Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account 2022-23

Excellent care with compassion

@LancsHospitals

Measuring success, keeping it simple

Throughout the Quality Account 2022-23 the following key symbols will be used as an easy reference tool.

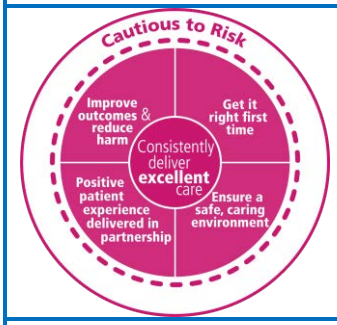
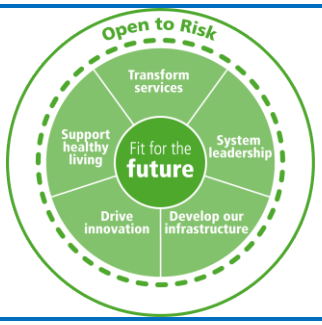
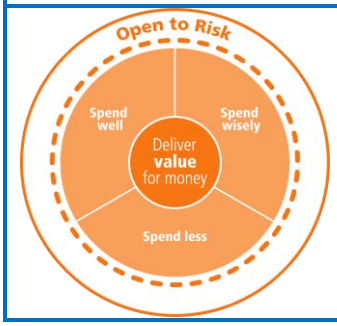
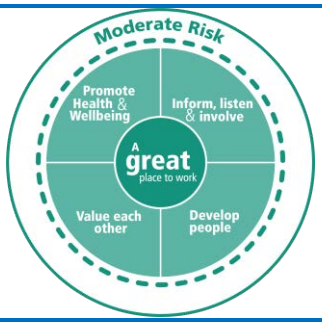
Symbol	Meaning
	The Trust continues to perform well and/or has improved
	The Trust is achieving well in some areas, but further areas require development
	The Trust is not achieving our target however are aware and have improvement projects in place

Key - Our Ambitions

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

1. To 'Consistently Deliver Excellent Care'
2. To 'Deliver Value for Money'
3. Be 'Fit for the Future'
4. Be a 'Great Place to Work'

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

Consistently Deliver Excellent Care		Fit for the Future	
	Improve outcomes and reduce harm Get it right first time Positive patient experience delivered in partnership Ensure a safe, caring environment		Transform services System leadership Develop our infrastructure Drive innovation Support healthy living
Deliver Value for Money		**Great Place to Work**	
	Spend well Spend wisely Spend less		Promote health and wellbeing Inform, listen, and involve Develop people Value each other

PART 1

Chief Executive's Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1 April 2022 to 31 March 2023. Over the last 12 months the National Health Service (NHS) has continued to face unprecedented challenges in dealing with the impact of the COVID-19 pandemic which has claimed so many lives across the world and within the communities served by our Trust.

As a centre for many specialist services across our region, Lancashire Teaching Hospitals treated many of those critically ill with COVID-19 alongside patients suffering from a range of other conditions requiring life-saving intervention. The Trust put in place vaccination and testing hubs, numerous research studies and trials, developed COVID-19 recovery and rehabilitation resources as part of the national strategy to help mitigate the effects of the virus, and set up the Nightingale Surge Hub at Royal Preston Hospital.

Despite the continued effects of the pandemic, the Trust has maintained focus on our mission and our ambitions as set out in our organisational strategy Our Big Plan which has a very specific focus on quality. Our year three metrics have been co-developed with our divisional teams and staff across the organisation.

Our Continuous Improvement (CI) Strategy reflects approaches for each level of improvement across the organisation and system and incorporates a digital approach to the design and delivery of improvement programmes.

The pandemic has supported strengthened partnership working with local partners: Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, third sector partners including our local hospices, Derian House and St. Catherine's Hospice with the Clinical Commissioning Group through a Central Lancashire Integrated Care Partnership and regionally with the Lancashire and South Cumbria Integrated Care System (ICS), to change the way the Trust works and provides care and treatment more effectively and efficiently, leading to better outcomes for patients and their families, closer to home. The last 12 months has seen more mutual aid between organisations and a more collaborative approach to the increased waiting lists to ensure that patients across the patch are treated equitably.

Although our financial pressures have increased due to continued growth in demand, rising costs, workforce shortages and the need to make our hospitals COVID-19 secure the Trust has continued to make improvements to its operational efficiency.

The Trust is extremely proud to see that our staff continue to be recognised for their outstanding achievements. The year has seen selfless fundraising activity, national and international recognition for our COVID-19 resource pack to aid patient recovery, accolades in innovation, research, and clinical trials, and much more.

Our staff have met the challenges described with courage and determination, providing compassionate care to our patients, often at personal cost. The Trust is exceptionally proud of them.

I would therefore like to record my thanks to all our staff, as well as our local partners and local communities for their unwavering dedication and support throughout a period which has been unlike any other experienced since the inception of the NHS.

Together with the support of Trust Directors, I confirm to the best of my knowledge that the following Quality Report complies with the necessary requirements and, indeed, the information in this document is accurate.

Kevin McGee OBE
Chief Executive
16.6.2023

PART 2

2.1 Priorities for Improvement

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

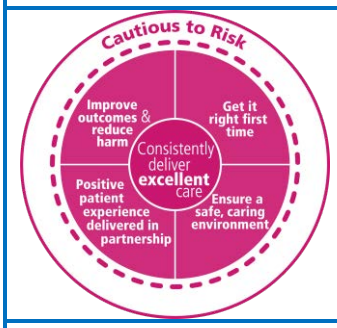
Our values underpin everything we do and support the delivery of our ambitions.

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

Our values

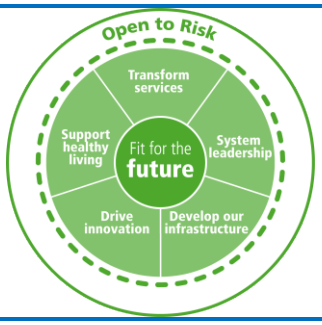
- Being caring and compassionate
- Recognising individuality
- Seeking to involve
- Building team spirit
- Taking personal responsibility

Figure 1 Our Ambitions

<table>
<tr><th colspan="2">Consistently Deliver Excellent Care</th><th colspan="2">Fit for the Future</th></tr>
<tr>
<td> 
</td>
<td>Improve outcomes and reduce harm

Get it right first time

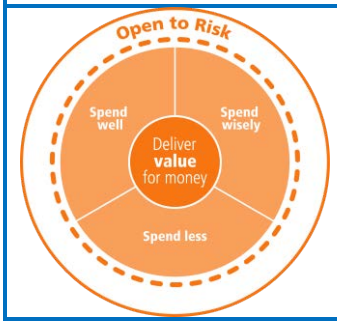
Positive patient experience delivered in partnership

Ensure a safe, caring environment</td>
<td> 
</td>
<td>Transform services

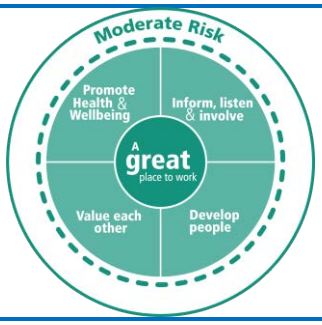
System leadership

Develop our infrastructure

Drive innovation

Support healthy living</td>
</tr>
<tr><th colspan="2">Deliver Value for Money</th><th colspan="2">Great Place to Work</th></tr>
<tr>
<td> 
</td>
<td>Spend well

Spend wisely

Spend less</td>
<td> 
</td>
<td>Promote health and wellbeing

Inform, listen and involve

Develop people

Value each other</td>
</tr>
</table>

Our Big Plan is enabled through the commitments in the new Clinical Strategy that has replaced the Nursing, Midwifery, Allied Health Professional (AHP) and Care Givers Strategy, as well as those in the Patient Experience and Involvement Strategy using the methodology and approach outlined in the CI Strategy.

Clinical Strategy commitments

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

The Patient Experience and Involvement Strategy commitments

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

Patient

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

Big Plan key priorities achieved or partially achieved:

During 2022-23 there has been positive delivery of a number of *Our Big Plan metrics as follows:

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

Table 1 Big Plan Achievements

Improve outcomes and prevent harm	
Achieve compliance with the 10 safety actions for maternity services	
Get it right first time	
Continue to deliver a Hospital Standardised mortality figure of <100	
Reduce the average length of stay for patient undergoing planned surgery to 3.4 days	
Reduce the number of times patients are moved more than 3 times by 10%	
Reduce the number of patients moved after 22.00hrs by 10%	
Reduce the number of patients re-admitted within 30 days to less than 7.7%	
Reduce the number of days pre-procedure non-elective patients spend in hospital prior to planned surgery to 0.60 days or below	
Reduction in 52-week waiters (target as per NHSI recovery plans)	
Reduction in 78-week waiters (target as per NHSI recovery plans)	
Reduction in 104-week waiters (target as per NHSI recovery plans)	
Ensure a safe caring environment	
Maintain 75% of clinical areas with Silver and above STAR accreditation	
100% participation of each directorate in the annual risk and governance maturity programme (as assessed by external audit)	
Promote health and wellbeing	
To increase staff perception that the organisation takes positive action on health and wellbeing to 60%	
To create outdoor recreational space at both Preston and Chorley hospitals	
To update 5 local staff rest areas	

To create 5 agile activity-based workspaces	

Areas not delivered as follows:

However, 2022-23 continued to be another challenging year due to moving to restoration following the pandemic impacting on delivery of a number of Big Plan metrics:

Table 2 Big Plan Areas for Improvement

Improve outcomes and prevent harm	
Reduce the number of cardiac arrests by 10% per 1,000 bed days	
Reduce the number of device-related pressure ulcers by 10%.	
Reduce the number of pressure ulcers by 10% through positive action	
Get it right first time	
Reduce the number of operations cancelled for non-clinical reasons to less than 1% of cancellations	
Pre-procedure elective – to reduce the number of days patients spend in hospital prior to planned surgery to 0.2 days or below	
Achieve no more than 3% of patients delayed within hospital	
Cancer 28 days from referral to diagnosis	
Achieve the 62-day cancer trajectory	
Achieve 90% of patients in the ED within 4 hours	
Ensure a safe caring environment	
Achieve zero Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia	
Achieve the annual target for *C. difficile* (trajectory to be below 118 cases)	
Reduce the number of falls by 5% per 1,000 bed days	
Promote health and wellbeing	
To reduce short term sickness absence to 1.25%	
To reduce long term sickness absence to 2.75%	
To reduce overall sickness absence to 4.0%	
Drive forward zero tolerance with regard to violence and aggression towards staff by reducing the number of incidents by 10%	
Reduce average duration of musculoskeletal (MSK) related absences by 1%	
Reduce average duration of psychological health related absences by 1%	

Priorities for Improvement 2023-24

Our Big Plan priorities for improvement for 2023-24 are as follows:

Consistently Deliver Excellent Care

- Reduce 104 week waits.

- Reduce number of patients waiting greater than 12 hours in Emergency Department (ED).
- Reduce delays in Ambulance handovers.
- Achieve 62-day cancer target.
- Mortality within the expected range for adults, children, and neonatal
- Reduce pressure ulcers by 10%.
- Deliver the *C. difficile* measure within nationally set trajectory.
- 90% patients rating services as good or very good.
- 75% clinical areas with Silver 'Safety Triangulation and Accreditation Review' (STAR) rating.

Great Place to Work

- Reduce sickness absence to 4%.
- Reduce vacancies by a further 5%.
- Maintain 90% for appraisals.
- Maintain staff engagement.

These priorities will be monitored through the Trust's governance and reporting processes, managed through the arrangements described in the relevant strategies and supported by the CI team.

Continuous Improvement and Always Safety First

Continuous Improvement

The Trust has launched its second Continuous Improvement Strategy and implementation of the first year of the Strategy has been delivered throughout the year.

The Lancashire and South Cumbria Flow Coaching Academy is now well established, delivering two cohorts and a third is currently in progress. 61 Flow Coaches have been trained and have applied the methodology in the following Big Rooms: Brain Tumour, Cauda Equina Syndrome, Chemotherapy, Colorectal, Deteriorating Patients, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), Emergency Mental Health, Enhanced Care, End of Life, Endoscopy, Ears Nose and Throat, Frailty, Gynaecology, Inflammatory Bowel Disease, Lung Cancer, Major Trauma, Neurology (Headache), Nutrition, Pain Management (Spine), Pneumonia, Pre-operative and Pre-habilitation, Respiratory, Sepsis, Stroke, and Vascular Surgery.

A third cohort is due to complete the programme in June 2023, adding a further 21 Flow Coaches and a further 10 Big Rooms will be established. These Big Rooms are: Breast Reconstruction, Deconditioning, Eating Disorders, Entry to Emergency and Urgent Care, Falls Prevention, Inpatient Avoidance, Inpatient Pre-operative Pain Management, Kidney Care, Neonatal, and Radiotherapy.

The Lancashire Microsystem Coaching Academy programme has now delivered four cohorts and a new fifth cohort is commencing in April 2023. With 50 areas trained in the Microsystem Coaching Academy methodology and 87 Coaches, the addition of the fifth cohort will see a further 15 areas and 20 Coaches skilled up and working on local level improvements.

Over the last 12 months we have also embarked on a new approach to deliver system level improvement across our Lancashire and South Cumbria ICS. Working in partnership with the Engineering Design Centre at Cambridge University we are working to improve services across the ICS for people living with frailty and who have respiratory conditions. As an ICS system cohort we are using the Engineering Better Care model to develop and test new ways to deliver healthcare for this population group. More locally across central Lancashire the team participating in the programme are focusing their efforts on reducing conveyance from care homes to the ED by working with place and system partners to develop more joined up support services and pathways to mitigate the need for ED attendance and support patients to live well and age well.

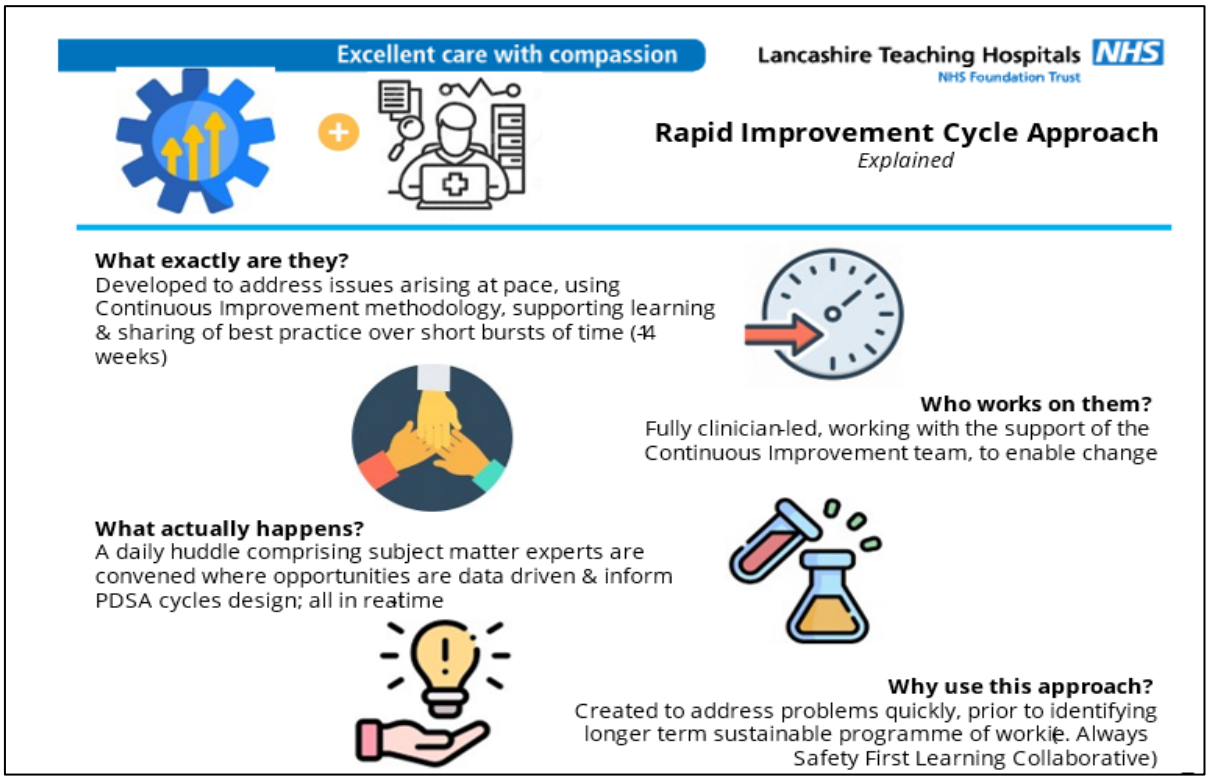
There has been a continued focus throughout the year on building CI capability across the organisation through the delivery of the CI building capability strategy in line with the NHS Improvement (NHSI) report and dosing formula for provider organisations for year one of the strategy.

CI support has been provided to a number of the divisions and corporate teams with the design, testing and implementation of improvement priorities in response to specific requests (out with the formal improvement programmes), often in response to organisational

pressures. In year, this has included:

- Supporting the Trust Always Safety First Strategy delivery and improvement programmes aimed at reducing avoidable harm through the development of highly reliable systems and processes.
- Supporting pharmacy to use a CI methodology to improve compliance to prescribing oxygen and development of a prioritisation process.
- Supporting the development of a waste programme within a number of divisions.
- Supporting organisational flow through the following initiatives: discharge lounge utilisation, patient flow programme, Be a Bed Ahead, Green Means Go.
- Supporting the patient experience team to drive improvements in patient experience, including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project.
- Utilising a CI approach to support the adoption of patient initiated follow up.
- Working collaborative with regional partners to improve the timely handover of patients from ambulances through the ICS collaborative: Hospital Handover led by the North West Ambulance Service and the Advancing Quality Alliance (AQuA).
- Co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures.
- Improvement project in maternity triage assessment unit.
- A patient flow improvement programme.

Figure 2 Rapid Improvement Cycle Approach



Always Safety First

The Always Safety First Improvement programme has been delivered in line with the Always Safety First Strategy (the Trust's response to the National Patient Safety Strategy), facilitating improvement in safety metrics across the organisation.

The Trust Board recognises the benefits of embedding a culture of continuous improvement across our organisation, supporting our staff to design, test, embed and sustain changes that benefit patients and our local population. To achieve a culture of continuous improvement in our patient safety metrics, the Trust developed Always Safety First, our long-term approach to transforming the way services are delivered for the better, utilising a robust improvement methodology.

Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialities, and learning to improve. Our work is underpinned by a real time safety surveillance system, making our data visible from Ward to Board. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical staff.

How is our continuous improvement in patient safety, access and patient experience delivered?

The Always Safety First Strategy is our Trust responses to the NHS National Patient Safety Strategy. This ambitious strategy outlines our plans and aspirations to improve quality of care and safety for our patients, service users and staff. To support the delivery of this strategy an Always Safety First Group continues to meet and is chaired by our Trust Patient Safety Specialists with representation from a wide group of staff across the organisation. This specialist multidisciplinary group is enabling a culture of continuous improvement and cross-system working to build the will to improve safety, making safety everyone's role. By reviewing systematic data from harms, incidents, and our Safety Surveillance System the group is initiating new targeted programme design and delivery to tackle our biggest challenges around safety, including pressure ulcers and medication safety.

The Always Safety First programme continues to mature its delivery and our teams are building on the learning and facilitation of virtual collaborative learning sessions. At these sessions participating teams are brought together to learn about the improvement interventions to be embedded, share learning and best practice, building improvement capability and actively participating, forming a positive continuous improvement culture.

The Trust is now developing an Always Safety First Phase II approach which is focusing much more on the scale and sustainability of our improvements which were developed and tested through our founding Breakthrough Series Collaboratives. This new approach will combine our learning and new improvement methods to deliver rapid testing and development of change solutions, which can then be guided through a formal scale and

sustainability process, supported by measurement, communication and governance to ensure our new improved ways of working are embedded.

Figure 3 Always Safety First Strategy

Risk Maturity

Our organisation has adopted a strategic approach to the management of risk by integrating risk into 'Our Aims' and 'Our Ambitions' so that they link to the strategic objectives of Our Big Plan and support the well-led aspect of the Care Quality Commission (CQC) requirements. It has also ensured the Trust continues to further develop the way risks are managed and support the improvement of safety, effectiveness, and the experience of patients through the way that services are delivered.

The ongoing focus on risk maturity is being achieved through continued embeddedness of risk management within the Trust by various means, including:

- The Risk Management Policy, which is available to all staff through the Trust's internet and intranet sites.
- Effective use of the strategic and operational risk registers at both divisional and corporate level, and the Board Assurance Framework (BAF).
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to Committees of the Board and the Board, if required.
- Embedding the use of dashboards, including themes, risk appetite, heat-maps,

trajectory of risk and qualitative narrative on actions and mitigations.

- Introduced automated governance dashboards for each division, providing easy access and removing the need for manual creation. These are monitored as part of the accountability framework in divisional improvement forums with a specific risk section.
- Strengthening of divisional accountability processes through Divisional Boards and the Accountability Framework through challenging performance of risk at Clinical Business Unit and Speciality Business Unit levels.
- Continued training at all levels of the organisation in line with the National Patient Safety Strategy.
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- The Senior Leadership Team meeting (formerly Executive Management Group) used as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive Team. This is achieved through presentation of a high risks report which contains key performance indicators each month alongside divisional and corporate risk registers on a cyclical basis.
- Actively monitoring all serious incidents at the Safety and Quality Committee on a quarterly basis and the Board annually.
- Using outcomes from complaints, incidents, claims, STAR visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Connecting performance across the Trust at Board, Committee, Divisional and Speciality level using integrated performance reports which provides Ward to Board reporting that includes a range of metrics encompassing each of the elements of Our Big Plan by strategic ambition and includes quality, operations, finance and workforce.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Report cover sheets linked to the Trust strategic aims and ambitions.
- Information within specific reports is categorised by and presented by strategic ambitions – for example, the Chief Executive's report and integrated performance report.
- Risks within Committee papers are connected to strategic risks within the BAF.
- 'Freedom to Speak Up' team in place for staff to raise concerns. The team is promoted within the Trust and any concerns are triangulated with other processes for management, improvement, and shared learning.
- Use of an equality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes.

Risk Appetite Statement

The Trust's Risk Appetite Statement was refreshed by the Board of Directors following developmental work undertaken with the Good Governance Institute (GGI). The Risk Appetite Statement outlines the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents.

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

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

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

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

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

Risk Tolerance

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

Table 3 The Risk Tolerance levels as agreed by the Board

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

Our principal risks and issues

The Trust continues to identify potential risks to achieving its strategic aims and ambitions as part of established organisational governance processes. The BAF is used to identify the strategic risks to the Trust alongside actions being taken to mitigate them. This enables the Board of Directors to evaluate whether there are the appropriate systems, policies, and people in place to operate in a manner that is effective in driving the delivery of the Trust's objectives.

During 2022–23, there were six principal risks presented below:

Figure 4 Principal Risks

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

All principal risks are reported to the Board of Directors and to the relevant aligned Committees of the Board. Principal risks are reviewed to consider the effectiveness of controls, assurances and mitigation plans to support the achievement of the target risk score, as determined by the Trust's risk appetite, set and approved by the Board.

In addition to the principal risks identified, during 2022-23, there have been four operational high risks escalated to the Board within the BAF. These are:

- **Impact of exit block on patient safety** which has been escalated to the Board via the Safety and Quality Committee since December 2020 but remains a risk with long lengths of stay in the ED and high ambulance handover times. To mitigate this risk, Standard Operating Procedures are in place which describe the processes for patient reviews, reporting of patient harm incidents and associated clinical governance arrangements. These procedures have been supplemented with a series of actions, including virtual wards, frailty, therapy pathway improvements and an increase in community bed base through the acquisition of Finney House Community Healthcare Hub, which are reflected within the urgent and emergency care transformation plan and reported to the Finance and Performance Committee. Monthly safety forums are also in place to identify further opportunities to improve flow and reduce long waits in the ED.

- **Elective restoration following the COVID-19 pandemic** which has been escalated to the Board via the Safety and Quality Committee since June 2021 with patients continuing to wait for a significant amount of time to receive non-urgent surgery. Plans remain in place to eliminate 104+ week waits and reduce waits with weekly reviews to oversee achievements and ensure performance against the trajectory is on track to deliver.

