

Lancashire Teaching Hospitals NHS Foundation Trust

Quality Report

Royal Preston Hospital
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

The Lancashire Teaching Hospitals NHS Foundation Trust has two hospitals delivering acute services from Royal Preston Hospital and Chorley and South Ribble Hospital. There are 877 general and acute beds of which 56 are Maternity beds and 28 are critical care. There is 7,775 staff, of whom, 782 are medical staff, 2,192 are nursing staff and 4,801 are other designations.

There were 133,083 inpatient admissions with 562,446 outpatient attendances between July 2015 and June 2016. There were 129,157 attendances at Accident & Emergency between August 2015 and July 2016.

We inspected the trust as a follow up to the inspection in July 2014 where the trust was found to require improvement in the safe and responsive domains and good in effective, caring and well led domains. We visited Royal Preston Hospital and Chorley and District General Hospital between 27 and 30 September 2016.

We rated Lancashire Teaching Hospitals NHS Foundation Trust as requires improvement overall. This was because;

Access and flow was a significant challenge to the trust resulting in not meeting the 4 hour A&E target although the trust had not reported any 12 hour trolley breaches, In addition the trust not meeting Referral to Treatment targets and there were high numbers of patients placed in areas not specific to their needs. Capacity and flow challenges meant there was frequent use of escalation areas including the occasional use of the theatre recovery area. Planned operations were being cancelled due to bed shortages. Patient experiences were hampered by the need to move wards during their stay and the number of delayed discharges was having a negative effect on capacity and flow throughout the trust. There were a large number of patients whose discharge was delayed. Underutilisation of some areas at the Chorley site added to the problem.

There were pressures in the emergency department regarding access and flow that meant patients were not always seen in a timely way. We found that some medics were unaware of the requirement to gain senior review of patients prior to discharge for patients with chest pain or re-attendance within 72 hours.

We found that the trusts governance processes needed to be strengthened. There was a significant gap between the locally held risk registers and the directorate and corporate registers. Information was not well aligned and therefore did not provide assurance as to the escalation of risks or actions taken to mitigate those risks. There was a recognised lack of capacity in the governance team which was being addressed through recruitment.

We were not assured that all policies and procedures were current as many we reviewed were not up to date or had been appropriately reviewed. We were also not assured that staff were utilising the most recent versions of policy and procedures.

In respect of the Duty of Candour regulation we found that this was not addressed in all cases in a timely way. The quality assurance processes needed strengthening and currently provided reassurance rather than assurance. There were some concerns regarding the daily review of patients by consultant especially in the medical division.

The information we have received from the trust regarding mandatory training has not been easy to interpret and it has been difficult to identify training uptake at service level. This questions the reliability of information to the Board regarding the training levels of staff. Some examples include that in the emergency department that medical staff training in BLS, ALS and APLS was significantly below expected levels in nursing and medical staff. In paediatrics the percentage of staff with relevant level 2 safeguarding training was below expected.

There were a number of examples of poor medicines management found including a lack of risk assessment of patients who were self-medicating, we found incomplete records. We also found concerns with the consistency of accurate recording of the use of controlled drugs.

Medical staffing was a recognised significant challenge and plans were in place to improve the recruitment of relevant medical staff. The staffing skill mix was similar to the England average.

Summary of findings

Across the organisation nurse staffing was found to be an ongoing challenge to the trust, although it was found that in all areas staffing levels were being actively managed to meet the needs of patients.

However, staffing in the paediatric department was not based on an acuity tool which meant we were not assured that the ward was always appropriately staffed. This was being managed through flexible working. Nevertheless it was a concern due to the lack of clarity as to the required staffing level. We noted on the unannounced inspection that staff were working to a new draft escalation policy and had closed the ward to admissions on the previous day.

In the neonatal service this nurse staffing challenge was more noticeable due to them only being compliant with BAPM standards 80% of the time. On the unannounced visit we saw the shift was covered by nine staff when the expected number was 12. However, this hadn't been escalated to senior managers. This was raised to Trust.

The trust had an Early Warning Score system in place however; we found the escalation of patients whose condition was deteriorating was not always appropriate and timely.

The safeguarding team was significantly understaffed due to sickness and vacancies affecting delivery. There were also concerns around the number of Deprivation of Liberty applications which were not responded to in a timely way by the local authorities.

We found the general physical environment was aged and worn. The discharge lounge at RPH was not conducive to promoting patient's privacy and dignity. The designated discharge lounge area had patients waiting to go home sat amongst patients waiting for an outpatient appointment and confidentiality was difficult to maintain. Observation of patients could be improved and the facilities did not have readily accessible means for calling for urgent assistance should it be required.

We raised the following specific concerns which have been addressed;

- Expressed breast milk on the post-natal ward was in an unlocked room, with unlocked fridge and no use of tamper proof tops.

- The storage/recording of fetal remains was much improved on the unannounced visit. There is now a log in/log out system on the ward, porter also logs in and logs out when transferring samples to mortuary. Separate locked fridge for remains only.
- Safe storage of IV fluids on emergency trolleys.

We saw several areas of outstanding practice including:

- The trust had launched the Sleep Improvement in Adult Critical Care Programme. Disturbed sleep in critical care patients is associated with delirium, in which patients become confused, restless and experience hallucinations. This can delay their recovery from critical illness. The trust recognised this and identified the potential disturbances to sleep. To minimise disruption to patients during the night, they offered eye masks and earplugs, dimmed lights, anticipated empty infusion alarms, turned down the volume on medical equipment and phones and encouraged staff to talk away from the bedside. Staff were also reminded to check regularly for signs of delirium. The project and associated resources were shared with neighbouring critical care networks and at national meetings. An initial research study showed that making small changes caused a 50% reduction in patient delirium and significantly improved the quality of sleep experienced by patients. The study had won an initiative award at the National Nursing Times Awards.
- The introduction in dermatology of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breeches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve the access and flow of patients through the trust.
- Review and improve the governance processes for the organisation to ensure robust policies and processes are in place that support safe care delivery, risk management and the management and learning from incidents and complaints.

Summary of findings

- Ensure the medicines management policy is robust and adhered to particularly with regards to self-medicating and controlled drugs management.
- Ensure that the mandatory training programme supports staff attending and maintaining their mandatory training requirements.
- Ensure that the process and practice for the escalation of the deteriorating patient is reviewed and embedded across the organisation.
- Improve the facilities utilised as a discharge lounge.
- Review and improve the staffing levels to ensure safe care and treatment, particularly within maternity, children's and neonatal services and where patients require intensive nursing at either level 2 or Level 3.
- Ensure that Safeguarding resources are adequate and training meets national standards and is taken up by relevant staff.
- Work with the Local authorities to improve the timeliness of authorisation of Deprivation of Liberty applications.

At Royal Preston Hospital the hospital must;

In Urgent and Emergency Care services;

- Ensure access to the main entrance paediatric waiting area is limited to reduce the risk of children exiting the area through the automatic doorway.
- Ensure intravenous fluids are stored securely and daily checks are completed with actions to address issues identified, completed.
- Ensure mandatory training, including safeguarding, compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED
- Ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- Ensure action plans following CEM audits target areas of poor performance and improve practice.
- Improve performance, particularly in relation to the department of health four hour target; wait times following a decision to admit, ambulance handovers.
- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.

- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person with review dates included.

In Medicine;

- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- Ensure procedures in place around medicine management are robust and that policies are followed.
- Ensure the risk registers are consistent and demonstrate mitigating actions and review dates

In Surgery;

- Take appropriate actions to improve staff training compliance in areas such as safeguarding training and life support training.
- Take appropriate actions to ensure that patients requiring escalation, as part of the national early warning score system (NEWS), are appropriately escalated by staff.
- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.

In Maternity and Gynaecology;

- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- Develop a baby abduction policy and take action to ensure that there is a safe system for protecting babies from abduction.
- Ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- Ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.

Summary of findings

- Complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Ensure that all staff receive medical devices training to ensure all equipment is used in a safe way.

