criterion than the SDEC. The AFU had 64 admissions in May 2023 and 74% had been discharged without admission to hospital. The SDEC had a standard operating procedure with the local ambulance trust in which some patients were taken directly to this ward instead of ED. On average, 6 patients per day were being taken directly to one of the assessment units and not through ED which meant patients got to the right speciality quicker.

The trust provided data for May 2023 that showed the average length of stay on most wards on the medical division including Fell view, Ward 21 and Ward 24 was shorter than the national average for elective and non-elective patients.

The average length of stay on the SDEC was half a day and on the MAU was 1.9 days, however over 80 patients had breached the 72-hour target on the MAU in March, April, and May 2023. We also saw evidence of a patient being on the AAU for 4 days, despite this being a 24 to 48-hour service.

Medical care (including older people's care)

Staff told us there are not enough beds on the medicine division and there were too many medical outliers (patients admitted to a ward that is not associated with their specific problem). At the time of the inspection, there were 21 medical outliers for the division**.** We observed the demand for patient beds on the division. We attended bed management meetings and heard that wards had reached and exceeded their capacity. Staff told us they had considered completing a thrombolysis procedure on the MAU on the 1st day of our inspection as there were no critical care beds available at the time. Although this did not go ahead, it emphasised the demand on the division. We also spoke to a ward manager on Ward 17 (care of the elderly) who had a patient on the ward who was awaiting a mental health bed and had been waiting just over a week.

The bed capacity for the respiratory high care ward (NIV) was full and therefore patients had to be situated on ICU (Intensive Care Unit) whilst they waited for a bed to become available. There were no 'ring fenced beds' (ensuring acute medical patients have access to surgical beds) for the stroke unit. Finney House, the step-down facility for patients who were medically optimised, was full on the day we inspected.

Staff said they tried to keep moving patients at night to a minimum, however there were times due to service demands that they needed to do this. Incident reports were completed if bed moves at night were completed. The division of medicine had moved 238 patients after 8pm in May 2023 which was an improvement in comparison to April (258) and March (301). From December 2022 to June 2023 there had been 1686 bed moves after 8pm. 1338 of the moves for both Preston and Chorley site have been due to capacity and flow site issues, 567 were due to patients needing a specialist ward and 178 were for a side room.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. They had 2 dedicated teams to review and treat medical outliers. However, medical reviews were not always completed.

The trust had developed their bed escalation and surge plan. It was used alongside the operational pressures escalation level (OPEL) actions cards to ensure all actions, in addition to the escalation of beds, was taking place as appropriate across all areas. (OPEL is a method used by the NHS to measure the stress, demand, and pressure a hospital is under.)

Managers and staff started planning each patient's discharge as early as possible. Staff, including discharge facilitators, planned patients' discharge carefully, particularly for those with complex mental health and social care needs. In handovers, huddles and bed meetings staff discussed patients ready to be discharged and referred to a gold, silver, and bronze system. A gold discharge referred to a patient being discharged before 10am, a silver was 10am onwards and a bronze was a patient who was ready for discharge but awaiting interventions.

The discharge lounge was open Monday to Friday 8am to 8pm and Saturday and Sunday from 8am until 6pm and had space for 20 patients. In April 2023, the discharge lounge discharged 806 patients compared to 554 patients the previous year. Since 2019 there has been a 50% uptake on patients attending the discharge lounge.

Managers monitored the number of patients whose discharge was delayed and knew which wards had the highest number. In May 2023 there were 46 patients who were deemed medically fit for discharge who could not leave the hospital safely. The main reasons were that patients were awaiting care homes, support from the local authority or awaiting joint care from the local authority and NHS. The amount of medically fit patients awaiting discharge had improved, in comparison to the previous 4 months. In April 2023 there were 80 patients who had spent 21 days or more in hospital (super stranded) for the medical division. This had increased from March 2023 but had decreased in comparison to January and February 2023.

The cancer specialities for the division of medicine were lung and neurology. In April and May 2023, the division performed better than its predicted trajectory for patients waiting 63 days or more following an urgent suspected lung cancer referral and for patients waiting for neurology following 65 weeks. Following the inspection, we received data which showed a continuous reduction of patients from the 65 week wait cohort awaiting their neurology appointments. Despite the division achieving the plan towards zero 65-week waiters for neurology by February 2024, the amount in May 2023 was considerable (3762).The division had implemented virtual wards which had helped people with care in their own home.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

From April 2022 to March 2023 the division of medicine (including ED) received 189 complaints which was better than their target of 264. From those complaints 7 had been upheld and 3 cases had gone to the Parliamentary and Health Service Ombudsman (PHSO).

As the medical division covers the emergency department, the main theme for complaints is the length of stay and delays. The trust had implemented actions such as the introduction of Finney House, which had led to almost a 7% reduction in patients who no longer meet the criteria to reside. Other actions will be described in the emergency department section of the report.

We reviewed a list of all complaints for the medical division that had been responded to in the last 6 months. The main themes from the complaints were poor staff attitude, failure to update the family regarding the patient and delays in patients receiving the appropriate treatment.

The division responded to 50% of complaints within 35 days in April 2023. In comparison, they responded to 95% of complaints within 35 days in April 2022. Leaders said this deterioration in performance was due to a period of restoration following the COVID – 19 pandemic in which most complaint responses had been paused. Meetings between the divisional governance team and Patient Advice and Liaison Service (PALS) team have been taking place to ensure oversight of the current position.

Patients, relatives, and carers knew how to complain or raise concerns. The service had a patient advice and liaison service (PALS) and displayed information in patient areas on how patients could make a complaint. Leaflets and posters provided advice on how to give feedback or raise a concern. We saw that on some of the notice boards on the wards they had a section with “you said, we did” where staff had actioned patients’ suggestions.

Staff understood the policy on complaints and knew how to handle them. They were aware of trying to resolve the complaint in the first instance before providing the patient or family member contact details for PALS. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Ward managers and matrons monitored complaints, identified themes, and fed back any learning to their staff.

We reviewed minutes for the last 3 months from the trusts weekly safety and learning group which included an agenda item where complaints were discussed. Learning from complaints was welcomed for discussion and appropriate actions for wider learning taken.

Medical care (including older people's care)

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. Leaders were visible and approachable in the service for patients and staff.

The leadership triumvirate for the division of medicine and emergency and urgent care consisted of a medical director, director of nursing and a director of operations. The triumvirate team had experience in their roles and had worked for the trust for several years. The divisional leadership team oversaw the accident and emergency department and medicine at the Royal Preston Hospital and a further care organisation within the trust.

Nursing leadership was provided at a ward level by a team of charge nurses and matrons who led and supported staff during their daily activities. Staff working at charge nurse level and above were supernumerary and were not counted in ward staffing numbers, however, some charge nurses informed us that if there was an urgent shortage of staff, they would support the ward.

Leaders told us that the main challenges to quality and sustainability for the division were safely maintaining the flow of patients, the workforce and retaining staff, and sizing the environment appropriately following the COVID19 pandemic and the Sentinental Stroke National Audit Programme (SSNAP) compliance. Leaders were knowledgeable about the actions to address these concerns, some of which were longer term, and some were impacted by financial limitations.

Most staff told us that opportunities for career development had improved but this was dependent on the role and department they worked in. Staff were supported to develop and progress into leadership roles as part of succession planning. Staff had access to leadership programmes provided by the NHS Leadership Academy. The trust also offered ward managers leadership and coaching training via a coaching academy.

Ward managers had regular contact with the matrons, sometimes twice daily. We saw evidence of close working relationships between ward managers and matrons.

Most staff told us they were supported and valued by leaders, and they were proud of the work that they did. We saw strong clinical leadership from the ward managers, lead nurses and matrons. During the inspection we saw the director of nursing on the medical wards and found they had a good rapport with staff. However, some staff told us on some wards there was a culture of silo working and how they did not feel listened to by executives regarding issues on the division, including ongoing estate problems due to financial restraints.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Medical care (including older people's care)

The trusts clinical strategy, which was developed in collaboration with staff, people who use services and external partners was called “Our Big Plan.” The mission was to provide excellent healthcare to local communities, to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria and to drive innovation through world class education, training, and research.

The vision and strategy for the division was to enable staff to exceed local and national targets with care and compassion. The vision and strategy had 6 objectives/priorities which were to provide safe care and offer a good patient experience, to respond to COVID-19 concerns, to deliver more elective care and reduce the backlog, to support the patient pathways and ensure the right sizing so that the patient is in the right place at the right time, to provide a 24/7 workforce and retain staff and recruit staff accordingly and to support education and innovation. The priorities outlined within the divisional strategy aligned to the trust strategy.

Metrics were used to compare the measure progress against the division and trust strategy. Progress against the delivery of the strategy and the objectives was reviewed yearly. A yearly report on each strategy was completed and reviewed by the divisional board. We saw evidence from board papers of analysis relating to progress towards “Our Big Plan” going to the board of directors in April 2023.

Most staff that we spoke to were aware of some of the trusts vision and strategy. They told us that it was made clear during meetings and appraisals.

We saw on the AAU the corporate strategy and next to that the goals that the ward had. These goals were aligned to the strategy and included reducing the amount of hospital acquired pressure sores, maintaining compliance in core skills training, and establishing fully integrated pathways with other clinical specialities.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most registered and unregistered staff, including AHP’s, said that they felt respected, supported, and valued and that there was a good culture throughout the medical division. However, there were some wards which had low morale. On 1 ward, staff told us that the lack of health care assistants was causing them stress, especially when they could not offer 1 to 1 nursing as required.

Senior doctors told us that there was a culture of ‘silo working’ on the MAU. They told us how the overcrowding and service demands does not make it conducive for junior doctors to learn and develop.

The trust had systems in place to monitor staff satisfaction and plans to improve it. Leaders for the division told us that the trust had an organisational development and leadership service, made up of chartered occupational psychologists, organisational development practitioners, knowledge and library experts, trained teachers in leadership development and qualified coaches who provided support to teams and specific wards to improve levels of team satisfaction and engagement which was measured through the staff survey. The respiratory ward, MAU and gastroenterology were highlighted as wards that had responded worse on the staff survey when compared to the wider trust average and therefore were either being supported by the Organisational Development (OD) Team or additional support was being sought following further discussion with divisions regarding their concerns.

The division offered incentives such as vouchers or gift cards for employee of the month. Some staff told us how they felt appreciated when they received recognition at the staffing award ceremony which was hosted by the trust. We also saw that a student had been nominated for an award by fellow students on ward 21.

Staff had access to mandatory training which included supporting patients and staff with learning disabilities and neurodivergence. Additional training offered to staff also included lesbian, gay, bisexual and transgender/transexual plus (LGBT+) training. We saw staff wearing LGBT+ badges as an indicator that they had completed the training.

Staff had access to health and wellbeing support located at the Preston site. The centre offered staff a confidential space to discuss their thoughts and feelings and attend classes including Yoga, arts, crafts, and mindfulness. The catering team provided a new health food choice menu for staff to encourage healthy eating and the trust had recently signed up to the Trade Union Congress 'Dying to Work Charter' which ensured that staff with terminal illnesses were supported with decisions regarding work during challenging times.

The medical division had an equality and diversity champion who promoted all aspects of equality and diversity both clinically and non-clinically. Equality and diversity champions worked closely with the Equality, Diversity and Inclusion subcommittee group who produced a report for the Chairperson, in line with the trust's equality, diversity and inclusion strategy (2021-2024) from a staff perspective and from a patient perspective. Staff completed mandatory training on equality, diversity, and human rights. The division had an overall completion rate of 98%.

Staff from the division were complimentary about the Freedom to Speak up Process. They told us that they felt confident escalating concerns to the Freedom to Speak up Guardian. Two members of staff told us how they had used the process and how they were both happy with how it was dealt with and the outcome. From the board papers from June 2023, we saw that 91% of staff that had used the Freedom to Speak up service would use it again.

In the yearly NHS staff survey for 2022, the trust was 1 of 3 trusts in the North West to have increased its overall staff satisfaction score. The trust scored above the national average in 71 out of the 96 questions that staff answered.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical division held monthly divisional board meetings which were attended by the triumvirate. Information was shared at the divisional board meetings from 3 sub committees which were divisional safety and quality, divisional finance and divisional performance and workforce.

A performance improvement forum, speciality governance meetings and committees for IPC, safeguarding, speciality governance and 'always safety first' were completed monthly and the main points from these minutes were escalated to the relevant safety, workforce, or finance subcommittee. Each speciality within the medical division, for example respiratory care, had their own governance structure.

If agenda items could not be resolved within those meetings, they would be escalated to a higher committee. We saw evidence of information from speciality governance meetings being shared at the divisional board committee and the escalation process was clear.

The triumvirate for the division held weekly meetings and told us they were in contact every day via email or text message.

Shift fill rates for nurses and non-registered nurses were monitored through the safety and quality committee. If fill rates were less than 80% this was discussed at the workforce committee and reviewed at matron meetings.

We saw evidence of a 6 monthly cycle of medicine assurance reports being reviewed in the Divisional Safety and Quality Meetings. Within the meetings from December 2022 medicine safety audits, controlled drug audits, prescription verification, medicine reconciliation, missed dose reports, among other areas were all reviewed.

The senior management team were responsible for patient flow on the medical division. The trust operational officer chaired daily capacity meetings and provided clinical leadership to the duty bed managers who liaised with the divisional management teams as required.

Staff had opportunities to meet and discuss issues regarding the division. Nurses, AHP's and corporate governance had an opportunity to meet with the chief of nursing on a weekly basis for any immediate learning from the meetings held. The 'raising concerns group' held meetings bi-monthly which reviewed and responded to concerns raised within the trust by staff. Once themes were identified, they were then fed back to the divisional leadership teams which had resulted in improvement opportunities.

Staff that we spoke to were clear about their roles and responsibilities.

Staff told us that governance structures were much improved, and that rapid incident reviews and investigations were robust.

Despite the governance processes being in place, the meetings were not always well attended. Between March and May 2023, 50% of invited staff attended the finance and performance committee, 33% the safety and quality committee, 19% attended the workforce committee and 52% attended for the divisional board meeting.

Matrons held monthly meetings with ward managers which reviewed the STAR assurance framework and ensured that all areas were being complied with. If some areas needed improvement, matrons and ward managers would collaboratively identify action plans. Matrons produced assurance reports for their wards which were reviewed at the clinical governance meetings. Ward managers would lead monthly ward or unit meetings and shared information regarding audits and targets. However, the division had not met the trust targets of 95% for monthly audits between February 2022 and February 2023 and in May 2023 58% had achieved silver or above for the comprehensive accreditation visits against a 75% trust target.

Management of risk, issues, and performance

Leaders and teams identified risks and issues and had plans to cope with unexpected events. However, some risks were not acted upon in a timely manner.

The trust had systems to record risks, issues, and performance. The risk register was held within the trust's incident and risk management system. The division had its own risk register which on the 1 June 2023 had 20 high risks, 66 significant risks, 12 medium risks and 1 low risk.

The risk register for the division clearly identified the risks and provided all the appropriate details, including the risk handler/owner, the controls and assurances and the risk levels which leaders then reviewed.

Medical care (including older people's care)

We reviewed meeting minutes from the renal clinical governance meetings between March and May 2023 and found that a review of the risk register was the 2nd agenda item. A review of the active risks was provided, and high risks, significant and moderate risks, controlled risks, and newly identified risks were reviewed. In the meeting for April 2023 a risk regarding no suitable ambulatory area for renal care for extremely vulnerable high-risk patients was reviewed and an update was provided on quotes from procurement regarding a tender which included plans to create more space on the unit.

The percentages of risks on the division with overdue actions between August 2022 and February 2023 was under 1% and risk reviews were above 90% within this time frame. The risk register from the division showed that high risks had been reviewed monthly and significant risks had been reviewed quarterly, in line with the trusts policy. However, the division had a target of 90% of active risks that would have an ongoing action plan. We received data from the trust from April 2022 to February 2023 which showed that they had not achieved this target 9 months out of 12. In February 2023 81% of active risks had an ongoing action plan.

The divisional leaders were well sighted on risks and issues in the service, could articulate these clearly, and had systems and processes in place to support good governance. They acknowledged the estate issues concerning the AAU and had an approved business case to increase the MAU's capacity, with plans to review the AAU space once this expansion was completed. In the short term, they had planned improvements for the AAU estate.

The division had pathways in place to support urgent and emergency care. The SDEC took 12% of patients whilst an average of 45% went to urgent care including the MAU and AFU. The division had introduced an AAU to reduce the waits in ED. They told us they needed to work on the right sizing of wards following the COVID-19 pandemic to improve access and flow. They had plans, which had been approved, to increase the size of the MAU from 30 beds to 42 and the AAU to 20 beds. The discharge lounge was being promoted at ward level to increase the number of daily transfers. Admissions to the discharge lounge had increased from a mean of 22.7 in May 2022 to 38.7 in May 2023 and admissions before 12 noon had increased from 4.9 to 11.9. The division had plans to increase admissions to the discharge lounge by the end of the year. To help with this, the division were participating in the development of a discharge whiteboard which identified all discharges within 24 to 48 hours. The division were working closely with the surgery division to capitalise on patients being discharged before 12pm to increase flow.

To address the shortage of HCA's and AHP's the division had ongoing recruitment and retention plans as part of the workforce plan. The medical workforce team were working closely with Clinical Directors and department managers to look to resolve the medical staffing vacancies. They were sourcing doctors through the medical training initiative in liaison with the Royal colleges, promoting vacancies through social media, relevant journals and websites and working with international placement agencies.

Regarding the thrombectomy service, the division was unable to offer it 7 days a week, leading to 8 severe harm incidents between March 2021 and December 2022. The trust acknowledged this as a risk and sought support from two local hospitals that provided the service. Unfortunately, due to their own capacity issues, this assistance was not feasible. However, the division made progress by recruiting a neurointerventional radiographer and expected the return of another staff member after parental leave. This enabled the 7-day service to be planned for availability from September 2023. Further expansion plans and recruitment discussions within the cross divisional thrombectomy mobilisation group were ongoing, with operationalisation expected by April 2024, aiming to offer the service from 8 am to 11 pm, 7 days a week.

Medical care (including older people's care)

The trusts SSNAP data had improved from an overall rating of a D to a B between January and March 2023 following successful initiatives including recruitment to services and the implementation of dashboards that allowed the team to monitor stroke patients in real time.

The division completed standard judgment reviews when deaths occurred. The audit and effectiveness department provided reports for the divisions and reported to the mortality and end of life committee which reported to the safety and quality committee. Between January and March 2023 there were 423 deaths reported for the division and 173 reviews completed.

The division had a lead sepsis nurse who completed a quarterly audit providing data on compliance with the trust sepsis policy. Following the most recent audit, risks were identified about the percentage of patients receiving antimicrobials within 1 hour of suspected sepsis diagnosis. An action plan was formulated which included refining the deteriorating patient dashboards to review the sepsis data within the divisional safety and quality forums and the 'Always Safety First' subcommittee.

The trust had a business continuity plan and an emergency planning, resilience, and response strategy.