- **The impact of strikes on patient safety following announcement of the national pay award and the probability of ongoing strikes** which has been escalated to Board via the Safety and Quality Committee since October 2022. Over the last 12 months, strikes have taken place for nursing, ambulance, and physiotherapists but further strikes are suspended at the end of March 2023. This is due to a negotiated pay offer for agenda for change staff under review by union members. In March 2023, the Trust has also experienced a 72-hour consecutive period of strike action from junior doctors, with further strikes planned. There is also a potential risk of strikes by consultants with the British Medical Association also undertaking a consultative ballot with consultants. The risks associated with ongoing strikes have been effectively managed in partnership with Staff Side, workforce, and clinical leaders at the Strike Action Emergency Planning Group with evidence of significant planning undertaken and learning implemented from previous strikes.

- **Impact of COVID-19** which was re-escalated to Board in December 2021. This risk was de-escalated in October 2022 following a recommendation from the Safety and Quality Committee, as the COVID-19 step-up, step-down criteria designed by the Integrated Care System Director of Infection Prevention and Control and Medical and Nursing Directors had been met. The guidance was also considered in detail by medical and nursing leads in the Trust to ensure teams had been involved in shaping how the new guidance was implemented in practice which led to a reduction in the risk.

The Trust continues to support risk mitigation strategies to deal with the recovery and restoration of services post-pandemic and the evolving external environment and will continue to engage and strengthen relationships with patients, staff, public and strategic partners to ensure long-term sustainability in the delivery of its strategic objectives.

Effectiveness of Governance and Risk Maturity

The effectiveness of the Trust's governance structures continued to be internally tested during 2022–23 via the process of internal and external audit, CQC inspections, Royal College Reviews, national audits, national staff surveys and external reviews.

In 2022-23, the GGI undertook a Risk and Assurance Review commissioned by the Board of Directors from February 2022 to November 2022. The review was positive about the Risk and Governance arrangements at the Trust and did not identify any legislative or regulatory requirements that were not being met. There were 26 recommendations for the Trust to consider, which were largely practical and supportive suggestions, recognising the maturing governance arrangements of the Trust. An action plan was developed which was adopted by the Board of Directors.

In addition to the GGI review, there have also been reviews undertaken by Internal Audit in relation to Divisional Risk Maturity and the Confidential Risk process. Both reviews received substantial assurance.

2.2 Statements of Assurance from the Board

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

During 2022-23 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 46 relevant health services.

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

The income generated by the relevant health services reviewed in 2022-23 represents 100% of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2022-23.

Participation in Clinical Audits

During 2022-23 55 national clinical audits including five national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 98% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust did not participate in the Inflammatory Bowel Disease (IBD) Registry due to pressures in the services and inability to field the relevant staff to support the audit.

The applicable national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2022-23 are listed below in Table 4 alongside the number of cases submitted to each audit or enquiry between 1 April 2022 and 31 March 2023.

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

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES			
National Programme Name	**Audit Title**	**Trust Participation**	**Cases submitted**
Breast and Cosmetic Implant Registry		Yes	15
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	1691
Child Health Clinical Outcome Review Programme	Testicular torsion	Yes	100%
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)		Yes	Hip: 96 Knee:126

Emergency Medicine Quality Improvement Programmes (QIPs)	Assessing cognitive impairment in older People	N/A	Data collection moved to 2023-2024
Emergency Medicine QIPs	Mental Health self harm	Yes	Ongoing
Emergency Medicine QIPs	Pain in Children	Yes	37
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (CYP)	Epilepsy 12 - National Audit of Seizures & Epilepsies in CYP 2021-2022 C4	Yes	4
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes	12
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes	558
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes	Ongoing
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Ongoing
Inflammatory Bowel Disease Audit		No	N/A
Learning Disability Mortality Review Programme (LeDeR)	learning from lives and deaths of people with a learning disability and autistic people	Yes	34
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE UK Saving Lives, Improving Mothers' Care Surveillance & Morbidity	Yes	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK: Perinatal Mortality (2020) Births	Yes	27
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Yes	62%
Medical and Surgical Clinical Outcome Review Programme	Crohn's disease	Yes	100%
Medical and Surgical Clinical Outcome Review Programme	End of Life Care	N/A	Data collection moved to 2023-2024
Medical and Surgical Clinical Outcome Review Programme	Endometriosis	Yes	Data collection ongoing
Medical and Surgical Clinical Outcome Review Programme	Epilepsy Study	Yes	10%
Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)		Yes	8

National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	Yes	All applicable cases
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes	Data collection ongoing
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes	Data collection ongoing
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes	Yes	50 (Jan-Dec 2022)
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes	90
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	565
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes	73
National Audit of Breast Cancer in Older Patients (NABCOP)		N/A	Audit is now finished
National Audit of Cardiac Rehabilitation		Yes	707
National Audit of Care at the End of Life (NACEL)		Yes	70
National Audit of Dementia	Care in general hospitals	Yes	RPH 80 CDH 40
National Cardiac Arrest Audit (NCAA)		Yes	CDH 125 RPH 542
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes	213
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes	CDH 180 RPH 170
National Child Mortality Database (NCMD)	NCMD National Child Mortality Database 2022-2023	Yes	34
National Emergency Laparotomy Audit (NELA)		Yes	56
National Joint Registry (NJR)		Yes	346
National Lung Cancer Audit (NLCA)		Yes	All applicable cases
National Maternity and Perinatal Audit (NMPA)	National Maternity Perinatal Audit (NMPA)	Yes	Data is pulled from NHS Digital
National Neonatal Audit Programme (NNAP)	NNAP National Neonatal Audit Programme	Yes	385
National Paediatric Diabetes Audit (NPDA)	NPDA National Paediatric Diabetes Audit 2020-2021	Yes	216

National Perinatal Mortality Review Tool	National Perinatal Mortality Review Tool	Yes	27
National Prostate Cancer Audit (NPCA)		Yes	Data collection ongoing
National Vascular Registry (NVR)		Yes	Data collection ongoing
Neurosurgical National Audit Programme		Yes	Data comes directly from the HES data
Perioperative Quality Improvement Programme (PQIP)		Yes	87
Renal Audits	National Acute Kidney Injury Audit	Yes	Data comes directly from laboratories
Renal Audits	UK Renal Registry Chronic Kidney Disease Audit	Yes	186
Respiratory Audits	Adult Respiratory Support Audit	Yes	Data collection ongoing
Respiratory Audits	Smoking Cessation Audit- Maternity and Mental Health Services	N/A	Audit on hold
Sentinel Stroke National Audit Programme (SSNAP)		Yes	735
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		Yes	30
Society for Acute Medicine Benchmarking Audit (SAMBA)		Yes	RPH 15 CDH 23
Trauma Audit & Research Network (TARN)		Yes	1089
UK Cystic Fibrosis Registry	UK Cystic Fibrosis 2021 Registry Only	Yes	20
UK Parkinson's Audit		Yes	All applicable cases
Urology Audits	Emergency ureteric injury management (REJOIN)	Yes	100%
National Audit of Patient Satisfaction with Cystectomy Pathway for Bladder Cancer		Yes	Data collection ongoing

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website https://www.hqip.org.uk/national-programmes/qualityaccounts

There were 23 reports published for the national clinical audits in 2022-23. The reports were reviewed by the provider and Lancashire Teaching Hospitals NHS Foundation Trust intends to

take the following actions to improve the quality of healthcare provided.

Table 5 National Audits and Confidential Enquiries – Intended Actions

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

Title of Audit	Actions
2022 UK Parkinson's Audit	• Areas of improvements identified: Implantable cardioverter defibrillator monitoring, non-motor questioning, support for carers. Actions assigned to Parkinson's Specialist Nurses and the audit lead.
British Association of Urological Surgeons (BAUS) Snapshot Audits: Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE)	• Multidisciplinary Team participants were made aware that the discussion of neoadjuvant chemotherapy needs to be documented. It is discussed but the documentation of the discussion needs to improve.
MBRRACE-UK: Perinatal Mortality	• The real time data monitoring to be included in maternity and Neonatal Safety and Quality Committee's papers and used to inform the mortality paper presented at Trust Board • To deliver Saving Babies' Lives Care Bundle (SBLV2) care bundle • To produce the guideline for placental investigations • To ensure that there are adequate resources available in multiple languages for women whose first language is not English • To publish local guidelines on preterm birth at the threshold of viability • To collaborate with Twins Trust to ensure pathways of care meet NICE guidance and SBLV2 care bundle.
National Audit of Inpatient Falls (NAIF)	• Post fall checklist to be built into the incident reporting system • The Flow Coaching Academy - Falls Big Room has been set up to look at necessary improvements
National Cardiac Arrest Audit (NCAA)	• Update basic life support level 2 eLearning package to make it shorter and less repetitive. • Increase delivery of training. • Rollout of new defibrillators. This will allow for dashboard feedback and analysis of performance for each cardiac arrest.
National Perinatal Mortality Review Tool	• Regular quarterly audits to demonstrate continued assurance that the Trust is meeting the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and Clinical Negligence Scheme for Trusts (CNST) requirements for review of all perinatal deaths within the Trust.
National Vascular Registry 2022	• To amend the carotid pathway with regards to the referrals • To audit amputations with focus on those happening post revascularisation attempts • To expand the Hot Clinic activity at Preston and non-arterial centres • To continue to regularly review the Network Pathways • To discuss with the Specialist Mobility Rehabilitation Centre (SMRC) team the barriers for regular psychological support for amputees • To continue to clear the COVID-19 backlog

NNAP National Neonatal Audit Programme 2021	• To work with the local ophthalmology team to ensure processes are in place to cover staff absence to ensure screening can be undertaken 52 weeks per year • To ensure that parent presence on the consultant ward round is recorded daily • To identify an infant feeding lead, to train and support staff, with protected time within their job plan for this role. • To set up Quality Improvement Projects to reduce mortality: timely antenatal steroids, deferred cord clamping, avoidance of hypothermia and management of respiratory disease.
NPDA National Paediatric Diabetes Audit	• New blood glucose targets agreed to drive continued improvement • Newly appointed diabetes nurse team leader to assist with contemporaneous data entry focussed support for high blood glucose and other complex patients. • To set up Multidisciplinary Team Meetings to access patients who have high blood glucose and tailor management accordingly.
Perioperative Quality Improvement Programme (PQIP)	• Commissioning for Quality and Innovation (CQUIN) Drinking, eating and mobilising (DrEaMing) measuring whether patients are supported to drink, eat and start being mobile after surgery has been published for 2023/24. The Trust will participate in the CQUIN.
SAMBA 2022 (Society for Acute Medicine Benchmarking Audit)	• To create a workstream to look at whether patients seen in ED need to go to Medical Assessment Unit (MAU) or can instead go to a more appropriate specialty ward • To increase the number of Acute Medicine MAU consultants by continuing to try and recruit to MAU consultant posts • To arrange regular training sessions for nurses about new patient prioritisation and conduction of Early Warning Score
The National Hip Fracture Database (NHFD)	• To increase the orthogeriatric cover to start bringing Best Practice Tariff • To improve physiotherapy assessments to a 7 day cover

The reports of 395 local clinical audits were reviewed by the provider in 2022-23 and some of the Lancashire Teaching Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are referenced in Table 6.

Table 6 Audit and Confidential Enquiry – Resulting Actions

Audit title	Actions intended/completed
Audit	Juvenile Idiopathic Arthritis Audit
Actions – complete	1. Raise the concerns to tertiary care hospitals for network support. 2. Set up and run separate Rheumatology clinics from pain clinic. 3. Appoint a clinical lead for Rheumatology 4. Educate the first contact clinicians like General Practitioners (GPs), ED doctors to identify patients with possible Juvenile Idiopathic Arthritis.
Audit	Audit of turnaround times for Herpes Simplex and meningococcal polymerase chain reaction (PCR) results
Action - complete	1. Use data to push for the new Biofire test, which is sent to a local laboratory rather than the Public Health England one in Manchester

Audit	Neonatal Sepsis Audit (Jan 2021 – Dec 2021)
Action – In progress Action – complete Action - complete	1. Try and identify if Early Onset of Sepsis (EOS) rates can be modified with early interventions – disseminate information to maternity team. 2. Introduce further measures to reduce central line-associated bloodstream infections – Environmental scrubbing. 3. Continued prospective data collection and monitoring to identify trends.
Audit	Re-audit Neonatal Jaundice Audit 2022 Data
Actions – In progress	1. Neonatal Intensive Care Unit to be commissioned to have full Badgernet access, meaning paper copies will be eradicated prior to the next Jaundice Audit. 2. Create a new proforma for auditing once the process is set up on the Badgernet system.
Audit	Early Pregnancy Assessment Unit- Serial human chorionic gonadotropin (HCG) and scans audit
Action – complete Action – In progress Action – In progress	1. Education of relevant stake holders to minimize the number of blood follow up tests in low-risk pregnancy of unknown location (PUL) and getting senior reviews for high risk PUL. 2. Introduce and implement new guidance on ectopic and the management of pregnancy of unknown location that triages and identifies patients at high risk of ectopic. 3. Register an audit of all early pregnancy scans to see if the rate of pregnancy of unknown location in the department is unexpectedly high.
Audit	Planned re-audit of postnatal care
Action – In progress Action - complete	1. Change request to be submitted to Clevermed to include 'Important Signs & Symptoms' the 'Items discussed' section of the Transfer of Care Smart Form. 2. Audit on a page for Postnatal Care to be produced and published to all staff via closed social media platforms and email.
Audit	Re- Audit the compliance of midwives asking the Whooley questions at booking and enquiring about mental health concerns during the antenatal period
Action – In progress	1. An update to the Badgernet maternity system is required to include a mandatory prompt question relating to asking women about their mental health and wellbeing at hospital antenatal clinic appointments.
Audit	Improving skills and competency in ear lobe capillary blood gas sampling (CBG) for respiratory physiotherapists
Action - complete	1. Deliver practical training for ear lobe blood gas sampling to embed confidence, skills and competence of respiratory physiotherapists.
Audit	Major Trauma Psychology Service Annual Audit 2021-22

Action - complete	1. Ensure consistent distress screening. Make both paper and e-copies available to team to ensure consistency.
Audit	Radiotherapy Outpatient Unplanned Admissions
Actions - complete	1. Extend skills of more review team members in blood cultures, cannulation, intramuscular injections. 2. Continue providing training to department staff who require training or support in learning to do observations. 3. Ensure all staff who admit patients are aware of responsibilities under Standard Operating Procedure. 4. Reintroduction of 6pm middle shift, when possible.
Audit	Re-audit of review of the bedside equipment and documentation of oral and maxillofacial surgery tracheostomy patients
Action - complete	1. Include the documentation of the bedhead at the nurses' safety huddle in the morning.
Audit	Escalation and Do Not Attempt Resuscitation (DNAR) of Vascular Patients at RPH
Actions - complete	1. Use of medical clerking proforma when clerking in new admissions, to encourage thorough functional status, and early discussions around escalation and patient wishes.
Audit	Quality of Dental Impressions
Actions – in progress	1. Arrange further training in mixing of impression material (alginate) and tray loading. 2. Discussions around how to reduce 'drag.'
Audit	Emergency eye clinic triaging
Action - Complete	1. To develop guidelines for emergency eye clinic triaging.
Audit	ENT Hot clinic referrals
Action – in progress	1. To review the hot clinic referral criteria.
Audit	Comparison of the Trust's Generic Consent form for Robot-Assisted Laparoscopic Radical Prostatectomy (RALP) with the British Association of Urological Surgeons' (BAUS) Information for RARP (RALP)
Action – in progress	1. Create and implement a standardised format for the Procedure-Specific Consent Form (PSCF) that includes all necessary information, outlines all relevant risks and complications associated with RALP and ensures consistency across all documentation.
Audit	Evaluation of Kidney Choices Event 2022
Actions - complete	1. The programme format has been changed to allow attendees to have more time at the event to ask questions and look at equipment. 2. The March 2023 event has been moved to a new venue in order to improve patient flow at the event.
Audit	Pleural Patients Experience

Actions - complete	1. The pleural service has been expanded and there is now a weekly clinic 2. We have increased the outpatient management of these patients where appropriate by launching a respiratory virtual ward in September 2022.
Audit	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit
Actions - complete	1. Staff have been reminded in a teaching session about the need to discuss and document DNACPR decisions with families 2. Staff are now prompted by a poster that was been attached to the DNACPR booklets on Wards 20 and 23
Audit	Pharmacist-Led Biologic Switch/Thiopurine Clinic Questionnaire
Actions - complete	1. Appointment letters have been amended to clarify appointment time frames and give pharmacist contact details for further patient queries. 2. We have also set up face to face clinics for patients preferring this option.
Audit	Ferrinject Administration for Iron Deficiency Anaemia (IDA)
Actions - complete	1. An Iron Deficiency Anaemia working group was set up which meets regularly to discuss continuous improvement 2. An education session on managing iron deficiency anaemia was provided to Medical Assessment Unit and Same Day Emergency Care (SDEC) staff 3. The pharmacy team have added an iron deficiency anaemia investigation set and Ferrinject pop-up box on the hospital patient system.
Audit	Audit of Statin Therapy for Ischaemic Stroke Patients on Rookwood B
Action - complete	1. A poster is now on display in the Rookwood B doctor's office to remind them to prescribe statin therapy to ischaemic stroke patients as per the national stroke guidelines.
Audit	Re-audit of patient waiting times for Neurovascular clinic
Actions – in progress	1. Consultants to find a replacement for any clinic sessions cancelled due to professional leave, rota or buddy system to be devised. 2. To commence Neurovascular Specialists nurse follow up clinics to alleviate pressures.
Audit	Are our operation notes up to current standards?
Action – complete	1. To make the amendments to the operation notes - these have now been made and sent to registrars to keep our op notes accurate.
Audit	Managing Vitamin D Levels in Melanoma
Action - complete	1. Email disseminated with regular reminders at clinics, educational presentation regarding importance of vitamin D management in melanoma patients.
Audit	Safe use of Intraoperative Tourniquets
Actions – complete	1. To complete data series by including distal radius Open reduction and internal fixation cases from Chorley Hospital 2. To add a poster to remind others about documenting tourniquet use, pressures and exsanguination in the theatre coffee room - poster has been created and will be printed and placed in

	Theatre coffee room in Royal Preston and Chorley Hospital 3. To discuss with Bluespier to make the questions about tourniquet use, pressure and exsanguination mandatory.
Audit	Is female breast tissue in the correct position to benefit from organ based tube current modulation (X-CARE) in CT?
Actions - complete	1. To remove the organ based tube current modulation (X-CARE) from default protocols that involve breast tissue. 2. A separate organ based tube current modulation protocol is made available, with clear instructions to radiographers of its uses and cautions. The scanner protocols have been updated.
Audit	Devastating Brain Injury management - are we there yet?
Actions - complete	1. Introduction of devastating brain injury checklist in 'unscheduled procedures' to ensure proper documentation and follow up of the patients, within 48 hrs of patient admission to Intensive Therapy Unit. 2. Ensure parent team documentation of devastating brain injury and family discussion. 3. Basic introductory teaching to new members of staff, honest discussions with family, duration of observation is based on multiple factors i.e. clinical, family, patient factors.
Audit	An audit of Bowel Cancer Screening Programme reporting standards
Action - complete	1. To increase awareness of current requirements

Clinical Research

Research Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Lancashire Teaching Hospitals NHS Foundation Trust in 2022-23, that were recruited during that period to participate in research approved by a Research Ethics Committee was 1,820.

Of these 1,664 patients were recruited to National Institute for Health Research (NIHR) portfolio adopted studies in this period. In total, there are currently 214 active research studies recruiting patients at the Trust. The return to a more balanced, pre-pandemic style portfolio has been pleasing and especially seeing commercial trials and studies back up to 16% of the mix from 9% at the beginning of the financial year.

Research Governance

The Department of Health benchmarks for the set up and delivery of clinical research in the NHS are currently suspended as per previous reporting period to 62 days for non-commercial and 80 days for commercial studies. However, we granted local confirmation of capacity and capability, and opened 55 new studies during this year.

Examples of Our Achievements in Research
Key achievements to note are:

Infrastructure

- Commencement of the new funding period of the NIHR Lancashire Clinical Research Facility (LCRF) status with 33% uplift in funding for 2022-25 of £1m.
- Commencement of the new NIHR Manchester Biomedical Research Centre (BRC) of which the Trust is a partner and will bring core funding of £750k (2022-27) via the LCRF. Professor Pierre Martin-Hirsch, Director of Research and said: *"The collaboration with Manchester University Hospitals and Lancashire Teaching Hospitals will stimulate the development of primary research across the two institutions. The clinicians, students and patients will benefit from integration of academic activity in healthcare in Lancashire, benefitting not only patient outcomes but will also raise the standard and profile of services."*

Workforce

- Leading Principal Investigators, Professor Shondipon Laha, Consultant in Critical Care Medicine and Anaesthesia, has won the regional Future NHS Award for his commitment to improving health care, championing research, and introducing innovative ideas throughout the COVID-19 pandemic, and was shortlisted for the 2022 NHS Parliamentary Awards.
- Clinical Academic Faculty lead and Speech and Language Therapist, Sarah Edney, has been awarded a Clinical Research Training Fellowship by 4ward North PhD Scheme. The prestigious fellowship combines research with clinical practice.
- Research nurse, Deepsi Khatiwada has been seconded until March 2023 as a nurse inclusion lead with NHS England (NHSE)/ NHSI Northwest to drive the Equality Diversity Inclusion (EDI) agenda, both for patients and workforce across the region.
- Deputy Director of Research and Innovation, Paul Brown, has been appointed UK Clinical Research Facility network (UKCRF) Director after Manchester University Hospitals NHS Foundation Trust successfully won the NIHR bid to host the network.
- Director of Research, Professor Pierre Martin-Hirsch was awarded the Royal College of Obstetricians and Gynaecologists (RCOG) Annual Academic award. The award distinguishes service to academic obstetrics and gynaecology. Nominees are recognised for their outstanding contribution to the academic aspects of our speciality (scientific discovery, pre-clinical and clinical research, academic education, and training). As winner, Pierre will be invited to give a keynote lecture at the 2023 Annual Academic Meeting.
- Katrina Rigby, Senior Research Midwife, has been accepted on to the NIHR Senior Leadership Programme which commences 1 April 2023. This is one of only 15 places across England.
- Nichola Verstraelen, Matron, has completed her lead role for NHS England project on a research toolkit for the Matron's Handbook and becoming Programme Lead for Research for the ICS.
- Research Scholars: Having never had a successful application for the NIHR Northwest Coast Clinical Research Network's (CRN's) Scholar scheme ,to train new Consultant-level clinicians and Nursing Midwifery Allied Health Professionals (NMAHPs) as Investigators, before 2022 we have had 3 successes this time on top of last year's 4.

- Candiss Argent, Paediatric Research Physiotherapist has just been appointed as the AHP Research Champion for the Northwest Coast 2023. This is part of a joint scheme between the Council for Allied Health Professions Research (CAHPR) and NIHR to develop a network of Research Champions.

Studies, Trials and Research

- The data from a cancer study we participated in, FOxTROT has now been published in the Journal of Clinical Oncology online. Dr Deborah Williamson was our local Principal Investigator for the study that looked at new treatment strategies to cut risk of bowel cancer return. The results show the new strategy can cut risk of return to 28%, along with confirming the safety of the approach and the importance of MMR status in selecting patients who benefit most.
- We have been successful in recruiting the UK's first participant into the innovative TRIDENT study for newly diagnosed glioblastoma patients. The study was brought to us by one of our former neurosurgical consultants, Mr Charles Davis. The study uses a device called Optune®, which delivers mild electrical fields called TTFields intended to disrupt cancer cell division. The study will use the TTFields concurrently with chemotherapy and radiotherapy. Congratulations to our local Principal Investigator Mr Isaac Phang and the rest of the multi-disciplinary team involved with this complex study.
- In collaboration with the International Agency of Research Against Cancer (IARC), a specialised agency of the World Health Organisation, Professor Martin-Hirsch, along with fellow local specialist Professor Ihtesham Rehman from the University of Central Lancashire (UCLan), has secured a multi-million-dollar grant from the National Institute of Health (NIH) in the USA to fund their research into early diagnosis of womb, cervical and lung cancer.
- Two commercial studies recently delivered by our Chronic Conditions team contributed toward study drugs that have been licenced. Both looked at the use of HIF-PHI oral medication for the correction of anaemia in chronic kidney disease. The Dolomites study (Astellas Pharma Inc and AstraZeneca) drug Roxadustat has been licenced in Europe and has National Institute for Health and Care Excellent (NICE) approval. The cost is the same as the therapy currently in use but much better for patients as it is an oral medication where currently they must give themselves an injection. It will also provide improved management for their anaemia. The Ascend D GalaxoSmithKline (GSK) study drug, Daprodustat will be licenced imminently.