In Critical Care;

- Ensure that escalation procedures are followed appropriately across the hospital where patients' National Early Warning Scores (NEWS) are greater than five and the patient may need to be assessed for admittance to the critical care unit.
- Ensure that any patients admitted to Ward 2A, who are assessed as Level 2 high dependency patients, receive nursing care at a ratio of 1:2 in accordance with national standards.
- Address action points on a gap analysis that showed that there was no availability for endoscopy for urgent gastro intestinal bleeds 24 hours a day.

In Children and Young People's services;

- Ensure that staffing levels in neonatal and children's services are maintained in accordance with national guidelines.
- Ensure that all relevant staff having regular contact with children, as defined by intercollegiate guidance, complete level three safeguarding training.
- Ensure that indicators for managing the changing condition of ill children are consistently used and responded to appropriately on the children's ward.
- Ensure that the isolation room used on the children's ward is free from access to ligature points
- Ensure that patient records are kept securely in the children's out patients department.
- Ensure that checks on emergency resuscitation equipment, are completed and accurately recorded on the neonatal unit.
- Ensure that secure access to the neonatal unit and children's ward is maintained at all times by staff, parents and visitors.

In Outpatients and Diagnostic Imaging;

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.

- Review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- Ensure staff complete mandatory training as per the trust policy.

At Chorley District General Hospital the hospital must;

In Urgent Care services;

- Take action to help control risks associated with the room identified for mental health patients must be actioned and appropriately documented.
- Ensure records of controlled drug use in registers are kept in line with trust policy.
- Ensure mandatory training compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED.
- Ensure action plans following CEM audits target areas of poor performance and improve practice and that clinical staff are aware of and engaged with the process of clinical audit.
- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person and review dates included.
- Ensure major incident plans are updated to reflect the current use of the department.
- Improve communication and improve the negative culture centred on a lack of communication and feelings of mistrust amongst staff.

In Medicine;

- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- Ensure procedures in place around medicine management are robust and that policies are followed.
- Ensure the risk registers are consistent and demonstrate mitigating actions and review dates

In Surgery;

Summary of findings

- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.
- Take appropriate actions to improve staff training compliance in adult and children's safeguarding training.

In Maternity and Gynaecology;

- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- Ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- Develop a baby abduction policy and take action to ensure that there is a safe system for protecting babies from abduction.

- Complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Ensure that all staff receives medical devices training to ensure all equipment is used in a safe way.

In Outpatients and Diagnostic Imaging;

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- Ensure staff complete mandatory training as per the trust policy.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Lancashire Teaching Hospitals NHS Foundation Trust

The Lancashire Teaching Hospitals NHS Foundation Trust has two hospitals delivering acute services from Royal Preston Hospital and Chorley and District General Hospital. The Trust offers regional specialist services including major trauma services, neurosurgery, cancer services, vascular and renal services. There are 877 general and acute beds of which 56 are Maternity beds and 28 are critical care. There is 7,775 staff, of whom, 782 are medical staff, 2,192 are nursing staff and 4,801 are other designations.

The trust has annual revenue of £436.0m with a full cost of £469.5m. Therefore having a surplus (deficit) of £33.2m.

There were 133,083 inpatient admissions with 562,446 outpatient attendances between July 2015 and June 2016. There were 129,157 attendances at Accident & Emergency between August 2015 and July 2016.

We inspected the trust as a focussed follow up to the inspection in July 2014 where the trust was found to require improvement in the safe and responsive domains and good in effective, caring and well led domains. We visited between 27 and 30 September 2016. We visited Royal Preston hospital and Chorley and District General Hospital.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Consultant colorectal surgeon with 6 years' experience as a medical director

Acting Head of Hospital Inspections: Lorraine Bolam, Care Quality Commission

The team included eight CQC inspectors, a pharmacy inspector, two assistant inspectors, an inspection planner and a variety of specialists including an emergency department Consultant and nurse, Consultant Geriatrician/General Physician, medical nurse, theatre

manager, consultant anaesthetist, Lead Nurse Acute Care Team and Hospital at Night team, Head of Midwifery/General Manager, Matron Maternity, Nurse Consultant/Advanced Paediatric Nurse Practitioner, Consultant in Clinical Oncology, Clinical Nurse Specialist Palliative Care, Urological and Surgical services nurse, Radiology General Manager, Senior Quality and Risk Manager, Director of Nursing, Equality and Diversity specialist, Specialist Community Paediatric Physiotherapist, gynaecology nurse and an expert by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at Lancashire Teaching Hospitals NHS Foundation Trust:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people

Summary of findings

- End of life care
- Outpatients

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal

care and treatment. We spoke with people who used the service and the people close to them and we also met with representatives of the Protect Chorley and South Ribble Hospital Campaign.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust

What people who use the trust's services say

- In the Friends and Family test the trust performance was below the England average each month between July 2015 and June 2016.
- The trust performed about the same as other trusts in the 2015 CQC Inpatient Survey.
- PLACE scores for cleanliness, food and facilities were better than the England average in both 2015 and 2016. Scores for privacy, dignity and wellbeing were better in 2015 and slightly lower than the average in 2016.

- The trust performed about the same as other trusts in the 2015 CQC Inpatient Survey.
- There was good performance in the National Cancer Patient Experience Survey 2015, with performance higher than expected for 13 out of the 50 questions and no questions where the trust performed lower than expected.
- Numbers of written complaints fell year on year for the last four years, from 593 in 2012/13 to 551 in 2015/16.


Facts and data about this trust

The Lancashire Teaching Hospitals NHS Foundation Trust serves a local population of 390,000 living in South Ribble, Chorley, and Preston boroughs. The health and

deprivation of people in Lancashire as a county varies, with just over half of the health indicators worse than the England average, such as binge drinking adults and life expectancy.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as requires improvement because:</p> <ul style="list-style-type: none">• Systems, processes and practices in place to keep people safe and safeguard them from abuse were not reliable. There was limited assurance that staff had received relevant training regarding safeguarding. Policies did not reflect the most current guidance and staff training did not meet the intercollegiate guidance.• There were two Never events reported, one in October 2015 and the other in August 2016. Both related to surgical procedures. There were 49 serious incidents including 20 falls and 7 incidents relating to adverse media coverage.• There was a clear process for the review of serious incidents to ensure the safety of patients and to establish learning however the Root Cause Analyses were not always as thorough as expected meaning that potential learning opportunities could be missed.• Medical staffing was a recognised significant challenge to the trust and plans were in place to improve the recruitment of relevant medical staff. The staffing skill mix was similar to the England average.• Nurse staffing was noted to be of concern within maternity services and children's and neonatal care. Nurse staffing on Ward 2a did not always meet the requirements of the levels of care required by patients on the ward.• Sickness absence rates were higher than the England average between April 2015 and March 2016. At the time of inspection, not all the shifts were filled as planned, despite agency and bank nurses being used to help fill staffing shortfalls.• Within surgical services and services for children concerns were raised regarding the appropriate escalation of patients, in response to national early warning scores, whose condition was deteriorating.• There was a Duty of Candour Policy which was up to date; however it did not accurately reflect the requirements of the regulation.• The Trust's current figures showed that 71% of patient's medicines were reconciled within 24 hours by the pharmacy team, which is below the Trust's target of 80%.• Despite medicines audits being conducted they did not highlight incomplete record keepings on the urgent care centre	<p>Requires improvement </p>

Summary of findings

in Chorley; intravenous fluids not stored securely on the ITU department and within the Trust's resuscitation trolleys or out of date medicines in the Outpatient department. All of these issues were found as part of our inspection.

- The system for protecting babies from abduction was not robust. Due to a shortage of electronic baby security tags, not all babies were issued with a tag on the postnatal ward. Baby security issues were raised with the trust at the time of our visit, immediate action was taken, and all babies were tagged before we left site.
- The system for recording and storing fetal pregnancy remains on the gynaecology ward was not robust. This was immediately raised with the trust and at the time of the unannounced visit, we observed changes in practice to assure us that pregnancy remains were stored safely and sensitively.