However, leaders' ability to achieve sustainable progress and consistently mitigate risks was often compromised by the breadth and complexity of the services delivered, and further compounded by the impact of financial challenge in key parts of the service. The sustainable delivery of quality care was put at risk by the financial challenge. Leaders told us how a lack of finances had impacted on recruitment of medical staff which had delayed the Hyper – acute stroke unit (HASU) being opened sooner. Staff from the stroke unit told us they saw how financial restraints were impacting on the quality of services being offered to patients including the patient gymnasium for rehabilitation having to close.

We frequently heard that although issues were raised appropriately to senior levels of the trust, there was frequently a perceived lack of shared priority from senior leaders for focus on the immediate service issues.

The division had performance committees in place, but poor performance was not always dealt with in a timely manner. We saw trust targets for pressure ulcers, patient moves, falls, stranded patients (14 to 21 days) and super stranded patients (21 days and above) had not been achieved, regardless of actions taken. The trust had not yet delivered 6 of the 10 requirements set out by the NHS for cancer waiting lists and although they were making improvements with some of the cancer waiting targets, others were lengthy.

Risks were discussed within governance meetings, as outlined in the governance section. Given the low attendance rate of key staff, we were not assured they had a clear oversight of risk and within the division.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The information systems were secure, well integrated, and reliable. The service used an electronic prescribing and medicines administration system.

The care organisation had access to electronic patient records.

Medical care (including older people's care)

Reviews of safe care, acuity, patient experience, incidents, and staffing were reviewed during workforce reviews. Following this the information was escalated to the trust quality committee and board and adjustments were made as required.

The division had access to safety surveillance dashboard which helped them to visualise the context on the ward. The tool provided a real time summary of information, including how many patients were on the ward, how many patients had a pressure ulcer, the number of outstanding risk assessments and the expected discharges for the day. The real time data fed into the safety surveillance dashboard.

We saw a dashboard for deteriorating patients with all electronic observations which all clinical members of staff had access to. The dashboard refreshed every 15 minutes and patients no longer appeared on it when their NEWS2 score reduced to 3 or under. The dashboard fed into a database which allowed the division to monitor how well they had responded to deteriorating patients.

The division submitted data to external organisations as required.

Staff did not always keep up to date with information governance training. Medical staff compliance was 89% whilst the trust target for information governance was 95%.

Staff said they did not have enough computers on the AAU which meant that uploading paper records was difficult.

There had been 4 externally reported data breaches between 2022 and 2023, 2 of which had been reported to the information commissioner's office (ICO) who are the United Kingdom's independent body for upholding information rights.

On some of the wards, including the AAU, patients' confidential details such as their names and where they were located on the ward were displayed on white boards in patient and visitor areas. Staff told us they were aware of this breaching confidentiality and were awaiting new boards that could close when staff did not require access to them.

Engagement

Leaders and staff openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division engaged with patient support groups such as the motor neurone disease steering group and the Lancashire and Fylde dystonia support group.

Experts by experience (people who have recent personal experience of using or caring for someone who uses heath care services) were utilised by the division. Leaders told us how they were used to support a recent recruitment process for matrons.

Patients thank you cards were displayed on most wards. Information about the family and friends test and for the patient advice and liaison service (PALS) were available on the wards. From May 2022 the trust had received 1437 more online responses, 3959 more paper responses, 737 more telephone responses and 942 more text messages than they had the previous year.

The wards that we visited had "you said, we did" notice boards on the wall near the entrance. These were not always completed but the ones that were showed what patients had fed back and how the ward had responded.

Leaders told us that ward managers and matrons had completed coaching and engagement training. An example of how this was used was through the 'love and nuts' exercise in which staff were encouraged to share what they loved about the ward and what annoyed them. This information was gathered and shared with the idea to resolve the issues identified. Coaches also held 'big rooms' (meetings available to all staff) for specific topics such as nutrition and mental health. The mental health 'big room' was well attended by colleagues from the trust and from the mental health liaison team with an ethos that improvement can be made by staff on the frontline.

The trust engaged with staff through staff survey presentations, staff survey drop – in sessions and junior doctors' engagement events.

We saw evidence of meeting minutes from the last 6 months for the equality and diversity strategy group, living with disabilities forum and LGBTQ plus forum. All these forums and groups were open for staff to attend.

The trust produced a weekly e-newsletter which staff could access on the trust's intranet, the newsletter covered organisation updates and changes.

Staff could access Schwartz rounds which were an opportunity for them to engage in conversations about the challenges they faced in their team and department.

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Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The trust had a continuous improvement strategy for 2021 to 2023 with priorities, as outlined in the 'Big Plan' at a system level, pathway level and local department and ward level. For the division of medicine some of the aims were risk assessment development, a pressure ulcer improvement cycle, patient flow, and discharge and improving stroke care.

Staff told us they were encouraged to participate within innovation projects, and they were committed to doing so.

The trust collaborated with the flow coaching academy programme across Lancashire and South Cumbria had led to 21 'Big Room' meetings being established for different areas including brain cancer, sepsis, DNACPR and frailty. These meetings allowed staff members on the frontline to collaborate and develop a shared purpose for improvement within the chosen areas. For example, the emergency mental health 'Big Room' had developed safety checklists to prompt staff on key areas of care processes.

We observed how staff had identified the vision and aims for the clinical pathway with a clear theory for change and measurement strategy. Staff told us how the deteriorating patient dashboard was developed as part of the flow coach academy continuous improvement work in the sepsis 'Big Room.' The 'Big Room' meetings provided quarterly submissions to the programme management team which reviewed whether the quality improvement work had been productive in achieving their goals.

The trust had implemented a new stroke triage tool which was powered by Artificial Intelligence (AI). The AI technology was able to analyse and categorise brain images following a CT (Computed Tomography) scan to detect signs of a stroke in 30 seconds, compared to the normal 30-minute scan to manual reporting timeline.

Staff across the services were involved in research, innovation, and clinical trials to improve patient care and treatment and routinely attended trust-wide research, development, and innovation committee meetings.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

Nursing staff received and mostly kept up-to-date with their mandatory training. During inspection, data we reviewed showed that not all nursing staff had completed their required mandatory training in all subjects. Subjects where there was lower compliance which was below trust training targets included Basic Life Support Skills (BLS), with overall compliance for all staff groups at 78.4%. For nursing staff there was 88.3% compliance for this training.

Of the total required number of band 6 and band 7 nursing staff, 70.3% of nurses had completed Advanced Life Support training. This data included staff who had recently joined the trust and who had been unable to access training modules to date.

For band 6 and 7 nursing staff required to complete Advanced Paediatric Life Support Skills training, there was 35.9% compliance, with only two staff still required to complete this. However, 100% of nurses in the Paediatric area were APLS trained and the service was meeting the minimal standard of one APLS trained doctor and nurse per shift. We saw that the practice educator continued to work to enable staff's access to complete their required life support skills training, including in engagement with external training providers to facilitate this

Managers confirmed they had completed a review of shift rotas and there was always a minimum of at least one ALS and APLS trained member of staff on each shift. .

Medical staff received but did not always keep up-to-date with their mandatory training. Compliance for completed BLS training by medical staff was 66%.

Training in infection prevention and control was 87.6% for all staff groups, just below the trust target for compliance.

The mandatory training was comprehensive and met the needs of patients and staff. At the time of inspection, trust data confirmed that in 10 of 13 mandatory training subject areas, all staff groups in the department were compliant. Subject areas where compliance was not met included Medicines Management for Clinical Staff (81%); Patient Safety for boards and senior leadership teams (86%); and Speak Up - Core Training for all Workers (37%). The trust advised that for Medicines Management, Speak Up - Core Training, and Oliver McGowan Learning Disability E-Learning had been newly mandated or updated modules which had only been added to the training needs analysis from 1 May 2023. There was a three-month grace period for staff to build the required compliance of 90% target, by 31st July 2023.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Urgent and emergency services

Managers monitored mandatory training and alerted staff when they needed to update their training.

The practice educator in the department monitored staff compliance for all training updates and provided regular face-to-face training sessions, as well as different opportunities for a range of contextual learning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although safeguarding training compliance for medical staff did not always meet trust targets.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding adults' level one and two training was above trust targets for nursing staff. For Safeguarding adults' level three training, there was 92% compliance for all qualified nursing staff. For Safeguarding children level two there was 99% compliance, and 91% compliance for safeguarding children level 3 for all qualified nursing staff.

Medical staff received training specific for their role on how to recognise and report abuse. However, medical staff were below the trust targets for completed safeguarding training in the following areas: Safeguarding Adults (Level 3) 74%, Safeguarding Children (Level 2) 88%, Safeguarding Children (Level 3) 71%.

The trust had an established safeguarding team, with named doctors and named nurses as safeguarding leads for children and adults. The trust's safeguarding team were described by staff as being accessible and responsive when requests were made for any safeguarding advice and concerns. there was a named consultant for safeguarding within the urgent and emergency service.

The trust had recently established a lead nursing role in the department to provide additional support for staff in a wide safeguarding context. The aim of this role was to strengthen existing systems and risk assessment processes, particularly for any patients who may be more vulnerable due to their needs. This included a wide range of patient needs, including for those patients with mental health needs and learning disabilities, patients who had experienced domestic violence, as well as patients who were at risk of falls.

A daily meeting had been established Monday to Friday morning, involving the unit manager, the trust's security team, mental health team and the lead nurse. This had improved communication between the different teams, enabling staff to respond to individual patient needs in a more effective way.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. PLACE assessments had been suspended during the pandemic. The trust's Monitoring Team and Domestic Services had conducted an internal PLACE audit in November/December 2022 across both hospital sites. The results of this were used within the department to identify any areas of concern. The trust was re-engaging with the full national PLACE programme this year 2023/2024.

The trust monitored a range of safety metrics through its Safety Triangulation Accreditation Review (STAR) programme, which included outcomes for infection prevention and control. The latest STAR report indicated that ED Royal Preston Hospital was one of the areas scoring red over the last three months. Performance boards for May 2023 in the children's ED showed 96.4% achievement in matrons STAR audit, however results for hand hygiene audits were not displayed.

Where we reviewed these during inspection, we saw that cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw in all department areas that equipment routinely displayed 'I am clean 'labels which were in date.

Environment and equipment

The design, of the department made it difficult to keep people safe; the maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Patients could reach call bells and staff usually responded quickly when called. We heard only isolated comments from some patients about having to wait before staff responded to calls.

The environment in ED was limited for space and the estate was ageing. This was a recognised and ongoing issue, where staff worked as well as they could within the limitations of the physical premises. We saw there were areas where equipment was stored on corridors and in general the department appeared cluttered in areas.

Following the COVID 19 pandemic, areas that had been reconfigured to manage the infection prevention and control needs of that time had now been returned to different clinical areas in daily use. Isolation rooms were still available in paediatric and adult areas in case of any patients with infectious diseases. There was paediatric resuscitation equipment available in a dedicated area of the emergency department". We saw that an issue regarding secure access to the paediatric department which was raised in the latest inspection report had now been addressed, with secure keypad access now in place.

Staff carried out daily safety checks of specialist equipment. We checked resuscitation equipment and saw that all resuscitation trolleys were stocked correctly with in date equipment and medicines. However, in one of the resuscitation trolleys we saw that records of completed daily and weekly checks were not all kept up to date.

We saw that action had been taken in response to three never events, one which had occurred originally in January 2022, followed by 2 more in January 2023. These were repeated incidents, regarding the unintentional connection of a patient requiring oxygen to an air flowmeter. The original incident in 2022 was identified retrospectively after the two incidents which occurred in January 2023. Among the actions taken included the removal of all medical air flowmeters from resus, Covid resus and green areas, and majors; identification of clear signage visible above all medical air ports, and fitting of temporary caps to the 400kpa medical air ports.

The service had suitable facilities to meet the needs of patients' families. Work was continuing to improve the child friendly aspect of the children's ED, in accordance with the Royal College of Paediatrics and Child Health's Facing the Future Standards.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient. They mostly minimised risks for patients, although mental health risk assessments were not always completed and actions to reduce risks for patients with mental health needs were not always taken. Staff identified and quickly acted upon patients at risk of deterioration.

The trust had worked with the NHS regional ambulance service to reduce delays in ambulance handover times. At the time of inspection, the percentage of attendees who were treated within 60 minutes of arrival had improved and from February to April performance had been better than the England average. The percentage of attendees who spent less than 4 hours in A&E has remained in line with the England average, at around 70-75%. A member of nursing staff was allocated to monitor any patients waiting in ambulances and ambulance staff would escalate any concerns to staff where patients needed to be seen more quickly.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff had access to the National Early Warning Scores tool to assess patients who may deteriorate.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Two triage nurses were available in the rapid assessment treatment area for assessing patients' needs on their arrival. Any urgent patients, including those brought by ambulance, would transfer straight to the majors or resuscitation area for any immediate treatment and care.

Suitably trained staff with Advanced Life Support skills (ALS) and Paediatric Advanced Life Support (PALS) Skills included Consultants, Senior and Junior Clinical Fellows, Specialist trainee year 4 and above doctors and Band 6/ Band 7 nurses. The trust confirmed that there was sufficient resource to provide 24/7 emergency cover, and that review of rotas confirmed there had been no incidents reported arising from lack of available trained staff for patients in an emergency.

Staff in the service used a mental health risk identification tool when assessing patients who attended ED with mental health needs. The mental health risk tool is a paper document that should be completed within one hour of the patient's arrival and is intended to support the ED nurses to carry out an immediate simple risk assessment and identify measures to reduce risk while the patient is waiting for a specialist mental health assessment.

We saw during each day of inspection that there were high numbers of patients attending who presented with differing urgent needs in relation to their mental health. The department only had one mental health assessment room, and during inspection we saw this was being used continually for different patients. When the mental health assessment room was in use, other patients with mental health needs would need to be seen in the regular department cubicles. We saw there were ligature risks in the wider environment, and actions to reduce risks were not followed up, where for example patients may have been at risk of self-harm. We also saw in three patient records we reviewed that mental health risk assessments were absent or had not been fully completed. We escalated our concerns to trust leaders during the inspection and they provided an immediate response with follow up actions to mitigate the risks that had been

identified. These included a full incident review of the patient incidents where we had identified concerns; implementation of the ED safety surveillance system, with updates to electronic patient record to allow for real time monitoring of compliance with this; learning for staff and plans for future auditing. After the onsite visit we wrote a letter of concern to the trust regarding the issues found. Following the inspection, the trust continued to implement relevant actions to improve and achieve sustained high performance in the areas of concern that had been identified.

Staff knew about specific risk issues and there were systems and processes documenting and escalating patients where there were any concerns. However, we saw that documenting patient records from their observations was not always completed. For example, we saw one patient who had a NEWS score of seven and been diagnosed with sepsis, however there was no record of a completed sepsis screening tool.

The service had 24-hour access to mental health liaison and specialist mental health support when staff were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The children's emergency department had a mental health calm room for any children presenting with distress due to their mental health.

Staff shared key information to keep patients safe when handing over their care to others.

A new role had recently been introduced in the department to assist on oversight of patients who were waiting for assessment and treatment. A band 6 'helicopter' nurse supported staff safety huddles, assisting department managers in providing continuing updates of any changing immediate needs for response.

Shift changes and handovers included all necessary key information to keep patients safe. We observed nursing handovers in which full information about patient care needs was discussed, including any risks identified such as safeguarding, mental health, falls and any immediate clinical risks.

Managers in the service were continuing to develop the ED safety dashboard, with work also in progress to link this to the electronic patient system.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The development of emergency pathways throughout the pandemic had led to an increase in the department's service delivery options to meet national standards, within the available physical space.to manage COVID-19. The staffing establishment had been increased by 74.81WTE at RPH in response to the pandemic. An ED nurse staffing report was presented at Safety and Quality Committee in November 2022, with the footprint of the Emergency Department currently under review.

During 2022 the trust had implemented a programme of international nurse recruitment, with several nurses joining the emergency department through this route. The trust's annual staffing review 2022 to 2023 identified that in Model Hospital data from (September 2022), Lancashire Teaching Hospitals was placed in the highest quartile for Care Hours Per Patient Day (CHPPD) when compared with neighbouring and peer organisations in the north-west.

We saw and heard from staff that nurse staffing levels had improved since the last inspection. Although there had been an uplift in nurse staffing, managers observed there had needed to be focus for supporting skill mix, due to the different levels of nursing experience for staff in the department.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Healthcare assistants worked flexibly across teams to provide additional support for nursing staff in case of any shortfall in registered nurses. Data provided by the trust confirmed that between 1 December 2022 and 31 May 2023 there was one incident reported within the Emergency Department in relation to insufficient staffing levels.

The department manager could adjust staffing levels daily according to the needs of patients. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low turnover rates, although at particular grades, such as for band five nurses where there was regular turnover. During 2023 -2024 to date nursing staff turnover was 0.45%. There were plans in place to manage any shortfalls in staffing numbers. Staff could be redeployed across the two ED's dependent on need. Senior managers could support staff as necessary. Meetings were held throughout the day where staffing levels were discussed. Bank and agency staff could be utilised if needed.

In the children's ED, staffing was also supported in flexible working arrangements with the Paediatric Assessment Unit. This assisted the service towards meeting the staffing requirements of the Facing the Future Standards, the Royal College of Paediatrics and Child Health.

The average sickness absence for nursing staff over the last six months was 6.34 per cent.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience, although patients were kept safe from avoidable harm and provided with the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff in workforce planning numbers, however staff worked well to keep patients safe and prevent avoidable harm to patients. Staffing was planned across both hospital ED's. The services were funded for 106 medical staff; there were 23 vacancies.

The service always had a consultant on call to provide cover out of hours during evenings and weekends.

Senior leaders identified staffing as a key risk in the department. The potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies was included in the ED risk register.

The overall sickness rates for medical staff was 2%. During 2023 -2024 to date medical staff turnover was 1.65%.

Managers could access locums when they needed additional medical staff. Advanced clinical practitioners (ACP's) were also available in the department to support medical staff and support patients in accessing ongoing care pathways.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Doctors worked in the emergency departments across both the hospital's locations and said there was good support available from senior doctors in the service, also to ensure patients were in the right place and receiving appropriate care.

As part of the people strategy there were plans to increase the numbers of advanced practitioners and non- medical consultant positions across urgent and emergency care to support the service.

The department met the Royal College of Paediatrics and Child Health's Standard for access to a dedicated consultant trained in paediatric emergency medicine. There was good access to a consultant on call during evenings and weekends in the service and doctors highlighted no concerns in this area.

Records

The service used electronic and paper systems to detail and record patients' care and treatment. However, staff did not always complete documentation or record this in a timely way. Records were clear, were stored securely and easily available to all staff providing care.

Patient notes were available for all staff to access them easily. The service had electronic and paper systems for recording different care interventions.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in the department.

Each area had a whiteboard to assist staff with required tasks. We saw this displayed patient information, including their bed number, full name, presenting complaint, observation of vital signs, if an electrocardiogram (ECG) had been performed, any blood tests taken, pressure area care, if a do not attempt cardiopulmonary resuscitation (DNACPR) was in place, any tasks needed and any other additional information. This meant that information about patients was visible to anyone in the department including relatives of patients.