Table 7	Lancashire Teaching Hospitals NHS Foundation Trust – Research Recruitment 1 January –31 March 2023				
NIHR Portfolio Study ID	**IRAS Number**	**Project Short title**	**Main Speciality**	**Project type**	**Recruited (org)**
	1003378	A Phase 1b/2 Study of Immune and Targeted Combination Therapies in Participants With RCC (KEYMAKER-U03): Sub study 03B	Cancer	Commercial portfolio	1
	219211	PET to assess early response to nivolumab in renal cancer	Cancer	Non-commercial non-portfolio	1
15511	133939	PLORAS version 1	Stroke	Non-commercial portfolio	1
31184	204585	PLATO - PersonaLising Anal cancer radioTherapy dOse	Cancer	Non-commercial portfolio	1
34216	216411	IntAct- IFA to prevent anastomotic leak in rectal cancer surgery	Surgery	Non-commercial portfolio	1
35561	229639	Drug Utilisation study	Children	Commercial portfolio	1
37450	239796	CYPIDES	Cancer	Commercial portfolio	1
38171	242263	DIMENSION-KD_Version 01 01.01.2018	Renal Disorders	Non-commercial portfolio	1
40195	255324	Persica 002 Phase1B PP353 vs Placebo in the treatment of low back pain	Anaesthesia, Perioperative Medicine and Pain Management	Commercial portfolio	1
47486	1003548	IMvigor 011 - Adjuvant MIBC study in ctDNA-positive patients	Cancer	Commercial portfolio	1
47662	287714	PRIMROSE Tissue: Collection and Analysis of samples in breast cancer	Cancer	Non-commercial portfolio	1
48029	277102	ENRICH-AF: Edoxaban for Intra Cranial Haemorrhage survivors with AF	Stroke	Non-commercial portfolio	1
48126	297323	Research of Talazoparib & Enzalutamide in Men with Gene Mutated mCSPC	Cancer	Commercial portfolio	1
49352	289197	CARE pilot trial	Surgery	Non-commercial portfolio	1
49707	298608	Modi-1 in Patients with Breast, Head & Neck, Ovarian or Renal Cancer	Cancer	Commercial portfolio	1
49804	289120	TACTIC	Respiratory Disorders	Non-commercial portfolio	1

50719	297416	ADAMS	Neurological Disorders	Non-commercial portfolio	1
51062	1004437	ARV-110 and Abiraterone in Participants with Metastatic Castration Resistant Prostate Cancer (mCRPC)	Cancer	Commercial portfolio	1
51498	306338	EF-32 TRIDENT	Cancer	Commercial portfolio	1
52908	310986	Flexor tendon repairs - FIRST Study	Musculoskeletal Disorders	Non-commercial portfolio	1
	278448	Born into care: Towards inclusive guidelines at birth	Health Services Research	Non-commercial non-portfolio	2
	301826	MD Exercise – determinants of physical activity		Non-commercial non-portfolio	2
35238	88372	Tonic 2 Phase 4	Neurological Disorders	Non-commercial portfolio	2
39336	225518	IRONMAN Registry Study	Cancer	Non-commercial portfolio	2
44406	269023	SurfON	Children	Non-commercial portfolio	2
45312	249991	The Tommy's National Rainbow Clinic Study	Reproductive Health and Childbirth	Non-commercial portfolio	2
47359	1003620	Lokelma DIALIZE-Outcomes	Renal Disorders	Commercial portfolio	2
50137	296470	PreSize Neurovascular: Real-World Evaluation	Neurological Disorders	Non-commercial portfolio	2
51978	1005180	HARMONIE	Children	Commercial portfolio	2
35757	214739	SC IL-1Ra in SAH - phase III trial	Stroke	Non-commercial portfolio	3
39901	281225	TTTS Registry	Reproductive Health and Childbirth	Non-commercial portfolio	3
40836	249552	OPTIMAS Trial	Stroke	Non-commercial portfolio	3
45615	286545	AMPLITUDE	Cancer	Commercial portfolio	3
49550	297513	Blood brain barrier dysfunction in cerebral small vessel disease	Stroke	Non-commercial portfolio	3
	242639	Archival gastro-intestinal tissue, blood, saliva and urine collection			4
51800	304633	Hydrotherapy in DMD	Children	Non-commercial portfolio	4

47078	284958	Giant PANDA	Reproductive Health and Childbirth	Non-commercial portfolio	5
48055	270544	CHOSEN trial	Stroke	Non-commercial portfolio	6
39722	247285	Reduction Of Surgical Site Infection using several Novel Interventions	Surgery	Non-commercial portfolio	7
44559	277060	PACT: Cluster RCT of the 'Your Care Needs You!' intervention Work package 6	Health Services Research	Non-commercial portfolio	7
45022	261352	COMMITS	Stroke	Non-commercial portfolio	7
12495	0	Trajectories of Outcome in Neurological Conditions Phase 2 Demographics and Clinical Info	Dementias and Neurodegeneration	Non-commercial portfolio	8
51863	311132	DETECT-ASCEND 2	Cancer	Commercial portfolio	8
12497	88372	TONIC Phase 3 Trajectories of Outcome in Neurological Conditions	Dementias and Neurodegeneration	Non-commercial portfolio	10
6726	162439	RADAR	Renal Disorders	Non-commercial portfolio	10
10416	209558	UK MS Register	Neurological Disorders	Non-commercial portfolio	11
49866	301896	CLOUDS Study	Surgery	Commercial portfolio	12
	266187	ECCE: Enhanced Computerised Colposcopic Examination	Reproductive Health and Childbirth	Non-commercial non-portfolio	14
35944	228894	REACH Pregnancy Circles Trial; Version 1.0	Reproductive Health and Childbirth	Non-commercial portfolio	14
32256	215928	Perioperative Quality Improvement Programme: Patient Study	Anaesthesia, Perioperative Medicine and Pain Management	Non-commercial portfolio	27
30936	156515	Fast Track Faecal Calprotectin	Gastroenterology	Non-commercial portfolio	29
49271	297802	Covid impact on RSV Emergency Presentations: BronchStart	Children	Non-commercial portfolio	41
				Total	**277**

Registration with the Care Quality Commission

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

- Diagnostic and/or screening services.
- Maternity and midwifery services.
- Surgical procedures.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Termination of pregnancies.
- Treatment of disease, disorder, or injury.
- Management of supply of blood and blood derived products.

CQC Finney House

The Trust acquired Finney House Community Healthcare Hub on 14 November 2022 and the registration was duly authorised by CQC. Finney House provides out-of-hospital community-based care through community services, clinics and support patients medically at satellite dialysis units and is registered with the CQC and licensed to provide:

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

The Trust had been delivering a vaccination hub service since 18 February 2021 at a community venue as part of the response to the COVID-19 pandemic. However, this service was terminated on 28 December 2022 due to there no longer being a need for it.

The Deputy Associate Director of Risk and Assurance had been the Nominated Individual with the CQC since November 2021 and this was changed to the Chief Nursing Officer from October 2022. The Chief Nursing Officer was also made the Registered Manager with CQC for Finney House Community Healthcare Hub upon its acquisition in November 2022.

The Foundation Trust is fully compliant with the registration requirements of the CQC.

Trust Inspections

The CQC undertook a system wide inspection of Urgent and Emergency Care pathways across Lancashire and South Cumbria. This system inspection was a new kind of inspection conducted in March and April 2022 looking at services across the ICS including General Practitioners (GPs), Northwest Ambulance Service, nursing homes, urgent care, mental health, and acute hospital providers and included an inspection of Urgent and Emergency Care and Medical Services on the Royal Preston Hospital site. The CQC published their findings on 22 July 2022.

Overall, the Urgent and Emergency Services at Royal Preston Hospital remained ‘Requires Improvement’, with inspectors providing a ‘Good’ rating for being effective, caring and well led, and ‘Requires Improvement’ rating for being safe and responsive.

Whilst Medical Services at Royal Preston Hospital were also inspected, no overall rating was given due to it being a focussed inspection looking at flow pathways and the 'responsive' domain.

In the main, the report highlighted several areas of good practice in both the ED and across the medical division, recognising improvements and positive changes the Trust has made to drive its safety and improvement culture while acknowledging various challenges including shortages of nursing and medical staff, bed pressures and flow. Inspectors also highlighted areas where further work was needed, including compliance with infection prevention and control practices and oxygen prescribing. An improvement plan was developed, and progress has been monitored through the Safety and Quality Committee.

Whilst the CQC did undertake an inspection of Urgent and Emergency Care and Medical Services on the Royal Preston Hospital site in 2022, CQC did not review the overall rating for the Trust as this was not considered as part of the system-wide inspection. Therefore, the overall rating of 'Requires Improvement' from the 2019 inspection remains the same with 'Good' for caring and 'Good' for well led. Specifically, a rating of 'Good' for caring means that people are supported and treated with dignity and respect and are involved as partners in their care and a rating of 'Good' for well led means leadership, governance and culture promote the delivery of high-quality person-centred care.

Radiotherapy Inspection

CQC also carried out a routine inspection of the Radiotherapy Service on 11 May 2022 to assess the department's compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and to check that radiotherapy was being safely delivered at the Trust.

The final inspection report was received on 23 June 2022. Although, no overall rating was provided, inspectors concluded that staff were knowledgeable about their roles and felt supported to achieve and maintain competency. Inspectors also felt that the Trust had appropriate oversight of radiation protection through its governance structures and that this was clearly documented.

The report did identify two breaches. These breaches did not justify regulatory action, but the CQC did make recommendations for action to prevent the Trust from failing to comply with legal requirements in the future and to improve the quality of services. The Trust formulated an action plan in response to these recommendations which have been monitored through the Safety and Quality Committee.

Finney House

Prior to acquisition, Finney House was operated by a private provider and during the last inspection by CQC, there were some areas for improvement identified and breaches of regulation. As part of its due diligence, the Trust undertook to develop an action plan to address the identified areas for improvement and progress is being monitored through the Safety and Quality Committee.

Well Led Inspection

The Trust as a whole, reviews its own leadership and governance arrangements periodically, in line with the requirements of NHSI that providers carry out developmental reviews.

Since the last Well Led inspection, the Trust has developed a Well Led and Governance Maturity Plan to drive improvement in the well-led domain of the organisation and this incorporated recommendations from a review undertaken of the divisional governance arrangements by the Quality Governance Lead from the Nursing Directorate at NHSE/NHSI which identified the Trust as an exemplar organisation in October 2020, a Risk Maturity Self-Assessment tool supported by Mersey Internal Audit Agency (MIAA), and a MIAA developmental well-led review in February 2021. In addition, two external consultants have been engaged from July 2021 to date. Firstly, an external leadership consultant undertook a series of development sessions with the Board. Secondly, the GGI undertook a Risk and Assurance review from February to November 2022.

Throughout 2022-23, the Trust has been able to demonstrate ongoing progress in meeting the recommendations from previous inspections through a number of programmes of work, including the Always Safety First Programme, a number of continuous improvement programmes, the Governance and Risk Maturity Plan, the Safety Triangulation Accreditation Review Framework as well as our Organisational Development and Equality and Inclusion Strategies.

The Trust continues to maintain a transparent relationship with CQC, sharing risks and concerns in respect of patient safety and quality as they occur, together with the actions taken or proposed in order to provide assurance that the Board has appropriate oversight of its quality governance and patient safety risks.

Quality of Data

Data Quality and Information Governance

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

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2022-23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.9% for admitted patient care.
- 99.9% for outpatient care.
- 99.2% for accident and emergency care.

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

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

All data set types are either consistent with or show an improvement compared to 2021-22, and all are above the national average for 2022-23.

As part of the Lancashire Teaching Hospitals NHS Foundation Trust annual assessment, the Data Security and Protection Toolkit (DSPT) is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2021-22 DSPT is 'standards met'. The 2022-23 submission is not due to be made until June 2023.

The Trust was subject to an internal Information Governance clinical coding quality assurance audit during 2022-23. Results indicate a high level of coding quality and completeness as follows:

- Primary Diagnosis 96%.
- Secondary Diagnosis 88%.
- Primary Procedure 94%.
- Secondary Procedure 80%.

Lancashire Teaching Hospitals NHS Foundation Trust has undertaken the following actions to improve data quality:

- Submission of a bi-annual Data Quality Assurance Report to the Board providing a summary of Data Quality Team activities, an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.

- In terms of the NHS Digital Data Quality Maturity Index the Trust scored the following for the latest position available, above the national average in all datasets.

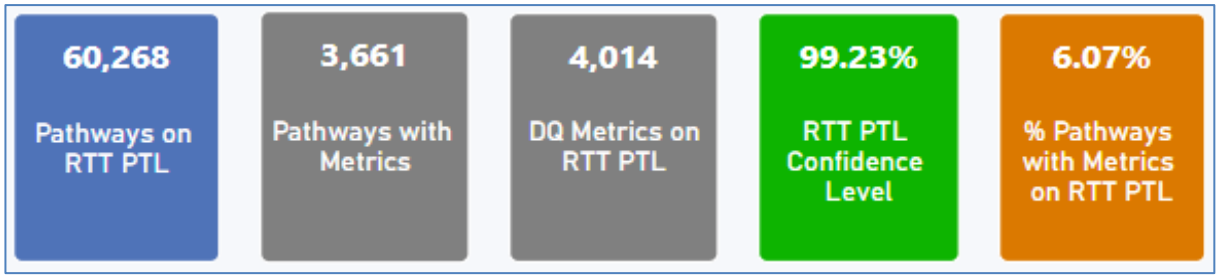
Table 8 NHS Digital Data Quality

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	82.8	83.1	93.5	92.3
Lancashire Teaching	91.2	83.3	99.3	98.4

Data source: NHS Digital/LTHTR Data Warehouse

National Waiting List Minimum dataset data quality confidence level of 99.23%, above the national threshold of 95%. Compliance is detailed below:

Figure 5 National Waiting List Data



LUNA National Data Quality Solution

- Integrated Performance Report aligned to Our Big Plan ambitions reflecting the golden thread of reporting from Board to Division and Sub-Committee to Specialty and Ward.

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

- Interactive workshops to ensure engagement with clinical and support staff regarding the importance of good data quality and individual responsibility.

- Establishing a Data Quality Forum to support improvements to data quality in core systems.

Information Governance 

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

The Trust experienced 4 externally reportable serious incidents in the 2022-23 period, 2 of these incidents reached the reporting criteria sent to the ICO. For all incidents full internal processes were followed and all 4 incidents were reported using the DSPT.

As part of our annual assessment, the DSPT is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2021-22 DSPT is 'standards met'. The Trust has submitted the baseline assessment for 2022-23 and is working towards the final submission which is due on 30 June 2023.

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

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

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

Adult Mortality Reviews and Investigation Data

We implemented the nationally recommended approach to Mortality Review (MR) during 2017-18 which was based on the Royal College of Physicians Structure Judgement Review (SJR) model. This has been embedded in practice for the past five years. The SJR mortality model was developed for the review of adult deaths, the outcomes of which are presented below.

Neonatal and child deaths are managed through different nationally defined review and reporting processes which are presented separately in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section in this account. The deaths listed in point 1.1 include Inpatient and ED deaths which are reviewed using SJR methodology.

1.1 During 2022-23, 2,015 of Lancashire Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 460 in the first quarter.
- 462 in the second quarter.
- 547 in the third quarter.
- 546 in the fourth quarter.

Data source: Trust data warehouse

1.2 By 31 March 2023, 1,016 case record reviews and 19* Strategic Executive Information System (StEIS) investigations have been carried out in relation to the 2,015 of the deaths noted above.

** 5 StEIS investigations have been concluded and awaiting coroner's inquest/inquest outcome, 10 are complete and 4 are ongoing.*

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

- 216 in the first quarter (plus 7 StEIS investigations).
- 267 in the second quarter (plus 6 StEIS investigation).
- 300 in the third quarter (plus 3 StEIS investigations).
- 233 in the fourth quarter (plus 3 StEIS Investigations).

Data source: Trust MR Database & Datix

1.3 4* representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient in relation to each quarter, this consisted of:

- 3 representing 0.15% for the first quarter.
- 1 representing 0.05%for the second quarter.
- 0 representing 0% for the third quarter.
- 0 representing 0% for fourth quarter.

Data source: Trust MR Database & Datix

These numbers have been calculated using the SJR Mortality Review process and the StEIS process. Of the 5 completed StEIS investigations awaiting Coroner's review in 2022-23 it is not possible to determine for all cases if deaths were on balance likely due to problems in care as some inquests have been delayed due to the COVID-19 pandemic and others are yet to be scheduled. It is noted that the new Patient Safety Incident Response Framework from NHSI, which is in the process of being implemented advises that avoidability of death should not form part of the terms of reference for StEIS investigations with that being the remit of HM Coroner.

1.4 Learning from the deaths identified in 1.3

The learning from investigations subject to inquest will be shared through our learning to improve process. The learning from the 4 StEIS cases (2 Diagnostic incidents, 1 Medication incident and 1 sub-optimal care of a deteriorating patient incident) where investigation has been completed and Coroner's inquest is not required includes, but is not exclusively:

- Closer review of prescribing practices within the Neurosurgery team including the review of clinical advice from other specialties when making decisions of medication prescribing.
- Improvement in clinical prioritisation tools and exploring potential for electronic alerts in patient record systems to identify patients on anticoagulants to enable prioritisation for their review.
- The need for a Task and Finish Group to address delays in clerking and medical reviews within the ED.
- Implement electronic discharge checklist in the ED and audit compliance through Always Safety First.
- Explore observation recording systems in the ED.
- Agreeing audit processes for Silver Trauma within the ED.
- Improve flow out of the ED to increase resuscitation capacity.
- Need to review triage system for Oesophago Gastro Duodenoscopy (OGD) requests with consideration for an algorithm to support triage.
- Review from the Orthopaedic Service into their handover paperwork to include discharge information and justifications on discharge paperwork when inpatient medication is not included.

1.5 Actions in relation to the learning in 1.4

The learning and actions from investigations subject to inquest will be shared through our learning to improve process when available. The action plans from the completed StEIS investigations in 1.4 are all recorded and monitored through the Trust's Datix system and through the Trust's Safety and Learning Group.

1.6 Assessment of the impact of actions described in 1.5

The assessment of the impact of actions from investigations subject to inquest will be shared through our learning to improve process. The assessment of the impact of actions in 1.5 will be evident from audits which are not available at this time.

It has not been possible to provide the avoidability of deaths data due to delays in investigations due to staffing pressures and the Trust's response to the pandemic and inquests

as a result of the COVID-19 pandemic. Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section of this account p.98.

2.3 Reporting Core Indicators

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

The NHS continued to face significant challenges in 2022-23 and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has continued to experience pressures as a result of the COVID-19 pandemic. Performance across the board, both emergency and elective has been impacted with operational pressures and infection, prevention control measures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures in response to increased demand resulted in high bed occupancy throughout the year with the need to focus both on COVID-19 non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside remained high throughout the year. This, together with both Influenza and COVID-19 demand resulted in significant capacity and demand pressures. Workforce capacity to undertake elective activity was also impacted by sickness absence and industrial action throughout the latter part of the year.

A health economy system-wide action plan is in place to address the urgent care system and pressures; with identified primary, community and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2022-23 the Trust took a lead role in bringing together operational delivery of the system-wide urgent and emergency care programme, including key transformational work streams identified and prioritised by all system partners: a Community Healthcare Hub at Finney House, providing health-led community bed capacity; the introduction of Virtual Wards; additional Home First capacity and crisis hours to support people to stay safe at home; and to expedite timely discharge from hospital.

Since the beginning of the COVID-19 pandemic the Trust has put in place a range of measures that continued into 2022-23:

- Additional medicine bed capacity to meet increased demand.
- Re-zoning of our estate to meet Infection Prevention and Control (IPC) requirements.
- Delivery of Same Day Emergency Care (SDEC).
- Additional Critical Care (CrCu) surge beds with additional staffing through redeployment.
- Nightingale Surge Hub capacity to support increased demand as a result of the Omicron variant of COVID-19.

During 2022-23 the Trust has:

- Stood down the Nightingale Surge Hub and established the Community Healthcare Hub at Finney House, providing 64 health-led time-limited community beds, reducing medicine bed capacity in hospital as a result.
- Reduced IPC measures, in line with guidance.
- Established an Acute Assessment Unit to reduce time spent in the ED and reflect the changes to zoning put in place during COVID-19.
- Launched Virtual Ward pathways for Frailty, Respiratory and Acute Medicine.
- Increased internal escalation measures, including Full Capacity Protocol to support ambulance handovers and capacity in the ED

These actions have all helped to support the Trust during these unprecedented times. However, the Trust has failed to achieve its objectives in relation to a range of measures within the risk assessment framework including: the 4-hour standard for Accident & Emergency (A&E); the 18-week incomplete access target, and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both Referral to Treatment (RTT) and cancer pathways was directly impacted by the COVID-19 pandemic and the reduction in elective activity during the peak periods of the pandemic with the prioritisation of urgent elective activity as part of the elective restoration plan. 2022-23 has focussed on recovery and significant progress has been made with both cancer 62-day performance and reductions in our longest waits to no more than 78 weeks, with an elimination of waits over 104 weeks unless patients are choosing to wait longer for treatment. Core Indicators: Summary position detailing performance 2022-23 is shown in table 9 below.

Table 9 Core Indicator Performance 2022-23

Indicator	2021-22	2022-23	Current Period
A&E - 4 hour standard	78.3	75.3	% - Cumulative to end Mar 2023 Position includes both ED and UCC locations.
Cancer - 2 week rule (All Referrals) - New method	77.7	58.6	% - Cumulative to end Mar 2023
Cancer - 2 week rule - Referrals with breast symptoms	54.6	82.2	% - Cumulative to end Mar 2023
Cancer - 31 day target	87.2	83.3	% - Cumulative to end Mar 2023
Cancer - 31 Day Target - Subsequent treatment – Surgery	72.4	59.3	% - Cumulative to end Mar 2023
Cancer - 31 Day Target - Subsequent treatment – Drug	99.3	96.8	% - Cumulative to end Mar 2023
Cancer - 31 Day Target - Subsequent treatment - Radiotherapy	97.7	82.3	% - Cumulative to end Mar 2023
Cancer - 62 day Target	55.8	43.2	% - Cumulative to end Mar 2023
Cancer - 62 Day Target - Referrals from NSS (Summary)	58.6	29.2	% - Cumulative to end Mar 2023
28 day faster diagnosis standard – compliance	72.0	57.5	% - Cumulative to end Mar 2023
MRSA	1	0	Cumulative to end Mar 2023
C.difficile Infections	129	196	Cumulative to end Mar 2023
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	58.5	50.5	% - sum of Apr-Mar 2022-23
% of patients waiting over 6 weeks for a diagnostic test	45.07	50.44	% - Cumulative to end Mar 2023

Data source: NHS Digital/LTHTR Data Warehouse

Summary of Performance against Core Indicators

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

NHS Digital Data availability

Summary Hospital-Level Mortality Indicator (SMHI) - Table 10 relates to 2021-22.
Readmissions within 30 days of Discharge - Table 11 relates to 2021-22.
Venous Thromboembolism – Table 12 relates to 2019-20 (remains paused since COVID-19).
Clostridioides Difficile Infection - Table 13 relates to 2021-22.
Patient Safety Incidents - Table 14 relates to 2022-23.

Table 10 Summary Hospital-Level Mortality Indicator (SMHI) * most current data

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

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

- NHS Digital categorises NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). The trust remains in band 2 which is within the expected range. The SHMI for the most current data available (Dec 2021 – Nov 2022) is 0.96 which is marginally higher than the previous 12-month period but still below the 1.0 average.

- The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.