However:

- The trust has committed to the Sign up to Safety initiative, committing to reducing avoidable harm by 50% over the next 3 years. Particularly in relation to falls, sepsis, pressure ulcers and healthcare associated infections. They have a safety improvement plan which works in conjunction with the Trust's Safety and Quality Strategy 2014 – 2017.
- There was a good culture of reporting incidents.
- The Trust had a Medicines Safety Officer (MSO) who worked within the pharmacy department to review medicine incidents. The MSO had embedded a Patient Safety Alert about the importance of reporting adverse drug reactions using the Yellow Card Scheme. In 2014, the Trust was the 13th highest reporter of Yellow Cards out of 32 in the local region. Following on from the MSO's campaign to increase the number of Yellow Cards used in 2015 the Trust was the fourth highest reporter.

Duty of Candour

- There was a Duty of Candour Policy which was up to date; however it did not accurately reflect the regulation in respect of the prolonged psychological harm or 28 days or more criteria.
- There was no reference within the policy with regards to issues of moderate harm or above identified through the review of complaints or actions staff should take to ensure the Duty of Candour is discharged.
- Duty of Candour was not referenced or linked to the complaints policy.

Summary of findings

Safeguarding

- The nominated lead for Safeguarding is the Associate Director for Patient Safety and Governance. This role was supported by a lead practitioner for adults and a named lead nurse for children's safeguarding.
- To support the team was a further 2.6 WTE band 6 and 1.6 WTE band 3 administrative support. However at the time of the inspection sickness had reduced the team significantly.
- The trust was represented on Lancashire Children's Safeguarding Board and is part of the sub-groups.
- The trust has asked to be part of the Lancashire Adult Safeguarding Board and was awaiting a review however there was representation on the sub groups and the lead was chairing a serious case review in Lancashire.
- There were weekly multidisciplinary meetings
- Following the appointment of the Nursing and Midwifery Director a Safeguarding board has been established with a non-executive director as a member.
- Safeguarding training was identified as a challenge with adult safeguarding training uptake at level 3 only 43% and level 2 at only 53%. Children's safeguarding training uptake was reported as 72% at Level 1; 37% at Level 2 and 72% at Level 3 however the training levels at the trust were not in keeping with the intercollegiate guidance although the trust had plans in place and was addressing this.
- The Adult Safeguarding Policy referenced No Secrets rather than the Care Act as would be expected. The Adult Safeguarding lead was aware of the need to update the policy.
- CAMHS were available seven days a week.
- The system for protecting babies from abduction was not robust. Due to a shortage of electronic baby security tags, not all babies were issued with a tag on the postnatal ward. Baby security issues were raised with the trust at the time of our visit, immediate action was taken, and all babies were tagged before we left site.
- The system for recording and storing fetal pregnancy remains on the gynaecology ward was not robust. Remains were stored in clear plastic containers in a fridge that stored other samples. This fridge was not locked and there was no system in place to log in or log out remains that had been taken to the mortuary. This was immediately raised with the trust and at the time of the unannounced visit, we observed changes in practice to assure us that pregnancy remains were stored safely and sensitively. Staff had also commenced a record book in use to log in and out remains that were transferred to the mortuary

Summary of findings

Incidents

- There were two Never events reported, one in October 2015 and the other in August 2016. Both related to surgical procedure.
- There were 49 serious incidents including 20 falls and 7 incidents relating to adverse media coverage.
- There was a clear process for the review of serious incidents to ensure the safety of patients and to establish learning however the Root Cause Analyses were not always as thorough as expected meaning that potential learning opportunities could be missed.
- The NRLS rate of incidents per 100 admissions slightly higher than the England average.
- There were 86 pressure ulcers, 25 falls and 58 Catheter Urinary Tract Infections (C.UTIs) reported to the safety thermometer from July 2015 to June 2016. Rates of pressure ulcers and falls fluctuated over the period; rates of C.UTIs were stable from April 2016 onwards after a peak in rates the month before.
- There were four MRSA infections reported between July 2015 and June 2016.
- There were 52 C.difficile infections reported over the same period, with rates fluctuating around the England average.
- There were 19 MSSA infections reported, rates were generally below the England average each month except for March 2016.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the Trust governance arrangements. We found that there was an open culture around the reporting of medicine errors. There was a system in place to learn from medication errors and this was fed down from the Medicines Safety Group. There had been medication incidents involving insulin, which had been highlighted as a risk and discussed at the Medicines Safety Group; however we asked staff from medical and surgical wards from both sites who could not recall such incidents.
- The Trust had a Medicines Safety Officer (MSO) who worked within the pharmacy department to review medicine incidents. The MSO had embedded a Patient Safety Alert about the importance of reporting adverse drug reactions using the Yellow Card Scheme. In 2014, the Trust was the 13th highest reporter of Yellow Cards out of 32 in the local region. Following on from the MSO's campaign to increase the number of Yellow Cards used in 2015 the Trust was the fourth highest reporter.

Summary of findings

Staffing

- Medical staffing was a significant challenge to the trust which was clearly recognised and plans were in place to improve the recruitment of relevant medical staff.
- The use of medical locums was most noticeable within medicine, neurosciences, accident and emergency and plastic surgery in June 2015. This was an increasing picture across that quarter for medicine and neurosciences and consistent in the other areas.
- The staffing skill mix was similar to the England average. Vacancy rates were reported as 9% for the last financial year.
- Nurse staffing was noted to be of concern within maternity services and children's and neonatal care. Nurse staffing on Ward 2a did not always meet the requirements of the levels of care required by patients on the ward.
- Sickness absence rates of 9% were higher than the England average between April 2015 and March 2016.
- The turnover rate for staff was reported as 11% for the last financial year.
- At the time of inspection, not all the shifts were filled as planned, despite agency and bank nurses being used to help fill staffing shortfalls.

Management of the Deteriorating Patient

- Comprehensive risk assessments were carried out on patients who received services and management plans were developed in line with national guidance.
- The trust used the National Early Warning Score system to monitor a patient's condition.
- Within surgical services and services for children concerns were raised regarding the appropriate escalation of patients, in response to changes in national early warning scores indicating that a patient's condition was deteriorating.

Medicines Management

- The Trust's current figures showed that 71% of patients were reconciled within 24 hours by the pharmacy team, which is below the Trust's target of 80%.
- Trust policies were regularly reviewed and covered most aspects of medicines management. They were accessible via the hospital intranet to all staff. Medicines management was regularly audited across the Trust and included; antibiotic management and missed medicines doses (including critical medicines). Minutes from the Medicines Safety Group showed that wards that were reported as having missed doses or

Summary of findings

missing signatures on the chart would be invited to the Medicines Safety Group to discuss the findings. An action plan would then be agreed with a view to reducing the incidents for the wards involved.

- The Trust also audited controlled drugs (CD) and how medicines were stored. The audits from the CD audit did not highlight incomplete record keepings on the urgent care centre in Chorley; and the safe storage of medicines audit did not highlight when intravenous fluids were not stored securely on the ITU department and within the Trust's resuscitation trolleys. The outpatient department had several medicines that had gone out of date
- The pharmacy department had reviewed the time taken for a patient to be discharged from being told they could go home and found the time taken to be approximately eight hours. A pilot using prescribing pharmacists to prescribe discharges and an introduction of a satellite pharmacy on a different floor reduced the discharge by five hours. The prescribing error rate for pharmacist discharges was 0.7% in comparison to 22% prior to the pilot commencing. The accuracy of information provided to GPs increased from 46% to 99%, which supports the current guidance [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015].

Are services at this trust effective?

We rated effective as requires improvement because:

- Guidelines and policies were found to be past the date of review which did not provide assurance that they were up to date with current guidance.
- Staff annual appraisals were not always completed.
- Delays in the authorisation of Deprivation of Liberty safeguards were not being addressed to ensure the legal and appropriate use of these actions.
- In medical services the myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14 showed the percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI), could have been managed better with results consistently below the national average..
- In the national diabetes inpatient audit 2015, the hospital was worse than the England average in 13 of the 17 indicators, this included patients receiving a foot assessment within 24 hours, medication errors, meal choice and staff knowledge.