We had been informed the service used new documentation for recording sepsis screening in accordance with NEWS2 methodology, and that the old forms had been removed from the department. However, during inspection we saw the old forms for recording against sepsis 6 procedures were still in use. We also saw that although staff acted appropriately to initiate treatment when patients presented with possible sepsis, in two patient records we reviewed there were gaps in the related documentation.

In records we reviewed during inspection we saw there was inconsistent documentation of pain assessments and there was incomplete documentation in three of four records fluid balance charts we checked.

Urgent and emergency services

Medicines

Staff did not always complete medicines records accurately or kept them up-to-date , although the service used systems and processes to safely prescribe, administer, and store medicines

Staff followed national practice to check patients had the correct medicines when they were admitted.

Doctors had access to the local care record to view patient's current medicines when patients were clerked in. However, capacity within the pharmacy team meant there was limited proactive clinical pharmacist review in ED. We saw that both nursing and medical staff actively engaged with the pharmacy team to discuss more complex prescribing.

Staff followed systems and processes to prescribe and administer medicines safely.

Since our previous inspection the trust's electronic prescribing and medicine administration (ePMA) system had been rolled out to the adult emergency department. Paper records remained in use in the children's ED with copies sent to the children's ward should the patient be admitted. Changes made to the electronic systems had successfully brought about an improvement in oxygen prescribing.

Staff stored and managed all medicines and prescribing documents safely. The implementation of ePMA gave improved visibility of medicines optimisation information.

The recent roll out of automated fridge temperature monitoring supported improvements in compliance with the trust's medicines safety audit. We also saw that appropriate action was taken when medicine room storage temperatures were too high in the children's ED.

Staff did not always complete medicines records accurately or kept them up-to-date. Compliance with the trust standards for controlled drugs management was poor, largely linked to record keeping. This was included on the department risk register. Improvement actions were being reviewed and monitored by the pharmacy team.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were known and visible in the department. Staff knew how to contact them for advice or to obtain medicines outside the normal working day. Pharmacy staff were deployed flexibly across the ED and Medical Admissions Units. Pharmacy vacancies and priorities in the admissions units meant that there was only limited dedicated pharmacist support to ED. For example, prompt pharmacy review of prescribing for patients with mental health concerns was being piloted, but only two records had been reviewed in the first week of the pilot.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Urgent and emergency services

Following the inspection, the trust provided details of incident reports raised in trust systems within urgent and emergency care. This confirmed there had been a total of 3, 659 incidents which were reported to have occurred within the Emergency Department during the period 1st June 2022 – 30th May 2023. The highest number of incident reports in month was for August 2022 with 352 incidents reported, and the lowest number of incidents reported was for May 2023, with 237 incident reports.

The highest reported incident type for urgent and emergency care in National Reporting and Learning System reports was 'Infrastructure (including staffing, facilities, and environment). Over 96% of these incidents resulted in no or low harm. There were 16 incidents falling under the specialty type 1, Accident and Emergency, as well as two more incidents were reported without a specialty but fall under UEC, giving a total of 18 overall incidents linked to urgent and emergency care.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

There had been three never events which had occurred between January 2022 and January 2023 related to the unintentional connection of a patient requiring oxygen to an air flowmeter. All three incidents had originally been categorised as low harm incidents.

Two of the incidents occurred within a two-week period during January 2023, following which the trust had completed a full retrospective review of any incident reports raised since 2019. We saw during inspection that 11 actions out of the total 14 identified actions had been completed, following the trust investigation of these incidents.

The initial investigation identified that in 2016, Lancashire Teaching Hospitals NHS Trust (LTHTR) had received a National Patient Safety Alert (NPSA); Reducing the risk of oxygen tubing being connected to air flowmeters (2016). However, staff in the service had not implemented immediate actions in response to the original safety alert.

Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers reviewed incidents to identify any themes and trends and discuss these findings with staff. Managers described and we saw that there was a proactive approach to incident reporting.

Managers and staff had access to support from the trust's risk and governance departments for additional advice where needed. Managers held weekly meetings to review incidents and safety performance, also attending the monthly divisional quality and safety meeting.

We saw there had been learning following an incident of patient deterioration in the children's ED, where the child had not always been under the immediate view of staff. Measures had been introduced to increase active monitoring of waiting areas for non-urgent patients following this incident.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. We saw local governance boards following incidents in the department. These displayed information about any identified learning from these, helping staff to complete the identified improvement actions.

There was evidence that changes had been made as a result of feedback. Following incidents of patient falls in the department, we saw a new approach had been introduced in which patients were provided with yellow blankets where they had been identified as at risk of falling.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

The trust provided data on request following inspection to indicate there had been 70 incidents reported on the trust's incident reporting system regarding restraint by security staff for patients presenting with mental health concerns between 1st December 2022 and 31st May 2023. All the incidents resulted in no harm or low harm.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Evidence-based service guidelines were available on the trust's intranet and in the electronic patient record.

Any changes in national guidance, such as the National Institute for Health and Care Excellence (NICE), were discussed at monthly governance meetings that covered both ED locations.

The service had implemented an action plan to meet the Royal College of Paediatrics and Child Health Facing Future Standards, Children and Young People Urgent and Emergency Care. Local audits were completed to measure compliance with policy and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. We heard during handovers staff included discussions about any patients who were anxious or agitated, together with the best approach for managing any individual patient needs.

The trust's sepsis lead nurse had worked with staff in the department to support improvements in practice. A new deteriorating patient dashboard have been introduced and this was used in close working between the department and critical care outreach team.

The trust's sepsis policy had been updated in line with the Academy of Medical Royal Colleges sepsis guidance (May 2022), supporting the appropriate use of antimicrobials in sepsis. There were plans to roll out a Patient Group Direction (PGD) for antibiotic administration supporting prompt access to antibiotics, if sepsis was identified.

The service had policies to ensure that people's behaviour was not controlled by excessive and inappropriate use of medicines. However, we saw one example where the use of rapid tranquilisation was not monitored in accordance with trust policy. We raised this immediately with the trust and appropriate actions were taken to help improve this compliance. The trust had a programme of local audit. Staff completed audits as part of the trust's safety triangulation accreditation review (STAR) process. This system was used to monitor performance in all areas of the trust and included monthly report of results and monthly reviews by peer review matrons. The trust's quality assurance team also completed accreditation visits as part of this process. Between January and April 2023, staff in the ED had scored between 66% and 71% in completed audits towards STAR accreditation and actions were being identified to improve this performance. Staff in the children's ED had achieved a silver rating in the trust's STAR process and was working towards a gold rating.

The service had access to a tissue viability nurse for any patients whose skin condition was more vulnerable due to their frailty or medical condition.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff mostly made sure patients had enough to eat and drink. However, several patients we spoke with during inspection who were in different areas of the department, including whilst awaiting triage, had not been asked if they needed anything to eat or drink. Of these, some had been waiting for more than several hours. Vending machines were available for public use in the waiting room. Dietary choices were available for patients' religious, cultural and other needs.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Staff in the ED completed monthly audits on completion of fluid balance documentation, with latest results from the trust indicating these were 65% achieved. We saw this performance had consistently improved since 1 December 2022, with results at 56%. An improvement action plan was identified to support staff in making improvements to scores.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The trust risk assessments included the calculation of a malnutrition universal screening tool (MUST) score.

The MUST Score was triggered once patients are admitted to the hospital and therefore compliance with MUST completion is not audited in the ED. However, to a system was in place to allow the nursing team in the ED to make electronic referrals for patients to see dieticians, where needed. The nutrition specialist nurses also provided support and in reach into the ED to manage any patients with nutritional needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

During the inspection patients told us they received pain relief soon after it was identified they needed it, or they requested it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. Managers used information from the audits to improve care and treatment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The sepsis audit had been updated to reflect changes in national guidance and the sepsis group was focussed on supporting improved compliance with this. Between October to December 2022, in a local audit of sepsis guidelines, of 50 patient records checked there was 66 % compliance in practice. Between January and March 2023, of 50 patient records checked there was 54% compliance.

From April 2022 to March 2023 there was overall compliance of 77% for NEWS 2 audits. The critical care outreach team also conducted quarterly audits of vital signs compliance; between April 2022 – March 2023 the lowest performance was 72.2% and the highest 86.10%. The lead nurse for sepsis was working in collaboration with the critical care outreach team to support staff in improving this performance.

As part of medicines management, we saw the department was now included in the trust's quarterly antimicrobial stewardship audit, showing good overall compliance. Additionally, there were plans to capture departmental performance data relating to medicines verification and medicines reconciliation for review.

The trust's Clinical Audit and Effectiveness Department monitored the performance of national and local clinical audits in relation to governance requirements, providing a regular report to the trust's Safety and Quality Committee. Among these included The Trauma Audit & Research Network (TARN) Audit and the Royal College of Emergency Medicine (RCEM) Audits.

The latest TARN results showed the trust were above the national average for both data accreditation and case ascertainment.

In 2022-2023, the trust signed up to the following RCEM audits 2022: Mental Health Self Harm Audit and RCEM 2022: Consultant Sign-Off Audit. For the reporting period 2022/23 the trust reported outcomes in RCEM audits for fractured neck of femur; pain in children; and infection prevention and control. In 3 of 4 overall metrics included in fractured neck of femur audits, the trust's performance was above average compared to nationally, with one metric additionally having no available national comparator.

For pain in children, the trust performed better than the national average in all three standards.

For infection prevention and control, the trust performed worse than the national average for the first two standards but better for the third standard of moving patients identified as potentially infectious to an appropriate area.

Staff in the paediatric service had undertaken a benchmarking exercise as part of the regional asthma network.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support in development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with said they were supernumerary for six weeks after starting work in the service and had good access to support from clinical educators. At the time we inspected, there had been four new starters in the department; newly qualified staff had a six-week induction, new to ED staff had a 4-week induction, and experienced in ED staff had a 2-week induction.

The clinical educators supported the learning and development needs of staff. Since the last inspection the service had introduced several roles particularly to support children's ED, including a neonatal champion and a new educator for children and young people (CYP) seconded to the service. Nursing staff were widely available as champions to support other staff, including for learning disability, dementia, and safeguarding.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. More experienced nurses were deployed to work alongside more recently qualified nurses and nurses who had been recruited from overseas, to support their day-to-day practice.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were some opportunities to access further training and funding was available for continuing professional development to support this. However, there was often difficulty in accessing external emergency care courses due to funding issues.

The trust was supporting a member of staff to complete a postgraduate qualification in paediatric advanced practice. Two staff were due to start training in September as paediatric advanced clinical practitioners. There were eight advanced clinical practitioners already established in the adult A&E services.

Managers made sure staff received any specialist training for their role. Staff completed different competencies related to their roles, including such as for non-invasive ventilation (NIV), thrombolysis, and tracheostomy. The clinical educator ran monthly update skills training within the service, including resuscitation skills and monthly simulation training for adult and paediatric emergencies. Clinical educators also supported healthcare assistants on study days, which included an introduction to equipment, blood tests from triage, pressure area care. Where available to do so, clinical educators frequently offered direct support to staff working alongside them in the department.

Managers supported staff to develop through yearly, constructive appraisals of their work. Compliance rates for both medical staff and registered nurses was 89% across both hospital ED's, just below the trust's target of 90%.

Urgent and emergency services

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. In particular, staff in the department worked with an independent 'high intensity user team' based in the trust. This team followed up contact with any patients who had more complex needs due to their social setting and ongoing health situations. This team engaged widely with different organisations including the police, local authority, and other community settings.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. There was close day-to-day working with the mental health liaison team based in the trust. Information was available for patients and staff regarding local authority support for mental ill health or depression.

Staff in the children's ED worked well with other services, including community-based services such as health visiting.

Seven-day services

Key services were available seven days a week to support timely patient care.

The emergency department was open seven days a week 24 hours a day. Staff could call for support from doctors including mental health services, 24 hours a day, seven days a week. Support from other disciplines and diagnostic services was routinely available Monday to Friday weekdays, and on call arrangements out of hours.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the department.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Where appropriate, staff provided information and signposted patients to support services, such as hospital drug and alcohol liaison services.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff mostly supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. We saw there was some variation in the assessment of patients who may lack capacity. In particular, we had concerns about capacity assessments completed for patients who presented with urgent needs in regard to their mental health.

Otherwise, staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff routinely checking with patients before any treatment or care interventions.

Urgent and emergency services

When patients could not give consent, staff made decisions in their best interest.

Staff made sure patients consented to treatment based on all the information available.

Staff recorded consent in the patients' records. However, when documenting capacity assessments, we noted that the trust's electronic patient record only indicated whether the patient had capacity or not. The system did not allow for recording any related specific decision, in accordance with the Mental Capacity Act 2005

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff in the children's A&E department had good awareness of the context for assessing children's competence, and how this applied for children & young people when making informed decisions about their treatment and care.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust confirmed that Mental Capacity Act training was included in Safeguarding Adults Level 1, Level 2, and Level 3, with compliance for this at 92%.

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Compliance for medical staff who had completed this training was 74%, which was below trust targets.

Staff did not always appear to understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. There appeared to be some confusion regarding what legal frameworks were appropriate for applying in situations where patients may be at risk of harm.

Security staff employed by the trust completed mandatory training in Control and Restraint Techniques (Restrictive Interventions). However, data provided by the trust showed that at the time of inspection, that 100% of staff had completed this, but only 59% of staff were in date towards the trust target of 100%.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

The trust completed audits for Do not attempt cardiopulmonary resuscitation (DNACPR) decision and reported 100% compliance across both hospital ED locations.

Is the service caring?

Good 

Urgent and emergency services

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. We saw how staff provided reassurance and encouragement in an appropriate manner, when caring for patients, their family members, or carers.

Staff mostly followed policy to keep patient care and treatment confidential. However, we observed a whiteboard in the emergency department displaying patient names and details of their diagnosis, which could be viewed by other patients and the public.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our inspection there were several patients we spoke with who were attending the department due to their mental health needs. We saw how staff were consistently professional and caring for each patient, despite often challenging circumstances in the service.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

The trust participated in the NHS Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Between May 2022 and April 2023 there was an average of 73% positive response for patients attending the emergency department. There was no response rate provided and data was presented across both hospital locations. In the children's ED, there had been a 96.4% positive response, which represented the highest score across the women's and children's division at the trust.

In the CQC adult inpatient survey, of the 47 questions in the survey the trust scored "about the same when" compared with other trusts for 42 questions. There were decreased scores for the indicator 'How long do you feel you had to wait to get to a bed after you arrived at hospital?',

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. However, we observed and heard of isolated comments about clinical staff speaking to patients in more public areas about their planned treatment. We heard this was often due to the lack of available treatment rooms in the department.

Urgent and emergency services

Additional support was available for patients with diagnosis of dementia or mental health needs.

Multi faith chaplaincy services were available for patients who wished to access these. The service provided for dietary choices to meet patients' religious, cultural and personal needs.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Family rooms were available in the paediatric and adult emergency departments, for use when staff needed to share difficult news with patients' relatives.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Nurses in the paediatric emergency department were alert to children's emotional needs when providing care and were flexible in responding to these changing needs.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. With only isolated exceptions, most of the patients we spoke with during inspection said they had been told what was happening and were kept informed of any plans for their treatment and care. In the CQC adult inpatient survey there was a decreased score for the metric question 'To what extent did staff looking after you involve you in decisions about your care and treatment? '

However, we observed staff talked to patients in a way they could understand. Communication aids were available to support patients where necessary. We saw widespread use of pictorial symbols for communication, particularly in the children's ED. Noticeboards displayed information regarding interpreter services, including British sign language.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported most patients to make informed decisions about their care. However, they did not always know how to support patients who lacked capacity to make their own decisions when experiencing mental ill health.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Urgent and emergency services were available 24 hours a day, seven days a week. Between 1 April 2022 and 1 May 2023, the total number of patient attendances for the emergency department was 62,730. The overall number of patient attendances, including for the co-located urgent care centre was 124,775.

Urgent and emergency services

Facilities and premises were mostly appropriate for the services being delivered, although the trust and service leaders recognised the environment was increasingly limited by the age of the estate. We saw the designated mental health assessment room for patients with mental health needs was not fully appropriate or always used appropriately, with equipment sometimes blocking the exit and introducing being potential ligature risks in the environment.

There was continuing engagement between the hospital and ambulance trust aimed at reducing ambulance handover times and signposting patients to alternative routes for emergency care needs. There was also ongoing engagement with the local mental health trust to identify support for patients who needed to attend the department with urgent mental health needs.

The service was co-located with an urgent care service that was managed by an independent health provider that was available for all age groups 24 hours a day, 7 days a week. Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The mental health liaison team was based in the emergency department and responsive to requests when these were made. A specialist lead nurse for learning disabilities, autism and dementia was available to support individual patients where needed.

Patients living with dementia were discreetly identified by a daisy cutout on their patient ID band. There was a range of individual support available for patients with dementia and a strong network of champions, led by a healthcare assistant who had a specialist interest in this area.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were no mixed sex breaches reported for the ED.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. A same day emergency care (SDEC) ward was available for patients to access, where this was appropriate. The service had also opened an acute assessment unit for patients to transfer to where they were anticipated to need a short hospital admission.

There was separate access and directions to the children's ED. Work to improve the child friendly aspects of the children's ED had been progressed, with a CALMS room now available in the department for children experiencing mental health illness.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, we saw that patient preferences documented in care plans were not always followed. However, we observed that on occasions, patients' wishes detailed in patient passports were not always fully taken into account when implementing urgent interventions for patients who were experiencing mental health illness.

There were some changes in the department designed to meet the needs of patients living with dementia, with the use of different signage and symbols.

Urgent and emergency services

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and the local community. These covered a wide range of conditions and health related issues including for example, advice for acute simple low back pain, scald injury, plasters and casts, sedatives. The service also provided QR codes for patients and relatives to access further specific information about care and other support organisations that were available.

There was continuing work to improve electronic systems to be able to add different alerts on the electronic patient record to identify individual patient needs.

There was a process to support patients deemed as high intensity users (HIU). The core principles of the HIU service were to identify, personalise, de-escalate, discharge, and manage relapse. The team worked with patients, their families, and other professionals to identify needs and implement a care plan to help reduce the need to attend the ED.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times, but patients could not always access emergency services when needed or receive treatment within agreed time frames and national targets.

National datasets reported by NHS England for Accident & Emergency attendances indicated the total number of type 1 attendees at the trust overall had increasedduring July 2022, with 6,664 type 1 attendances for Lancashire Teaching Hospitals NHS Foundation Trust. On August 2022, there was 11,460, a difference of 4,796. The trust went from the lowest number of attendees in the Integrated Care System to the highest. At the same time the percentage of attendees who were admitted, transferred, or discharged within four hours increased from 49% to 68%. However,data provided by the trust following inspection confirmed that the number of type 1 attendances locally for Royal Preston Hospital emergency department during this period had remained stable.