Table 11 Readmissions within 30 days of Discharge * most current data

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

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

Banding key:

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

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

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

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

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

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

- The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years, and 75+ years.
- The banding has been presented to indicate the Trust performance.
- The 0-15 year's readmissions are consistent with the England average which shows a slight deterioration from the last reported figure and the Trust remains lower than the highest rate of 12.6.
- The Trust re-admissions rate for patients 16-74 & 75+ is either as expected or lower than the average.

Table 12 Venous Thromboembolism (VTE) Risk Assessment * most current data

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

NHS Digital VTE data collection and publication was paused to release NHS capacity to support the response to COVID-19. The Trust's VTE risk assessment compliance data continues in 2022 -23 to be collated and reported to Safety and Quality Committee in an assurance report.

Table 13 *Clostridioides Difficile (C. difficile)* Infection * most current data

	2019-20	2020-21	2021-22*
The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period	**Trust = 62.9**	**Trust = 74.5**	**Trust = 71.4**
	High = 142.8	High = 140.5	High = 138.4
	Low = 0	Low = 0	Low = 0

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

There has been a national increase in *C. difficile* infection in a significant proportion of Trusts nationally which was reflected in our Trust during 2022-23.

- The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2022/23, the national objective set by NHSE was no more than 122 hospital associated cases.
- There was however an increase in hospital associated cases during 2022-23 in comparison to previous years with a total of 196 cases. This was a 48% increase from 2021/22 which had a total of 132 hospital associated cases.

Lancashire Teaching Hospitals NHS Foundation Trust has taken the following actions to reduce *C. difficile*, and so the quality of its services, by:

- Continuing Post Infection Reviews (PIRs) which is a multidisciplinary approach to investigate each hospital onset *C. difficile* case.
- Sharing lessons learned from PIRs and implement quality improvement actions.
- Continuing to focus on antimicrobial prescribing with community partners.
- Continuing to promote best practice around antimicrobial stewardship.
- Continuing to be responsive to the need for isolation.
- The implementation of Redi-rooms to mitigate the lack of isolation rooms.

- The implementation of the Gastrointestinal Rapid test to identify infection earlier.
- Promoting hand hygiene commode, Mattress and environmental cleaning.
- Promoting joint clinical revalidation audits and environmental audits.
- Promoting infection prevention and control education Trust wide with the implementation of a robust E-Learning package and bespoke training.
- Trials of alternative decontamination systems.
- Promoting the standardisation of documentation with the new nursing Kardex.
- Promoting bowel monitoring with the introduction of the Ward specific Whiteboards.

Table 14 Patient Safety Incidents * most current data

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	October 2017-March 2018	**October 2018-March 2019**	**October 2019-March 2020**	**April 2020 - Mar 2021**	**April 2021 - Mar 2022**	**April 2022 – Mar 2023***
(i) Rate of Patient Safety Incidents per 1000 Bed days	**Trust Number = 6506 Trust Rate = 43.6**	**Trust Number = 7250 Trust Rate = 52.4**	**Trust Number = 7766 Trust Rate = 51.8**	**Trust Number = 14428 Trust Rate = 68.9**	**Trust Number = 19773 Trust Rate = 67.8**	**Trust Number = 20626 Trust Rate = 66.1**
	England – 42.1 All * Trusts Rate High = 69.0 All * Trusts Rate Low = 23.1	England – 45.2 All *Trusts Rate High= 95.9 All *Trust Rate Low = 16.9	England – 49.6 All *Trusts Rate High = 110.2 All *Trusts Low = 15.7	England – 57.3 All *Trusts Rate High = 118.7 All *Trusts Low = 27.2	**NHS Digital Data not yet released** England – All *Trusts Rate High = All *Trusts Low =	**NHS Digital Data not yet released** England – All *Trusts Rate High = All *Trusts Low =
(ii) % of Above Patient Safety Incidents = Severe/Death Rate = per 1000 Bed Days	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**
	Trust Number = 62 Trust Rate = 0.42 % of all incidents = 0.95%	**Trust Number = 60 Trust Rate = 0.43 % of all incidents = 0.83%**	**Trust Number = 49 Trust Rate = 0.33 % of all incidents = 0.63%**	**Trust Number = 88 Trust Rate = 0.42 % of all incidents = 0.61%**	**Trust Number = 80 Trust Rate = 0.27 % of all incidents = 0.40%**	**Trust Number = 110 Trust Rate = 0.35 % of all incidents = 0.53%**
	England – 0.35% All *Trusts Highest % = 1.54% All *Trusts Lowest % = 0%	England – 0.32% All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0%	England – 0.30% All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0%	England – 0.44% All *Trusts Highest % = 2.80% All *Trusts Lowest % = 0.03%	England – **NHS Digital Data not yet released** All *Trusts Highest % = All *Trusts Lowest % =	England – **NHS Digital Data not yet released** All *Trusts Highest % = All *Trusts Lowest % =

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

- The Trust continues to improve education regarding the reporting of incidents and near misses, the importance of doing so and the outcome of the learning gleaned from incident reporting.
- Continued improvements to the reporting system to make it easier to report in a timely manner, whilst obtaining essential information.
- Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients.
- Increased proportion of incidents following the decline of the pandemic response related to delayed appointments, diagnostics and treatment.
- Incident dashboards and an automated interactive Governance Dashboard are now in use across the Trust for embedded incident analysis.

The Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- Continued Learning 2 Improve work through the Governance and CI Teams to address areas of concern from Incident trends (Pressure Ulcers, Never Events, and Safeguarding etc.).
- Implementation of the Patient Safety Incident Response Framework (PSIRF) and 'Learning From Patient Safety Events' (LFPSE) national directives for improving Trust investigation management and patient safety incident data sharing at a national level.
- Continue to develop and improve the scope and agenda for Safety & Learning group to ensure systematic delivery on action plans and the embedded improvements for patient safety results in improved outcomes. This has been built into the Datix system.
- Continue to link incident analysis to the risk register and the Trust's Risk Maturity Programme of work. Linking incident and risk intelligence to *Our Big Plan*.

Table 15	Responsiveness to Personal Needs * most current data		
Q 48. The Trusts overall experience of patient's personal needs during the reporting period	**2018-2019**	**2019-2020**	**2020-21***
	Trust = 66.2	**Trust = 66.8**	**Trust = 8**
	England = 67.2 High = 85.0 Low = 58.9	England = 67.1 High = 84.2 Low = 59.5	England = 8.1 High = 9.4 Low = 7.4

This indicator value is based on the average score from the National Inpatient Survey, which measure the experiences of people admitted to NHS Hospitals. Please note that the data methodology changed in 2020 and the scores are presented as those in the published report 2021. * Due to methodology changes in 2020, we do not do historical comparisons any earlier than 2020. The historical comparisons include the England average for 2020. The national average for 2020 is calculated from the average score for all trusts that exist in the data set for that year. (Source CQC: https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey)

Where patient experience is best

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

Where patient experience could improve

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

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

- Continually improving responsiveness to needs to through all our patient experience and professional strategies in our pursuit of 'consistently deliver excellent care.'
- By responding to feedback from patients and families through the Friends & Family test as well as national and local surveys.
- The STAR accreditation system drives continuous improvement in our services being responsive to the personal needs of patients.
- Strengthen the connection between equality, inclusion and diversity agenda between patients and staff.
- Delivery of patient contribution to case notes, an innovative patient held record to promote patients as partners in care.

Table 16 Staff Recommendation as a Provider of Care * most current data

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (%) (From 2021) 2020 historical NHS Digital Data 21/22 NHS Staff Survey Data	2020	2021	2022*
	Trust = 69.0	**Trust = 61.9**	**Trust = 59.9**
	England = 74.3 High = 91.7 Low = 49.7	Best = 89.5 Ave = 67.05 Worst = 43.5	Best = 86.4 Ave = 61.9 Worst = 39.2

Historically NHS Digital provided the data for the Quality Account however the site now directs the user to national survey results, consequently the data is now being presented in alignment with the National Staff Survey format.

As you will see from the data presented, there is work to be done to improve how colleagues feel in regard to recommending the organisation if a friend or relative needed treatment, as our results are slightly below the national average and historically, we can see a downward trend emerging.

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

1. **Launching the new Workforce and Organisational Development People Strategy**
   Through delivering against one of our strategic aims 'to engage, retain, reward and recognise' our colleagues, we will bring about improvements across the whole colleague employment lifecycle.
   This includes focusing on the colleague experience of work, from how they are welcomed into our organisation, their levels of job satisfaction, how engaged they feel in their work and team, how we seek to support career progression, how valued, rewarded and recognised they feel for their contribution, through to helping individuals to leave our organisation positively.
   How colleagues experience work can strongly influence their levels of advocacy for us as an employer, as a service provider and their willingness to strive towards our organisational vision of delivering excellent care with compassion.
2. **Implementing continuous improvement programmes**
   We involve clinical and non-clinical staff in our improvement journey which has been presented in the continuous improvement section in this Quality Account.
3. **Sustaining and improving our listening channels**
   We aim to have an 'always-on' engagement approach by providing regular and ongoing opportunities for colleagues to feedback and enable team conversations to take place. Formal channels we participate in include NHS Staff Survey and National Quarterly Pulse Survey.

We are also working to further embed our already established Team Engagement and Development Tool (TED) and approach which supports and empowers team members to have regular and open conversations about what it feels like to work in their team and provides the framework for the team to focus on actions that are within their team's circle of control and influence. We know these are the things that make a difference to the colleague experience on a daily basis and have more impact on overall levels of satisfaction and advocacy.

Alongside this, as a Trust we are committed to using a wide variety of listening channels such as our annual culture survey, wellbeing survey, 'Freedom to speak up' process, 'Fresh eyes' forums, new starter discussions, exit interviews and questionnaires. We continuously review and refresh our listening channels to ensure we are continuous improving them and taking forward new ideas.

We also host weekly Strategic Operational Group (SOG) meetings available to all colleagues to provide updates and feedback from the SOG along with monthly Executive Question & Answer sessions which are open forums for colleagues to ask questions and feedback.

4. Driving awareness to support Advocacy

This year as part of our staff survey corporate action plan we are exploring new ways we can support and increase feelings of advocacy across teams, with teams valuing the patient care delivered by other teams not just their own. This will include:

- Increasing direct engagement with teams through a simple 'Colleague Engagement Roadshow.' This aims to provide consistent messaging and information as well as engage and provide an opportunity for the team to ask questions. The core purpose is to help colleagues to feel inspired and re-connected with the Trust.
- Create and share 'Reasons to be proud of Lancs. Teaching' campaign to support and increase advocacy for the Trust. A key outcome will capture team stories and co-create a list of team achievements or key facts to be featured as part of our induction and wider Trust communications.

Freedom to Speak Up

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

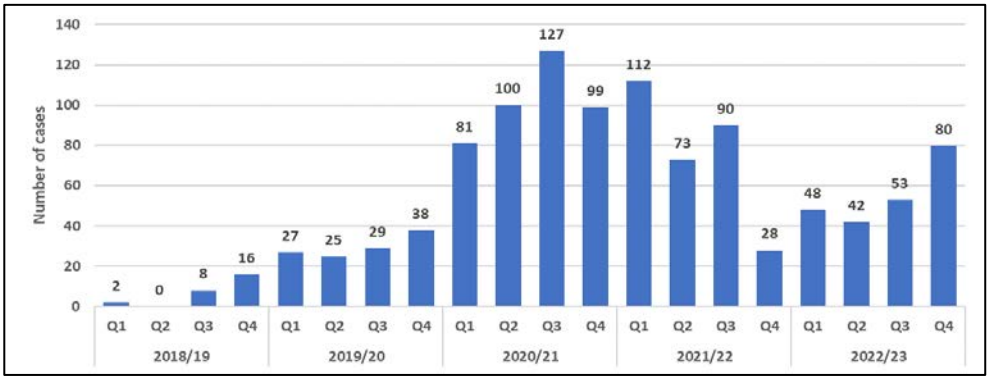
- The appointment of a Freedom to Speak Up (FTSU) Guardian.
- Establishment of Board level representation (Executive and Non-Executive Directors) for staff raising concerns.
- Establishment of Trust policy.
- Quarterly reporting of concerns and learning that comes from them.
- Inclusion of importance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

The ability to raise concerns in a safe way is essential as a contribution to the delivery of safe, effective care. The Trust recognises that this ability is also a key element towards a positive staff experience, affecting our ability to retain our staff. Our staff are encouraged to raise any concerns, including those about: patient safety and quality of care; bullying and harassment; or financial impropriety, to immediate line managers or their line manager's superior as they feel able. Where there are immediate safety concerns, staff are encouraged to report to their line manager and to record this as a patient safety incident in Datix.

Where staff feel that their concern has not been addressed, they can raise their concern with our FTSU Guardian, either directly or via the Datix Freedom to Speak Up function; a FTSU Champion; or their union representative.

In 2022 MIAA undertook a review of speaking up arrangements in the Trust and reported that there was substantial assurance with a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

Figure 6 Quarterly FTSU activity since 2018



Source: FTSU activity data/Datix

[1] Francis Enquiry 2013

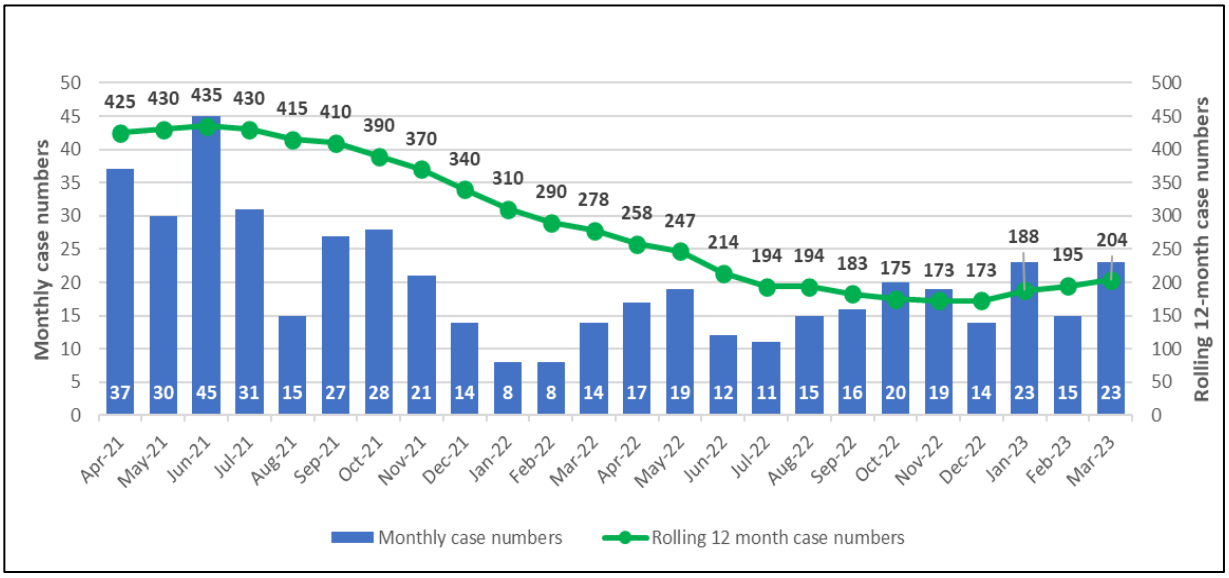
[2] Freedom to Speak Up Report 2015

During 2022-23 there were 204 contacts with the FTSU service compared with 303 in 2021-22 and 408 in 2020-21, representing a 33% reduction in activity in the previous year and a 50% reduction against 2020-21 activity. It should be noted that at the end of 2021-22, the Freedom to Speak Up service passed the enquiries function on the Trust intranet to the Communications team, but still retained responsibility for responding to concerns raised by staff. This will have undoubtedly impacted on the level of activity and the comparability of year-on-year performance.

Other variables, including organisational development activity in respect of behaviour, leadership development and culture change may have also impacted positively on the proportion of staff whose concerns were listened to by their managers.

Of the concerns raised, 68 (33.5%) involved concerns about patient and/or worker safety, and 43 (22%) reported bullying and harassment from managers (15%) and peers (7%).

Figure 7 Monthly and Rolling 12-month FTSU case numbers



Source: FTSU activity data/Datix

Whilst activity is reduced compared to last year, the rate of reduction has levelled off during 2022-23 as forecast in the previous annual report (2021-22). In that report, seven key priorities were identified to strengthen and embed Speak Up Listen Up Follow Up across the Trust:

- That the Guardian committed to maintaining his own knowledge, skills, and credibility.
- To ensure that staff are aware of arrangements for speaking up, listening up and following up.
- To promote protection for those who speak up.
- To make available training tools for leaders and for all staff that promote a speak up, listen up, follow up culture.
- To make available training tools for senior leaders that promote a speak up, listen up, follow up culture.
- To ensure that the Board of Directors and senior leaders behave in a way that encourages others to speak up.

The Freedom to Speak Up Guardian attended the National Guardian's Office Freedom to Speak Up annual conference in 2022 and has actively attended and participated in regional network meetings.

All new staff receive information about speaking up as part of their Trust induction and information about speaking up is available in the dedicated webpages on the Trust intranet. The Guardian has met with teams and individuals on many occasions both virtually and in person to raise awareness of the importance of speaking up and to managers and others in supervisory positions on the importance of listening and responding.

Fear of detriment can be a barrier to speaking up, so allowing staff the option of anonymity is a means of creating a safe environment for colleagues. Anyone raising concerns through the Datix Freedom to Speak Module has the choice of remaining anonymous or not. During 2022-23, 25 colleagues (12.3%) chose to remain anonymous. On occasion, concerns are raised where subsequent triangulated evidence supports the need for further intervention to identify themes and trends within a team/service. In such circumstances, the Organisational Development team provide opportunity and support through a range of measures to provide a confidential environment in which staff can speak safely.

During 2022-23 e-learning Freedom to Speak Up training was made available to all staff in the Trust via the Trust intranet. Completion of the core training module will be mandatory for all staff. In addition, further training is also available for those in management and supervisory positions on listening and responding.

The FTSU Guardian delivered a workshop to Executive and Non-Executive Directors in February 2023 with a focus on the promotion of speaking up, during which discussion took place around personal behaviours and how they can encourage others to speak up, when they interact with colleagues. In addition, an e-learning programme is also now available on the intranet specifically for senior leaders.

During 2023-24, the Trust will build on previous successes and ensure that:

- Trust Freedom to Speak Up policies and procedures are consistent with national guidance.
- Recruitment of Freedom to Speak Up Champions continues to ensure that support for those raising concerns is more accessible.

Arrangements are strengthened to ensure that the Trust Freedom to Speak Up strategic objectives and actions are integrated into other relevant Trust strategies, particularly those supporting an improved listening and responsive culture.

The importance of speaking up, listening, and responding to concerns continues to be promoted across the Trust and informs the provision of safe, high-quality care and treatment along with a positive staff experience.

Our FTSU Guardian will also offer support to any members of staff who suffer detriment as a direct result of raising concerns with the FTSU service. During 2022-23 no staff reported detriment because of speaking to the FTSU Guardian, but three colleagues experienced or witnessed what they considered to be detrimental behaviour attributable to speaking up in their

workplace. 12 additional staff expressed a fear of reprisal or detriment. There was no evidence that detriment was experienced by these colleagues and their anonymity was protected.

Our FTSU Guardian provides assurance to the Board that the Trust is responsive to concerns and meets regularly with our Chief Executive and Chair to share any concerns, emerging themes, and trends.

Trust policy encourages staff to seek internal resolution but also specifically tells staff who wish to raise concerns externally how they can do this in a safe way, providing contact details of organisations they can go to.

The Trust recognises that FTSU activity should not be viewed in isolation. The Trust's Raising Concerns Group meets on a quarterly basis and reviews data and intelligence from several sources including workforce and organisational development data, safety incidents, complaints, staff surveys, and safeguarding information. Areas of concern and good practice, along with themes, trends, and actions taken are reported to the Workforce Committee and to the Board of Directors. During 2022-23, the group has strengthened its contribution to the Divisional Improvement Forums where areas of concern can be explored, and assurance of learning and improvement can be obtained. The Executive Freedom to Speak Up Lead and other group members are active participants in this process.

Promote wider learning across our leadership.

We aim to ensure that external stakeholders are engaged and have access to FTSU information and intelligence. A series of actions to facilitate improvement in the areas above have been identified. Progress against these priorities will be monitored by the Raising Concerns Group and reported to the Workforce Committee and the Board of Directors. However, completion of these and other actions does not represent an end point. The Trust recognises that there is more to do to ensure that raising concerns is business as usual for all our staff, and that when they do so they can be confident that those concerns will be heard and, as appropriate, acted upon.

PART 3

Review of Quality Performance – Patient Safety

The Trust considers the safety of patients to be our principal priority. To ensure the organisation is a safe place to receive care and treatment, the Trust monitors performance against certain factors and continually aims to reduce and eliminate patient harm where possible. In 2021-22 the Trust responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals' Always Safety Firs*t* programme. During 2022-23 this has continued to be led by the Chief Nursing Officer and Chief Medical Officer and supported by the Governance, Nursing and Continuous Improvement teams. The programme promotes staff to always consider safety across the organisation and has involved lay representatives from the community to support the programme to provide opportunities to share their ideas. This section of the Quality Account presents indicators relating to patient safety, clinical effectiveness and patient experience as outlined below.

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

The Patient Safety Incident Response Framework

In March 2020, NHSE and NHSI published PSIRF. This framework is being implemented through a phased approach with several nationally appointed 'early adopter' Trusts and commissioners working to implement it, with wider implementation across the NHS planned. During 2022-23 the Trust commenced the transition to PSIRF with full transition to PSIRF mandated by Autumn 2023.

The PSIRF sets out significant changes to the approach taken by the NHS in response to patient safety incidents. This reflects the fact that the current system is frequently a reactive process where opportunities to reduce recurrence of harm are often missed. The new approach is intended to address these by refocusing systems, processes, and behaviours to improve the quality of investigations and deliver a sustained reduction in risk. A change in approach to incident management, the new framework sets out a broader, more proactive, and risk-based approach.

PSIRF provides guidance for organisations on how to respond to patient safety incidents, defined as *"unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare."* Some incidents will qualify for a Patient Safety Incident Investigation (PSII), but it is recognised that there may be other alternative proportionate responses (e.g., 'being open' conversations; after action review; and audit) as well as some incidents where 'do not investigate' or 'no response required' will be appropriate. The selection of incidents to be investigated as PSIIs will be based on the opportunity for learning and need to cover a range of incident outcomes. most significant risks. However, there are incident categories for which a PSII is nationally mandated and these include maternity and neonatal incidents which meet the 'Each Baby Counts' and maternal criteria and which must be referred to Health Service Investigation Branch (HSIB); and child death, incidents which meet the Never Events and Learning from Deaths criteria and any locally defined incidents requiring local PSII for example emergent incidents which justify a heightened level of response because the consequences are so significant and potential for learning so great.

The Trust has a nominated lead and an implantation group charged with oversight and delivery of the PSIRF implementation group. Reporting on progress with implementation of the PSIRF is provided internally to the Trust Safety and Quality Committee and externally to the Lancashire and South Cumbria Integrated Care Board (ICB) Patient Safety Incident Response Framework Implementation Working Group.

Safety Triangulation Accreditation Review (STAR)

The Trust designed the STAR Quality Assurance Framework in 2017 with Trust teams to provide an evidence base to demonstrate the standard of care delivery, identify what works well and where further improvements are required. STAR is broken down into two aspects:

- STAR Monthly Reviews – 17 audit questions are undertaken by the Matron or professional lead for each area.