However:

Requires improvement



Summary of findings

- The SHMI (Jan 15 to Dec 15) was 99.48 (within the expected range)
- The HSMR (Jun 15 to May 16) was 93.2 (positive outlier)
- There was a Trust Wide Forward Programme of Clinical Audit and Effectiveness Activity 2016-2017.
- The trust had in place service dashboards which provided ongoing data around indicators of patient outcomes.
- The Trust was active in monitoring the use and compliance of antibiotics and had embedded the NICE Antimicrobial Stewardships

Evidence based care and treatment

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. Although we did find examples where audit findings were not always subject to robust action planning to secure improvement.
- Guidelines and policies were found to be past the date of review which did not provide assurance that they were up to date with current guidance. However the documents did refer to national guidance relevant to the policy.
- The trust had in place service dashboards which provided ongoing data around indicators of patient outcomes. These were used to alert services to areas for improvement and to monitor patient outcomes.
- The Trust was active in monitoring the use and compliance of antibiotics and had embedded the NICE Antimicrobial Stewardships: Systems and process for effective antimicrobial medicines use Aug 2015. The Trust at the time of our visit had a microbiologist and antibiotic pharmacist ward round.
- The Drug and Therapeutics and Medicines Safety Group oversaw and managed patient safety alerts, medicines incidents and medicines use, including controlled drugs, within the Trust. Minutes from these meetings showed appropriate actions and management of identified issues with clear action plans put in place where needed.
- There was a Trust Wide Forward Programme of Clinical Audit and Effectiveness Activity 2016-2017. However we found that actions following audit were not always clearly identified or monitored.

Patient outcomes

- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent

Summary of findings

methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. Risk is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England average. A score of more than 100 means more adverse (worse) outcomes than expected. Between January 2015 and December 2015 the SHMI score for Lancashire Teaching Hospitals NHS Trust was 0.995 (within the expected range).

- The HSMR (Jun 15 to May 16) was 93.2 (positive outlier)
- HSMR represents a positive shift of 13.4 points from the SCMR of 106.6 in 2014/15
- There had been an increased focus on mortality review within the Trust, along with health economy wide improvement programmes in respect of chronic obstructive pulmonary disease and end of life care.
- There were two mortality outlier alerts reported for follow up in 2013 (intestinal obstruction without hernia and intracranial injury). There had been one maternity outlier received in July 2015 for Puerperal sepsis (not including other infection).
- The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry.
- The national joint registry (NJR) data between April 2003 and July 2015 showed that hip and knee mortality rates at the hospital were in line with national averages.
- Performance reported outcomes measures (PROMs) data between April 2015 and March 2016 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement was similar to the England average.
- The proportion of patients with improved outcomes following varicose vein procedures was much better than the England average during this period, with fewer patients reporting a worsening and more patients reporting an improvement after treatment, compared to the national average.
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was better than the expected range for all specialties except for elective urology and trauma and orthopaedic surgery.
- The trust reported that overall readmission rates were 7.38% compared with the internal trust target of 7.39% and no clinical concerns had been raised relating to readmission rates.

Summary of findings

- The divisional medical director for surgery also told us a review was underway to determine if there was any data quality or coding issues in relation to the reporting of patient readmission rates.
- The average patient length of stay was better than the England average for all specialties except elective trauma and orthopaedics, which was only slightly worse than average (3.9 days compared with average of 3.4 days).
- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14 showed the percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI), could have been managed better with results consistently below the national average. For example 85.9% of patients were seen by a cardiologist prior to discharge, which was worse than the national average of 94.3% and 24.4% of patients were admitted to a cardiology ward, which was worse than the national average of 55.6%. Senior managers were unaware as why the number of patients admitted to a cardiology ward was low as there were no current issues. When asked senior managers regarding the results of patients admitted to a cardiology ward but told us they would look into it.
- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results for October 2015 to March 2016 rated the hospital overall as a grade 'C', which highlighted that although the service had improved from a 'D', improvements to the care and treatment of patients who had suffered a stroke were still required. This showed us that there had been an improvement in the care of patients who had suffered a stroke. Senior managers told us an action plan had been implemented and would provide a copy.
- The 2013/2014 heart failure audit showed the hospital performed better than the England average for ten out of the eleven clinical indicators.
- In the national diabetes inpatient audit 2015, the hospital was worse than the England average in 13 of the 17 indicators, this included patients receiving a foot assessment within 24 hours, medication errors, meal choice and staff knowledge. Senior managers told us they were looking at setting up an integrated service with primary care and that an action plan had been devised; we requested a copy of the action plan, however, at the time of inspection we had not yet received it.

Summary of findings

- Data from the Lung Cancer Audit (2015) showed mixed performance in the quality of care at the trust. The trust achieved the expected or exceeded level in the process, imaging and nursing measures in two of the four indicators. Treatment measures achieved the expected or exceeded level in two indicators, and were significantly better than the national level in one. However they were below the expected level on two indicators and significantly worse on one treatment measure.
- Between February 2015 to January 2016, Hospital Episode Statistics (HES) data showed the readmission rates for the hospital were better than the England average for elective respiratory medicine and haematology, as well as non-elective general and respiratory medicine. Rates were similar to expected for other specialties.

Multidisciplinary working

- Across all services there were well established Multidisciplinary teams (MDT) with patients having input from a range of allied healthcare professionals (AHP's) including Occupational therapists, physiotherapists and speech and language specialists.
- Plans of care were available to staff to review patients goals. There was effective daily communication between multidisciplinary teams and good working relationships with staff at the hospital and in the community.
- 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.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- There was a consent policy in place and no concerns regarding the gaining of consent were identified during the inspection.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- Staff were supported on the Mental Capacity Act and Deprivation of Liberty Safeguards by the Adult Safeguarding lead.
- Trust data confirmed that mental capacity act (MCA) training was included in safeguarding training.
- There were 15 to 20 Deprivation of Liberty applications per month which was an increase however the authorisation of the

Summary of findings

applications was not being done in a timely way by the local authorities with some taking several months. These were not always reported as incidents and therefore action to improve was not forthcoming.

Are services at this trust caring?

We rated caring as good because:

- As part of our inspection we observed patients being cared for with dignity and kindness, with privacy maintained at all times.
- All patients who were at their bedside or in bed had access to call bells and staff responded promptly.
- All interactions between staff that we witnessed were patient centred and displayed compassionate and respectful responses from staff.
- The trust performed about the same as other trusts in the 2015 CQC Inpatient Survey.
- PLACE scores for cleanliness, food and facilities were better than the England average in both 2015 and 2016. Scores for privacy, dignity and wellbeing were better in 2015 and slightly lower than the average in 2016.
- Visiting times met the needs of both patients and those close to them..
- Patients and relatives we spoke with all told us that staff were busy but were responsive to their needs very approachable.
- There was evidence of staff supporting both patients and relatives with their emotional needs.

However:

- In the Friends and Family test the trust performance was below the England average each month between July 2015 and June 2016.

Compassionate care

- Patients were complimentary about staff and the care they had received.
- As part of our inspection we observed patients being cared for with dignity and kindness, with privacy maintained at all times. All patients who were at their bedside or in bed had access to call bells and staff responded promptly.
- All interactions between staff and patients that we witnessed were patient centred and displayed compassion and respect.
- The trust performed about the same as other trusts in the 2015 CQC Inpatient Survey.

Good



Summary of findings

- There was good performance in the National Cancer Patient Experience Survey 2015, with performance higher than expected for 13 out of the 50 questions and no questions where the trust performed lower than expected.