The trust has consistently seen more than 50% of patients waiting more than four hours from the decision to admit to admission. This metric had been higher than the England average for the last two years. The number of patients waiting more than 12 hours had remained consistent between 120-175 patients per month.

The percentage of attendees who were treated within 60 minutes of arrival was improving and from February to April performance has been better than the England average. The percentage of attendees who spent less than 4 hours in A&E has remained in line with the England average around 70-75%.

Urgent and emergency services

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers and staff started planning each patient's discharge as early as possible.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

The service moved patients only when there was a clear medical reason or in their best interest.

In February 2023 the COVID Majors area of the ED had been re-allocated to acute medicine reducing the ED footprint and the number of patients the ED nursing and medical teams needed to oversee.

Acute medicine and respiratory had been working together to create an Acute Assessment Unit in this space using an innovative Advanced Clinical Practitioner led model to proactively pull patients with an expected length of stay of 72 hours or less from the ED, either at triage assessment or just after. The trust noted that early data was not yet indicating a significant reduction in length of stay in ED for medical patients, however the data did demonstrate that on average an additional 5 patients per day were being discharged home due to these changes.

During April a Rapid Improvement Event had taken place with the Same Day Emergency Care (SDEC) Unit, with the aim of increasing the number of patients who arrived by ambulance going directly to the SDEC and avoiding the ED. The event was successful and increased the number of patients going to SDEC and avoiding ED by an average of 5 per day from less than 1 per day. A weekly improvement group was now established with the acute medicine team to further develop both the Acute Assessment Unit and the SDEC to continue to avoid patients needing to attend the ED and reduce length of stay.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Between December 2022 and May 2023, a total of 20 complaints regarding the service had been reviewed and completed. Of these, 10 were not upheld and 9 partially upheld. One complaint regarding children's ED was upheld. Common themes of complaints included waiting times; communication issues and missed diagnosis; communication support and assistance provided for elderly or vulnerable patients.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Urgent and emergency services

Managers shared feedback from complaints with staff and learning was used to improve the service. Clinical and non-clinical staff described some of the support that had been provided for assisting staff's awareness when responding to patients with communication needs. There were also plans to provide reclining chairs in waiting rooms, to improve experience for patients who may need to wait for lengthy periods.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Service leaders had the skills and abilities to run the service. The divisional leadership team managed the urgent and emergency services at both of the trust's main hospital sites. Since the last inspection, there had been strengthening of the local leadership team, which now included a senior nurse leader whose responsibilities spanned across the urgent and emergency care and medical services at the hospital. This had particularly helped support initiatives to improve access and flow through the emergency department, which was a key focus for service leaders.

There had also been development of the children's A&E leadership structure, with establishment of more direct relationships and communications with inpatient children's wards. Although some of these roles were more recently established, we saw that leaders already had a holistic view of all aspects of the service and had shared priorities for the service overall.

There was regular contact between leaders in their day-to-day oversight of services, as well as routine planned weekly meetings.

Staff had confidence in their local leaders and told us leaders were accessible and responsive when needed. We saw during inspection how leaders were visibly present in the department as a routine, and they had good knowledge of the operational challenges in the service. Otherwise, staff we spoke with told us that senior leaders of the trust were not really visible and visited the department only occasionally.

Service leaders described some of their challenges as working in a busy department with an old infrastructure, and many of the service priorities were related to this. Work to increase staffing levels over the past 18 months had seen an increase in numbers of nursing staff, particularly supported by a programme of overseas nurse recruitment. However, staffing remained one of the key challenges for the service. There was a focus on building and establishing the skills within the workforce, with an ambition to grow future leaders from within the service.

Work was already beginning in this way, with a Practice Nurse Associate now also available in the service and offering monthly supervision and one-to-one support for teams. Leaders of the children's ED had been working with services across different divisions, including community paediatrics and paediatric assessment unit to assist with staffing issues,

Leaders also acknowledged the increasing challenges of patients attending the department with acute mental health needs. Leaders were continuing to work with the local mental health trust and other services to review this situation and plan future actions.

We heard from doctors during inspection saying there was good support for the medical workforce, with senior doctors approachable and readily available.

Staff worked well as a multidisciplinary team and supported each other. Local clinical leads were available and accessible in the emergency department and provided support to junior team members.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had an overall vision for what it wanted to achieve in the service as a whole.

The ED's the vision was "… for patients to receive the right pathway first time, from pre-hospital to in hospital. For the Emergency Department to resuscitate, treat the trauma and acutely unwell, save lives through outstanding timely patient-centred care that is driven by educational innovation, high performing teams, and practice-changing research. This will be supported by system care delivery closer to home."

Urgent and emergency care was one of the trust and divisions strategic priorities that included:

- Providing the right pathway.
- Delivering high quality safe and effective care.
- Reducing mental health delays.
- Obtaining a right sizing of estate to improve patient flow.
- Being responsive to surges in demand.
- The development of a workforce that enabled front end assessments, with a clear roadmap of development opportunity for nursing, medics, and allied health professionals.
- Providing a well-defined wellbeing strategy

The service had a divisional service strategy and an action plan detailing key timelines for achieving this. Metrics were linked to the trust's strategic ambitions and actions towards achieving this progress was reviewed regularly in the divisional improvement forum.

Urgent and emergency services

Leaders could clearly articulate the priorities for the service strategy and action plan and shared this effectively with staff at all levels in the service. The vision and strategy were well aligned to the trust's strategic ambitions and the local health needs of the community served. Staff we spoke with had relevant understanding of the service aims and the key areas of current focus.

During inspection we saw notice boards displaying information for the public, patients, and staff regarding the department's strategic aims. We saw these were aligned to the trusts 'Big Plan, strategic goals, with clear identification of specific targets at local level within the urgent and emergency service. Amongst these aims included to maintain triage time within 15 minutes, and to reduce the time for patients waiting to be seen; to aspire to silver STAR accreditation; to achieve 90% appraisal rate; and to recruit to vacancies across the department.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during inspection said they felt well supported by their managers. Leaders described staff in the service as keen and enthusiastic, acknowledging the work of each individual as part of the team Across the service we saw how staff worked together to provide best care for patients. There was a positive culture evident in the service which was focused on the needs of patients using services. Staff were proud to work in the service and were positive about their achievements. There were good opportunities for development, and during inspection we heard of several examples where staff were being supported to progress in their careers.

Staff promoted equality and diversity in daily work, recognising the individual needs of patients regarding their different cultural backgrounds. Over the previous 12 months there had been a programme of international nurse recruitment in the trust, with a number of international nurses now working in the emergency department. We saw how staff at all levels worked well to support each other in different ways.

Medical staff told us there was good support from consultants and their peers. We saw there was effective team working in the department, despite the service pressures. As reflected in previous inspection reports, we frequently heard about frustrations with the limited accommodation in the emergency department, and the challenges of access and flow through the hospital. Doctors felt this had impact on their ability to provide best care for patients.

There was an open culture in the service and staff we spoke with said they felt confident to raise concerns if they had any. Managers provided opportunities for staff to give feedback and responded to any issues as needed. Staff had access to a network of freedom to speak up champions and staff were aware of how to follow trust processes in case they needed to raise any concerns.

Patients we spoke with said they would be comfortable to raise any concerns.

Health and well-being support was available for staff to access, with information boards prominently displaying leaflets and contact details for these organisations. Staff we spoke with said they had received good support when they have needed to access this and were supported by managers to be able to do this.

Urgent and emergency services

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had effective structures, processes, and systems of accountability to support the delivery of the strategy and quality in the services being delivered. Leaders attended a monthly directorate governance meeting within the service, with key reports from this feeding into the trust's overarching governance committees.

The ED governance framework included representation from different disciplines working across both emergency departments, to allow for full oversight across the service. Governance meeting minutes we reviewed showed there was effective communication and mechanisms for escalation of any issues that were identified.

The standard agenda included different topics including a review of highest risks on the risk register; progress in local and national audits; implementation of NICE guidance; medicines updates; and review of patient experience reports. The meeting also included review of an action log, for monitoring any key items needing to be progressed. We saw from meeting minutes that there were appropriate actions and monitoring systems in place for continued effective governance.

The ED lead pharmacists provided assurance and exception reporting to ED governance to promote discussion and capture the improvement actions where standards were not being met. Specialist pharmacists in ED have started to do Directorate Medicines reports. The Medicines Safety Officer provided divisional safety reports every month for discussion at divisional always safety first. In additional there were rapid improvement cycles. The divisional lead pharmacist for medicines provided Medicines Assurance Reports shared at Divisional Safety and Quality meetings.

Staff at all levels were clear about their roles and accountabilities and were given opportunity to learn about the performance of the service. In different areas of the department, we saw governance boards displaying key service information, indicating service goals and performance towards achieving this. In the children's ED, some of the goals included on board displays were to triage all patients within 15 minutes; to hold a monthly well-being meeting; and to reduce agency cost.

The service worked closely with the co-located urgent care centre that was manged by an independent provider. They collaborated to ensure the most appropriate pathways for patients.

We saw during inspections a 'Green ED – sustainability board', related to early project work led by one of the doctors.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were clear arrangements in the service for managers to be able to have oversight of risks and performance. Staff and managers followed systems and processes to identify and escalate any risks when these emerged.

Service leaders recorded departmental risks in a local risk register document, with the highest-level risks also escalated to a trust wide risk register for continuing monitoring at trust board level. Service risks were reviewed and discussed at monthly governance meetings, with review of continuing action plans to remove and mitigate any risks identified.

Urgent and emergency services

During inspection we saw there were five risks scored as 'high risk' which included: falls in the emergency department; impact of exit block on patient safety who are referred to inpatient areas; potential risk to patient safety and staff workload pressures due to shortage of medical staff due to vacancies; delays in mental health pathway for patients with mental health needs; patients being cared for in the waiting room due to impact of exit block; and medication errors.

In the case of the risk identified as 'Impact of exit block on patient safety', this had been escalated to Trust Board, with the Safety and Quality Committee noting the risks and the continued work to review this long-standing risk. In March 2023 the trust had appointed an executive lead as Senior Responsible Officer for Urgent and Emergency Care Improvements. An Urgent and Emergency Care Board had been established in the trust to oversee delivery of 3 main transformation programmes aimed at reducing length of stay and crowding in the ED.

Service leaders were able to clearly describe the local risks that were recorded, and we saw there were relevant action plans related to each of the risks. As a general observation, service leaders also told us that financial restrictions were an everyday challenge, particularly regarding equipment issues. Leaders had routine day-to-day contact with senior managers in order to raise any immediate concerns if this was needed. During inspection we also noted that the local risk registers were an accurate reflection of the service challenges and were a good representation of the areas of concern frequently raised in discussions with staff. Action plans identified relevant leads for continuing monitoring and review of progress towards achieving these.

Service leaders implemented a systematic programme of clinical and internal audit to monitor quality and operational processes, and there were systems to identify where action should be taken.

Staff at all levels frequently stated that one of the departments main risks was a lack of space. The ageing estate and limitations of the physical environment in the department were clearly acknowledged and recorded as a trust wide issue.

We saw that staff worked flexibly and as best they could to meet this challenge, and used opportunities where they could, to influence any change. The trust's safety and quality committee notes recorded that work was continuing to improve the environment in the ED at Royal Preston Hospital, with plans to increase the isolation capacity in the ED to 12 isolation cubicles. This would improve infection control standards and reduce the risks of hospital acquired infections in the ED, with work beginning in May 2023.

Following the last inspection, staff in the children's ED had followed up an action regarding secure access through an internal entrance to the department. In their reconfiguration of the department although this issue had been rectified, there was still a shared corridor where staff in the adult A&E service continued to access the route. The service met the standards set out by the Royal College of Paediatrics and Child Health Standards for children in emergency care settings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers and staff had access to a range of information and data to monitor service activities and performance, both in daily reports and review reports of service performance over time. Staff had access to computer terminals in the department for accessing the information they needed.

The trust used dashboards to monitor performance, including live dashboards which indicated patient waiting times, ambulance handover times, and any delays in patients being transferred to other wards and departments.

Staff completed training in information governance and were aware of the confidentiality requirements of record keeping.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders engaged with patients and the public. A revised patient experience and involvement strategy was launched in 2022 with contributions from patients, relatives, and carers as well as staff, governors, and partner organisations.

Engagement with public groups, with the exception of the NHS Friends and Families Test, had been stopped prior to the COVID pandemic, although this was starting to be progressed again. Examples we heard about during the inspection included the 'red rose and recovery group'. This was a community engagement for patients who had attended with mental health needs, and which offered support looking at support for patients with drug and alcohol addiction. The sepsis lead nurse was also developing plans for a 'sepsis survivor' group.

We also heard how there had been active engagement with the youth forum in the development of the CALMS room in the children's ED.

Governance boards in different areas of the department also provided information including 'you said we did' updates, and general notices.

Staff at all levels received information and feedback from the trust through different communications, including newsletters from the chief executive and intranet bulletins. Staff had the opportunity to meet together in weekly team meetings, with different social media groups for staff to share updates. These included a 'WhatsApp' group for managers group and a patient flow.

Managers engaged with staff in different ways, also taking opportunities for staff recognition. In one example we saw there was a "team paediatric staff praise board", and "team ED be kind appreciation board". We saw messages acknowledging staff for "being so supportive and caring" and" thank you for all your hard work".

There was an extensive range of employee wellbeing support available for staff to be able to access. In addition, one of the trust's volunteers who was passionate in acknowledging the commitment and work of staff in the department, looked after the trust's wellbeing dog. We heard how staff in different areas around the hospital positively appreciated the support provided in this wellbeing initiative.

Included in the 4440 responses in the 2022 staff survey, there were 240 responses from the ED and acute medicine division. The responses were RAG rated in comparison to the whole organisation. There were six responses rated green, 42 that were amber and 49 that were red. There were 80% of staff who thought there were opportunities to show initiative frequently in their role. There were 65% who said that team members often meet to discuss the team's effectiveness. There were 62% of staff who responded that said the organisation acts fairly with career progression and

57% said they were involved in deciding changes that affected their work. However, of the responses that were worse than the average for the organisation, there were 14% who said that they are never or rarely worn out at the end of work, 20% who said they were satisfied with their pay and there was 32% who said their appraisal left them feeling that the organisation valued their work.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff in the service had participated in mental health awareness week during May 2023, identifying various resources and activities for staff learning. These included a mental health bulletin, and the findings identified as good practice from the mental health risk assessment tool.

The service had engaged with the regional NHS ambulance provider in a quality improvement programme 'hospital handover collaborative'. Staff from different services worked together to identify actions aimed at improving ambulance turnaround times. In early results, data for Royal Preston ED showed that from December 2022 to March 2023 average ambulance handover times had reduced by 42%, from 40.4 to 23.3 minutes.

The children's ED had been continuing work to raise awareness of promoting safer sleep for babies, with information provided for every parent or carer of an under 2-year-old attending the department. The service had been nominated for the trust's 'our people award' for this work.

One of the middle grade doctors in ED had begun work with focus on the 'green footprint' of the department. This involved improvement actions such as being 'paper lite' and monitoring the use of nitrous oxide. The department had been recognised with a Royal College of Emergency Medicine award for the work focussing on sustainability in the department.

Maternity

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Training compliance for the trust was 90% and included training such as, conflict resolution, fire safety, infection prevention and control, maternity antenatal screening, maternity post op, patient safety, newborn feeding and human factors.

The service was not able to split mandatory training compliance data by location, therefore we could ascertain if areas of lower compliance related to maternity services at Royal Preston Hospital.

The service had a training needs analysis for maternity skills and drills training; it was in date, version controlled and next due for review in June 2026. There was an additional spreadsheet which outlined other mandatory training required for each role. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards. It covered all members of the multidisciplinary team and the management of non-attendance at skills training.

There was a blended approach to training sessions and sessions were either classroom based, e-learning, simulation training and workshops.

All maternity staff completed the maternity specific essential training, which included several key topics in managing maternity obstetric emergencies, such as, management of obstetric emergencies, sepsis training, maternal AIMS course which provided midwives tools on how to deal with obstetric emergencies and care of the critical ill pregnant or postpartum woman.

Specialist midwives completed additional training dependent on their specialty and role. For example, the infant leading attended additional training for advanced clinical tongue tie, breastfeeding and relationship building and the fetal monitoring lead midwife attended additional training on baby's lifeline and the national fetal monitoring lead network meetings.

Maternity care assistants attended a two-week health care assistant course prior to commencing in clinical areas and completed the care certificate.

Most midwifery staff completed mandatory training and compliance was good across all modules except resuscitation training. For level 2 immediate life support, only 66% of midwives had completed the training and only 64% of midwives had completed paediatric immediate life support training. However, newborn life support was included in obstetric emergency training. This meant that staff did not have the appropriate level of training to provide lifesaving treatment to women and birthing people and babies in their care.

Medical staff overall compliance with training targets was 83%, which was below the trust target of 90%. Only 61% of medical staff had completed required growth assessment protocol/gestational related optimal growth (GAP/GROW) training.

The service provided training and competency-based assessments on the use of Cardiotocography (CTG). Midwifery staff compliance with CTG update was 99%, CTG and fetal monitoring competency was 99% and CTG equipment competency was 99%. For medical staff the compliance was 94% with CTG update, 91% for CTG and fetal monitoring competency and 94% with CTG equipment competency. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

Staff completed regular skills and drills training. Ninety-nine percent of midwifery staff and 89% of medical staff had completed obstetric emergency training.

Staff told us they completed skills and drills in pool evacuation. However, the service did not provide information to show that staff completed pool evacuation training or compliance rates. Therefore, we could not be assured there would be enough staff trained to evacuate women, birthing people and babies from the birthing pool in an emergency.

The service had a practice development midwife who supported staff to access training and facilitated face to face fetal monitoring, obstetric emergency and public health training days.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. We looked at the contents of the safeguarding training that staff completed; it covered the expected modules for safeguarding level 3 training.

At the time of the inspection the service had not yet fully implemented the Oliver McGowan or equivalent learning disability eLearning. This was required training to ensure staff in the NHS have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. The service provided information that showed the training had been agreed by the trust. Following the inspection, the service provided information which showed staff had met the trust target in learning disabilities, autism and neurodiversity training.

Safeguarding maternity e-learning was part of all maternity staff induction and included perinatal mental health, alcohol and pregnancy, domestic abuse, female genital mutilation (FGM) and ICON training. ICON training is interventions on abusive head trauma. Following the e-learning, staff completed a competency assessment.

Following initial safeguarding induction training, staff completed a yearly 4-hour mandatory safeguarding training as part of their public health study day.

Staff received training specific for their role on how to recognise and report abuse. Training records showed that staff had completed both Level 3 safeguarding adults and safeguarding children training at the level for their role as set out in the trust's policy and in the intercollegiate guidelines.

Medical staff overall compliance with safeguarding training was 83% for level 3 safeguarding adults and 73% for safeguarding children level 3. This did not meet the trust target of 90%

Maternity

Nursing and midwifery staff compliance with training targets was 95% for safeguarding adults and children level 3. This met the trust target.

Support staff/unregistered nursing staff completed level 2 safeguarding adults and level 3 safeguarding children training. The compliance with training targets was 100% and 94% respectively. This met the trust target.