- STAR Accreditation Visits – an in-depth CQC-style audit is undertaken by the Quality

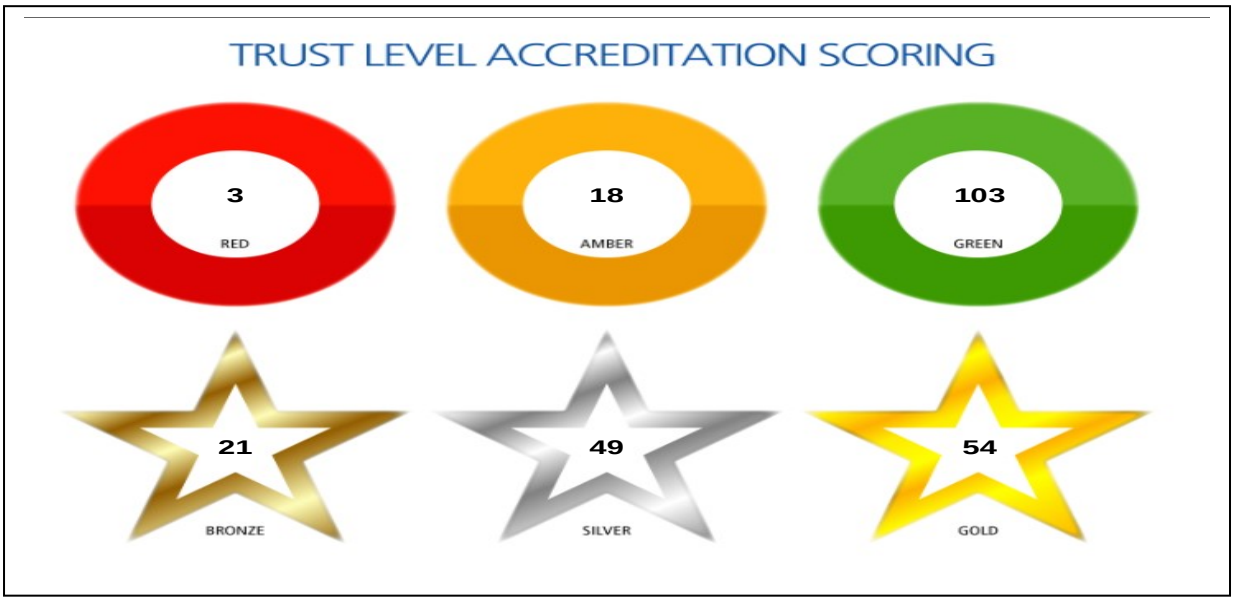
Assurance Team with support from staff, governors, and volunteers from across the Trust.

In 2022-23 there were 126 clinical areas registered for the STAR Quality Assurance Framework. Participants in this safety programme undertake monthly peer review audits using the Trust audit system AMaT. The system hosts the actions required for improvement which are monitored by the ward Matron or professional lead. A performance dashboard is also made available on the Trust Business Intelligence (BI) portal.

STAR visits result in a red, amber, or green score depending on the level of assurance gained and the outcome of the visit will determine the revisit frequency.

Up to the end of March 2023 a total of 124 areas had STAR visits completed and there are two new areas awaiting their first STAR visit. These have resulted in the following scores:

Figure 8 STAR Accreditation Scores



Source: LTHTR data

The Trust currently has 103 areas achieving a Silver star or Gold star status equating to 82% which achieves our target in Our Big Plan of 75% of areas achieving Silver or above by the end of March 2022.

In order to achieve a Gold star-rating our clinical areas must demonstrate consistently that they have met all the standards set for their staff and patients. This means that the team have worked together to:

- Achieve 3 green rated STAR accreditation visits.
- Leaders have supported a peer ward or department to achieve an improvement in their rating.
- There is evidence that staff, learner, and patient feedback is consistently responded to.
- Evidence of high standards of audit practice and environmental cleanliness.
- Evidence that these criteria have been met is to be presented to a panel which would comprise senior nurses, midwives, and allied health professionals. The Trust currently has

54 clinical areas which have successfully maintained three consecutive Silver stars and have progressed onto a Gold star.

Gold award celebrations were held in October 2022, and May and June 2023, supported by our Chief Executive, Chair, governors, Chief Nursing Officer and Deputy Director of Nursing, Midwifery and AHPs along with the Divisional Nurse, Midwifery and AHP Directors. The Gold teams presented virtually on their progression to achieving the Gold star, with many sharing very honest, inspirational stories. Key themes from the progression of the teams related to:

- Leadership and teamwork.
- Sharing and learning from each other.
- Networking and collaboration with others.
- Listening to staff and patients.

Our Gold star teams all showed determination and commitment to act upon feedback and drive improvement to ensure the best possible care for our patients. There are currently 20 areas achieving two consecutive green scores, who currently have silver stars potentially progressing onto a third consecutive green on their next visit and therefore potentially a further 23 Gold stars.

15-Step Challenge

As part of the STAR accreditation visit the 15-step challenge is undertaken by a member of the visit team, and there is usually a governor or volunteer who is not familiar with the clinical environment. The 15-step challenge is based on first impressions on entering the clinical environment and how confident the assessor is that the ward or department supports good care, in particular, that the area is:

- Welcoming
- Safe
- Caring and involved
- Well-organised and calm
- Well-led

Areas are given a scoring based on the following:

- A = Very confident
- B = Confident
- C = Not very confident
- D = Not confident at all

If a C or D rating is given for the 15 steps the relevant Matron or professional lead will be responsible for liaising directly with the ward or department manager and the Divisional Nursing or AHP Director to ensure immediate action on the areas of concern and implement recommendations in the report.

Table 17 15-Step Challenge Results

	A Very confident	B Confident	C Not very confident	D Not confident at all	N/A
Trust Overall	79	42	2	0	1

Source: LTHTR data

The STAR Quality Assurance Framework is being continually reviewed and improved to ensure the delivery of a robust and supportive framework. There is ongoing review of the STAR Quality Assurance Framework in order to deliver an effective, dynamic and robust quality assurance framework.

Following phase 5 review in January 2022, some additional changes were made following the CQC inspection. effective from June 2022. Phase 6 review updated the STAR Monthly Reviews effective from February 2023.

Our STAR accreditation visits are unannounced and conducted over a longer period of time to capture handovers and safety huddles. Feedback is mainly delivered virtually to the divisional teams, ensuring the Trust is responsive and able to apply any immediate supportive measures and can cascade for a wider response if required. There is ongoing reflection and evaluation of the impact of these changes, with lots of positive feedback received to date.

STAR learning including themes, trends and actions are discussed via the divisional Always Safety First meetings. STAR is reported via the Always Safety First Group, Safety and Quality Committee and Board reports, and through the Nursing, Midwifery and Allied Health Professionals Board.

Falls Prevention

Falls prevention continues to be one of our key priorities for improvement and Our Big Plan target is to achieve a year on year 5% reduction in falls.

Falls and falls-related injuries are a common and serious problem for people aged 65 and over with 30% of people older than 65 and 50% of people older than 80 falling at least once a year (NICE, 2013). Falls prevention is a complex challenge due to the large array of influencing factors requiring multifactorial patient assessments and implementation of individualised falls prevention measures. Increased age and frailty, history of falls and cognitive impairment significantly increase the risk of falling and risk of harm from falls.

Falls are one of the most commonly reported incidents affecting inpatients. Although most falls result in no harm or low harm, the consequences to the patient and their relatives/carers can be considerable. The impact may appear minimal; however, the patient can suffer pain, distress, loss of mobility and independence, depression, psychological distress or anxiety, and loss of confidence leading to social isolation. Falls can result in moderate or severe levels of harm including fractures, cerebral haemorrhage, and even result in death. Hip fractures within a hospital setting are associated with poorer outcomes including an increase in mortality.

The risk of having an increased level of injury or harm from a fall is difficult to predict but there are a number of known risk factors such as increased age, frailty, osteoporosis, bone metastases, blood clotting disorders, multiple co-morbidities and medications such as anti-coagulants.

Over the past nine years the Trust has implemented several falls prevention initiatives as part of the ongoing falls improvement project work. In this reporting period improvements have included development of a Falls Prevention Big Room using the continuous improvement methodology, developed through the Flow Coaching Academy and Falls Prevention Champion role for teams to drive improvements in falls prevention within the Divisions. Other falls prevention improvement actions have included:

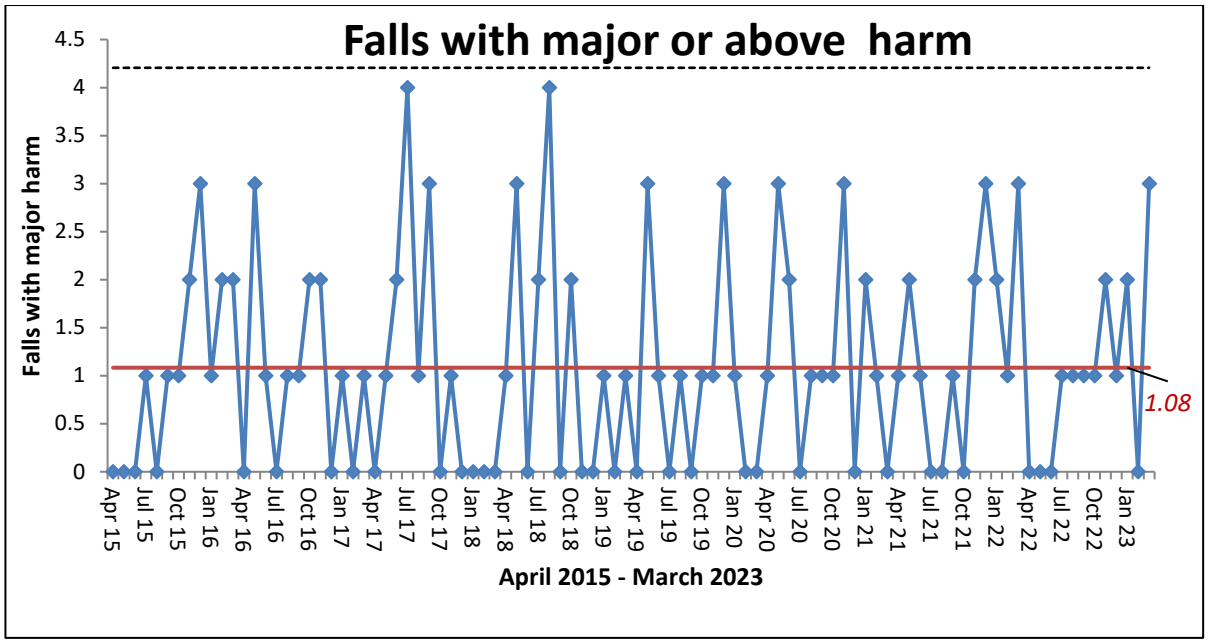
- Continuous development and cascade of a Safety Surveillance System and digital whiteboards for wards to highlight key safety concerns such as falls risk and highlight real-time compliance with risk assessments. These can be used during handovers and huddles.
- Continuation with the Royal College of Physicians (RCP) National audit of inpatient falls, an ongoing action plan which includes medications reviews, visual assessments, and the provision of mobility aids.
- Learning from falls and falls with severe harm is discussed at Divisional Governance and Always Safety First meetings and at the Safety and Learning Group.
- Falls risk assessments, moving and handling assessments, bedrails assessments and falls prevention care plans are being reviewed as part of risk assessment and care plan improvement work in collaboration with the Chief Nursing Information Officer, Digital Change team and our Continuous Improvement team.
- Reviewing of falls with severe or above harm at the Serious Incident (SI) panel quarterly at the ICB highlighting learning, themes and trends, and learning from HM Coroner Inquests.
- Compliance with NICE guidance and (NICE CG 161) and quality standards (QS86).

Future improvement plans include:

- Improvement in patient information and evidencing discussions with patient about how to prevent falls.
- Updating the falls prevention e-learning package.
- Further development of the Falls Prevention Big Room.

Falls prevention remains one of our key priorities. The end of year falls statistics demonstrate an increase in the overall number of inpatient falls. The total number of falls with major and above harm (severe, death) was reduced); there were 12 inpatient falls resulting in major or above harm.

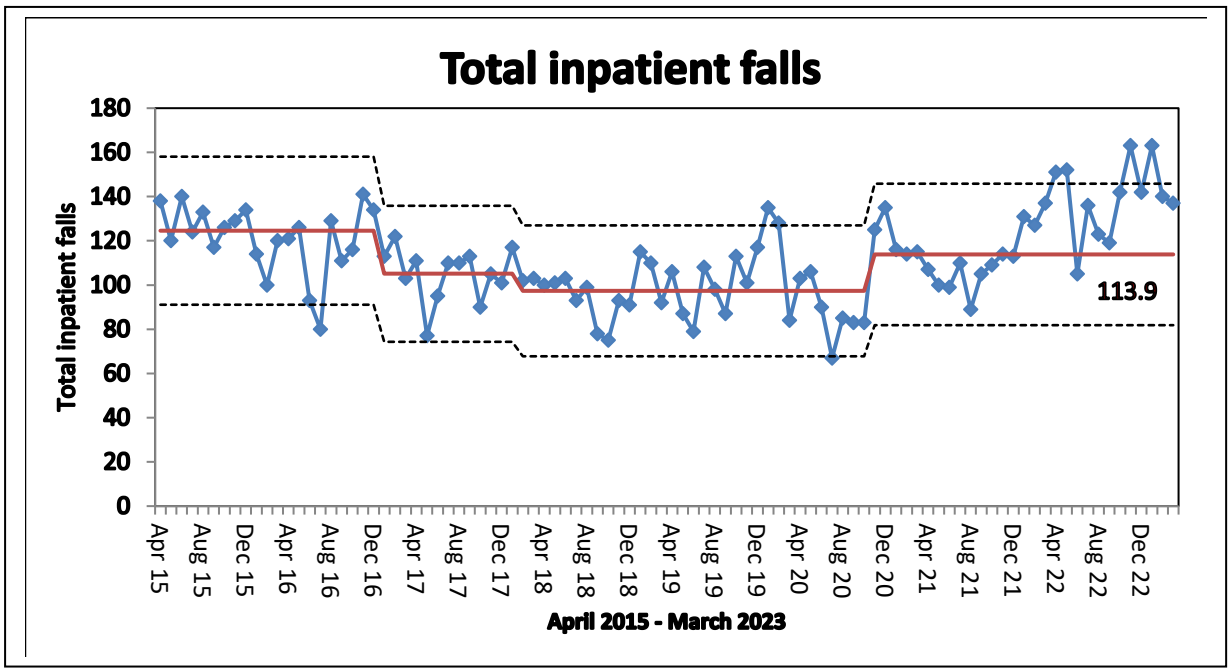
Figure 9 Total Inpatient Falls with Major or Above Harm – April 2015 to March 2023



Source: LTHTR data

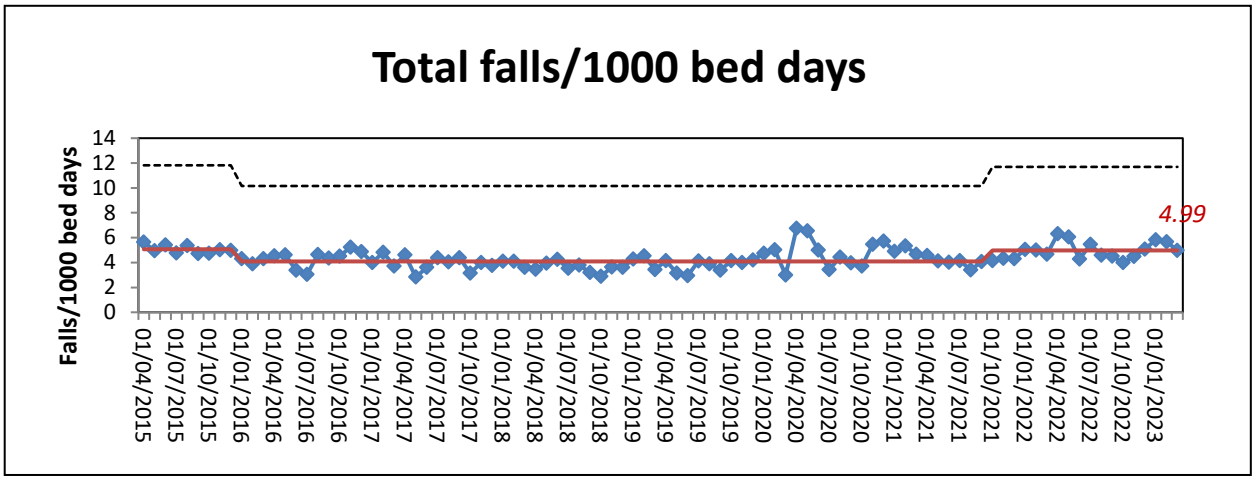
The total falls data since April 2015 is presented in Figure 10. Since 2021-22 there has been a 19% increase in the number of inpatient falls with 1,341 inpatient falls during 2021-22 increased to 1,590 inpatient falls in 2022-23.

Figure 10 Total Inpatient Falls – April 2015 to March 2023



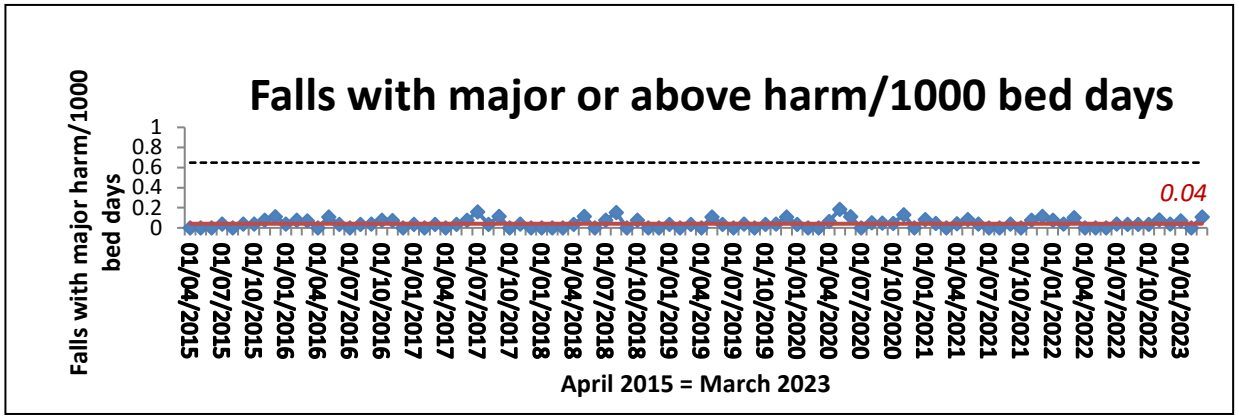
Source: LTHTR data

Figure 11 Total Inpatient Falls/1,000 bed days – April 2015 to March 2023



Source: LTHTR data

Figure 12 Falls with major or above harm/1,000 bed days



Source: LTHTR data

The Trust's Our Big Plan falls prevention target for 2022-23 was to achieve a year on year 5% reduction in inpatient falls. This was not achieved during 2022-23, there was an increase of 249 falls compared to the previous year which is an increase of 19% for inpatient falls. It is noteworthy that there has been a substantial increase in our bed-base and inpatient capacity, bed occupancy and acuity during this 12-month period. The falls per 1,000 bed days demonstrates normal variation. The Trust is still facing the pressures of the COVID-19 pandemic. There has remained a notable increase in the frailty and dependency of many inpatients. Reduced staffing levels due to sickness and isolation requirements and decrease in patient flow and capacity has further impacted upon the organisation as demonstrated by the continued major incident status.

We continue to prioritise falls prevention as part of our Always Safety First Strategy. The annual falls report and action plan is shared among the divisions alongside Falls Prevention Champions' training to strengthen knowledge and awareness of falls prevention strategies and support ongoing improvements within clinical teams. The development of a new Falls Prevention Improvement Forum Big Room in collaboration with multidisciplinary colleagues using continuous improvement methodology commenced during February 2023 is very promising as a catalyst for future falls prevention improvements.

Safeguarding

Lancashire Safeguarding Adult Board and Children's Safeguarding Assurance Partnership

The Trust is well represented across the local safeguarding partnership arrangements including at Executive and senior operational level via the Chief Nursing Officer and Head of Safeguarding currently recruiting for the post. The Trust is fully sighted and actively involved in the safeguarding agenda and Board priorities for Lancashire and South Cumbria, the Board priorities are linked to the activities undertaken within the safeguarding team annual work plan. In addition, the named professionals and safeguarding team are active members on several subgroups to the Lancashire Safeguarding Adults Board (LSAB) and Children's Safeguarding Assurance Partnership (CSAP). These include:

- Lancashire and South Cumbria ICS Safeguarding Health Executive Group.
- ICS Safeguarding System Leaders Business meeting.
- Children's Health Connectivity Group.
- Lancashire Contextual Safeguarding Operational Group.
- Lancashire Neglect Operational Group.
- Neglect Task and Finish Group.
- LSAB Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) Implementation Group.
- LSAB Quality Assurance, Audit and Performance Group (put on hold).
- LSAB Safeguarding Adult Review Group.
- Pan-Lancashire Child Death Overview Panel (CDOP) Case Discussion meeting.
- Pan-Lancashire Sudden Unexpected Death in Childhood (SUDC) Prevention Group.
- ICON Men's Steering Group.
- North-West ICON meetings.
- Pan-Lancashire Domestic Abuse Steering Group.
- Lancashire Domestic Abuse Forum.
- Lancashire & South Cumbria Trauma-Informed Training Education Network.
- Safeguarding Adult Board Voice/Making Safeguarding Personal Sub-Group.
- Self-Neglect Task and Finish Group.
- MCA Task and Finish Group.
- MCA Regional Network Meeting.

Safeguarding Audit Activity

The annual safeguarding audit activity is directed by the local Safeguarding Board priorities, CQC 'must do's and should do's,' All-Age Section 11 Children Act (1989, 2004) and Care Act (2014) Compliance Audit, CCG Safeguarding Standards Audit and local and national safeguarding practice reviews. Audit activity for 2022-23 includes:

- Trust-wide audit of domestic abuse knowledge amongst staff and management of incidents.
- Trust-wide themes and trends audit relating to safeguarding incident management and

Section 42 enquiries.

- Trust-wide audit of MCA and DoLS, Least Restrictive Practice and Enhanced Levels of Care knowledge amongst staff and monthly compliance of application.
- Monthly audit in Adult ED (16–17-year-olds), Children's ED and Paediatric Assessment Unit in completion of the children's safeguarding checklist.
- Paediatric Assessment Unit (PAU) safeguarding recognition and referral assurance audit.
- Monthly audit of completion of children's safeguarding checklist in MAU and Surgical Assessment Unit (SAU).
- Maternity Perinatal Mental Health audit regarding routine enquiry and compliance with NICE.
- Maternity domestic abuse audit regarding routine enquiry and compliance with NICE Guidance.
- FGM Audit.
- Substance/Misuse/alcohol in pregnancy audit.
- Safer Sleep.

Lessons Learnt from Safeguarding Audit Activity

- Trust-wide audit of domestic abuse demonstrated good overall understanding of recognising and responding to victims and their families. Child safeguarding procedures demonstrated 100% compliance giving strong assurance that the 'think family' message is embedded in practice.
- Trust-wide audit activity showed positive results in relation to staff knowledge of MCA and DoLS. This includes improvements in the quantity and quality of MCA and DoLS applications, giving strong assurance the patient's human rights are protected whilst in our care.
- Good overall assurance is noted within the annual incident management and Section 42 enquiries themes and trends audit. Areas highlighted for growth include adverse discharges, compliance of nursing risk assessments and care planning to support patient care.
- Findings from the audit have been cascaded into the Trust's Always Safety-First Discharge Programme.
- Female Genital Mutilation (FGM) Audit provided significant assurance that staff were asking routine enquiry into FGM in pregnancy and following the recommendations in the FGM Guideline.
- Good assurance that routine enquiry into domestic abuse during pregnancy is being undertaken. The implementation of BadgerNet will again increase compliance.
- A Safer Sleep audit was completed which showed significant assurance that maternity staff were completing the safer sleep assessment tool in accordance with the Safer Sleep Guidance for Children in Blackburn with Darwen, Blackpool and Lancashire.
- Mental health looked at the compliance of midwives asking the Whooley questions at booking and enquiring about mental health during pregnancy. This provided significant assurance of compliance.
- Routine enquiry regarding domestic abuse in pregnancy provided significant assurance that routine enquiry is being completed in pregnancy.
- The PAU audit on recognition of safeguarding and referrals was positive and showed a good level of assurance that safeguarding cases were being identified and acted upon.

Audit to be repeated in 2024.

- Monthly audits of the safeguarding checklist across ED, Adult ED and PAU have been variable, but with improvements over the past quarter particularly for ED (compliance rate of 100%) and PAU (compliance rate of 90-100%).

Safeguarding Adults - Activity for 2022-23 includes.