Understanding and involvement of patients and those close to them

- Visiting times met the patients and those close to them. Open visiting times were available if patients needed support from relatives.
- The trust were participating in 'John's campaign', which focused on caring and supporting carers to stay with their loved ones in hospital. Identity badges were provided to carers of patients with learning disabilities or dementia; this ensured all staff were aware of who the carers were, and staff told us they valued and liked to include carers to be part of the team.
- Patients and relatives we spoke with all told us that staff were busy but were responsive to their needs and were approachable.

Emotional support

- There was evidence of staff supporting both patients and relatives with their emotional needs. This ranged from ensuring they had clear information on which to make decisions to support during the end of life for both patients and their families and carers.
- Staff understood that being a patient or supporting a patient could be a very stressful time and staff offered support and reassurance to patients and those close to them as appropriate.
- There was a chaplaincy team available 24 hours a day, seven days a week. The team consisted of chaplains and volunteers from all denominations. Staff would visit wards and offer support as required and would take patients to weekly prayer or services.

Are services at this trust responsive?

We rated responsive as requires improvement because:

- The latest data provided showed that inpatient review by consultant twice daily for acute patients was only happening in 38% of cases during the week and 27% at the weekend. Review by consultant daily for non-acute patients was only happening

Requires improvement



Summary of findings

in 45% of cases during the week and 34% at the weekend.

Evidence of communication with patient regarding diagnosis / treatment within 48 hours was only happening in 43% of cases during the week and 46% at the weekend.

- The trust had significant delayed transfers of care relating to a number of reasons.
- HSCIC - Delayed Transfers of Care (01/06/2015 - 31/05/2016) data showed that the trust performance on transfers was similar to national statistics however they had a significantly higher number of delays relating to patient and family choice being the reason for delayed discharge.
- Performance against the Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. Between March and August 2016 the RPH department consistently failed to meet the target with an average of only 83% of patients meeting the target. At Chorley UCC between March and August 2016 prior to changing the department from an ED to a UCC (March up to 18 April 2016) the target was not met (77% in March and 85% in April). However, following the change, the centre had consistently met the target between May and September 2016 with an average of 99.7% of patients admitted, transferred or discharged within the four hour target.
- The average bed occupancy rate across the trust between April 2016 and July 2016 was around 90%, compared with the trust target of 85%.
- There were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Trust data showed from July 2015 and July 2016 there was on average 49 to 75 outliers per day at the hospital.
- Records showed there were nine instances where non- theatre surgical patients were kept in the main theatres recovery area during August and September 2016. This included three instances where patients were kept overnight.
- The proportion of cancelled operations as a percentage of elective admissions was higher (worse) than the England average between July 2014 and June 2016.
- There were 1,059 operations cancelled between October 2015 and September 2016. NHS England data showed there were no urgent operations cancelled during this period. The most frequent reasons for cancelled operations were 'no bed on ward' (44%).

Summary of findings

- NHS England data showed the trust performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and June 2016 for all surgical specialties except trauma and orthopaedics (77.6% compared with the average of 69.9%).
- The Complaints Policy and procedure did not include or reference Duty of Candour.
- We were not assured of the competence of staff undertaking complaints investigations as no standards were specified or determined.
- The trust was not meeting the key performance indicator to provide a final response to complaints within 25 working days. The trust was meeting this in 67 to 70% of cases at the time of the inspection.
- The trust did not have a process for the monitoring of actions following investigations of complaints to ensure the identified actions were completed. This was the responsibility of the Division and was not monitored at trust level.

However:

- Diagnostic imaging waiting times (percentage over six weeks) were better than the England average between July 2015 and May 2016.
- The trust was an early implementer site for the implementation of the 10 clinical standards for 7-day services developed by NHS Improving Quality.
- The expanded role of prescribing pharmacists has been rolled out across the Trust to generate all prescriptions at the point of patient admission and discharge, thus releasing medical staff time for patient reviews.
- The trust participated in the Quality Mark for Elder-Friendly Hospital Wards, with two wards at CDH (Rockwood A and Rockwood B) achieving the quality mark.
- There were clear flowcharts for the varied routes of admission for a patient with learning disabilities.
- The hospital Learning Disability Champions were established to support people who attend the hospital with a learning disability.
- Although the trust does not have an electronic tagging system at present, it is being considered as part of the IT programme, they have implemented an innovative Patient ID band identifier (a cut-out shape of a Forget-me-not flower) that informs staff (when checking the patient ID band) that this person has a diagnosis of dementia.

Summary of findings

- The trust also has a nurse led Older People's Programme with a focus on improving dementia care throughout the Trust as well as over 300 Dementia Champions.
- The trust was meeting the standard to formally acknowledge complaints within three working days in 97% of cases.

Service planning and delivery to meet the needs of local people

- In 2014-15, Lancashire Teaching Hospitals was successful in its application to become an early implementer site for the implementation of the 10 clinical standards for 7-day services developed by NHS Improving Quality. The Trust has participated in the 6-monthly national 7-day services data collection.
- The latest data provided showed that inpatient review by consultant twice daily for acute patients was only happening in 38% of cases during the week and 27% at the weekend. Review by consultant daily for non-acute patients was only happening in 45% of cases during the week and 34% at the weekend. Evidence of communication with patient regarding diagnosis / treatment within 48 hours was only happening in 43% of cases during the week and 46% at the weekend.
- "Four Eyes Insight" have been commissioned to work with the Trust to improve patient flow. This work includes standardising practices on the wards including daily Board / Ward rounds, and review of the consultant's job plans to ensure capacity to support ward clinical work.
- Delayed Transfers of Care (DToC) improvement has been supported by NHS Improvement.
- The expanded role of prescribing pharmacists has been rolled out across the Trust to generate all prescriptions at the point of patient admission and discharge, thus releasing medical staff time for patient reviews.

Meeting people's individual needs

- The trust was the regional centre for vascular surgery, neurosurgery, burns and the major trauma centre for Lancashire and South Cumbria.
- There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital, such as cardiothoracic surgery.
- The ward and theatre areas we inspected were compliant with same-sex accommodation guidelines.

Summary of findings

- There were daily meetings with the bed management team so patient flow could be maintained when possible and to identify and resolve any issues relating to the admission or discharge of patients.
- The trust participated in the Quality Mark for Elder-Friendly Hospital Wards, with two wards at CDH (Rockwood A and Rockwood B) achieving the quality mark. The elder friendly quality mark is quality-improvement programme, which ensures a consistent quality care to patients over 65 years of age.
- The Proactive Elderly Care Team (PECT) provided patients and staff in identifying and assessing needs of older people and carried out dementia assessments for patients over the age of 75 years of age.
- The Trust had introduced two pharmacy technicians who both worked part time to visit patients at home who had recently been discharged. The pharmacy technicians provided information on medicines and allowed patients to understand the importance of their medicines, to understand changes in medicines and to improve the communication between hospital and general practice.

Learning Disabilities

- There was a comprehensive policy for the care of people with learning disabilities in place however the date for review had passed in December 2015.
- The policy used data from Mencap (1998) and the projected learning disability populations for the two areas (Preston and Chorley & South Ribble) to estimate that between 898 and 2486 people with learning disability would be admitted to Lancashire Teaching Hospitals Trust each year, in addition to those using outpatient services.
- There were clear flowcharts for the varied routes of admission for a patient with learning disabilities.
- The hospital Learning Disability Champions were established to support people who attend the hospital with a learning disability.
- The 'Orange Folder' containing up-to-date information relating to Learning Disabilities as well as how to contact your Learning Disability Champion is held on the Trust Intranet site on the Equality and Involvement Link.
- When the learning disability needs are complex (profound learning disabilities, challenging behaviour or where a learning disability may be suspected) additional advice and support can be obtained via Lancashire Care NHS Foundation Trust.