The safeguarding team consisted of a named safeguarding midwife, specialist midwife for perinatal mental health and specialist midwife for enhanced support. The enhanced support midwife supports teenage pregnancy and women experiencing domestic abuse and women using drugs and alcohol. This team is also supported by band 6 midwives.

The team worked closely with the perinatal mental health midwife and supported staff. The safeguarding team were visible and attended the daily safety huddles.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

The safeguarding team and maternity services had developed and piloted “HOPE” boxes for those women who were separated from their babies either permanently or temporarily. This was being used across local maternity and neonatal systems (LMNS) and nationally to support loss and grief for mother and the child if a long-term separation is the final outcome.

The lead midwife for safeguarding represented the trust at the ICON babies cry, you can cope task and finish group within the local area, which then fed into the national ICON steering group. ICON provided key messages and awareness to women, birthing people and their families to show babies crying is normal and there are methods which could be taken to help parent and families’ cope. To educate parents and to reduce head trauma in babies.

The service worked with local partnerships to provide community-based simulation training to support midwives to recognise areas of risk and safeguarding concerns during home visits. For example, post-natal follow up care.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Maternity

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

The service-controlled infection risk well. Staff used equipment and control measures to protect woman and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. During our inspection we saw cleaners, cleaning all areas throughout the day. The flooring in the clinical areas and associated corridors allowed for effective cleaning.

Staff cleaned equipment after contact with women and we could see 'I am clean' stickers to identify when equipment was cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff used the right level of PPE, which was stored on wall mounted displays. Staff were bare below the elbow and hand sanitiser gels were available throughout the service.

Data provided by the trust showed both medical and midwifery staff were trust compliant in infection, prevention, and control (IPC) training.

The service had effective processes to manage cleanliness and infection control. We looked at the most recent infection prevention and control audit and saw action plans developed to improve compliance with infection prevention and control standards. Actions were monitored through the divisional infection prevention and control meetings. The service generally performed well for cleanliness, and we saw evidence of the unannounced accreditation visits, with each area displaying a STAR certificate. We were told that the maternity service was consistently good in their STAR ratings with the birth centre and delivery suite scoring gold. Antenatal clinic, maternity A antenatal ward and maternity day case scoring silver and maternity B postnatal ward scoring bronze.

The service audited infection control standards every month. We looked at audits for March to May 2023 and saw overall compliance across all areas was 95.3%. Compliance had declined in May 2023 on maternity A and B ward from 100% to 94.4% and on delivery suite from 100% to 88.9%.

The service had effective processes to monitor hand hygiene. We looked at the most recent audit for March to May 2023 which showed 100% compliance in all areas.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The design of the environment followed national guidance. The maternity unit was situated in a purposed built part of the hospital with a separate entrance into maternity. The maternity assessment unit was on the ground floor and included maternity triage and antenatal clinics. Situated upstairs was the delivery suite, maternity ward A (antenatal), maternity ward B (postnatal) and the midwifery led birthing centre. Out of hours the maternity triage was based within Maternity ward A.

Maternity

Inductions of labour took place on the antenatal ward and there was a separate transitional care area within the postnatal ward. The transitional care bay had 4 beds with an additional bay used if required. There was one neonatal nurse allocated to 4 babies.

All equipment and store cupboards were visibly clean, tidy, and uncluttered. A fridge specifically for infant milk storage was kept in a locked room which stored medicines and dressings. The name, hospital number, date and time expressed were written clearly on all labels. The milk-fridge was checked daily to ensure it was always locked, maintained at the correct temperature for safe storage.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support. Equipment such as birthing balls, aromatherapy and knee pads were also available on request.

The service had a system to monitor equipment safety checks completed and due. All new equipment underwent acceptance testing and was placed on an asset database which generated a schedule for preventative maintenance.

We reviewed records of planned and reactive equipment maintenance and saw 121 out 124 planned maintenance jobs and 251 out of 257 reactive equipment maintenance jobs had been completed.

Ligature point risk assessments had been completed for maternity services in each area. Each item of risk was identified, a risk score agreed, and control measures put in place.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the birth centre there were pool evacuation nets in all rooms and on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration.

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

Staff identified and quickly acted upon woman and birthing people at risk of deterioration. Staff used a nationally recognised tool to identify woman and birthing people at risk of deterioration and escalated them appropriately.

During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators, and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

Maternity

The dashboard showed several areas which had been given a red flag as performance was lower than expected. These included 3rd/4th degree tears following assisted birth, postpartum haemorrhage (PPH) over 1500ml and the still birth rate. We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measures to ensure all patient safety incidents were reported to NRLS. The service took immediate action to ensure all staff reported incidents of 3rd and 4th degree tears and PPH over 1500ml to the online reporting system in accordance with guidance.

The service provided information that showed declining performance in relation to the time taken from making the decision to carry out a category 1 (urgent) caesarean section to delivery in line with clinical guidance. The number of category 1 caesarean sections had increased each month since November 2022. The service reported the number of category 1 caesarean sections where the time from decision to delivery was less than or equal to 30 minutes was 68% in May 2023, this had declined from 100% in November 2022. In May 2023 the number of category 1 caesarean sections was 25 compared to 18 in November 2022. However, there were 21 cases in March 2023 and the trust was still at 90.5% compliance.

The service had 5 postnatal readmissions within 14 days of discharge between September 2022 and May 2023.

One to one care on labour was achieved on the delivery suite for 98% of births between June 2022 and May 2023, this was 100% for Preston Birth Centre.

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Staff used a situation, background, assessment and recommendation (SBAR) tool when handing over the care of women, birthing people and babies to others.

We reviewed audits of SBAR completion carried out in May 2023 which showed low compliance with documentation of the SBAR in women's and birthing people's notes. SBAR was recorded when transferring care between shifts in 40% of the time on maternity ward A, 60% of the time in intrapartum care and 55% of the time in postnatal care. When transferring from the antenatal ward to intrapartum care the SBAR was completed 90% of the time and 80% of the time on transfer between intrapartum care to the postnatal ward. However, the audit stated that a verbal SBAR had been completed in 100% of cases. The service had an action plan to address low compliance, a poster was developed to educate staff and actions were on track for completion by the end of September 2023.

The service completed monthly Cardiotocography (CTG) and fresh eyes audits. CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audit for October 2022 to April 2023.

We saw compliance with hourly CTG reviews had declined at 80% in April 2023 and compliance with hourly 'fresh eyes' reviews had increased to 83%. However, this was below the target of 85% compliance. The service had an action plan to address low compliance and planned to continue quarterly audits to check improvement.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists every month. We reviewed audits for January to June 2023 and saw some areas of low compliance in relation to sign in, time out and sign out. The service explained this was related to audit questions which were no longer required as part of the WHO checklist and had an action plan to address areas of non-compliance. Compliance with these areas had improved in the audit completed in June 2023, with 4 out of the 6 areas within the audit being 100% completed. The two areas with compliance of less than 100% were the WHO signing in checklist which scored 93.9% and WHO surgery checklist timeout. WHO checklist compliance was monitored via the divisional risk register.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. The newborn observations using track and trigger system (NOTTS) is designed to be used by healthcare professionals working in areas caring for newborns in the early postnatal period to identify babies at risk of clinical deterioration and provide a standardised observation tool to monitor clinical progress. The service audited NOTTS completion. We looked at the audit for the April to June 2023 and found 29% of observations were not performed on time. Most delays were for observations due to be performed within the first hour of life and at 12 hours. The audit identified 100% compliance with appropriate escalation to the neonatal team.

The service used a nationally recognised tool called Maternal Early Warning Scores (MEWS) in detecting the seriously ill and deteriorating. The MEWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016).

Audit results for April to June 2023 showed the overall compliance for the completion and escalation of MEWS scores for delivery suite was 98% and for maternity ward B (postnatal) was 84.2%.

The maternity assessment suite (MAS) had partially introduced a nationally recognised safety tool for use within maternity triage to prioritise care for pregnant women and birthing people. There were a core team of midwives working within the MAS. The service had not adopted all the principles of the nationally recognised safety tool due to the MAS environment and medical and maternity staffing pressures.

The partial implementation of the triage safety tool had been risk assessed and was a current active risk on the divisional risk register.

The telephone triage line was not within a dedicated space and was not always staffed by a qualified midwife at night. The telephone line was not dedicated to maternity assessment triage. During the inspection, staff told us there was no system to monitor missed calls or drop off rates. However, following the inspection the service put in place a telephone system to monitor missed calls or drop off rates.

Maternity

From January 2023 to June 2023, there were 51 incidents reported which showed women and birthing people frequently waited over 15 minutes for an initial triage by a midwife, which was not in line with trust policy. However, the trust provided information that from January 2023 to June 2023 the average compliance rate for women and birthing people to be seen within 15 minutes was 90%. From April 2023 to June 2023 97.8% of women were seen by a doctor within the triage tools timeframes.

Women and birthing people who were not fully triaged within 15 minutes were risked assessed by midwives to maintain safety. The MAS midwives used their clinical judgement to prioritise the order in which women and birthing people were seen and an incident report was completed so that the case was reviewed to identify if there was any harm.

Following, the inspection a review of further information of data and from staff, we issued a Letter of Intent under section 31 of the Health and Social Care Act 2008. We requested further assurances from the trust that risks to women, birthing people and babies across the maternity pathway were assessed and risks were mitigated. The trust responded to the letter of intent confirming they had sourced a telecommunication software package. The software could be customised to the service and allowed a filter for calls not intended for maternity triage, allow a hold-the line message and queue option as well as a call back option, to allow for monitoring of any missed calls.

There were delays in the induction of labour pathway, both to the start of induction of labour and once induction of labour had been started. The audit for induction of labour showed between April to May 2023 there were 52% of cases experiencing a delay in starting induction of labour with the main cause being 'unit activity'. There were 14 out of 23 women and birthing people who experienced an additional delay in the induction of labour process following start of induction of labour, 7 cases where the induction of labour process from first induction cycle to birth was over 56 hours with the longest being 90 hours 30 minutes. The audit also found over half the cases did not have an explanation for delay documented in the woman or birthing person's notes and there was decreasing compliance with maternal observations in induction of labour from the previous audit.

Following, the inspection a review of further information of data and from staff, we issued a Letter of Intent under section 31 of the Health and Social Care Act 2008. We requested further assurances from the trust that they would take action to address delays in induction of labour. The service had now introduced a new booking process to support the reduction of delays in the induction of labour process and an audit would be completed in August 2023 to review this progress. The delays to induction of labour were also placed as high risk on the maternity risk register, there were specific maternity red rated options on the electronic incident reporting system for staff to use. Delays were also reported within the monthly maternity and safety quality committee reports and the number which were due to unit acuity.

Elective caesarean section lists over running was placed as high risk on the maternity risk register.

Following the completion of The BirthRate plus assessment in 2022 it was identified there was an increase in complexity of cases and emergency caesarean sections had increased by 11.9% and elective caesarean sections by 19.6%.

This meant it had put additional pressures such as staffing and a lack of capacity for emergency caesarean sections. To support the pressures the service scheduled additional theatre lists if increased capacity was anticipated. There was a daily review of cases and a weekly scheduling meeting to confirm the appropriateness and times of surgery.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns. Women and birthing people who had severe or complex mental health were supported by the perinatal mental health midwife throughout their pregnancy.

Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to- date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

Midwifery Staffing

The service had issues with recruitment and retention and sickness of staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service last completed a staffing and acuity review in December 2022 and reported this to board in July 2023. It said the service did not have enough staff to meet the planned needs of women. There were plans in place to address this and to provide safe care to women who used the service. Actions to address the shortfall included rolling recruitment, department specific roles and recruiting internationally trained midwives.

From June 2023, there was a registered midwifery vacancy rate of 10.6 whole time equivalent (WTE), with a further 18.8 WTE of staff leaving or on maternity leave from June 2023, totalling 29.47WTE staffing gap by August 2023. A recurrent advert to fill all vacancies was ongoing with 8 prospective midwives recruited on condition of qualification. The service had a predicted maternity support worker vacancy of 4.41 WTE by August 2023.

The service introduced department specific roles to retain existing staff and attract new staff to the trust. There was an international recruitment process with 3 midwives joining the service. There was a plan to recruit a further 13 international midwives throughout the year.

All unfilled shifts were offered as bank and then were converted into agency if they had not been filled within 2 weeks.

There was not always enough appropriately skilled and trained staff to provide safe care and treatment to women and birthing people presenting to triage and the maternity assessment centre at night. The service had completed an audit activity to confirm safer staffing levels within the triage area at night, this was 1 whole time equivalent trained midwife. However, we to staff who felt midwifery staffing within the triage area at night was not sufficient to both assess women and birthing people coming into triage and to answer the triage telephone line. The service followed up our concerns quickly and introduced a maternity support worker (MSW) into the MSU day and night to support within triage and were actively recruiting more staff into the unit. From August 2023, a speciality doctor was dedicated to the MAS, Monday to Friday from 1pm to 5pm. Outside of the hours were covered by the medical on-call team.

Maternity

The service operated within the Northwest Maternity Escalation Policy and Operational Pressures Escalation Levels Framework. This was supported by a local policy which covered out of hours consultant role, anaesthetic cover and duties, clinical escalation, maternity staffing levels and escalation to on call manager support.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Ninety-one per cent of midwifery staff and 93% of medical staff had received an appraisal. However, the service did not break down compliance rates by location, so it was not possible to ascertain appraisal compliance for this location.

Managers made sure staff received any specialist training for their role. Midwives had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course. The maternity service had a team of practice development midwives, which included lead midwives for practice development for staff and for students, clinical skills facilitator, lead fetal monitoring midwife.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. In May 2023 the service reported 72 red flag incidents. The highest reported delays included a delay in review for more than 30 minutes for obstetric review in triage and delay in time critical activity.

Staff working within the maternity assessment suite, maternity ward A and maternity ward B told us they were regularly moved staff from areas they were working in to cover staff shortages within the delivery suite. This meant there were extra pressures within other areas of the maternity departments.

There was a supernumerary shift co-ordinator on duty around the clock who had oversight of the staffing, acuity, and capacity. Supernumerary compliance was monitored within the service monthly and reported to the trust safety and quality committee. The service had 100% compliance.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had worked with other local trusts to create and implement a new preceptorship package for newly qualified midwives. The package included a two-week induction to complete skills and training. A 5-week supernumerary rotational period through intrapartum care, antenatal clinics and community midwifery services. The preceptorship team introduced social media groups for newly qualified midwives and coffee mornings and a monthly preceptorship drop in.

The service was continuing to work to improve recruitment and retention and had introduced specialist midwives to support this agenda. Leaders worked with local maternity and neonatal systems partnerships (LMNS) to develop a support package for midwives who had been recruited from other countries and to evaluate the experiences of international recruitment.

Maternity

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep women and birthing people and babies safe and medical staff did not always match the planned number.

There were 21.31 funded whole time equivalent (WTE) consultant posts with 3.09 vacancies. The 3 vacant consultant posts were currently filled by long term locums. Two of the vacant posts had been recruited and were due to start in August and September 2023.

The service had 15 WTE of middle grade and specialty trainee doctors, with 2.23 WTE vacancy.

The service also had in place 12 foundation doctor's speciality level doctors. All posts were recruited to and there were 3 trainee clinical fellows to train to become middle grade doctors within 12 months.

Obstetric consultants were allocated duties via the consultant rota. Consultants allocated to the delivery suite did not cover alongside other duties due to the delivery suite taking priority. The obstetric consultant was allocated to be resident from 8.30am to 9pm on weekdays and for 7.5 hours on public holidays and weekends.

The on-call consultant attended morning handover 7 days per week. The handover was multidisciplinary and took place on the delivery suite. Following handover, the medical team completed a ward round on the delivery suite with the on-call team. The team completed a ward round on maternity ward A antenatal as well as any postnatal readmissions.

Managers made sure locums had a full induction to the service before they started work. There was a local induction checklist for locum staff. The checklist included an introduction to the department, working practices and procedures, clinical and ward-based protocols.

There was a clear process for the admitting consultant or consultant of the week to follow to make sure the locum doctor was supported and had a clear understanding of their role.

The service met the 90% compliance for appraisal rates, with 93% having had an appraisal in May 2023.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily. The trust used an electronic notes system and staff were confident and competent to use them.

We reviewed 7 records and found they were clear and complete. We saw good examples of information regarding communication and mobility for women attending the service with a disability. Safeguarding alerts were visible on the electronic records along with management plans. The service audited records every 3 months. Following, the inspection we reviewed record keeping audits and found lower compliance related to documentation of postnatal care at Royal Preston Hospital.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records. The trust used electronic records which had a 'break glass' system to view electronic records held by other trusts. This system meant if a women or birthing person transferred to another team, even if that team was part of a different provider, the records were available to anyone providing maternity care.

Records were stored securely. Staff locked computers when not in use and had individual computer tablets to use in the birthing rooms.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service had systems to check staff competency when using medicines was in line with trust policy and national guidelines. A management training and competency package was launched in May 2023. The service told us they aimed for 90% of staff to complete this by the end of July 2023 and by the end of May 2023 71% of midwifery staff had completed it. Following the inspection, the service told us that in September 2023 training compliance was 84%.

The service had systems to check staff competency when using medicines was in line with trust policy and national guidelines. We saw 100% of midwives had completed intravenous drug administration training and were signed off as competent.

Staff reviewed each woman's medicines regularly and provided advice to woman and birthing people and carers about their medicines.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Medication was kept secure, neat, and tidy in medication cupboards. Staff completed medicine records accurately and kept them up to date. Woman and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed 4 incidents reported in the 3 months before inspection and found them to be reported correctly.

Staff could explain how to report serious incidents clearly and in line with trust policy. Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Ward managers attended the perinatal mortality reviews to ensure learning from incidents across the trust maternity services was shared. They shared learning from incidents at regular team meetings.

Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff described learning from trust wide cardiotocography (CTG) monthly review meetings where any incidents which featured CTG were discussed and learning from those. Staff received a monthly safety briefing which included lessons learnt form incidents and investigations.

From January 2023 to March 2023 there were 7 perinatal deaths, 1 death did not meet the criteria for the Perinatal Mortality Reviews Summary Report (PMRT) tool. All 6 eligible cases were notified to MBRRACE within 7 working days, with the review of information in each case completed within 1 month. MBRRACE is a national audit programme to collect information on late fetal losses, stillbirths, neonatal and maternal deaths. For all 6 cases the service informed parents for the PMRT review and gave them the opportunity to ask any questions or to provide any information for the review.

Quarterly reports submitted by the Director of Midwifery to the trust board included details of all deaths reviewed and action plans. The quarterly reports formed part of the agenda for the maternity safety champion meetings.

The Corporate Governance Team had a rolling programme of submission to the National Reporting and Learning System (NRLS). Incidents were uploaded once an incident was closed on the trust incident reporting system, to allow for update on the national database of any changes to the categorisation of harm. They re-uploaded following investigation which they told us accounted for any other delays.