- Following a period of change the Adult Safeguarding Team is now at a full complement of staff, following the recruitment to the Named Nurse for Safeguarding Adults and the Specialist Safeguarding Practitioner posts. In addition, the recruitment of a Named professional for MCA/ DoLS has been completed and is now in post.
- A review of the workstream previously known as the Multi-Agency Safeguarding Hub (MASH) pilot is underway, following the restructure within the Local Authority. Dialogue is taking place between the Safeguarding Team, the Governance Teams within each Division and partners within the Local Authority, to ensure that all safeguarding alerts received against the Trust are logged, investigated and reported back in a comprehensive and timely manner.
- Strengthened Datix redesign to facilitate and reflect the requests and restructure within the Local Authority, and to ensure that accountability remains within the Divisions and themes and trends are identified and learning disseminated Trust-wide where appropriate.
- Strengthened digital developments through ward whiteboards and Flex has been implemented to support vigilance/compliance and monitoring of patients with Safeguarding/MCA/DoLS vulnerabilities.
- A request has been circulated to all adult patient-facing areas to confirm names of Safeguarding Champions, with a view of restarting quarterly champion events. These will be all age safeguarding events sharing important safeguarding messages and local and national themes and trends.
- Themes and trends analysis of safeguarding concerns/incidents internally recognised and externally identified on admission shared with relevant partner agencies to enable public health economy analysis.
- The Adult Safeguarding team play an active role in the Lancashire Safeguarding Adult Board and its sub-groups.
- Bespoke MCA/DoLS training on request and in areas where a need is identified.
- This has included the delivery of training to staff who predominantly work nightshifts and are unavailable for additional daytime training.
- Increased visibility of the Safeguarding team within high acuity areas across the Trust.
- Development and implementation of bespoke safeguarding supervision for high acuity departments.

Adults & Children's Safeguarding Training Compliance

At the end of March 2023 training compliance was greater than the Trust target of 90% for all levels of safeguarding training.

Our Trust-wide Adult Safeguarding Level 1, 2 and 3 and Prevent training compliance over the past 12 months has achieved the 90% compliance target all areas. The training packages and Training Needs Analysis are in accordance with the requirements of the Royal College of Nursing (RCN) Adult Safeguarding: Roles and Competencies for Health Care Staff (2018). Prevent returns are submitted quarterly and consistently pass the standards set by the Home Office. Each Division reports on Safeguarding training through the monthly Trust Safeguarding Board, hotspots of low compliance are identified, and action plans put in place by the Division.

Child safeguarding training compliance continues to remain above 90% for level 1-3 training. This training is available as e-learning packages to enable staff to continue to access their essential child safeguarding training. In addition, safeguarding supervision is embedded within ED, Ward 8, PAU, Neonatal Intensive Care Unit (NICU), Specialist Community Services and hospital-based services including paediatric physiotherapy and audiology. This enables staff to discuss current cases and those in retrospect to support learning and identify any changes or training needs.

Safeguarding Children

Our Child Safeguarding team are visible within Paediatrics, Neonates and the ED and the Trust utilises its BI system to gain an oversight of all children aged 16-17 who have been admitted to an adult ward. The team operates a safeguarding duty system whereby one of the safeguarding practitioners is available to support staff with a wide range of child safeguarding concerns. A child safeguarding risk assessment is undertaken for every child who attends an assessment area. This includes ED, PAU, MAU and SAU. The National Child Protection Information Sharing system (CP-IS) is also used in unscheduled care settings to provide assurance that children on Child Protection Plans or who are Looked After by the Local Authority are identified and appropriately safeguarding.

During 2022-23 the Safeguarding team received between 54-85 child safeguarding enquires each month from across the Trust. The Trust made between 8-21 referrals per month to Children's Social Care over the past year. The number of enquires and referrals fluctuates each month. The majority of referrals to Children's Social Care come under the category of neglect with 74 referrals this year, and emotional abuse with 52 referral this year. Our team have close links with the local MASH and wider safeguarding system partners including the local CSAP.

Following lessons learned from local and national Child Safeguarding Practice Reviews and child deaths, the Trust has again this year been involved in promoting the ICON messages with parents including the creation of a video for Healthier Lancashire and South Cumbria's Better Births. This video has been shared with partner agencies over the past year.

This work will help to ensure that the Trust embeds lessons learnt following serious incidents by increasing staff knowledge and confidence in providing parents with Safer Sleep and how to cope with crying baby messages. This supports the aim to reduce the number of child deaths and traumatic head injuries in young babies. The ICON message and safer sleep risk assessment tool has been shared Trust-wide with various departments involved, in ensuring the safer sleep messages with families are embedded in practice.

Maternity Safeguarding

Improvements include:

- Membership of the National Maternity Safeguarding network with NHSE, providing a national voice for safeguarding midwives working for or on behalf of maternity service providers.
- Participation in the production of Safer Sleep message videos following publication of national guidance regarding the increased risk of babies/children sleeping 'out of routine.'
- Fortnightly allocations meeting with Children's Social Care (CSC) managers are now embedded.
- Development of an e-learning package for ICON. Training package shared with partner agencies across Lancashire. We represent the Trust at the ICON Lancashire-wide meeting and Engaging Men Steering Group.
- Review of the Perinatal Mental Health Pathway is underway in collaboration with the North West Coast Strategic Clinical Network.
- Specialist Perinatal Community Mental Health (SPCMHT) Multi-Disciplinary meeting now embedded within Maternity.
- Relaunch of the Inspire Partnership Clinic with Maternity.
- Specialist midwife for perinatal mental health is seconded to the Reproductive Trauma Service 2 days a week.
- Participation in a two-year national research project Born into Care which aims to improve professional practice when the Local Authority intervenes in the lives of new-born babies. Following on from this HOPE Boxes were developed and our Trust has been a pilot for the HOPE Box. These are designed to minimise the trauma experienced by parents and baby when babies are removed from their care.

Safeguarding/Mental Health Operational Groups Adult and Child

The Children's Safeguarding/Mental Health Operational Groups are held on a monthly basis reporting directly to the Trust Safeguarding Board via a chair's report. The Children's Safeguarding/Mental Health Operational Groups include representation at a senior level across all divisions and undertake the operational business of the safeguarding/mental health agenda ensuring divisional Matrons and safeguarding leads work together to make improvements and

share this agenda. The operational groups ensure delivery of key messages from the wider safeguarding/mental health partnership system and establish divisional ownership to improve practice in relation to both local and national safeguarding practice reviews and developments in safeguarding/mental health policies/procedures including the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Treat as One for both adult and child.

A mental health risk assessment audit is completed on a monthly basis. This comprises a cross section of 50 patients through age and location within the Trust. This enables assurance to the Board and highlights areas requiring improvement and those areas promoting best practice. A mental health training report is received monthly and presented to the Safeguarding Board.

Maternity Safety

Maternity staffing metrics are displayed on the maternity specific safety and quality matrix each month. The metrics collated triangulates with workforce information with safety, experience and effectiveness measures in order to provide a holistic overview of maternity services. The maternity matrix is reviewed at the maternity Safety and Quality Committee on a monthly basis with any concerns escalated through the divisional Safety and Quality Committee. The matrix is also detailed in the monthly report submitted to the Trust Safety and Quality Committee.

The matrix reflects increased compliance with Practical Obstetric Multi-Professional Training (PROMPT) since September 2022 and Cardiotocograph (CTG) competency training since May 2022. The additional training compliance is captured in the monthly divisional training report to the maternity Safety and Quality Committee.

The home birth rate has been consistently above the national average of 2% for over twelve months and above the regional mean rate, this positively reflects the continuation of the continuity model.

Key performance related to booking by 9+6 weeks gestation has been below the expected target range since October 2021. SPC data shows a recovering position. Performance continues to be closely monitored by the operational team and the digital maternity team. As of April 2023, the service anticipates significant improvement with this key performance indicator.

The maternity stillbirth rate is monitored by the maternity Safety and Quality Committee. At this time, the mean stillbirth rate is below the national average.

The service declared compliance with all ten Clinical Negligence Schemes for Trusts (CNST) safety indicators for year four and this was validated by the Local Maternity Neonatal System (LMNS) prior to submission.

Incidents and Never Events

Incidents

Our incident data has been presented in section 2 of this report with a rationale for the data and actions taken and planned. The levels of harm from incidents in 2022-23 are presented below.

Table 18 Level of Harm Related to Incidents 2022-23

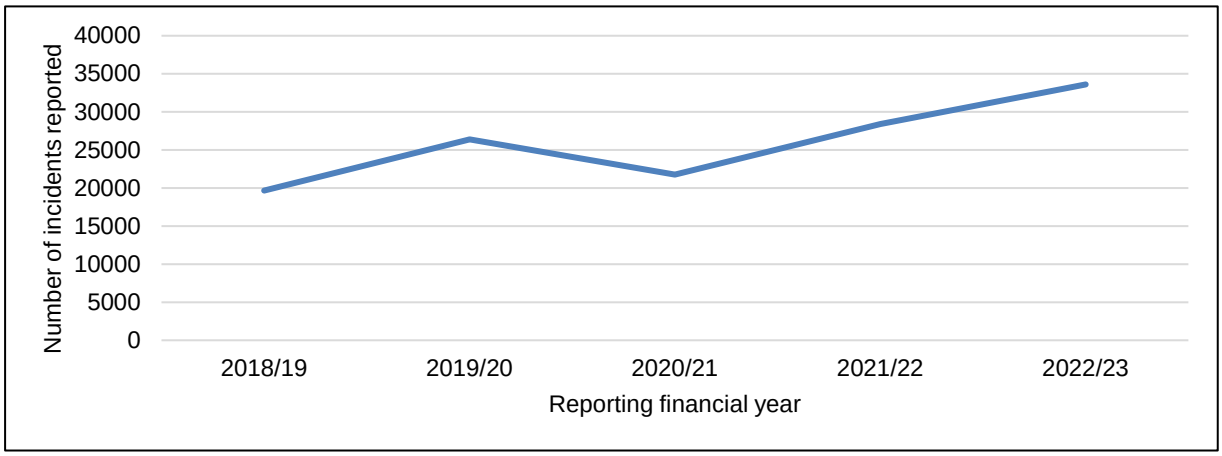
Level of Harm	Number of Incidents Reported
No Harm	23, 910
Low Harm	8, 227
Moderate Harm	1, 330
Severe Harm	112
Death	24
Total	**33,603**

Source: LTHTR Datix data

Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. In order to promote and develop our culture of incident reporting the Trust continues to improve education regarding the reporting of incidents and near misses, the importance of reporting and the learning the Trust obtains from incident reporting. More detailed education around the importance of incident reporting and how to report an incident have been included in the Trust's induction programme, along with the Trust's annual training which all staff must complete. The Trust has also continued to make further improvements to our reporting system Datix to make it easier to report appropriate information in a timely manner. Governance and incident dashboards are in use across our organisation to embed incident reporting and analysis. The Trust has also continued to link our incident analysis to our risk register to promote our Risk Maturity programme of work in line with Our Big Plan.

Our incident reporting has over successive years continued to improve which is demonstrated in figure 13 below.

Figure 13 Incidents Reported 2018-2023



Source: LTHTR Datix data

In 2021-22 the number of incidents reported shows a significant increase, correlating with the recovery of hospital activity but also accounting for the significant number of hospital-acquired COVID-19 infection incidents reported and a significant number of delayed diagnosis and treatment incidents as a result of the COVID-19 pandemic. This upward trajectory continues through 2022-23.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes and can damage patients' confidence and trust.

During 2022-23 the Trust reported two Never Events, one in Quarter 3 (Wrong site surgery) and one in Quarter 4 (Unintentional connection of a patient requiring oxygen to an air flowmeter).

All Never Events are subject to a serious incident review and reported to the local ICB as well as nationally to StEIS and the National Reporting and Learning System (NRLS). Learning from both systems is shared nationally. Both never events in the reporting period 2022-23 have undergone full investigation and action plans have been developed and are either complete or being monitored.

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

Duty of Candour

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

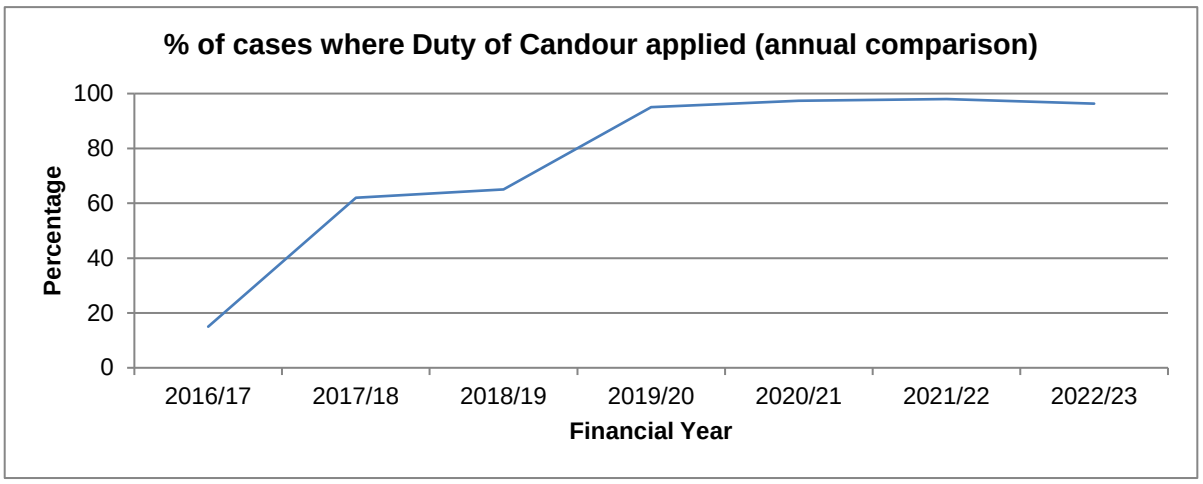
The investigation of incidents where actual or potential for harm has occurred, is carried out within a culture of openness and transparency with an absolute commitment to explaining and apologising to patients who have suffered harm. This is a key aspect of us delivering excellent care with compassion. The Trust monitors compliance with Duty of Candour on a weekly basis through the Safety and Learning Group.

In the year 2022-23 the Trust identified 1,217 cases where Duty of Candour was applicable. This is an increase in cases since the previous financial year but is still much higher than historic financial years due to hospital-acquired COVID-19 cases which have required Duty of Candour. Of the 1,217 cases where Duty of Candour was applicable, 392 of them were probable or definite hospital-acquired COVID-19 cases. Of those 1,217 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 1,172 occasions (96.3%).

The remaining 45 cases (3.7%) have documented validated reasons as to why Duty of Candour has not been carried out. Reasons for Duty of Candour not being applied relate to:

- No known address of the patient or appropriate person.
- Patient is too acutely unwell to receive the letter but will be delivered once the condition improves.
- Patient or appropriate person is untraceable.

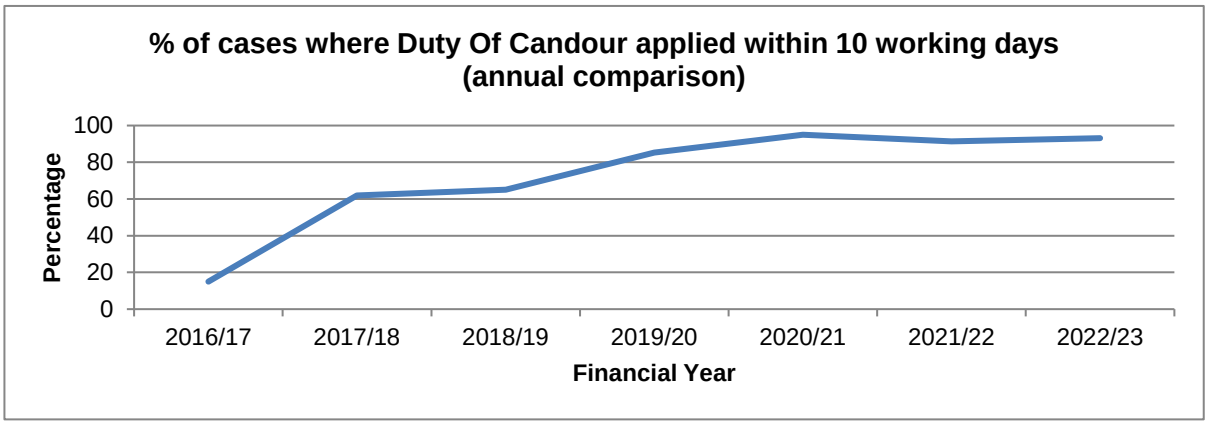
Figure 14 Percentage of Cases with Duty Of Candour Applied (Annual Comparison)



Source: LTHTR Datix data

Of the 1,172 occasions where Duty of Candour has been undertaken, 1,093 cases (93.2%) were achieved either verbally or in writing within 10 working days of the incident being reported. This is an increase compared to 2021-22 where 91.3% of cases had Duty of Candour carried out within 10 working days of the incident being reported.

Figure 15 Percentage of Cases with Duty Of Candour Applied in 10 Working Days



Source: LTHTR Datix data

Figure 15 demonstrates a strong trend of improvement over the last 6 years regarding timely application of Duty of Candour and provides further assurance that the application of Duty of Candour is embedded in our culture and practice. There was a slight decrease in compliance with application of Duty of Candour within 10 working days in 2021-22 due to pressure from the COVID-19 pandemic however this is being recovered into 2022-23.

A Learning Organisation

Incidents

The Trust continues its commitment to being a learning organisation and a Safety and Learning Group meets weekly, chaired by the Associate Director of Safety and Learning. The group provides an assurance process which includes evidence of completed actions and, where indicated, evidence that actions are developed and embedded over time and shared across the organisation and are leading to the reduction of risk. This includes the commissioning of Always Safety First Working Groups in response to incidents where complex organisational learning and improvements are needed. These groups will be commissioned by the Patient Safety Specialists. The group has adopted a safety 1 and safety 2 approach. Always Safety First bulletins are produced further enhancing the open approach to learning.

Review of Quality Performance - Effective Care

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

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

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

Getting it Right First Time

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

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

The GIRFT visits to the Trust commenced in 2016, completing 43 visits across 32 specialties, 11 of which were revisits. A further four specialties have been identified and await review

dates. These include anaesthetics and perioperative medicine, oncology, paediatric medicine, and diabetes. Learning from the pandemic, GIRFT has now transitioned to a Regional Gateway Review, to facilitate a systems approach to improving patient care and experience, providing opportunities to develop pathways. To enhance this approach, in January 2023, a Lancashire and South Cumbria GIRFT Oversight Group was set up to enable access to a wider network of support and shared learning.

The Trust has developed an improved Governance structure around GIRFT to support Divisional oversight and re-establish GIRFT into safety and quality forums. This includes embedding a Trust-wide monitoring process. A collaborative approach has been adopted to support specialities in the identification of their top five high impact actions to optimise outcomes. These will align to safety and quality, productivity, and finance in keeping with the Trust's key priority areas. The Model Hospital System and GIRFT best practice guidance will also be used to identify opportunities and areas for improvement. GIRFT actions will be linked to the relevant cost and quality improvement workstreams within the Trust, where these are already established.

Tissue Viability – Pressure Ulcer Incidence and Prevention

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

The root cause of pressure ulcers is multifactorial including having reliable robust systems and processes to ensure care is implemented effectively, enabling timely risk assessment, skin assessment and repositioning. The multiple factors for the development of the pressure ulcers require a multidisciplinary approach for improvement.

We have an established programme of prevention and management of pressure ulceration, which includes training, education, clinical advice, and support for clinical teams facilitated by the Tissue Viability Nurses (TVNs).

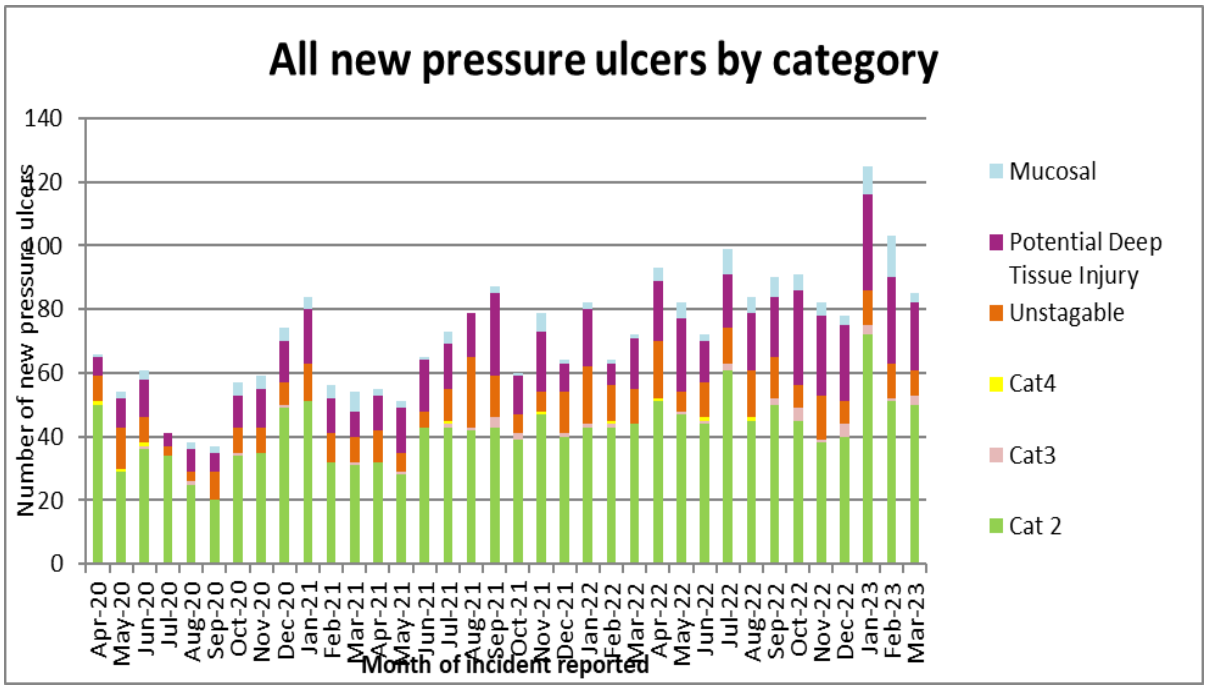
Education and audit of pressure relieving equipment is another key role of the TVNs, supported by the Medstrom clinical nurse advisor. Education has resulted in improved recognition of patients who need pressure relieving equipment and the selection available for use. The effective utilisation, management and education of the pressure relieving surfaces is vital for both preventing and treating new hospital-acquired pressure ulcers and also the effective care for the most vulnerable patients who are admitted with pressure ulcers.

Restoration and recovery from the COVID-19 pandemic has begun, the pandemic had a significant impact upon the organisation from reduced staff availability, patient flow, reduced fill rates, redeployment and challenges of infection prevention and control procedures. All these factors also impacted on the potential for pressure ulcer development.

Pressure Ulcers

The Trust acknowledges that there has been an increase in the overall number of patients with pressure ulcers since 2018. The reason for this is multifaceted which includes the complexity and frailty of patients, increase in the number of patients admitted to hospital and the increased bed capacity of the hospital. When monitoring pressure ulcers within the Trust it is important to correlate the numbers of incidents that have occurred with the Trust activity in bed days. This is done by analysing pressure ulcer incidents per 1,000 bed days allowing for that comparison of incidents and Trust activity. The bar chart below in Figure 16 highlights the category of harm.

Figure 16 New Pressure Ulcers by Category April 2020 – March 2023



Source: LTHTR data

Medical Device Related Pressure Ulcers

Medical device related pressure ulcers are clearly identified within our incident reporting as outlined in NHSI guidance (2018). This promotes clearer visibility of these types of pressure ulcer and enables further targeted pressure ulcer prevention improvement actions. The key to preventing these pressure ulcers is careful skin assessment under and around any medical devices.

The 'Essentials of Care' chart was rolled out in all adult inpatient areas in December 2021. This document contains clear sections to be completed every shift to support skin inspections, including under medical devices. Further improvements have been made within adult inpatient areas in the recognition of patients who have a Plaster of Paris (POP) to identify these devices as high risk.

Table 19 Device Related Pressure Ulcers

Trust	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Cat 2 (d)	11	10	8	17	11	7	10	13	10	12	9	10
Cat3 (d)	0	0	1	1	0	1	0	1	1	0	0	0
Cat4 (d)	0	0	0	0	0	0	0	0	0	0	0	0
Unstagable (d)	1	1	0	1	3	3	0	1	4	5	3	3
Potential Deep Tissue Injury (d	1	1	4	2	3	2	3	3	3	2	2	1
Mucosal (d)	4	4	2	7	4	6	5	4	3	8	12	3
Total	17	16	15	28	21	19	18	22	21	27	26	17

Source: LTHTR data

Learning and Improvement

The Pressure Ulcer Prevention Champion role has been reviewed and re-established after the COVID-19 pandemic. This role is to provide cascade training for other members of the ward team and to be the first line source of pressure ulcer prevention knowledge and advice in ward areas. The team is looking to develop the training provided to the Pressure Ulcer Prevention Champions with support on the ward and update sessions. To ensure all staff are kept updated with current practice, an e-learning annual update is available, alternatively there is the availability of face-to-face sessions provided by the TVNs.