Summary of findings

Dementia

- From December 2014 to November 2015 the trust had 1813 admissions of patients over 75 years with a pre-existing formal dementia diagnosis via the Emergency Care Pathway.
- The trust does not have an electronic tagging system at present although it is being considered as part of the IT programme. They have implemented an innovative Patient ID band identifier (a cut-out shape of a Forget-me-not flower) that informs staff (when checking the patient ID band) that this person has a diagnosis of dementia. This is discrete and provides essential information to all staff regardless of access to IT system. This originated in ED and is being implemented across the Trust.
- As part of the dementia screening process, patients with a formal diagnosis of dementia who also present with multiple frailties may be referred to the Specialist nurses within the Proactive Elderly Care Team via phone/ bleep or verbal referral. The Business Intelligence unit provides the Proactive Elderly Care Team with a list of patients admitted to the Trust via the Emergency Care pathway, aged 75 years or above.
- Patients previously screened by PECT as having a formal diagnosis can then be identified on the dementia screening database and a Forget-Me-Not booklet included in the patients notes.
- Those patients with no formal diagnosis who are not exempt from screening (critically ill/ readmission within 6 months/ lack of translator/ Sensory impairment/ Severe speech difficulties/ Palliative care) or identified as having delirium are asked a dementia screening question.
- Those patients responding positively to this or who are observed as likely cognitive impairment, are then invited to undergo the cognitive assessment (6CIT- 6 Item Cognitive Impairment Test).
- For patients scoring above 7/28 on the 6CIT, their GP is notified either by the Hospital Discharge summary or by letter and a request made to review and refer the patient on to the Specialist Memory Assessment services.
- The trust also has a nurse led Older People's Programme with a focus on improving dementia care throughout the Trust as well as over 300 Dementia Champions.
- The trust participate in the RCPsych Quality Mark for Elder Friendly wards and have five wards accredited and two more undertaking inspection in Spring 2017.
(<http://www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark.aspx>).

Summary of findings

Access and flow

- The trust had significant delayed transfers of care relating to a number of reasons.
- HSCIC - Delayed Transfers of Care (01/06/2015 - 31/05/2016) data showed that the trust performance on transfers was similar to national statistics however they had a significantly higher number of delays relating to patient and family choice being the reason for delayed discharge.
- Delayed discharges and the designation of the Chorley District Hospital urgent and emergency care service from an Accident and Emergency Department to an Urgent Care Centre was having an effect on the number of attendances at the Royal Preston Accident and Emergency department.
- Performance against the Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. We reviewed data between March and August 2016 which showed the RPH department consistently failed to meet the target during this period with an average of only 83% of patients meeting the target. The lowest percentage was 77% in August and the highest was 89% in April 2016. We reviewed data for Chorley UCC between March and August 2016 which showed that prior to changing the department from an ED to a UCC (March up to 18 April 2016) the target was not met (77% in March and 85% in April). However, following the change, the centre had consistently met the target between May and September 2016 with an average of 99.7% of patients admitted, transferred or discharged within the four hour target.
- The average bed occupancy rate across the trust between April 2016 and July 2016 was around 90%, compared with the trust target of 85%.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Trust data showed from July 2015 and July 2016 there was on average 49 to 75 outliers per day at the hospital. Senior managers told us this had reduced over the recent weeks and at the time of inspection there were 23 outliers.
- The theatre and critical care escalation policy outlined the contingency plans during busy periods and provided guidance for staff when the recovery area was used as an escalation area for critical care or for the stabilisation of patients from other parts of the hospital.
- Records showed there were nine instances where non- theatre surgical patients were kept in the main theatres recovery area

Summary of findings

during August and September 2016. This included three instances where patients were kept overnight. These patients received safe care and were supported by critical care staff from the adjacent critical care area. However, the matron for theatres told us the use of recovery beds for critical care escalation reduced the availability of recovery beds for surgical patients and led to delayed or cancelled procedures.

- The proportion of cancelled operations as a percentage of elective admissions was higher (worse) than the England average between July 2014 and June 2016.
- There were 1,059 operations cancelled between October 2015 and September 2016. NHS England data showed there were no urgent operations cancelled during this period. The most frequent reasons for cancelled operations were 'no bed on ward' (44%) and 'overrun due to complications with previous patient' (14%).
- The proportion of patients whose operations were cancelled and were not treated within the 28 days across the trust was significantly worse than the England average between July 2014 and June 2016. There were 221 patients whose operations were cancelled and were not treated within the 28 days during this period. There was a worsening trend as 104 of these cancellations (47%) took place between January and June 2016.
- NHS England data showed the trust performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and June 2016 for all surgical specialties except trauma and orthopaedics (77.6% compared with the average of 69.9%).
- Records showed consistently poor compliance in two specialties during this period: oral surgery (58.4% compared to average of 75%) and neurosurgery (55.6% compared to average of 76.2%).
- The incomplete referral to treatment waiting time standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment.
- Records showed that none of the eight specialties achieved the 92% standard during the period between February 2016 and August 2016. Prior to this period four of the eight surgical specialties (urology, orthopaedics, ophthalmology and ear, nose and throat) achieved the 92% incomplete pathway standard between September 2015 and January 2016.

Summary of findings

- There was a worsening trend as overall compliance across the surgical specialties was 90% in September 2015 and this reduced month on month to 82% compliance in August 2016. This meant the number of patients waiting longer than 18 weeks for treatment had steadily increased during this period.
- Diagnostic imaging waiting times (percentage over six weeks) were better than the England average between July 2015 and May 2016.
- The two week wait performance was better than the national standard in the last four quarters prior to our inspection. The service provided a number of rapid access clinics such as chest pain, emergency eye clinic and ENT neck lump to enable patients to access an appointment quickly.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was better than the standard for the last three quarters of 2015/16 but was worse than the standard in the first quarter of 2016.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Non-admitted pathways means those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Royal Preston Hospital. Of the 16 separate specialties reported nine were below the England average, the lowest scoring being neurosurgery at 71%.
- For incomplete pathways, referral to treatment rates were similar to the standard between July and November 2015 before falling below the standard and continuing to fall gradually each month until June 2016. Of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- The trust had a number of patients who failed to attend for their appointments. The 'did not attend' (DNA) rates were similar to the England average at all sites within the trust.
- At our last inspection we told the trust to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time. Data provided by the trust showed an improvement since our last inspection. Between April 2016 and July 2016 the percentage of clinics cancelled within six weeks averaged 2.5% with one exception of 11% in April. Clinics

Summary of findings

cancelled over six weeks ranged between 9% and 4%. The main reasons for cancellation were annual leave, study leave and sickness. This information was trust-wide and not specific to Royal Preston Hospital.

Learning from complaints and concerns

- The Complaints Policy and procedure did not include or reference Duty of Candour. There was a Duty of Candour Policy which was up to date and appropriate.
- We were not assured of the competence of staff undertaking complaints investigations as no standards were specified or determined.
- The trust was meeting the standard to formally acknowledge complaints within three working days in 97% of cases.
- The trust was not meeting the key performance indicator to provide a final response to complaints within 25 working days. The trust was meeting this in 67 to 70% of cases at the time of the inspection.
- During the last 12 months, the trust experienced increased delays in the timeliness of some responses to complaints. Whilst some of these related to adjoining investigations or inquests, the majority were due to delays in receiving information relating to the complaint from individuals concerned, primarily from within medical and surgical services.
- Processes were under review by the corporate and division leads to strengthen principles of responsibility and accountability and further strengthen focus on the importance of achieving the required timescales with strengthened escalation processes.
- There was no data regarding the reopening of complaints.
- The quality assurance in regards to complaints management was weak. There was no systematic review of compliance against standards set in the policy.
- The trust did not have a process for the monitoring of actions following investigations of complaints to ensure the identified actions were completed. This was the responsibility of the Division and was not monitored at trust level.
- Complaints performance against key performance indicators was not reported to the Board.

Are services at this trust well-led?

We rated well-led as requires improvement because;

Requires improvement



Summary of findings

- Recent and intended changes to the governance structures, personnel and reporting arrangements had not been clearly articulated to the divisions and staff were unaware of the changes.
- The trust had identified the need for improvement of quality and governance within the organisation and recruited an associate director to support the required changes.
- A high number of the policies and procedures we reviewed were found to be out of date and lacked timely review.
- There was no evident risk management strategy; there was a lack of assurance regarding the regular review of risk at divisional level and the competency of staff to perform risk management and incident review, particularly Root Cause Analysis.
- The process for meeting the Fit and Proper Person regulation lacked robustness and had not been fully applied and documented.