However, the service did not consistently report incidents to the National Learning and Reporting System (NRLS), nor did they report all incidents in a timely manner. We issued a letter of intent under section 31 of the Health and Social Care Act 2008, asking the trust to take immediate measure to ensure all patient safety incidents were reported to NRLS. In the response, the service provided information that showed it took the corporate governance team an average of 85 days to report incidents to NRLS. This was not in line with local and NRLS guidance which stated incidents should be reported within 1 month. The trust took immediate action to ensure all patient safety incidents were reported to NRLS accurately and in a timely manner in accordance with guidance.

The maternity dashboard showed the service reported a rate of 3rd and 4th degree tears of 2.7%, from January 2023 to May 2023. However, we reviewed NRLS for January to June 2023 and found only 4, 3rd or 4th degree tears had been reported.

The dashboard showed 39 post-partum haemorrhages (PPH) over 1500ml between January and May 2023. However, we reviewed NRLS from January to June 2023 and found only 5 reports of PPH over 1500ml. We asked for further information from the trust within the letter of intent issued.

Maternity

Information received highlighted that the service did not report all 3rd and 4th degree tears and PPH's as incidents. These cases were reported to the regional maternity dashboard and all cases were reviewed. If there was a gap in the care given or an opportunity for learning, then the service would report these cases as an incident and report to the NRLS.

Following the inspection feedback, the service gave assurance that all 3rd and 4th degree tears and cases of PPH over 1500ml would be reported as an incident.

Following a never event in January 2023 in a theatre that wasn't used by maternity services, the service introduced additional peer review audits in April 2023. These highlighted areas of low compliance with WHO checklists, which improved from May to June 2023.

In the last 6 months, 3 incidents had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation. We reviewed the rapid reviews of these incidents and found they were comprehensive with clear action plans to address immediate learning.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Leaders understood and managed the priorities and issues the service faced. There was a clear triumvirate leadership structure in place.

The service was within the women's and children's division. This was led by a divisional director, divisional midwifery and nursing director, divisional medical director and divisional nursing lead for children and young people, also known as the 'quad'. The quad was supported through clear professional arrangements and had professional reporting lines to the medical director and chief nurse.

There was a maternity leadership team which consisted of a clinical director, associate medical director, divisional midwifery and nursing director, deputy divisional midwifery and nursing director, consultant midwife, clinical business manager and clinical governance lead. The maternity department and birthing centres cross site were managed by the divisional midwifery and nursing director.

The leadership team also included the safety and quality matron, lead midwife for safeguarding, midwifery led care matron, complex care matron and specialty business manager. There were clear lines of reporting from the maternity leadership team to the quad. The maternity leadership team managed a team of band 7 specialist midwives, managers and coordinators.

Maternity

Leaders were visible and approachable in the service, for woman and birthing people. Leaders were respected, and most staff told us they found the matrons would listen to them, were supportive, approachable, and keen to drive improvement. However, not all staff we spoke to felt they were listened to when raising concerns around staffing.

Each area of the service had a designated ward manager, who worked clinically when required. Staff told us they were well supported and listened to by ward managers.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The service was supported by maternity safety champions and non-executive directors. Maternity safety champions carried out regular visits and walk rounds at Royal Preston Hospital. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

Leaders recognised the importance to support staff in developing their skills and to take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help staff progress.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy covered 2021 to 2024 and was called 'Our Big Plan'. It was developed in consultation with key stakeholders and staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

The vision had 4 key objectives. These were to provide outstanding personalised care for women and families, to provide safe and high-quality evidence-based services, to provide opportunities for research, innovation and continuous improvement and to care for our workforce providing a supportive workplace where compassionate leadership is a priority. The 4 key objectives were aligned to national strategic drivers and clinical priorities, with clear actions attached.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The maternity service aimed to support and empower women and birthing people to make informed choices about their care, with plans in place to be able to support the continuity of carer pathway to women and birthing people from socially deprived backgrounds and from a Black, Asian or other Minority Ethnic group (BAME).

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The maternity service strategy linked to the overarching trust strategy.

Culture

Staff mostly felt respected, supported, and valued. Staff were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and birthing people, their families could raise concerns without fear.

Maternity

During the inspection we spoke to some staff who were not positive about the culture within the maternity department or its leadership team, and concerns around safety and staffing had not been addressed and they were not always listened to. We found there was a clear difference in opinion in regard to support from the inpatient midwives working compared to the community and continuity teams.

This was also reflected in the overview the service provided around the main themes identified from the most recent staff survey in 2022. They identified the lowest and highest scoring teams and analysed the reasons for those scores. The survey showed staff on delivery suite and maternity wards A and B scored low on how they felt about their team, the people in the organisation, their managers and their personal development. In contrast, the maternity continuity team and specialist midwives were highest scoring teams in the division with high scores for working with colleagues and support from managers.

The service had undertaken a number of actions to address burnout and fatigue, including funding higher education course for midwives, holding a local maternity conference, awarding 'shining star' recognition awards monthly, relocating senior midwives to the wards and refurbishing a new staff breakout room. They also were taking steps to address staffing short falls which impacted on morale and resilience. However, some staff continued to tell us the areas they were working within felt unsafe and staffing had not improved.

The May 2023 Maternity Service bi-annual safer staffing review identified sickness levels within the service had been significantly above the trust target for over 12 months. The report highlighted that the staff survey indicated there was work to do to improve the way that some staff felt about work. Following the identification of sustained high sickness rates, the division had requested further follow up and support to ascertain how sickness could be improved.

Staff were fully focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Women and families, we spoke to during our inspection spoke highly of the staff and told us they were treated with dignity and respect.

The trust measured against other NHS organisations to compare against workforce race equality standards (WRES). These standards are a set of measurements to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The results for staff from all other ethnic groups were lower or similar to results for white staff at the trust.

The trust scored positively compared to the national averages for staff, with a lower proportion of staff from all other ethnic groups having experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months and a similar proportion of staff from all other ethnic groups who had experienced harassment, bullying or abuse from staff in the last 12 months. The trust did not score as positively for the measurements against the workforce disability equality standards (WDES). Results showed staff with a long-term condition or illness had poorer experiences compared with staff without a long-term condition or illness. The trust's results were similar to the average for comparable NHS organisations.

Midwives had additional training to become professional midwifery advocates (PMAs) to support the practice and development of midwives. PMA's supported restorative supervision, provide leadership to midwives, supported local governance, risk management and staff development.

Maternity

The maternity and neonatal safety champions met every 2 months. We looked at meeting minutes for the last 6 months and saw they were comprehensive, with a set agenda aligned to the key lines of enquiry. They covered all key safety elements such as incidents, staffing, mortality reviews and equality and diversity. Clear actions were recorded in minutes and the dates for future safety champion walk rounds.

Oversight of safety in maternity services was reported to the board every month. We reviewed the last 3 reports and found they covered key safety and staffing data, risks and challenges. These were reflected in other reports we reviewed and what we found during our inspection.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. For example, they had used this data in the annual review of still births to identify any themes or trends for women, birthing people and babies from ethnic minority and disadvantaged groups.

The service recently carried out a mapping exercise with the local maternity and neonatal system to look at how they could provide enhanced continuity of carer teams in geographical areas of greater deprivation or greater numbers of women and birthing people from ethnic minority and disadvantaged groups.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement.

The service had an open culture where women and birthing people and their families could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. There had been six complaints about the care received at Royal Preston Hospital between April and June 2023.

All complaints and concerns were handled fairly, and the service used the approach ,most applicable to deal with complaints and progressed complaints through formal processes where appropriate.. The service gave information about how to raise a concern in welcome packs in each birthing room. Staff understood the policy on complaints and knew how to handle them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a strong governance structure that supported the flow of information from frontline staff to senior managers.

There was a divisional governance group which consisted of a divisional governance lead, 2 divisional governance facilitators and 2 band 7 governance risk managers. Relevant information was escalated to the Trust quality and safety committee.

Maternity

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings which outlined how key information and risks flowed from maternity speciality level through to divisional committees, boards and improvement forums to the executives, board committees and board of directors. The divisional governance structure reflected the requirements of the Ockenden report. There was a clear structure for escalating higher scoring risks from divisional board to the trust board through the senior leadership team and board committees.

Clinical governance meetings were held monthly. We looked at meeting minutes for the last 3 months and saw they comprehensively covered expected areas of safety and quality. This included clinical effectiveness, audits and performance dashboards, key risk including risk register review and safeguarding, incidents and lessons learnt, staffing and feedback from women, birthing people and their families. The meeting was attended by relevant managers, midwives and stakeholders.

Managers and staff carried out a programme of repeated audits to check improvement over time. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

The service did not provide the last 3 meeting minutes for the divisional quad meetings, therefore we could not review the contents of the meetings, themes, actions or learning.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

The service had a meeting structure which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

There were opportunities for managers to meet with the senior management team on a monthly basis, and key areas including performance, staffing and incidents were discussed in these meetings.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

There were plans to cope with unexpected events. The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. All diverts were incident reported and women and birthing who were affected were contacted to check on their wellbeing and an apology letter was sent to them. Leaders in the service monitored diverts through their dashboard. Between March and October 2022, the unit had been closed 4 times with 17 women and birthing people affected. The unit had not been on divert since the end of October 2022.

Serious incident investigation reports were approved by the division and reviewed at the trust wide safety and learning group each month. The group provided oversight and approval of all serious incident investigations and reviewed any external reports produced. We looked at minutes for the last 3 months and saw the group discussed incident reports, duty of candour and involvement of women, birthing people and their families as well as providing challenge to the incident report.

The service had an adverse incident reporting, management and investigation policy and procedure. This outlined key principles for incident reporting and the roles and responsibilities of staff in relation to internal and external reporting of incidents. It gave clear guidance to staff on the management and investigation of incidents and included guidance on reporting incidents to HSIB.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 safety initiatives. Within 2 safety initiatives there was an exception, 1 relating to one-to-one care in labour and the other to antenatal corticosteroids. The service had submitted action plans to board to address these areas an ensure they met required compliance levels. This meant they declared fully compliant with the scheme. We saw they provided sufficient evidence of their compliance to the trust board in February 2023.

The service used a quality assurance framework called STAR designed to provide an evidence-based assessment to show how maternity areas demonstrated the required standards of care delivery, what is working well and where further improvements were required. There were two elements to the framework. The first element was monthly reviews of maternity areas completed by the matrons and professional leads for the division. The second element was accreditation visits undertaken by the quality assurance team with support from staff, governors and volunteers across the trust.

The outcomes from the STAR monthly audit formed part of the monthly assurance report. This was monitored by the divisional and committee of the board as part of the safety and quality dashboard, to provide ward to board assurance monthly. Outcomes from the monthly audits were also included in the divisional improvement forums and within in divisional meetings.

Maternity

The maternity assessment service (MAS) introduced a nationally recognised maternity triage tool in February 2021 following the introduction, the service identified that MAS was unable to deliver a full implementation due the estates of where MAS is currently situated and medical and midwifery staffing. The service continued with a partial implementation of the tool and in March 2023 an external review of the use of the tool was completed. The findings of the review identified there was not a designated telephone triage line, or triage space, midwives were working at an unsustainable level to manage current flow and workload. This was also identified during our inspection and during discussions with staff from MAS.

The partial implementation of the triage safety tool and the actions found following the independent review were assigned to an active risk on the risk register and compliance was monitored. Key performance monitoring was ongoing, with waiting times audited monthly.

Following the inspection, we issued a letter of intent around the concerns raised regarding staffing and triage. The service provided the required further assurance around extra staffing and the implementation of a new dedicated telephone triage line that would monitor waiting times for calls and call drop off rates.

The service monitored stillbirths, fetal loss, neonatal and post-neonatal deaths using the Perinatal Mortality Reviews Summary Report (PMRT) tool and produced a quarterly report. This data was provided to the national MBRRACE survey.

The service was an outlier for still birth, neonatal mortality and perinatal mortality rates, for data submitted for 2021 and was more than 5% higher than the average for a similar trust in all 3 measures. The stabilised and adjusted still birth rate was 4.5 per 1,000 births, the stabilised and adjusted neonatal mortality rate was 2.09 per 1,000 births and the stabilised and adjuster perinatal mortality rate was 6.57 per 1,000 births. The neonatal mortality rate had worsened over the last 3 years of the MBRRACE report.

We reviewed board papers related to the MBRRACE survey. We saw the service had identified the increased still birth rate prior to the survey publication and carried out a review and identified no themes or trends. They identified the need to make improvements to triage and an action plan was in place for this. The service had a still birth outlier action plan which was monitored and updated regularly. The action plan showed all 8 key actions had been completed with evidence provided. All still births were reviewed through the perinatal mortality review process.

The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. The audit plan ran from April to March each year and all audits were registered on the trust online audit system (AMaT). All mandatory national audits were added to the forward audit plan, as well as local audits.

There was a system for local manager's audits which were recorded on the AMaT system. Managers gave examples of actions taken to improve audit results, for example refresher training with midwives to improve compliance with carbon monoxide monitoring at booking.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. The service had a risk register in place. We reviewed the risk register and saw it identified 6 high risk, 9 moderate risk and 1 low risk items across both maternity locations.

Each risk was clearly defined with controls and assurances and any gaps in these identified. The risks aligned with challenges we found during our inspection and mitigating actions described by staff. Senior managers reviewed risks regularly and each risk had a clear set of actions taken to reduce it, with clear action owners and target dates. The risk register clearly outlined where action had been taken to address identified risks.

Levels of inhalational nitrous oxide (Entonox, or gas and air: for pain relief in labour) was listed as high risk on the maternity risk register. There was no data available regarding the current exposure to staff across intrapartum care. However, the service mitigated these risks by completing an estates inspection of Entonox seals within the intrapartum areas to ensure compliance, staff provided women and birthing people with instructions on the correct use of Entonox equipment and housekeeping audits of the piping for Entonox was implemented.

We saw through clinical governance meeting minutes that risk was discussed at the monthly meetings.

The service had a workforce action plan in place. The plan was regularly updated and monitored progress against key actions. The workforce plan reflected the current staffing position and challenges we found during our inspection. It identified actions to address shortfalls in staffing including, recruitment, redesign of staffing models and use of temporary workforce, as well as action to improve retention such as health and wellbeing activities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it**.** They had a live dashboard of performance which was accessible to senior managers. During this inspection we reviewed the service's maternity quality dashboard. The dashboard benchmarked against national indicators and provided target figures to achieve. There was a system to use the dashboard as a benchmarking tool.

The dashboard reported on clinical outcomes such as level of activity, mode of delivery, postpartum haemorrhage and perineal trauma and neonatal clinical indictors. It also covered data in regional and national dashboards such as the monitoring of induction of labour.

The information systems were integrated and secure**.** The service had a digital midwife to support staff accessing electronic information systems and they visited the birth centre regularly.

Data was collected to support higher risk women at all booking appointments. This included women's ethnicity, their postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced maternal age and co-morbidities. This data was used in planning women’s care. Managers also used this information to inform decisions around service delivery such as continuity of care teams and community caseloads.

Data or notifications were consistently submitted to external organisations as required. The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that required local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Maternity

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity and Neonatal Voice Partnership (MNVP) to contribute to decisions about care in maternity services. The chair of the MNVP had left but the service was involved in the recruitment of a new chair and had engaged with the chair of a neighbouring MNVP to ensure women and birthing people's voices were still heard in the interim.

The MNVP had completed a 15 Steps visit and report. Staff from the continuity of carer team had developed an infographic about latent labour for women and birthing people in collaboration with the MNVP and service users.

Maternity voices partnership engagement meetings were scheduled quarterly and included all key partners from health and the third sector. The service had a Maternity and Neonatal Voice Partnership (MNVP) work plan based on the principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trusts. We reviewed the plan and saw all actions had deadlines set, were monitored and were fully or partly achieved. The service told us that once the new MNVP lead was appointed that actions would be adjusted to ensure that the plan was co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

Senior leaders told us they were proud to work with the local community to improve services and had recently organised and set up a maternity stall at a local festival.

The lead midwife for bereavement worked with service users to develop bereavement services for families and were developing an antenatal and peer support offer for families who are experiencing a pregnancy following a miscarriage, infant loss, stillbirth or neonatal death.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity.

Leaders understood the needs of the local population. They took opportunities to engage with the local population and promote the centre as a birth option. Staff from the service had taken part in the Leyland festival, to promote birth options and key health promotion messages such as infant feeding. Staff had taken part in the pregnancy circles research project where midwives combined clinical care with antenatal education and peer support. This was done in partnership with local family centres and has shown group antenatal care has a positive impact on women's experiences of antenatal services

In the Antenatal Clinic, Ultrasound and Maternity Assessment Suite there were pregnancy schedule visual displays, and the pregnancy journey and the postnatal ward there were information boards on recovery pathways for caesarean sections.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

Quality improvement was routinely discussed at team meetings. We saw that what was not working well was discussed at team meetings for midwifery led services and staff engaged in conversation about their ideas and innovations. For example, during the Maternity Summit held in June 2023 the service held a 'Flashes of Brilliance' competition. This was to encourage staff to suggest service improvements or changes to way of working and encouraged staff to submit any ideas no matter how big or small.

Leaders encouraged innovation and participation in research. The service was part of the Health Foundation Flow Coaching Academy Big Rooms & Microsystem Coaching Academy and meetings were held weekly. The purpose of the weekly meetings was to coach improvement and design tests of change, review results and plan next steps and action notes were taken to record improvement.

Staff received training and coaching to lead and facilitate improvement at ward and department level through the microsystem coaching academy. This trained staff to be coaches trained to internal quality expert level (as defined in the NHSI national guidance). One example of an improvement project being led by delivery suite staff was a project to reduce the time taken for women and birthing people from the delivery suite to the postnatal ward.

The service took part in continuous improvement programmes and activities aligned to the trust-wide continuous improvement strategy for 2021 to 2023.

The service took part in wave 1 of the national MatNeo programme on the optimisation and stabilisation of the pre-term infant and shared learning regionally and nationally.

There were hearing loop signs around the maternity service to help support hearing aid reception for women and families using hearing aids.

There was a 52% gestational diabetes increase in women and birthing people in 2021/2022. Due to the increase diabetic service provision had been adapted and the service held a joint obstetric and diabetic clinic. The clinic consisted of 2 diabetic consultants, diabetic registrar, diabetic specialist nurse, diabetic specialist midwife and a dietician.

Tulip team was a continuity of care team for all women and birthing people with diabetes. Designated midwives completed all care for women within the team and supported women and birthing people with advice, clinic appointments and birth plans.

The maternity service had developed and displayed a number of infographic information for women, birthing people and their families. This information was displayed throughout the maternity unit. Information displayed showed information learning posters on neonatal seizures, extreme prematurity, as well as sharing learning with families that had been developed from incidents. For example, aspirin in pregnancy and the importance of routine urine testing.

Following a response from women, birthing people and their families the maternity service developed the maternity pregnancy schedule. The schedule provided information on the named midwife and consultant for women and birthing people. There were two pathways, one for a standard pregnancy schedule and the other was for women and birthing people who required multiple scans during pregnancy. The schedule provided information as to the pregnancy journey, including routine scans and antenatal checks.