The combination of electronic and written documentation has been identified as an obstacle in providing a holistic overview of patients and their needs on each shift. A review of the electronic Waterlow, skin assessment, pressure ulcer care plan and wound chart has been undertaken by the TVNs, helping to standardise and streamline processes with the aim to make it simple, meaningful, and easily accessible to all involved in patient care.

Pressure ulcer improvement strategies also include:

- The Datix system is inclusive of patients in the pressure ulcer review process to improve patient involvement in the investigation and learning process.
- Witness statements to HM Coroner Inquests, providing an overview of the pressure ulcer prevention measures in place.
- Nutritional Big Room, looking at Malnutrition Universal Screening Tool (MUST) and weight compliance to identify patients requiring additional nutritional support.
- Purchase of additional weighing PAT slides within the Trust.
- Close working with ED reviewing equipment, training and the pressure ulcer review process.
- Pressure ulcer prevention training provision for HM Coroner's Team (2019, 2021, 2023).
- Review of any severe harm incident with Divisional governance and senior leader team.
- Weekly in-depth Divisional review of all Trust acquired pressure ulcers.
- Monthly Divisional Always Safety First meetings focusing on shared learning.
- Trust-wide learning included as part of the Always Safety First Learning bulletins.
- TVN link practitioner days twice yearly.
- Pressure ulcer prevention training for healthcare assistance on induction.
- Pressure ulcer prevention training to support international nurses and level 3 apprenticeship.

- Various tissue viability sessions for inter professional learners (IPL).
- Student spoke days with the TVN's once a week.
- Student placement development within the tissue viability team.
- Collaborative working with the Continuous Improvement team in developing a specific pressure ulcer prevention program of work due to start May 2023.
- Development of a standardise wound care formulary across the ICS

Nutrition for Effective Patient Care

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

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

Many patients require artificial feeding using either enteral feeding tubes or intravenous feeding. Our INCS service is designed to assess patients swiftly, make nutritional care plans, including feeding device selection, and undertake appropriate follow up.

The nursing 7-day service provides a rapid access clinic which is an admission avoidance measure and improves quality of care and experience for patients as they have a dedicated telephone helpline to gain this expert advice.

Our Speech and Language Therapy department offer high quality services to patients with communication and swallowing difficulties including complex presentations. Direct access to instrumental swallowing assessments using fibreoptic endoscopes and video fluoroscopy is available onsite, informing diagnosis, decision-making and provision of appropriate nutrition.

Our Dietetic service provides highly specialist care for a wide group of patients both adults and children. The service offers a variety of specialist clinics including paediatric diabetes, paediatric ketogenics, adult coeliac and adult renal, as well as providing a comprehensive inpatient service over both hospital sites.

The Trust continues to work alongside the catering services so that services are fully compliant with legislation relating to allergens. There is ongoing work to support the new bulk trolley system and menu development.

In addition, The Tobacco and Alcohol Care team (TACT) provide a 7-day service to all inpatients admitted to hospital who are identified as having an alcohol-use disorder or who smoke. The team expanded last year to include the treatment of tobacco addiction, securing funding to employ three band 3 tobacco and alcohol advisors and two full-time band 6 posts.

All patients admitted are assessed for smoking and alcohol use. The audit-c alcohol assessment tool identifies hazardous, harmful or dependent drinkers via HarrisFlex and an automatic referral to the TACT alcohol worklist is generated. Patients are then offered a more comprehensive assessment which aids planning of care, risk assessments, pharmacotherapy and psychosocial interventions. The team have three Non-Medical Prescribers (NMP's) who can ensure prescribing for alcohol withdrawal syndrome is safe and effective.

A new smoking cessation pathway has been developed to ensure that all smokers are offered the opportunity to receive specialist assessment and advice, and to ensure that even those patients who do not want to quit are offered nicotine replacement therapy in line with the Trust's smokefree policy. Discharge pathways have been set up with the current community provider, Quit Squad and into community pharmacies who offer the stop smoking service. The service is monitored by the ICB who are currently providing funding, and success will be monitored via data sharing regarding 4, 8 and 12 week quit rates.

During 2022-23 our services key achievements were:

- Being fully compliant with legislation relating to allergens.
- Cook/chill trolley system now implemented across both hospital sites.
- The further development of the weekly integrated secondary and primary care nutrition multidisciplinary team meetings.
- The MUST tool has been updated and relaunched following work in the Big Room led by Head of Dietetics.
- Further Big Room workstreams continue to develop around identifying patients on special diets.
- Additional Big Room continues to progress the fluid balance improvement work.
- Revised the policies and pathways around improving Nasogastric tube (NGT) safety. This has resulted in no NG tube placement Never Events for over 28 months.
- Completion of the Electronic Patient Record (HarrisFlex) team to refine the electronic documentation of NGT management.
- Approval of a difficult feeding service in Speech and Language Therapy (SLT) for 2-5 years.
- Dietetics and SLT services now have electronic inpatient referral systems.
- Increased SLT and dietetic services within critical care following a CQC should do.

Medication and Incident Monitoring

Medicines Safety

Medication errors are a major concern for patient safety in the UK healthcare system, with a report from the CQC indicating that medication safety incidents are the most commonly reported safety incidents in healthcare settings. In 2019-20, medication errors were a factor in 29% of patient safety incidents reported to the CQC. To address this issue, the Medicines and Healthcare Products Regulatory Agency (MHRA) launched a campaign to raise awareness of medication safety risks, particularly in the context of the COVID-19 pandemic.

At Lancashire Teaching Hospitals Pharmacy Department, medication safety is a top priority, and efforts are ongoing to improve systems and processes to reduce the risk of medication errors and their impact on patient safety. The Pharmacy Medication Safety team is dedicated to promoting a positive incident reporting culture, which aligns with the principles of Safety 2. Our efficient reporting system, Datix, allows medication errors to be quickly reported and thoroughly investigated.

Over the period of April 2022 to March 2023, medication incidents accounted for an average of 8.78% of all reported incidents, with an average of 238 incidents reported each month, representing a 4.8% increase from the previous year's monthly average of 227 incidents.

Data from the Model Hospital dashboard indicates that the national average for the proportion of reported medication incidents causing harm is 11%. Throughout 2022-23, the Trust has maintained a proportion of reported medicine incidents causing harm incident rate of 3.49%, which is significantly lower than the national average. This demonstrates the effectiveness of the Trust's medication safety initiatives and the importance of maintaining a positive reporting culture to prevent future harm and improve patient safety.

Figure 17 Medication Incidents Reported

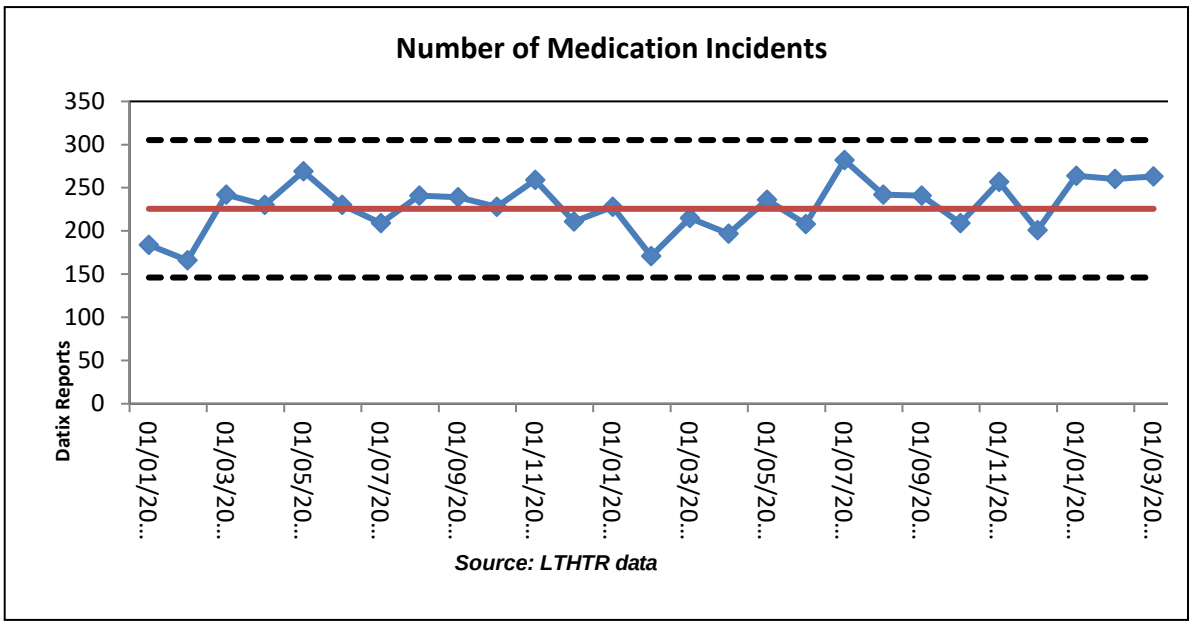
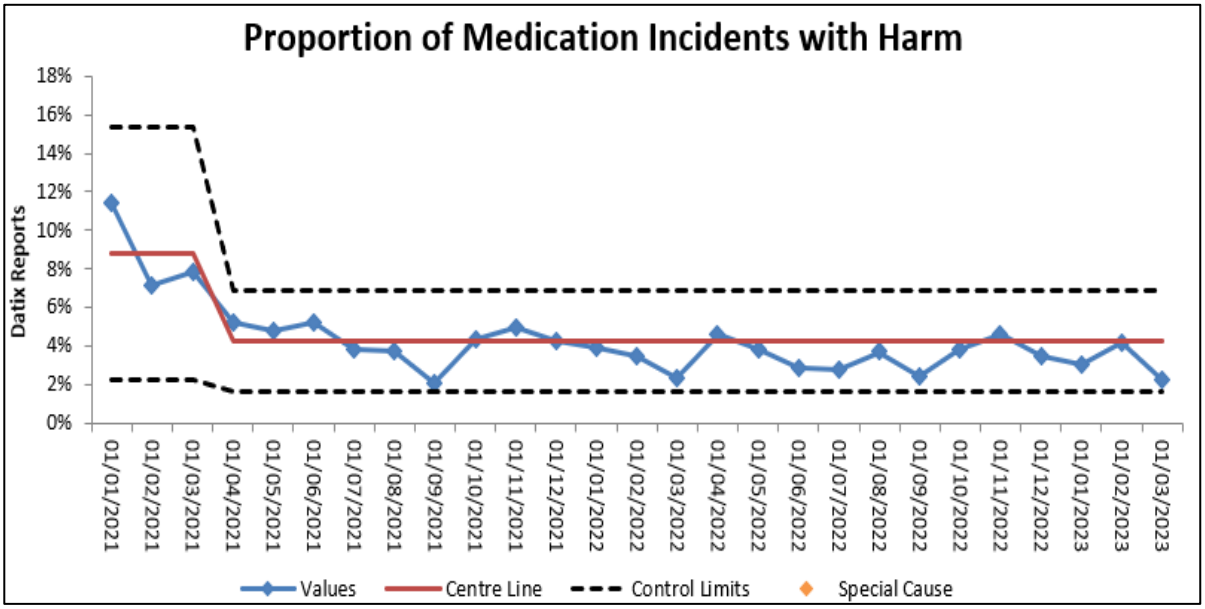


Figure 18 Medication Incidents Leading to Harm



Source: LTHTR data

We have a robust system to rapidly review moderate harm or above incidents, led by our Divisional Governance team with support from our Medication Safety Officer and Divisional Lead Pharmacist. Early impact interventions are prioritized, identified, and disseminated before formal investigations are completed.

Our proactive approach to medication safety includes sharing incident themes with relevant divisional areas, presenting Medication Safety reports at Always Safety First meetings, and a network of Medication Safety Champions who meet monthly to share learning and act as an education forum. Our Medication Safety Pharmacist supports these champions.

We monitor our performance monthly and report harm and near miss themes and trends to the Medicines Governance Committee, which maintains a cycle of business for risk assurance reporting aligned with our Trust's Risk Maturity agenda. This proactive monitoring and sharing of medication safety information help us continuously improve our processes, reduce harm, and ensure the best outcomes for our patients.

Medicines Reconciliation

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

Following the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system across the Trust, a pharmacy dashboard was developed within the Trust's BI portal application. The dashboard uses data from the live EPMA system, which is updated every 15 minutes, to provide real-time information on medication-related processes. This includes a ‘freeze’ position recorded at 5pm every day to build a long-term picture of

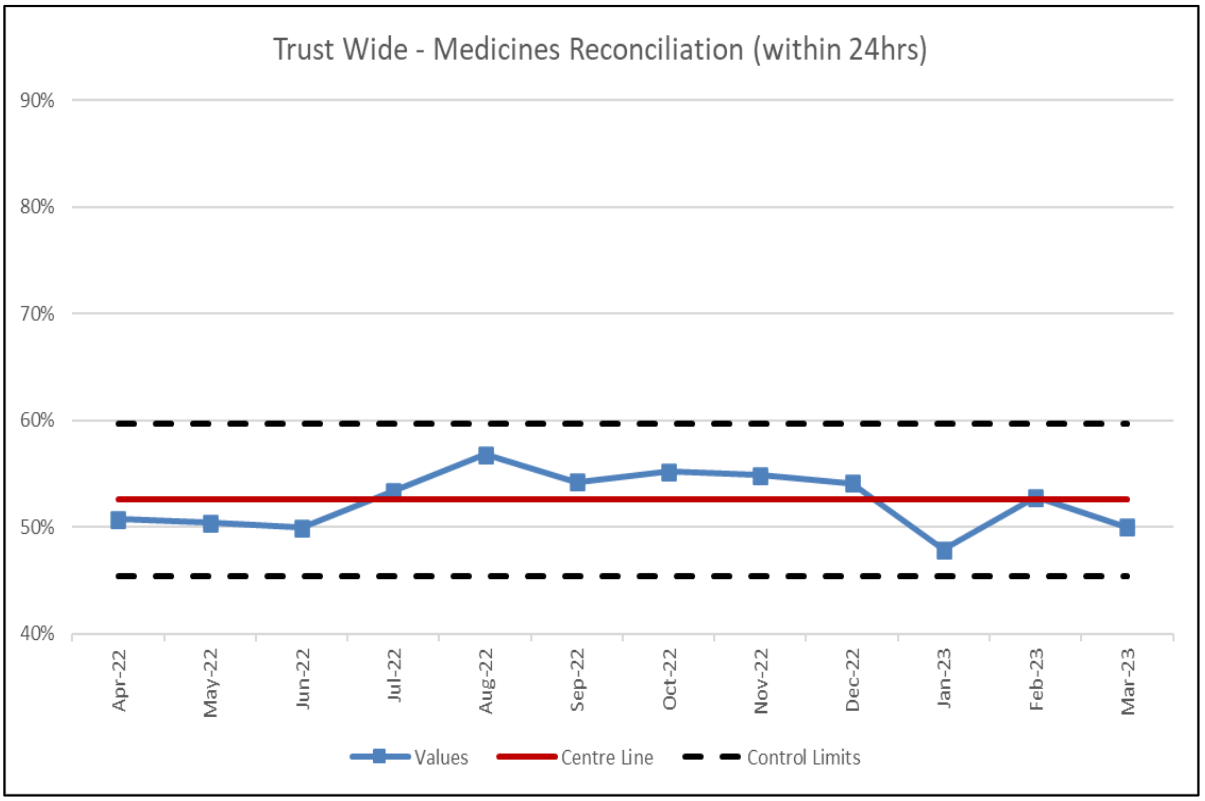
performance, as well as live data used throughout the day to aid decision-making regarding the best deployment of pharmacy staff based on workload pressures.

In 2022-23, medicines reconciliation was completed within 24 hours of admission for 52% of patients, which is a slight decrease from 53% in 2021-22. However, on average, 78% of all patients in an inpatient bed have a medicines reconciliation completed, which is an improvement from 74% for 2021-22. Despite the challenges faced due to the COVID-19 pandemic, the Trust has taken significant steps to improve medicines reconciliation performance.

Factors impacting on performance relating to medicines reconciliation include significant pharmacy staffing challenges, such as vacancies (40% at junior pharmacist level) and increased staff absences due to COVID-19, as well as significant numbers of additional unfunded beds due to patient flow issues across the system.

To support improvements in performance, the Pharmacy Department has implemented a new team structure, bringing about improvements to leadership as well as the deployment of both registered and non-registered pharmacy staff across all clinical areas. The department has also increased its use of data daily to direct the use of staff, cleansed its data to ensure only inpatient areas are included, optimized the use of the medicines management technician in completing medicines reconciliation, and developed a clinical pharmacy prioritisation whiteboard. These improvement actions demonstrate the commitment to ensuring that medicines reconciliation is completed in a timely and accurate manner, ultimately contributing to improved patient outcomes.

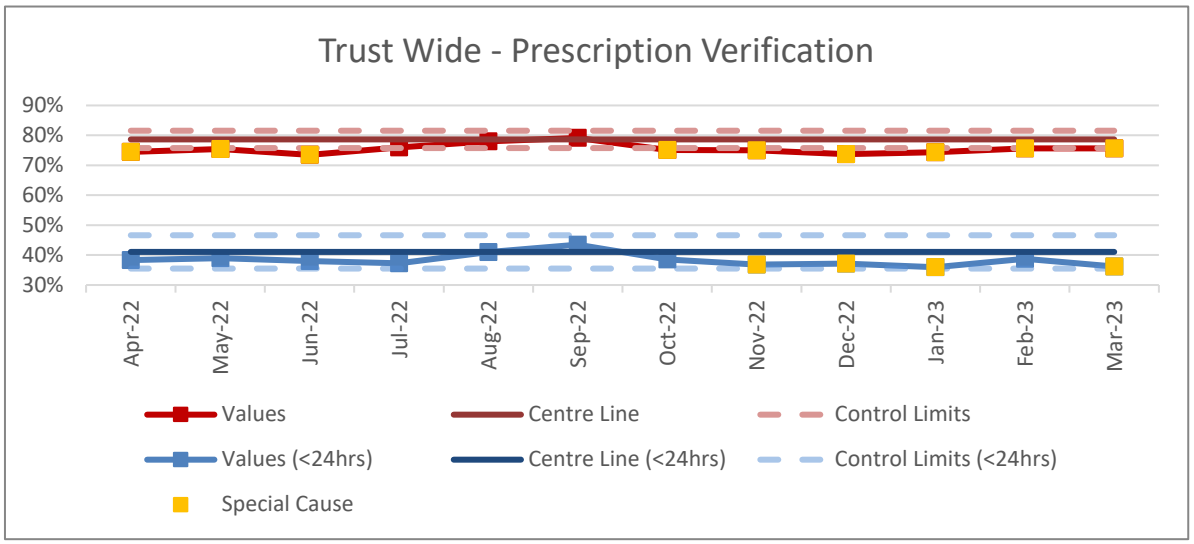
Figure 19 Medicines Reconciliation (within 24 hrs)



Source: LTHTR data

Prescription Verification

Figure 20 Prescription Verification



Source: LTHTR data

Our pharmacists play a vital role in assessing prescriptions for dose, legibility, interactions, appropriateness of therapy, formulary compliance, and legal requirements. However, we recognize that compliance with prescription verification within 24 hours has been a challenge, with the average compliance rate currently standing at 38%, down from 48% in 2021-22. On average, 75% of all live prescriptions are verified, down from 79% in 2021-22.

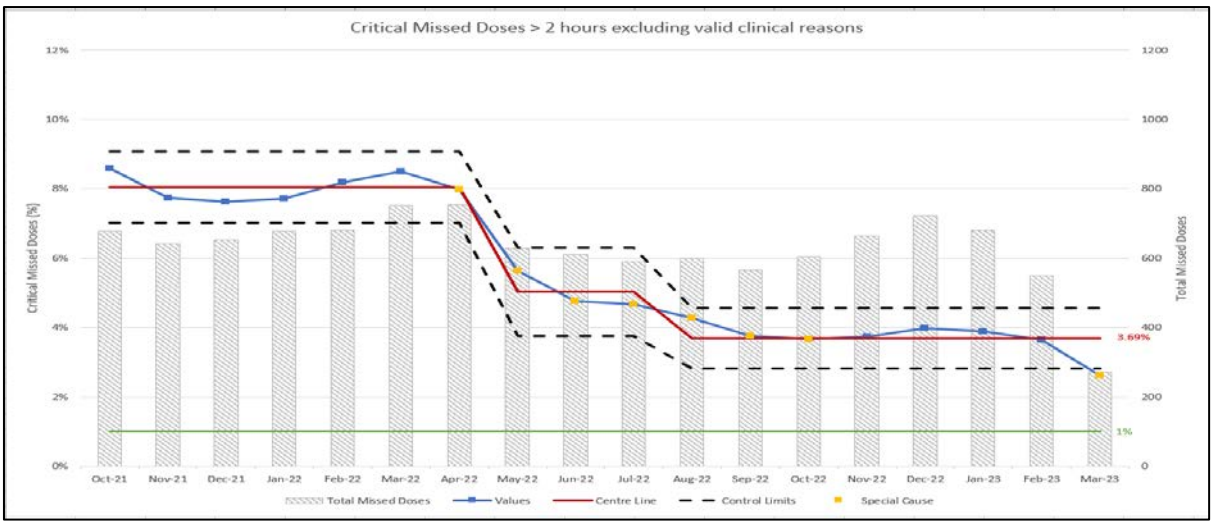
It is important to note that some medicines have a higher risk of causing harm than others, which can be due to a range of factors, such as dosing with respect to weight, renal function, age, or the pharmacological impact of underdosing or overdosing. To address this issue, we have developed a pharmacy clinical prioritisation whiteboard to target antimicrobials, anticoagulants, insulin, and anti-epileptic medicines for priority review. This continuous improvement project involves the development, pilot, and rollout of the whiteboard, and we are currently in the stage of data review. Our pharmacists remain committed to ensuring the safe and effective use of medications, and we are continuously working to improve our prescription verification processes. Through the use of targeted interventions such as the pharmacy clinical prioritisation whiteboard, we aim to increase compliance rates and minimize the risk of medication-related harm to our patients.

Administering medicines

Administering medications as prescribed is a fundamental aspect of patient care in hospitals. However, we recognize that there have been instances where doses have been missed in the UK with some organisations reporting in excess of 20% of doses missed, which can contribute to suboptimal treatment outcomes and potentially harm patients. To ensure that all medications are administered as prescribed, our Trust uses data from the electronic prescribing and medications administration system to identify all doses that are not given. This information is then used by our pharmacy and nursing teams to take appropriate action, either by administering the missed doses or documenting a valid clinical reason for not administering

them. Our BI App updates every 15 minutes, providing up-to-date information to nursing staff and pharmacy teams regarding the number of missed doses for their patients. Our Trust is committed to continuously improving our medication administration processes. Through a collaborative effort involving Nursing, Pharmacy, and Continuous Improvement teams, we have seen a significant reduction in the rate of missed doses of critical medications across the Trust. The initial rate of 8% has been reduced to 2.6% over a period of 16 months. This continuous improvement project has led to better patient outcomes and increased confidence in the safety and effectiveness of our medication administration processes.

Figure 21 Critical Missed Doses



Source: LTHTR data

Antimicrobial Stewardship

Our Antimicrobial Stewardship team conducts audits across all in-patient areas, with an automated data collection process facilitated by EPMA. All patients prescribed antimicrobials in every inpatient ward are now included in the audit, marking an improvement from the small sample size of snapshot paper-based audits. The audit assesses compliance with documentation of antibiotic indications, the Trust's antimicrobial guidelines or Microbiology recommendations, and review date guidance. Compliance with documented reviews within 72 hours is also monitored.