However:

- The Board was roughly representative of the local population. The executive and non-executive team were aware of the challenges of the organisation and there was clear understanding of the improvements required.
- There was a Clinical Service Strategy framework in place, supported by a Strategic Plan Document for 2014-19.
- The strategic plan (2014 – 2019) took into account the financial position of the Trust which is severely challenged throughout this 5 year period.
- The trust was actively involved in the Lancashire wide review and discussions regarding the improvement of services across both health and social care.

Leadership of the trust

- The Board was roughly representative of the local population and had undertaken E&D training with unconscious bias training also being considered demonstrating an appreciation of the E&D agenda.
- The executive team was fully established at the time of the inspection.
- The Director of Nursing was recently appointed and there was acknowledgement by the trust of the need to strengthen the nursing leadership. The incumbent Director of Nursing demonstrated a clear understanding of the improvements required.
- The Chief Executive Officer and the Chairman demonstrated clear understanding of the vision for the trust and also the areas

Summary of findings

of pressure and concern which required improvement. They also demonstrated a clear acknowledgement of the environmental limitations which were having a negative effect on the delivery of services. These were being addressed through involvement in the Five Year Forward View discussions and plans.

- The Medical Director was fully aware of the medical staffing challenges and explained the work being undertaken to review the medical workforce including job plan reviews, increased shared working practices and the use of a performance dashboard.
- The Non-Executive Directors played a significant role within the safety and quality agenda chairing the relevant committees. We were assured that they were aware of the challenges of the trust and provided challenge to the executive team.

Vision and strategy

- There was a Clinical Service Strategy framework in place, supported by a Strategic Plan Document for 2014-19.
- There was a comprehensive Strategy in place however it required updating to reflect the new governance committee which had recently been established.
- There were clear links from the strategy to other trust strategies, policies and procedures however the review of policies and procedures was not robust or timely.
- The strategic plan (2014 – 2019) took in to account the financial position of the Trust which will become severely challenged throughout this 5 year period. Efficiency requirements to achieve a modest surplus between 2015-16 and 2018-19 would require a continued efficiency level of over 4.5% per annum. Between 2010/11 and 2013/14 the Trust achieved efficiencies of over £60m, an average of 4% per annum. This is now proving extremely difficult to sustain. The Trust's assessment is that realistically 2% per annum can be achieved by operational departments with this rising to 3% towards the end of the plan period as a result of service transformation across our two hospitals to drive further efficiencies. The Trust cannot foresee further internal transformation to achieve beyond the 3% and would require system change to support services.
- The Trust must also prioritise the redevelopment of the deteriorating estate at the Royal Preston site. It may be unaffordable if the financial challenge is not resolved.
- The trust was actively involved in the Lancashire wide review and discussions regarding the improvement of services across both health and social care.

Summary of findings

Governance, risk management and quality measurement

- The trust has a triumvirate model with the Director of Nursing holding the governance lead with a divisional and clinical lead.
- Divisional governance meetings feed in to the Quality and Safety Committee and the Risk Committee which exception report to the Board.
- The trust had identified that the governance structures required review and were establishing a Clinical Governance Operational Group to mediate between the divisions and Quality and Safety Committee.
- The trust had also recruited an Associate Director for patient safety and risk to strengthen the team; they were due to start in October 2016.
- A high number of the policies and procedures we reviewed were found to be out of date and lacked timely review meaning that there was a risk that the evidence base for those documents could be out of date. As of 30 November 2016, 17% were out of date, 3% had been given extended review dates and 80% were in date.
- The process for the review of the policies and procedures lacked robustness and was under resourced.
- There was no evident risk management strategy; there was a lack of assurance regarding the regular review of risk at divisional level and the competency of staff to perform risk management and incident review, particularly Root Cause Analysis.
- Identified high level risks were investigated but the moderate and low level risks were not interrogated with any depth. This limits the learning which can be gained from incidents.

Culture within the trust

- The Board were aware of the challenges the staff faced daily and acknowledged the pressure of work and the outstanding response from their staff.
- There was an open, patient-centred culture, where staff were encouraged to raise any concerns about safety and staff were proud and positive about their work.
- In general staff across the services reported they felt they had a valuable role within the trust. Staff were passionate, conscientious, respected and valued.
- Staff said they felt supported and able to speak up to their immediate manager if they had concerns. Some said that morale fluctuated from day to day due to staffing and workload pressures, but staff told us they felt proud of what they do.

Summary of findings

- Staff told us that both nursing and medical staff were approachable and able to provide them with good support.
- However, the staff within urgent care services were feeling challenged and demoralised in some cases following the change in service provision.
- Whilst acknowledging the challenges about staffing shortages and manager's awareness of the issues, some staff felt there was low morale and some told us they felt exhausted and worried once they went home at the end of a shift.
- Many staff across the service spoke enthusiastically about their work and were proud of the care they delivered as a whole team. They described that there was a culture of 'good will' within the services, but staff were worried about how far that good will could sustain the provision of good patient care.
- The core values were published on the website and included "Caring and compassionate – We treat everyone with dignity and respect, doing everything we can to show we care. Recognising individuality – We respect, value and respond to every person's individual needs".

Equalities and Diversity – including Workforce Race Equality Standard

- The equality strategy 2015-18 was published on the trust website. It clearly articulates legal and regulatory requirements and also provides context about local population and future health needs. WRES outcomes are utilised in the strategy. A workforce diversity annual report was presented to the Board each January as was an equality of access report.
- EDS2 is utilised by the organisation as the framework for self-evaluation. Their EDS2 summary was published in July 2016.
- The trust workforce equality outcomes are positive i.e. higher than population levels of BME representation across the organisation, increasing levels of disabled staff from 2013-14 onwards, equal gender balance on the Board.
- There was a WRES report published in March 2016 with an associated action plan.
- There were mixed staff survey results. Improvement in bullying and harassment from patients and public overall and in physical violence from staff, public and patients. Experiencing discrimination in last 12 months was the same as the national average 10%. Believing trust provides equal opportunities for progression was 85% against a national average of 87%, with a white average of 86% and BME average of 70%. (BME manager focus group had one attendee who noted the lack of BME manager representation).

Summary of findings

- Equality champions were in place for dyslexia and gender reassignment and more were being recruited.
- E&D training was mandatory and current compliance level is 83%.

Fit and Proper Persons

- There was a policy for the application of the Fit and Proper Person regulation (September 2014) which states that it will apply to all directors and “equivalents”.
- We reviewed all the director and non-executive director files and found that the process was not fully implemented regarding internal promotions where no photo ID or occupational health reference were filed.
- We also found that not all non-executive directors had been subject to a DBS check and this had been recorded as not being required.

Public engagement

- There were patient involvement groups for deaf patients, those with learning difficulties and carers. They were setting up a frailty group. The trust used Disabled go and real patients to assess accessibility issues. There was an adaptation to website to ensure patients with visual impairment or ESOL can access trust documents and comment. There were LD “health days”, dementia groups and champions. There were 130 Learning Disability champions across trust.
- The CDH UCC was involved in work to educate the public regarding the decision to temporarily change the ED to an UCC. Leaflets were available for the public in the reception area, and clinical managers met with a local Member of Parliament (MP) to discuss the change. The trust website displayed information, including answers to a range of queries and responses to suggestions made by the general public. Leaflets were also distributed via local doctors’ surgeries and executive managers held public meetings as part of the process.
- Despite this, staff told us they did not think local GPs had been properly informed about the change in service provision because some patients were signposted there based on the incorrect assumption the department was still an ED.

Staff engagement

- Annual report 2015-16 states that the Staff Engagement Plan (2016-18) introduces new initiatives e.g. team diagnostics; whole systems approach to staff survey, engagement events, use of multi-media and staff recognition interventions. Staff engagement plan based on output from staff survey results.