Surgery

Good ➔➔

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

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

Training compliance rates for staff in the surgical division were above the 90% target rate for conflict resolution; equality, diversity and human rights; fire safety; fraud and bribery in the NHS; health, safety and welfare; infection prevention and control levels 1 and 2; moving and handling; patient safety for all staff and patient safety for boards and senior leadership teams.

Three further mandatory training courses had been introduced with effect from 1 May 2023 and the relevant committee had authorised a 3-month grace period to build compliance to over 90%. These were medicines management for clinical staff with an overall compliance rate of 87% at the time of our inspection; speak-up core training for all workers with a compliance rate of 49% and staff also completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia, the Oliver McGowan learning disability e-learning. Compliance data for this training was not available at the time of our inspection.

Resuscitation training was undertaken by medical and nursing staff with a compliance rate of 90%. Most levels of resuscitation training had met the trust target with the exception of level 2, adult basic life support and paediatric basic life support for medical staff with a compliance rate of 79%, level 3, immediate life support for nursing staff with a compliance rate of 83% and level 3 paediatric immediate life support for nursing staff with a compliance rate of 70%.

Sepsis training undertaken by staff had compliance rates of 70% for medical staff and 95% for nursing staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a monthly report of staff who needed to complete training and staff were informed in safety huddles. There was capacity to allow 2 staff members each month to concentrate on bringing mandatory training up to date.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Medical and nursing staff undertook safeguarding adults training, levels 2 and 3 and safeguarding children, level 2. These courses were aligned with the Core Skills Training Framework England version 1.1 (the latest iteration). The training provided also adhered to the inter collegiate guidelines for roles and competencies for health care staff.

The trust had an overall compliance target of 90% for safeguarding courses. Data provided showed that medical staff in the division of surgery had 100% compliance for safeguarding adults level 2; 93% for safeguarding adults level 3 and 94% for safeguarding children level 2.

Data showed that nursing staff had achieved 98% compliance for safeguarding adults level 2; 94% for safeguarding adults level 3 and 98% for safeguarding children level 2.

Non-clinical staff undertook safeguarding adults levels 1 and 2 and safeguarding children levels 1 and 2. Data provided showed that compliance was 95% or above for all of these courses.

Staff also received training in the prevent (anti-radicalisation) strategy, child sexual exploitation and female genital mutilation as part of their safeguarding training and staff we spoke with had a good understating of how to identify these.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

The trust had safeguarding policies available to support staff and these could be accessed on the trust intranet. Staff were aware of how they could seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff disposed of clinical waste safely. Waste management audits showed 100% compliance from December 2022 to April 2023 for the division.

There were enough hand wash sinks and hand gels. Staff we observed followed hand hygiene and 'bare below the elbow' guidance. Staff and visitors were encouraged to wash their hands.

We reviewed hand hygiene audits from December 2022 to May 2023 and saw there was an average compliance of 98.5% in the division.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we observed wore suitable personal protective equipment, such as gloves and aprons while delivering care. Gowning procedures were adhered to in the theatre areas.

PPE compliance audits from December 2022 to May 2023 showed an average of 91.5% compliance for the division.

Patients identified with an infection could be isolated in side-rooms. We saw that appropriate signage was used to protect staff and patients. Staff told us they could seek advice and support from the trust-wide infection prevention and control team if required.

We looked at the organisational and site scores for the Patient-led Assessment of the Care Environment (PLACE) scores for 2022, part of which measures cleanliness in hospitals, however, there was no data available for the trust or Royal Preston Hospital. We were therefore unable to make a comparison with the national average for cleanliness.

Staff used records to identify how well the service prevented infections.

Staff worked effectively to prevent, identify and treat surgical site infections. Patients receiving elective surgery were screened for infections such as C.difficile, MRSA and MSSA at a pre-operative assessment clinic. Emergency admissions were screened for infections on the ward.

Cases of C.difficile versus the trajectory were tracked and reported to the safety and quality committee within the monthly safety and quality dashboard. From April 2022 to March 2023, the division had 39 cases of hospital onset hospital associated C.difficile cases. The objective total for the trust was 122 cases.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The design of the environment followed national guidance. The ward and theatre areas were well maintained and free from clutter. The equipment in the theatre areas was also well maintained, fit for purpose and checked in line with professional guidelines.

Access to the surgical wards was secure and the ward and theatre areas required key code access for entry. Patients could reach call bells and staff responded quickly when called.

All the ward areas had sufficient shower and bathing facilities. The ward areas were free from clutter, and we saw that equipment and consumable items were stored appropriately and were not stored on the floor.

Staff told us equipment was routinely checked and cleaned in between use. Equipment (such as hoists and blood pressure monitoring machines) we saw were visibly clean. Single-use, sterile instruments and consumable items were within their expiry dates.

The service had enough suitable equipment to help them to safely care for patients. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Ward staff also told us they did not have any difficulty obtaining any equipment. Equipment was serviced by the trust's medical engineering team under a planned preventive maintenance schedule. Staff told us they received good and timely support if a fault was reported.

Emergency resuscitation equipment was available in all the areas we inspected, and this was checked daily by staff. We saw that daily and weekly equipment check logs were complete and up to date in the areas we inspected. There were 5 cardiac resuscitation trolleys in the main theatre area plus 3 difficult intubation trolleys that were all checked daily. There was also a major haemorrhage cupboard that contained emergency equipment to deal with a major bleed. Staff could access this quickly in case of an emergency.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The division had a live safety surveillance dashboard in place that gave an indication of the likely reliability of safety on the ward at any time based on number of patients on the ward Vs actual staffing numbers; patients requiring risk assessments; number of patients requiring discharge; patients with NEWS scores of 3,5 or 7 or above; patients requiring hourly or less observations; patients with acute kidney injuries and patients with sepsis. It also included missed doses of medication.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks.

Managers told us the pre-operative checklist for patients was checked and the patient was unable to leave the ward for surgery unless the checklist had been validated as correct.

All patients over 65 years of age, or if they met the criteria, were given a falls risk assessment. Staff had access to specialist falls nurses who could provide support.

Patients identified as high risk were placed on care pathways and care plans were put in place, so they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours so any changes to the patient's medical condition could be promptly identified. Patient records we looked at showed that patients were reviewed regularly and escalated appropriately when required.

Staff knew about and dealt with any specific risk issues. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

Surgery

Staff were aware of the NEWS score escalation process so that patients with a NEWS score over five were seen and assessed by medical staff as soon as possible. Staff were encouraged to use clinical judgement so that if a patient's observations were not triggering an escalation, but the patient did not look well they could still escalate and make a medical emergency team call.

Staff followed appropriate guidelines, pathways and screening tools, based on national guidelines for the management of patients with sepsis. Staff we spoke with understood how to identify the signs of sepsis and management of sepsis in line with national guidelines. Nursing staff had received training and used a sepsis kit on the ward for those patient's displaying signs of sepsis, this included antibiotics and fluids. At April 2023 89.2% of relevant staff in the division had received sepsis training.

If the sepsis pathway was triggered, patients were usually treated within the hour. The trust had carried out audits to ensure that the treatment being delivered with presumed sepsis was within the recommended pathway timeline. The sepsis audit data for April 2022 to March 2023 showed that there had been 85 patients screened. Of these, 69 (81%) had been treated within the recommended pathway timeline and 16 (19%) had not. There was a working group in place to identify actions to improve compliance.

The service carried out audits and produced an annual report on Local Safety Standards for Invasive Procedures (LocSSIPs). There were different LocSSIPs for different surgical invasive procedures and each had a clinical audit or checklist assigned, how often this should be conducted and how it should be recorded.

The annual report for LocSSIPS confirmed that the trust was compliant with national requirements and that there were robust governance arrangements in place to effectively manage and audit them. The report confirmed that there had been no identified themes and trends relating to the procedures and no single incidents that had necessitated escalation.

The theatre teams followed the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. There was a monthly audit to check staff compliance against the safer surgery checklist across the theatre areas. This included observational audits to observe staff practice and a review of completed checklist records. Each part of the WHO checklist was audited separately so there was close monitoring of the "team brief"; "sign in"; "time out"; "prosthetic pause"; "sign out" and "de-brief" phases of the WHO checklist. Monthly audits showed high levels of compliance and follow-up actions where anything had been observed to be missed.

During our inspection, we observed 4 WHO checklists in theatres and found that these were all performed as required.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Surgery

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

The senior nurses and ward managers carried out daily staff monitoring and escalated staffing shortfalls to the matrons due to unplanned sickness or leave. Managers told us that if the ward was not staffed safely, they would escalate this by using the red flag system so that additional staff could be found.

Staff participated in huddles at the start of each day and nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues.

The trust carried out an annual safe staffing review and this was regularly reviewed and monitored throughout the year at the safety and quality committee.

The number of nurses and healthcare assistants matched the planned numbers. The division of surgery had an overall planned nursing establishment of 266.44 full time equivalent (FTE) and an actual establishment of 296.56 full time equivalent staff. There was an over-establishment of 35.88 FTE staff which, when staff on maternity leave was accounted for, was an over-establishment of 23.24 FTE nursing staff at the time of our inspection.

The service had minimal vacancy rates. There were only 3 wards within the surgical division that had any nursing vacancies. These were the major trauma ward with 3.64 FTE vacancies; ward 16 (orthopaedics) with 1.96 FTE vacancies and ward 11 (upper GI) with 0.16 FTE vacancies.

The service had low turnover rates. From November 2022 to April 2023, the division of surgery had a staff turnover rate of less than 1% each month for nursing staff. Staff turnover for allied health professional during the same period was an average of 0.95%.

From May 2022 to April 2023 (12 months), there was an average sickness absence rate for nursing staff of 7.45%. From May 2022 to April 2023 (12 months), there was an average sickness absence rate for allied health professionals of 6.49%.

The service had low and reducing rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

In the six months from December 2022 to May 2023, data showed that the percentage of duties requested (to cover substantive staff absence) were filled an average of 67.2% of the time by bank staff and an average of 10.4% of the time by agency staff.

Over the same period, an average of 22.3% of duties requested were unfilled.

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The numbers of medical staff did not match the planned number across the division of surgery, but shortfalls were met using bank, locum and agency medical staff, for example, the worked versus funded variance for April 2023 showed a shortfall of only 0.33 WTE.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

April 2023, data showed the division of surgery had overall funding for 413.47 medical staff and there were 378.13 WTE contracted staff in post, a shortfall of 35.34 WTE medical staff. This equated to an 8.55% vacancy rate. This vacancy rate had remained steady throughout the previous 6 months. The trust were recruiting for vacant posts though speciality surgeons (for example neurosurgeons) could not always be recruited in a timely way.

The three specialities with the highest number of medical staff vacancies were neurosurgery with 9.52 WTE vacancies (22.9%); anaesthetics with 7 WTE vacancies (5.7%) and Upper GI/colorectal with 4.6 WTE vacancies (9.6%).

The service had low and reducing turnover rates for medical staff. From November 2022 to April 2023, the division of surgery had an average staff turnover rate of 0.98% for medical staff.

Sickness rates for medical staff were low. From May 2022 to April 2023 (12 months), there was an average sickness absence rate of 2.82%.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. All specialities in the division of surgery had junior doctors on shift 24 hours a day, 7 days a week.

The service always had a consultant on call during evenings, overnight and weekends. They were supported by an on call middle grade doctor.

Medical staff undertook twice daily ward rounds.

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. Staff used electronic patient records for recording risk assessments, care plans and for medical and nursing notes, care plans and patient assessments. When patients transferred to a new team, there were no delays in staff accessing their records.

Staff used electronic records for standardised nursing activities, such as daily observations and nutritional care. We saw that observations were well recorded, and the observation times were dependent on the level of care needed by the patient.

We looked at the records for 5 patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.

Patient risk assessments were reviewed and updated on a regular basis. We found that patient's care plans were person-centred and were completed to a good standard. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

Patient records were checked for accuracy and completeness as part of routine audits, such as the routine weekly and monthly quality audits undertaken by ward managers.

Medicines

The service used systems and processes to safely prescribe, record and store medicines but monitoring times between doses were not managed well on some wards and the division was not always compliant with guidelines for the prescribing of antimicrobials.

Staff followed systems and processes to prescribe medicines safely.

The trust used an electronic prescribing and medicines administration (ePMA) system on the wards, paper prescribing was used in theatres this was on the trust risk register, with plans to roll out ePMA later in 2023.

We found people's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine they had previously reacted to. The trusts medicine safety improvement work had resulted in a reduction in the number of missed doses of critical medicines. Audit results showed the missed doses had reduced from 4.20% December 2022 to 2% in April 2023.

We found medicines were not always administered as prescribed. We found that when people were prescribed medicines with a minimum time interval between doses, for example paracetamol, doses were sometimes given too closely together placing the people at risk of side effects. This was raised with staff during the inspection to increase awareness and review systems to address the issue.

We found that antimicrobials that required additional monitoring were safely prescribed and monitored. The trust's antimicrobial stewardship audit showed good overall compliance, but the surgery division was not always compliant with guidelines for the prescribing of antimicrobials with an increase in use of broad spectrum antimicrobial use.

The period January -March 2023 showed it was below the target at 84% 'compliance with guidelines', however they did meet the target for documented indication on the prescription at 92% for the same quarter.

The service reported medicine related incidents and near misses for investigation and lessons learnt to be shared to reduce the risk of recurrence.

Staff stored and managed all medicines and prescribing documents safely.

Surgery

We found medicines were stored safely and securely. Staff knew the process to access medicines out of hours and an on-call rota for pharmacy staff was in place to provide pharmacy support. The pharmacy team attended the wards at regular intervals to ensure stock was appropriately managed and checked medicine expiry dates.

We randomly checked expiry dates of medicines and found no concerns. Medicine safety audits were completed monthly by the trust's pharmacy governance team. The audits showed compliance was repeatedly below target with a number of recurring themes. The audits also highlighted non-compliance against the trusts standards regarding controlled drugs due to recording issues. The concerns had been added to the risk register and new actions were being devised to drive forward improvement.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The pharmacy team were present on several wards to support the clinical staff and complete medicines reconciliation to ensure people were prescribed the correct medicines when they were admitted to the wards.

However, information provided by the trust showed between September 2022 to March 2023 less than 50% of reconciliations were completed within 24 hours of admission to the hospital. There was a risk people may not be prescribed all of their medicines as they had not had a medicines reconciliation within 24 hours of admission (National Institute for Health and Care Excellence (NICE) NG5).

This was linked to pressures within the pharmacy department, with the trust confirming they had an approximate 40% vacancy rate of some pharmacist roles and approximately 30% of pharmacy technician roles in the year to March 2023, a number of the vacant roles have been recruited to in quarters 2 and 3 in 2023. The trust had identified the need to review the lack of pharmacy provision at the surgical assessment unit and pathways for elective surgery.

The trust had introduced a clinical prioritisation tool to identify and focus medicines reconciliation for people who were taking high risk medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

The division of surgery had reported 1 never event during 2022/23. This was in relation to wrong site surgery (wrong side anaesthetic block) and occurred in October 2022. An investigation found that parts of the WHO checklist had not been followed which would likely have prevented the incident from occurring if they had.

We saw that actions from the investigation included a series of observational audits for regional block cases across theatres to ensure that the "stop before you block" process was being followed.

Surgery

Managers shared learning about never events with their staff and across the trust.

Staff reported serious incidents clearly and in line with trust policy.

The trust produced an annual thematic review report for serious incidents and never events. This report provided a high-level overview of level 3/STEIS serious incidents reported between 1 April 2022 and 31 March 2023. The report identified any emerging incidents or themes of concern. No themes of concern were identified in the division of surgery.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Duty of candour was monitored in all cases requiring this and the thematic review found that duty of candour had been applied in a timely way for all cases unless a justifiable exclusion had been identified. Compliance with duty of candour was reported to the Safety and Learning Group on a weekly basis.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made because of feedback. The trust had Always Safety First (ASF) working safety groups which were part of the incident management maturity programme of work to better manage long term improvements and wider organisational learning. The working safety groups involved point of care staff and senior clinicians and decision makers. There were frequent meetings to ensure pace and continuity of the work. There were current working groups, for example, reduction in pressure ulcers, falls and hospital acquired infections.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Data showed that, in the division of surgery in 2022/23 there had been 22 level 3 STEIS reported incidents. These were made up of 8 pressure ulcer incidents; 4 relating to suboptimal care of the deteriorating patient; 2 relating to slips trips and falls; 2 relating to treatment delay and 1 for each of diagnostic incident inducing delay; medication incident; accident and treatment not available or not completed.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance, such as from The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards.

We reviewed care pathways for a number of surgical procedures and found these were based on best practice guidance. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

The surgical directorate leads had oversight of policies and procedures relating to surgery and were responsible for their ratification. Speciality leads were assigned to updating speciality specific policies and procedures. The governance team tracked policy updates to ensure that they were updated in a timely way.

Policies were stored electronically and were easily accessible to staff. Review dates for policies and procedures were monitored monthly.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced one to one monitoring and supervision. Staff could also seek support and advice from the trust-wide safeguarding team and mental health liaison teams from another trust when providing care for these patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used the Malnutrition Universal Screening Tool (MUST), which was a nationally recognised screening tool to monitor patients at risk of malnutrition. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for patients who needed it. The patient records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff. Patients with difficulties eating and drinking were placed on special diets.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Optional menus were available for patients with specific requirements. We saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Patients waiting to have surgery were not left nil by mouth for long periods.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an appropriate pain scale for patients that were unable to communicate effectively, such as those living with dementia or a learning disability. Acute pain symptoms were managed by the surgical consultants.

Pain scores were recorded electronically. Staff prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.

Patients received pain relief soon after requesting it. The majority of patients we spoke with told us staff gave them pain relief medicines when needed and their pain symptoms were managed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. There was a clinical lead for audit for the division of surgery.

National mandatory audits were recorded on a clinical audit assurance system. A monthly report showed where audits were up to, action plans and audits or actions that were outstanding. At speciality level there was a named consultant who kept oversight of clinical audits. When audits were complete and results evaluated, leads had 3 months to put an action plan in place. Action plans were monitored by speciality leads.

There was a clinical audit team who assisted in facilitating clinical audits.

Managers and staff used the results to improve patients' outcomes. The trust produced an annual clinical audit and effectiveness plan.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

The trust had a Safety Triangulation Accreditation System (STAR) quality assurance framework that was developed to standardise and reduce duplication and the number of audits undertaken each month and ensure a consistency of approach. Ward managers and matrons undertook monthly audits feeding into the framework. In addition, independent, unannounced accreditation visits were also made to clinical areas to test standards of care alongside experience for patients and staff. These were undertaken by the quality assurance team, governors, volunteers and colleagues from across the trust.

In the division of surgery, all inpatient wards and theatres undertook the monthly STAR audits. These looked at 17 specific areas, including environment; performance data; medicine management; infection prevention and control; well led; acutely unwell; harm free care; documentation; staff health and wellbeing; safeguarding; end of life care; patient feedback; discharge and communication and safety.

Accreditation visits resulted in the ward of a bronze, silver or gold star rating. A bronze star was awarded where an area received a red or amber rating; a silver star was awarded where an area received a green rating and gold stars were awarded to those areas receiving three consecutive green ratings and had supported a peer ward or department to achieve an improved rating.

Surgery

In the division of surgery a total of 45 areas were registered for STAR though this included Chorley Hospital. Data showed that at 31 March 2023, 42 areas had a green rating, 2 areas had an amber rating and 1 had a red rating. Following accreditation visits, 3 areas had a bronze star, 20 had silver stars and 22 had achieved gold star status.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Managers made sure staff received any specialist training for their role. The staff we spoke with told us they routinely received competency-based training in their specialty area and felt confident to do their role. Staff received role-specific training in areas such as venepuncture, cannulation, acute kidney injury, aseptic non-touch technique, dementia, falls prevention, nasogastric awareness, pain management, palliative care, safe use of insulin, sepsis awareness and NEWS2.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Competency-based assessments and training support was provided by the managers and practice-based educators based in the ward and theatre areas. Staff told us that they were well supported by their line managers to undertake development opportunities and additional learning.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided showed that, at the time of our inspection 95% of medical staff had received an annual appraisal and 94% of nursing staff.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Surgery

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical, nursing and allied health professional staff as well as staff from other hospitals within the trust or external hospitals where patients received care and treatment from more than one healthcare organisation. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Seven-day services

Key services were available seven days a week to support timely patient care.

Records showed nursing and medical staff levels were sufficiently maintained outside normal working hours and at weekends across most of ward and theatre areas based at this hospital.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds taking place seven days per week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The ward and theatre staff we spoke with told us they received good support outside normal working hours and at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information leaflets were readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addiction to alcohol and drugs could be offered treatment and provided with support from specialist trust-wide liaison teams.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records we looked at showed that patient consent had been obtained and that planned care was delivered with their agreement.

Staff made sure patients consented to treatment based on all the information available. Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient.

Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act and Deprivation of Liberty training was incorporated into the adult safeguarding training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. A range of multidisciplinary staff were trained to carry mental capacity assessments (such as nurses and medical staff) and capacity assessments were documented in the electronic patient records.

We did not identify patients with Deprivation of Liberty Safeguards (DoLS) in place within the surgical wards we visited. However, ward staff were able to demonstrate a good understanding of DoLS processes.

If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that had lasting power of attorney and could legally make decisions on the patient's behalf. Where this was not possible, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff could seek support from the trust-wide mental health liaison team and the safeguarding team for advice and guidance on mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

The trust audited do not attempt cardio-pulmonary resuscitation (DNACPR) decisions and documentation. From December 2022 to April 2023 93.4% of the documentation and decisions made were compliant with relevant policies.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy.

Surgery

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Patients calling for assistance and call bells were answered in a timely manner across the wards we visited.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness. We spoke with 9 patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.

The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between March 2022 and April 2023 showed that the monthly satisfaction scores across surgical wards at Royal Preston Hospital was consistently above 90%. This indicated the majority of patients were positive about recommending the hospital's surgical wards to friends and family.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions.

Surgery

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so that they met the needs of the local population. There were daily meetings with the bed management team so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints and there was daily involvement by the matrons and ward managers to address these risks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines: we observed that male patients were cared for in separate areas to female patients.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, gastroenterology and colorectal surgery, ophthalmology, urology and vascular surgery.

Facilities and premises were appropriate for the services being delivered although the hospital estate was tired and buildings were often in need of repair. The trust was in the early stages of a new hospital building programme to future proof services for the local population.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service had information leaflets available in the areas we inspected. These could be provided in different formats or in languages spoken by the patients and local community if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Surgery

Staff completed training in dementia awareness. Staff used specific care plans when providing care and treatment for patients with a learning disability or those living with dementia. We saw evidence of these care plans in use in the records we looked at and they included reasonable adjustments and additional support and advice for patients and their carers.

We observed during our inspection some surgical wards and theatre areas were not fully implementing the dementia strategy. However, there were measures in place, for example the forget-me-not symbol was in use at patient beds to identify patients living with dementia. Carers of patients living with dementia or other needs were identified with a specific lanyard. Clocks on some wards were dementia friendly along with toilet signage. There were red rails in bathrooms. The neurosurgical wards had a memory box for patients living with dementia and another for visually impaired patients. Patients who were mobile and living with dementia were identified by purple socks.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. Staff could contact dementia or learning disability specialist nurses for advice and support in relation to caring for patients living with dementia or a learning disability.

The trust was shortly to introduce the "Think yellow" campaign for patients at high risk of falls who would be identified by yellow blankets on the bed and yellow socks.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Because the hospital was also a specialist surgery and major trauma centre, patients were also admitted from other hospitals for specialist surgery and brought directly there following a major trauma, either by ambulance or air ambulance.

Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The England average length of stay for patients having elective surgery was 5.1 days in 2022. The England average length of stay for patients having emergency admissions was 9.1 days in 2022.

The trust as a whole had an average length of stay of 4.9 days which was better than the England average.

Because of the nature of the hospital as a specialist regional surgical centre, there was a wide range of average length of stay, dependent on the surgical speciality, on the complexity of the surgery and expected post-surgical recovery. The lowest average length of stay was for ophthalmology and plastic surgery at 1.7 days.

Surgery

The highest average length of stay was for spinal surgery at 17.4 days. Patients undergoing spinal surgery often had to wait for a place in a specialist spinal unit to continue their recovery and this increased the average length of stay. Similarly, repatriation of patients who had received specialist surgery, back to the referring trust for further recovery sometimes impacted on the length of stay as it was dependent on a bed being available in the receiving trust.

Since our last inspection and the Covid-19 pandemic, the trust had re-planned surgical services to reduce waiting lists whilst still maintaining their specialist and major trauma surgical status. Most general surgery elective services had transferred to Chorley and South Ribble Hospital so that specialist surgeries referred from other trusts and emergency surgeries could take place at the Royal Preston Hospital site.

The trust was performing well in the percentage change in waiting list and was in the top 25% of trusts when compared to other trusts nationally and overall waiting lists were falling steeply.

However, when all metrics were taken into account, at February 2023, the trust ranked 133rd out of 135 trusts nationally.

The trust was in the bottom 25% of trusts when compared to other trusts nationally for the new pathways as a percentage of completed pathways; for referral to treatment within 18 weeks and referral to treatment within 52 weeks but patients waiting more than 52 weeks for treatment had dropped very sharply from October 2022 to February 2023.

The trust had addressed their 104 week waits and 78 week waits and was tackling 52 week waiting lists at the time of our inspection. From April 2022 to February 2023 the 52 week waiting list had been reduced from 5363 to 2987 (44.3%).

The surgical specialities with the highest waiting lists at February 2023 were other surgical services, general surgery and oral surgery.

The specialities with the lowest performing 18-week referral to treatment at February 2023 were oral surgery and neurosurgical services.

The specialities with the highest 52-week waits for treatment at February 2023 were oral surgery, general surgery and other surgical services.

The trust told us that, following reconfiguration of where elective surgery was being delivered, they had concentrated on improving cancer waiting times. At February 2023, the trust remained in the bottom 25% of all trusts for their 2-week performance and third lowest in the North West. However, performance had increased from a low of 40% of patients seen within 2 weeks in June 2022 to 79% in February 2023. This was below the England average of 86%.

For cancer patients agreeing their treatment plan within 31 days of referral, the trust was in the bottom 25% of all trusts at February 2023 and the fourth lowest in the North West. However, there was an increase from 80% to 88% from January to February 2023. The England average at February 2023 was 92%.

The trust was in the bottom 25% of all trusts for cancer patients beginning their treatment within 62 days of referral and the fourth lowest in the North West at February 2023. Performance had improved from the previous month from 37% to 46% and this was against an England average of 58% at that time.

The trust had an elective recovery plan in place. However, because of the nature of the service, taking major trauma patients that took precedence in theatres and referrals from other trusts, the service acknowledged it was a challenge for them to be one of the best performing trusts in terms of waiting times.

Surgery

The service was not meeting targets for review of patients by a senior clinician within target timescales. There was a target of 90% for patients receiving a clinical assessment by a consultant within 14 hours from the time of admission. Data provided showed that from April 2022 February 2023 only 48% of patients received this.

There was a target of 90% for patients to be reviewed by a senior decision maker every 24 hours. Data provided showed that from April 2022 to February 2023 only 49% of patients received this on average.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards although managers told us that this was not a regular occurrence.

Managers worked to keep the number of cancelled operations to a minimum. The trust had an elective care transformation board which focussed on theatre utilisation improvement. There was a workstream on cancellations and processes to improve this. Theatre utilisation had improved from 68% at the start of the recovery programme at Royal Preston Hospital to 78%. The main elective hub had been moved to Chorley District Hospital and this had aided improvement. The trust told us that, over the last 4 years, cancellations had decreased, especially on the day by more than 50%.

Data provided showed that from December 2022 to May 2023, there were 320 (2.34%) cancellations on the day of surgery for clinical reasons. The highest instances by reason were patient deterioration, emergency cases clinically prioritised and an inadequate pre-operative assessment.

Data provided showed that from December 2022 to May 2023 there were 198 cancellations on the day of surgery for non-clinical reasons. The highest instances by reason were previous surgery overrun, an unrealistic number of patients on the list and no bed available. The trust had a target to reduce the number of operations cancelled for non-clinical reasons to 1%. From April 2022 to February 2023, they had achieved a figure of 1.45% of surgeries cancelled for non-clinical reasons.

Managers monitored that patient moves between wards were kept to a minimum.

Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust had a target of 50% of surgical patients to be discharged on their expected date of discharge but had only achieved 21% from April 2022 to February 2023. As described above, this was often because patients were repatriated to their referring trust and had to wait for a bed to become available.

There was a target of 33% of patients being discharged for this to happen by midday. From April 2022 to February 2023 14% of patients were discharged by midday.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. The ward and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

Staff understood the policy on complaints and knew how to handle them. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning.

Staff could give examples of how they used patient feedback to improve daily practice.

From April 2022 to March 2023, the division of surgery received 172 complaints which equated to 35% of the overall complaints received by the trust during this period. The trust told us that key themes of complaints about surgery were around consent, confidentiality and communication, particularly around communication of plans in relation to care, treatment and discharge.

Of the 172 complaints received about the division of surgery 10 were upheld.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The division of surgery was led by a triumvirate leadership team comprising a divisional director of nursing, divisional medical director and divisional director of operations. They were supported by service leads and deputies that had responsibility at surgical speciality level.

The surgical wards were managed by matrons who had responsibility for surgical wards within a speciality and each ward had a ward manager. The theatre manager was responsible for overseeing theatre services.

The trust offered a number of leadership courses that managers were encouraged to go on. There was a systems leadership course available via the leadership academy. The courses covered a variety of topics around culture and development of leaders. Band 7 managers received a specific away day to develop their leadership skills. There were also external leadership courses available, such as the Nye Bevan NHS programme and a masters degree.

There were medical leadership programmes available, such as new consultant programme and a consultant leadership stretch programme with clinical director topics also available.

Senior leaders we spoke with had undertaken relevant courses and had the skills and abilities to run the service. They understood the challenges to quality and sustainability and could identify actions needed to address them.

Staff spoke positively about the leadership team and organisational structure. The theatres and ward based staff told us that they understood their departmental reporting structures clearly and described leaders as approachable, visible and who provided them with good support. Staff said they felt well supported by the leadership team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trusts clinical strategy, which was developed in collaboration with staff, people who use services and external partners was called “Our Big Plan.” The mission was to provide excellent healthcare to local communities, to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria and to drive innovation through world class education, training, and research.

The vision and strategy for the division was to enable staff to exceed local and national targets with care and compassion. The vision and strategy had 6 objectives/priorities which were to provide safe care and offer a good patient experience, to respond to COVID-19 concerns, to deliver more elective care and reduce the backlog, to support the patient pathways and ensure the right sizing so that the patient is in the right place at the right time, to provide a 24/7 workforce and retain staff and recruit staff accordingly and to support education and innovation. The priorities outlined within the divisional strategy aligned to the trust strategy.

Metrics were used to compare the measure progress against the division and trust strategy. Progress against the delivery of the strategy and the objectives was reviewed yearly. A yearly report on each strategy was completed and reviewed by the divisional board. We saw evidence from board papers of analysis relating to progress towards “Our Big Plan” going to the board of directors in April 2023.

Staff that we spoke with were aware of some of the trust’s vision and strategy and confirmed that strategic objectives were discussed in team meetings.

Wards had goals displayed on notice boards. These goals were aligned to the strategy and included reducing the amount of hospital acquired pressure sores, maintaining compliance in core skills training, and establishing fully integrated pathways with other clinical specialities.

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The divisional staff survey results for 2022 showed that there were 9 themes that scored better than other comparable trusts. Thes included colleagues feeling their role made a difference to patients and service users, colleagues feeling that they are encouraged to report incidents and that the organisation will act upon this and colleagues feeling that they have development opportunities to improve and grow in their career.

The staff survey for 2022 showed 11 areas that scored lower than other comparable trusts. These included colleagues not feeling they have realistic time pressures, colleagues feeling that relationships at work are strained, colleagues feeling worn out, tired and frustrated and colleagues feeling they regularly work extra unpaid hours.

Staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services. They told us there was a friendly and open culture and that matrons and clinical leads were visible and approachable.

The medical and nursing staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and nurses told us they received good training and learning opportunities. Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared.

The majority of staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed and who they were. All staff had undertaken the freedom to speak up training.

The low staff turnover rates and high staffing levels reflected a positive culture in the division.

The service promoted equality and diversity in daily work. There was an equality, diversity and inclusion strategy in place and an annual report. There were divisional level equality, diversity and inclusion actions to increase representation of colleagues with specific protected characteristics in the workforce and to improve experience of work and to seek to remove discrimination. There were inclusion ambassador forums in place for ethnicity, living with a disability and LGBTQ+. There were also recently established menopause and carers groups.

However, only 52.8% of all staff in the trust with a disability believed that there was equal opportunity for career progression or promotion. This was compared to 60% of staff without a disability. More ethnic minority staff (45.5%) than white staff (44.6%) believed the organisation provided equal opportunities for career progression and promotion. Leaders were sighted on actions to improve these outcomes.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The division of surgery had clear governance structures in place that provided assurance of oversight and performance against safety measures.

The nursing and medical staff participated in routine local team meetings to monitor governance, risks and performance and share learning from divisional and care group meetings. Information was also shared through daily staff huddles and newsletters.

Ward level meetings took place monthly and included some standard agenda items, such as actions from previous meetings, the matron's report and audits. Meeting also included staff feedback, medicines safety and culture as well as other items of importance.

Ward level meetings fed into speciality quality and safety meetings. These were held monthly and included matrons, ward managers, consultant nurses, clinical governance leads, consultants and clinical directors. The agenda covered governance updates, documentation reviews, issues of concern and actions from previous meetings.

There were clinical business unit meetings attended by all heads of specialities and high level risks and information from these meetings fed into the overall divisional quality and safety meeting and from there to the divisional board and divisional improvement forum, attended by trust executives. High level risks or matters of importance would then be fed to the trust board.

There was a divisional "Always safety first" group that examined safeguarding and audits with high level results feeding into the quality and safety meetings for the division along with matters of importance from the infection prevention and control meetings and clinical investigation meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A risk manager was responsible for speciality local risk registers. Oversight of all the local speciality risk registers was performed by a governance lead who ensured that they were regularly updated.

A monthly risk report gave a breakdown of risks in the division, when they were last reviewed and highlighted risks that were due to be reviewed and actions required.

Quarterly risk management reports gave a summary of the risks, new risks, closed risks and any themes and trends.

Local risk owners tended to be matrons, clinical directors or governance leads within specialities. They were supported by clinical business managers within the governance team.

The trust used an electronic risk register system to record and manage key risks. The division of surgery risk register documented key risks to the surgical care services and the divisional register incorporated the individual departmental / ward risks. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Each risk had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to divisional and trust level.

Surgery

We reviewed the risk register for the division of surgery and noted that the trust was clearly sighted on the key risks to the division. These were the non-compliance with national cancer wait targets; theatre capacity; theatre overruns; deteriorating vascular patients (who were at greater risk of deteriorating than other patient groups); nurse staffing and the use of bank and agency staff, especially where strike action had impacted on staff numbers, and pressure ulcers developing in patients.

The results of STAR audits were triangulated with CQC findings in order to produce a reasonable indicator of areas that required additional support and focus.

Individual specialities reviewed and discussed morbidity and mortality in monthly audit or directorate meetings. Structured Judgement Review meetings had replaced mortality meetings. Data provided showed that there had been 341 deaths in the division from April 2022 to March 2023 and 259 (76%) had undergone a structured judgement review.

The service had a comprehensive performance dashboard to manage performance effectively. It was red, amber and green (RAG) rated giving a visual picture of areas of the service where improvement was required.

The service held a surgery division improvement forum that was attended by the executive team, divisional team, business partners and other support staff. The performance dashboard, staffing, financial use of resources and transformation projects were discussed at the forum with action plans arising from the meetings.

The service had a comprehensive audit programme to aid the monitoring of performance. In 2022-2023 the service carried out 18 national audits and 185 local audits. Oversight of audits was by the clinical audit team and audit leads within the specialities.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were electronic. We saw that paper-based patient records were kept securely.

There were 2 incidents reported to the Information Commissioners Office in the 2022-2023 period, neither of which related to the division of surgery,

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke did not identify any concerns relating to accessing IT systems or any connectivity issues.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Staff also undertook information governance training that had a compliance target of 95%. Compliance figures supplied showed a compliance rate of 87% for medical staff and 98% for nurses.

Surgery

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The majority of staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Staff were provided with emotional support. For example, clinical supervision and debrief support was put in place to support staff.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

Staff told us that they were actively engaged in making improvements to their work areas and managers sought feedback from staff on how things could be done better and acted upon suggestions where they could.

The trust had patient engagement groups which provided opportunities to share their views. There was a cancer patient and carer forum for the surgery division that met monthly. They focussed on improving the experience for future patients,

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had established “The Big Room” methodology to make drive improvements and innovations. Where a need for improvement was perceived in a speciality, staff were brought together from multidisciplinary teams to establish a joint approach to improvement and co-designing new pathways or other improvements, with the patient at the heart of the work.

The multidisciplinary teams did not just include clinical staff but also staff such as IT colleagues and administrative staff who were brought on board at the earliest opportunity to provide input into how pathways could reduce wait times for appointments and results, for example.

The trust was consistently the lowest performing trust in England for cancer backlogs following the Covid-19 pandemic. The colorectal cancer backlog was the highest cancer patient tracking list with over 900 patients awaiting diagnosis. The trust pioneered an enhanced recovery ops support transformation programme with a one-stop approach and the colorectal backlog was cleared within 8 weeks. The overall patient tracking lists had been halved overall for cancer patients and there was faster diagnosis, early diagnosis, the quality, experience and outcomes for patients had improved and teams were being helped to reduce health inequalities.