Summary of findings

- “Valuing your Voice” intranet page allows staff to directly access senior leadership team with issues
- The trust board also engaged with staff via briefings and through the trusts internal intranet site.
- The trust performed about the same as other trusts surveyed across England in the 2016 General Medical Council trainee doctor survey.
- The staff survey completed in 2015 was reported to the board in March 2016. The survey had a 35% response rate from staff. An analysis of the responses was performed and an action plan developed. In February 2016, the trust arranged three ‘Big Conversation’ events to investigate the top three positive and negative themes and what would make a difference to staff. The result was a comprehensive staff engagement proposal for 2016/18.
- There was a mixed response from staff at the CDH UCC regarding the handling of communication with them during the difficult change in the provision.

Innovation, improvement and sustainability

- The urgent care department belonged to a national network focusing on supporting and accelerating the local development of ambulatory care through the spread and adoption of good practice and utilisation of improvement methodologies.
- During our inspection, managers were waiting for the Birthrate Plus report in order to assess and recruit more staff. The report findings were to be presented within the Surgical Division and then to the Trust Board in November 2016, when an increase in investment for midwives would be requested.
- After our inspection, the trust provided us with the Nursing and Midwifery Staffing and Skill Mix Report issued in November 2016. The report was based on a full review of the staffing levels across all inpatient clinical areas and a review (using Birthrate Plus) of the whole of maternity services midwifery staffing. The findings showed that there was an overall shortfall of 33 posts in midwifery. This included 19 whole time equivalent (wte) band 6 midwives and 14 (wte) midwifery support staff.
- The matron for elective surgery told us there was scope to increase surgical services and activity at the hospital in order to meet the increased demand.
- Collaborative working with services across Lancashire had improved knowledge of the challenges faced by EOLC teams and enabled the creation of shared documentation to streamline processes and improve access.
- Since March 2016, the trust participated in delayed transfer of care (DTC) Improvement Programme. The trust worked with

Summary of findings

health and social care services, along with NHS improvement in a 90 day improvement programme and achieved a reduction in the DTOC from 6% to 3.8%. Senior managers told us this had resulted in several improvements, including the implementation of a check list to meet the agreed criteria for a continuing health care assessment, which has reduced the amount of assessments performed in hospital, thus expediting decisions around place of discharge.

- The trust were currently trialling a system where a recently recruited nurse reviewed delayed discharges and medical outliers on a daily basis, to identify any actions that can be taken the same day to facilitate discharge. Senior managers told us they felt this had contributed to the reduction in medical outliers trust wide.

Overview of ratings

Our ratings for Royal Preston Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Chorley and South Ribble Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Lancashire Teaching Hospitals NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The trust had launched the Sleep Improvement in Adult Critical Care Programme. Disturbed sleep in critical care patients is associated with delirium, in which patients become confused, restless and experience hallucinations. This can delay their recovery from critical illness. The trust recognised this and identified the potential disturbances to sleep. To minimise disruption to patients during the night, they offered eye masks and earplugs, dimmed lights, anticipated empty infusion alarms, turned down the volume on medical equipment and phones and encouraged staff to talk away from the bedside. Staff were also reminded to check regularly for signs of delirium. The project and associated resources were shared with neighbouring critical care networks and at national meetings. An initial research study showed that making small changes caused a 50% reduction in patient delirium and significantly improved the quality of sleep experienced by patients. The study had won an initiative award at the National Nursing Times Awards.
- The introduction in dermatology outpatients of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breeches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.
- In urgent care at Chorley District Hospital the housekeeper helped elderly patients who sustained illness or injury when out shopping for food provision, by ensuring they received basic groceries such as milk and bread, to go home with following discharge.

Areas for improvement

Action the trust MUST take to improve

In Urgent and Emergency Care services;

- Ensure access to the main entrance paediatric waiting area is limited to reduce the risk of children exiting the area through the automatic doorway.
- Ensure intravenous fluids are stored securely and daily checks are completed with actions to address issues identified, completed.
- Ensure mandatory training, including safeguarding, compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED
- Ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- Ensure action plans following CEM audits target areas of poor performance and improve practice.
- Improve performance, particularly in relation to the department of health four hour target; wait times following a decision to admit, ambulance handovers.

- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person with review dates included.

In Medicine;

- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- Ensure procedures in place around medicine management are robust and that policies are followed.
- Ensure the risk registers are consistent and demonstrate mitigating actions and review dates

In Surgery;

- Take appropriate actions to improve staff training compliance in areas such as safeguarding training and life support training.

Outstanding practice and areas for improvement

- Take appropriate actions to ensure that patients requiring escalation, as part of the national early warning score system (NEWS), are appropriately escalated by staff.
- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.

In Maternity and Gynaecology;

- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- Comply with recommendations of Standards for Safer Childbirth 2007, which recommends 98-hour consultant obstetrician presence.
- Develop a baby abduction policy and take action to ensure that there is a safe system for protecting babies from abduction.
- Ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- Ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.
- Complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Ensure that all staff receive medical devices training to ensure all equipment is used in a safe way.

In Critical Care;

- Ensure that escalation procedures are followed appropriately across the hospital where patients' National Early Warning Scores (NEWS) are greater than five and the patient may need to be assessed for admittance to the critical care unit.
- Ensure that any patients admitted to Ward 2A, who are assessed as Level 2 high dependency patients, receive nursing care at a ratio of 1:2 in accordance with national standards.
- Address action points on a gap analysis that showed that there was no availability for endoscopy for urgent gastro intestinal bleeds 24 hours a day.

In Children and Young People's services;

- Ensure that staffing levels in neonatal and children's services are maintained in accordance with national guidelines.
- Ensure that all relevant staff having regular contact with children, as defined by intercollegiate guidance, complete level three safeguarding training.
- Ensure that indicators for managing the changing condition of ill children are consistently used and responded to appropriately on the children's ward.
- Ensure that the isolation room used on the children's ward is free from access to ligature points
- Ensure that patient records are kept securely in the children's out patients department.
- Ensure that checks on emergency resuscitation equipment, are completed and accurately recorded on the neonatal unit.
- Ensure that secure access to the neonatal unit and children's ward is maintained at all times by staff, parents and visitors.

In Outpatients and Diagnostic Imaging;

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- Ensure staff complete mandatory training as per the trust policy.

At Chorley District General Hospital the hospital must;

In Urgent Care services;

- Take action to help control risks associated with the room identified for mental health patients must be actioned and appropriately documented.
- Ensure records of controlled drug use in registers are kept in line with trust policy.
- Ensure mandatory training compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED.
- Ensure action plans following CEM audits target areas of poor performance and improve practice and that clinical staff are aware of and engaged with the process of clinical audit.

Outstanding practice and areas for improvement

- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person and review dates included.
- Ensure major incident plans are updated to reflect the current use of the department.
- Improve communication and improve the negative culture centred on a lack of communication and feelings of mistrust amongst staff.

In Medicine;

- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- Ensure procedures in place around medicine management are robust and that policies are followed.
- Ensure the risk registers are consistent and demonstrate mitigating actions and review dates

In Surgery;

- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.

- Take appropriate actions to improve staff training compliance in adult and children's safeguarding training.

In Maternity and Gynaecology;

- Ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- Ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- Develop a baby abduction policy and take action to ensure that there is a safe system for protecting babies from abduction.
- Complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- Ensure that all staff receives medical devices training to ensure all equipment is used in a safe way.

In Outpatients and Diagnostic Imaging;

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not put at risk.
- Ensure staff complete mandatory training as per the trust policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (2) (a): assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity.

Regulation 17 (2) (b): assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 (2) (d): ensuring that premises used by the service provider are safe for use for their intended purpose and are used safely.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 (1): Sufficient numbers of qualified, competent, skilled and experienced persons must be deployed.

Regulation 18 (2) (a): Persons employed by the service in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 (5): A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.