Table 20 Antimicrobial Stewardship Point Prevalence Audit Results

	Nº of patients on antibiotics	Nº of antibiotic prescriptions Audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q4 2022-23	336	453	95%↓	88%↑	90%↑	86%↓
Trust Wide Q3 2022-23	374	493	96%↓	87%↓	89%↓	88%↑
Trust Wide Q2 2022-23	354	454	97%↔	90%↓	91%↓	77%↓
Trust Wide Q1 2022-23	340	445	97%↓	94%↔	95%↔	87%↓

Source: LTHTR data

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

Recent improvements include a mandatory electronic process integrated into the ward round proforma for capturing documented reviews. The use of order sets within EPMA is being promoted, which has consistently shown to improve the duration of antibiotics.

Overall compliance with guidelines is strong, with a significant improvement in timely review seen from last year. Our commitment to continuous improvement and patient safety remains a top priority, and we will continue to work towards achieving the highest standards for our patients.

Infection Prevention and Control 

MRSA Bacteraemia

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

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

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

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention and Control to identify causes and actions for future prevention. The hospital associated case identified in January 2023 was reviewed with no key contributing factor identified. There was however learning identified to strengthen systems and processes moving forward.

Clostridioides difficile Infection

Clostridioides difficile (C. *difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores from the environment.

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2022-23, the national objective set by NHSE for the Trust was no more than 122 hospital associated cases. There was an increase in hospital associated cases during 2022-23 in comparison to previous years with a total of 196 cases. This was a 48% increase from 2021-22 which had a total of 132 hospital associated cases.

The national and regional picture

There has been a national increase in *C. difficile* infection and a significant proportion of Trusts nationally are above trajectory. There is a UK Health Security Agency (UKHSA) and NHSE study in-progress to understand the reasons for this national increase, but likely contributors include:

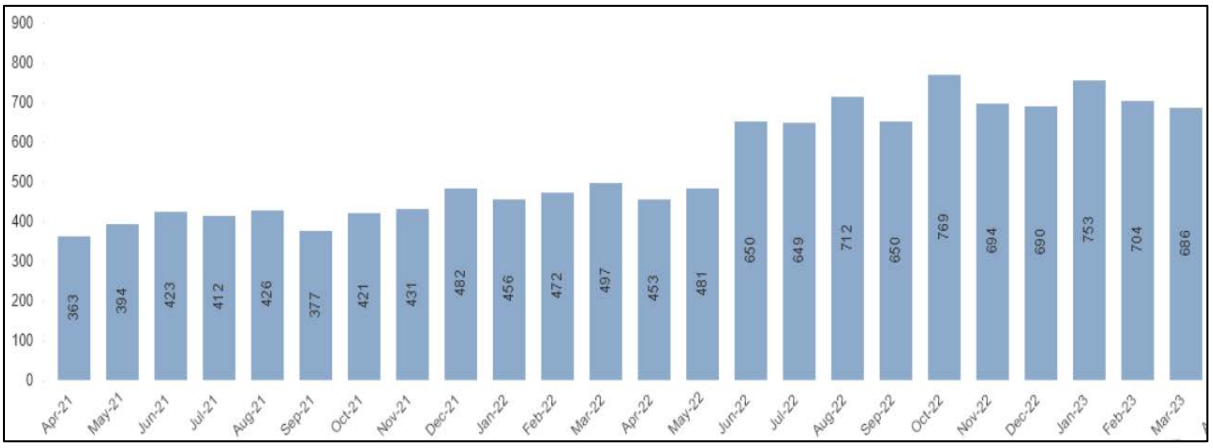
- Increased susceptibility of patients to infection due to an ageing population with multiple co-morbidities.
- The potential impact of the COVID-19 pandemic on population health.
- High antibiotic-use due to the COVID-19 pandemic and particularly broad-spectrum antibiotics that place patients at higher risk of *C. difficile* infection.
- Overcrowding of patients on hospital sites because of increased demand.
- Insufficient decant facilities for more intensive decontamination of the environment ('Fogging' or Ultraviolet technology).
- Sub-standard estate due to reduced funding for repairs and insufficient decant to perform repairs.
- Insufficient side-room capacity worsened by COVID-19 numbers.
- Understaffing and its impact on IPC practice.

In the Northwest 12 out of 24 Trusts (50%) were over their objectives in February 2023. There were 408 instances of lapses of care identified in *C. difficile* Post Infection Reviews (PIRs) from April 2022 to March 2023. Some PIR meetings identified multiple lapses of care from single cases. The information in terms of lapses in care are now logged in Datix, making the process for monitoring themes and trends easier than previous years. Common themes in terms of lapses in care included:

The impact of a change in definition of diarrhoea

The increase at the Trust was also compounded by a change in the definition of diarrhoea (as recommended by NHSE). Prior to June 2022, only type 6/7 stools were treated as diarrhoeal. NHSE recommended that we also include type 5 stools, which resulted in increased testing and the inclusion of patients with mild *C. difficile* infection in our figures, presented in Figure 22 below.

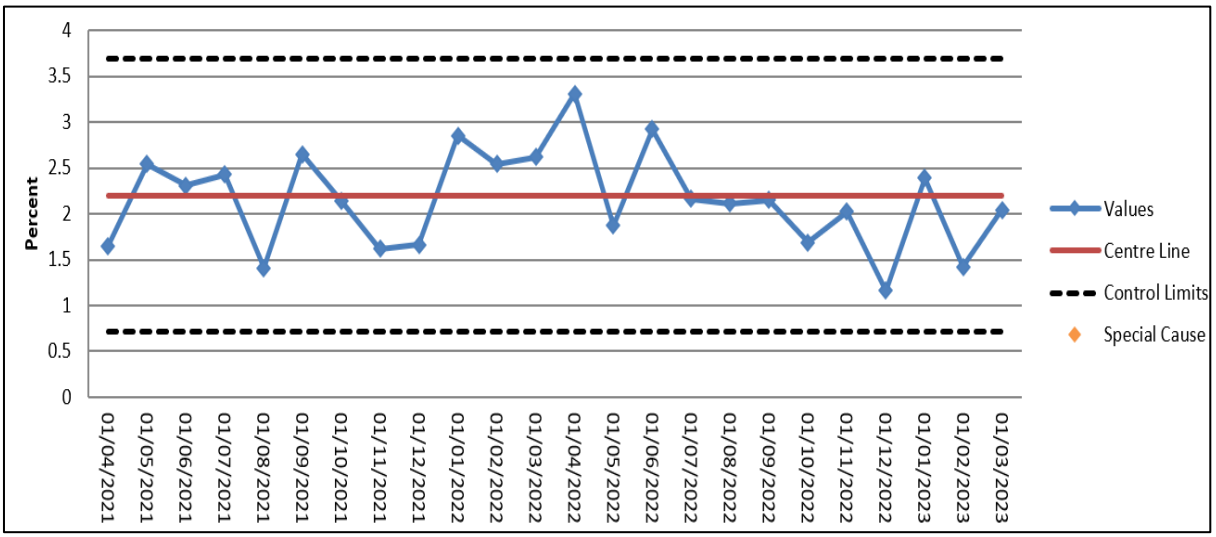
Figure 22 Inpatient laboratory test numbers for *C. difficile*



Source: LTHTR data

Figure 23 below. represents an attempt to account for the change in testing, by assessing *C. difficile* test positivity for Healthcare Onset/Healthcare Associated (HOHA cases), as a proportion of inpatient tests. This proportion has decreased since June 2023.

Figure 23 HOHA cases as a proportion of total Inpatient tests



Source: LTHTR data

Lapses in Care

All hospital cases are reviewed by an expert group including the Director of Infection Prevention and Control, Infection Prevention and Control Matron or Infection Prevention and Control Nurse, Antimicrobial Pharmacist or Specialist Antimicrobial Technician, Governance representative, Ward Manager, Ward Matron and Consultant in charge of the patient's care.

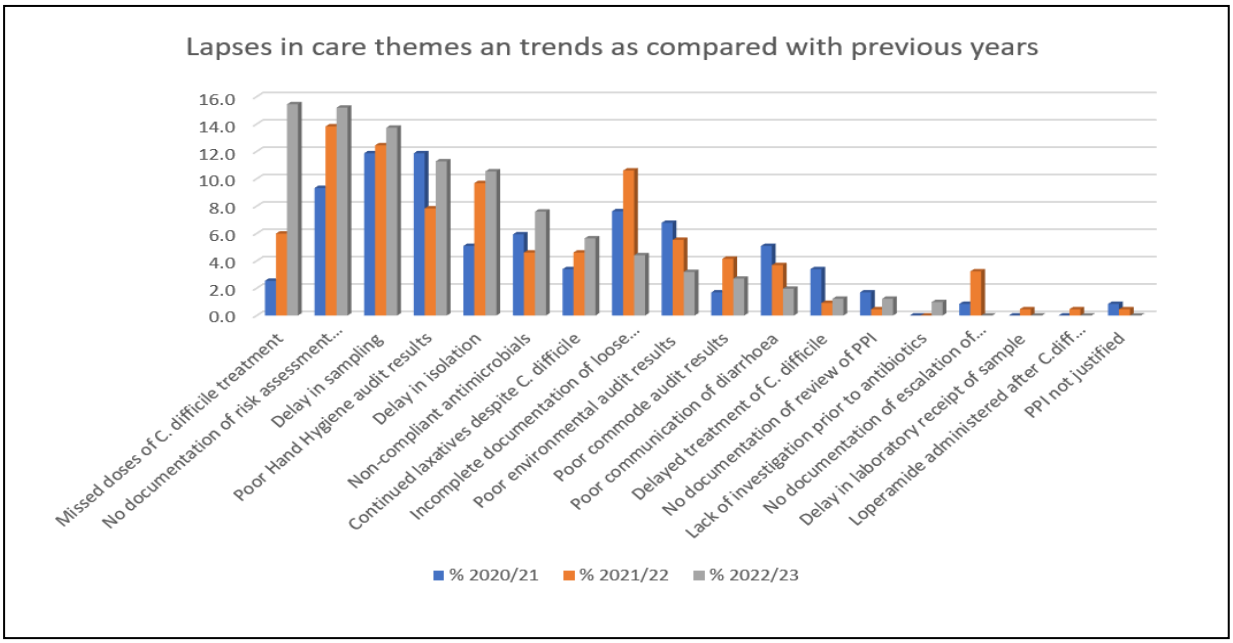
The review process facilitates a greater understanding of the individual cause of the C. *difficile* cases to determine whether there were any lapses in the quality of care provided. This is so that we can develop an appropriate plan of action to address any problems identified and to promote learning and best practice. A lapse in care is based on the checklist detailed in the national guidance and includes omissions which would not have contributed to the

development of *C. difficile* infection or Missing doses of *C. difficile* treatment:

- Poor or no documented risk assessment of loose stools on the day that diarrhoea began
- Delay in sampling
- Poor hand-hygiene audit results
- Delay in isolation
- Non-complaint antimicrobials

These failings encompassed approximately 75% of all lapses of care identified in PIR meetings and will be a focus of improvement work for the coming year.

Figure 24 Themes of lapses of care



Source: LTHTR data

Focus on learning from lapses in care are triangulated in our Antimicrobial Management Group (AMG) and Divisional Infection Prevention and Control meetings and we have focused on antimicrobial stewardship, hand hygiene, environmental cleanliness, and timely isolation of patients with symptoms of diarrhoea. Hospital onset *C. difficile* review is undertaken during the monthly CDI Panel meeting with the ICB leading to a health economy-wide approach to learning and reduction.

Rapid Intestinal Test

Only approximately 20% of beds at Lancashire Teaching Hospitals are in side rooms, which is one of the lowest isolation capacities in the country. The inclusion of type 5 stools as diarrhoeal, which was part of UKHSA guidance and advocated by NHSI leads, has also led to a doubling of the number of patients diagnosed as having diarrhoea, further exacerbating the problem. Typically, at any time, there are 100 patients who have had type 5, 6, or 7 stools in the last 48 hours.

Since April 2022, to improve the efficiency of side-room utilisation, a rapid intestinal screening test was trialled via the point of care team. When this test is negative (typically a rectal swab), which happens in 77% of diarrhoeal cases, the patient does not require a side-room or Redi-room. The results of the trial are expected in the coming weeks.

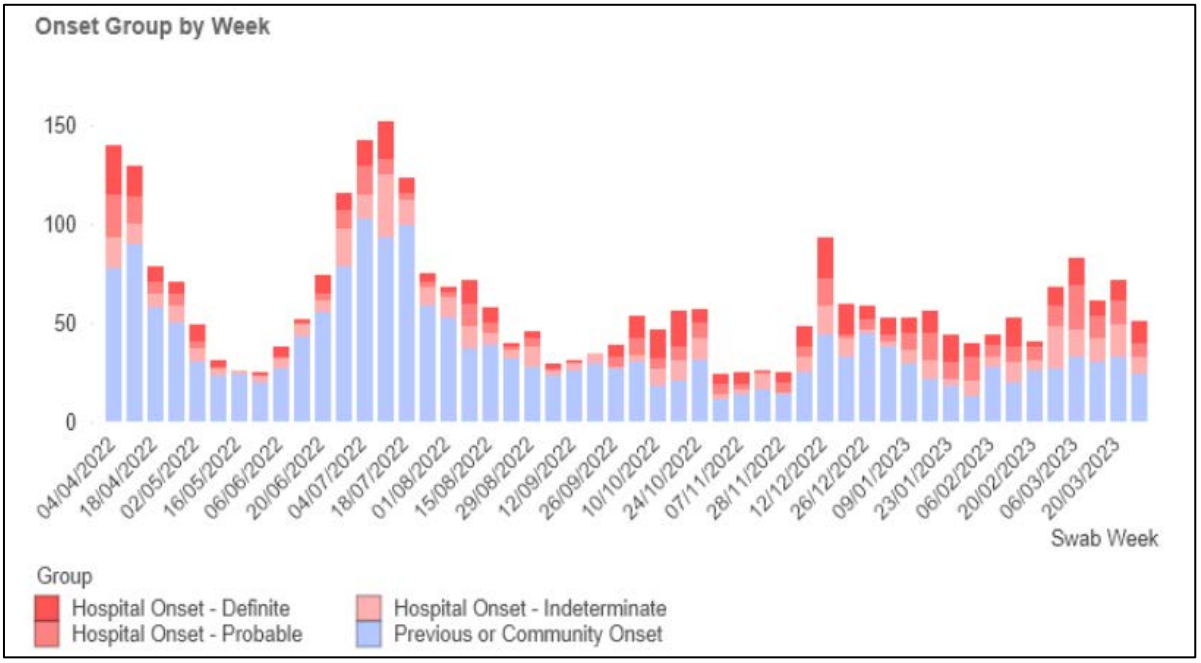
SARS coronavirus-2 (SARS-CoV-2) – COVID-19

On 31 December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified, and symptoms were flu-like initially and also including a loss or change in the normal sense of taste or smell.

The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. We suffered from key disadvantages as compared to other similar trusts when it comes to preventing nosocomial COVID-19, mainly relating to its estate.

Only 20% of the beds at the Trust are in side rooms making it difficult to segregate patients. A large number of hospital bays have virtually no ventilation and COVID-19 spreads more readily in poorly ventilated areas. A 2-metre separation between bed spaces was not possible in most areas.

Figure 25 Hospital Onset versus Community Onset COVID-19 infections

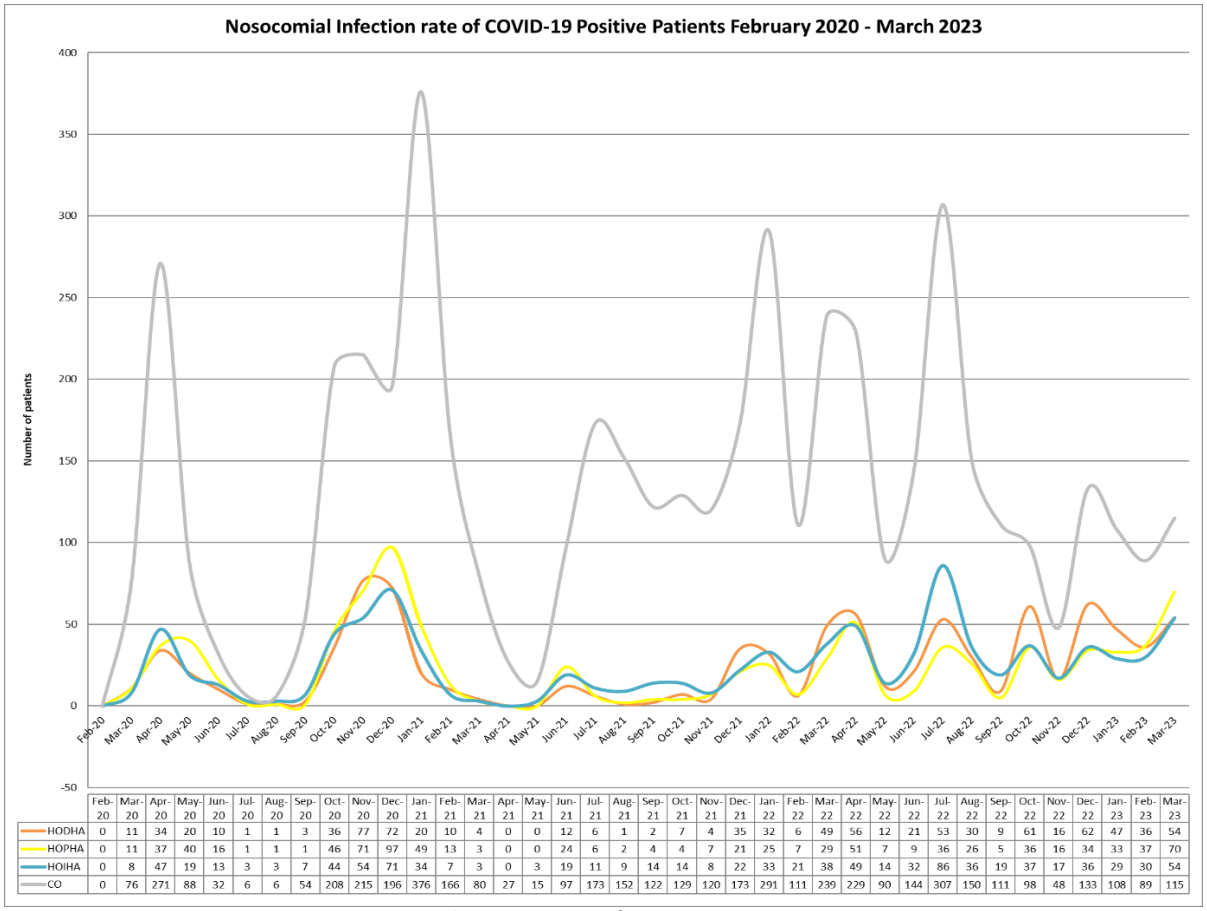


Source: LTHTR data

During the year 2022-23 updates in National Guidance for COVID-19 changed regarding testing, isolation and the management of patients and staff members. Changes were implemented in accordance with the National Guidance with the exception of continued

universal mask-wearing. The COVID-19 Trust Policy was continuously updated in line with the National Guidance. Any changes were discussed prior to being introduced. Figure 26 shows the total numbers of COVID-19 positive inpatients broken down by nosocomial infection from the beginning of the pandemic in March 2020.

Figure 26 Nosocomial Infection rate of COVID-19



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
HODHA	0	11	34	20	10	1	1	3	36	77	72	20	10	4	0	0	12	6	1	2	7	4	35	32	6	49	56	12	21	53	30	9	61	16	62	47	36	54
HOPHA	0	11	37	40	16	1	1	1	46	71	97	49	13	3	0	0	24	6	2	4	4	7	21	25	7	29	51	7	9	36	26	5	36	16	34	33	37	70
HOIHA	0	8	47	19	13	3	3	7	44	54	71	34	7	3	0	3	19	11	9	14	14	8	22	33	21	38	49	14	32	86	36	19	37	17	36	29	30	54
CO	0	76	271	88	32	6	6	54	208	215	196	376	166	80	27	15	97	173	152	122	129	120	173	291	111	239	229	90	144	307	150	111	98	48	133	108	89	115

Source: LTHTR data

Gram-negative bacteraemia

NHSE published objectives for Trusts to reduce *Escherichia coli* (*E.coli*), *Klebsiella species,* and *Pseudomonas aeruginosa* in 2022-23. The 2022-23 objective for *E.coli* bloodstream hospital associated infections was 112. The Trust ended the year with a total of 108 hospital associated *E. coli* cases which was 4 cases below the objective.

The 2022-23 objective for *Pseudomonas aeruginosa* bacteraemia bloodstream hospital associated infections was 13. The Trust ended the year with a total of 19 hospital associated *Pseudomonas aeruginosa* bacteraemia bloodstream cases for the year 2022-23, this is 6 cases above the objective of 13.

The 2022-23 objective for *Klebsiella* species bloodstream hospital associated infections was 26. The Trust ended the year with a total of 23 hospital associated *Klebsiella* species cases for the year 2022-23, which was 3 cases below the objective.

To better understand themes and trends related to gram-negative bacteraemia, the Director of Infection Prevention & Control (DIPC), Matron, Lead Nurse, and data administrator from IPC, met on a regular basis to review *E. coli* bacteraemia HOHA cases for 8 months in 2022-23.

The data in Table 21 below outlines the sources that were identified.

Table 21 Sources of *E. coli* bacteraemia HOHA cases

Source of infection	Frequency	Percentage
Urinary tract infection	14	36.8
Gastrointestinal/intraabdominal collection	10	26.3
Hepatobiliary	5	13.2
Catheter associated UTI	2	5.3
PICC infection	2	5.3
CAPD peritonitis	1	2.6
Diabetic ulcer	1	2.6
Prosthetic Hip infection	1	2.6
Skin infection /diabetic foot	1	2.6
Unknown	1	2.6

Source: LTHTR data

Patient hydration and urinary catheter care were identified as key interventions to reduce risk and will be focuses of intervention in the coming year.

OTHER OUTBREAK INVESTIGATIONS IN 2022-23

Norovirus Outbreaks

The year 2022-23 saw 4 Norovirus outbreaks:

Acute Frailty Unit – October 2022

- Number of positive patients – 3.
- Number of symptomatic staff members – 1.
- Number of bed days lost – 12.

Summary – 2 Bays affected and both bays closed. Staff isolated patients within Redi-rooms which delayed the incubation period prolonging the outbreak time in total.
Outcome – Education on the use of Redi-rooms and IPC practices.

Cardiac Cath Lab with Ward 23 – November 2022

- Number of positive patients – 8.
- Number of symptomatic staff members – 1.
- Number of bed days lost – 0.

Summary – 2 Bays affected on Cardiac Cath Lab which seeded into Ward 23.
Potential cause of outbreak – shared staff between wards and shared staff break room.
Outcome – strengthen IPC practices.

Fellview – January 2023

- Number of positive patients – 6.
- Number of symptomatic staff members – 0.
- Number of bed days lost – 0.

Summary – Index case identified as positive in ED by rapid test and transferred to an isolation room on Fellview. 2 Bays affected 5 days later – potential cross infection.
Potential cause of outbreak – Cross-infection.
Learning – strengthen IPC practices.

SAU – March 2023

- Number of positive patients – 2.
- Number of symptomatic staff members – 1.

Summary – Index case admitted with symptoms of Norovirus, admitted to Bay, identified positive on rapid GI and isolated, 1 contact patient in bay tested positive.
Potential cause of outbreak – community acquired infection admitted to Bay
Learning – Complete rapid test earlier and completion of Situation – Background-Assessment-Recommendation (SBAR) documentation

Historically, Norovirus outbreaks have resulted in closure of entire wards and a large number of trapped beds. In January and February 2019, there was an outbreak of Norovirus in the neurosurgery unit which led to 156 bed-days lost.

In the past, Norovirus testing was only performed by the laboratory when specifically requested by the Infection Prevention and Control team and this generally occurred when a ward outbreak was already established. ED staff are now encouraged to isolate and test all patients who present with suspected infectious diarrhoea with the rapid intestinal test. If the patient is negative, the patient does not require isolation. A positive result will ensure that the patients are managed appropriately from an infection prevention and control perspective so that a ward outbreak is prevented. Every case of Norovirus not managed appropriately, because staff are unaware of the diagnosis, has the potential to cause an outbreak.

The introduction of the rapid intestinal screening test trial has been integral in the early identification of patients with Norovirus and the management of these patients. As seen in Table 22, 48 of 105 (45.7%) of rapid tests identifying Norovirus were taken in the EDs. By this early identification patients were able to be promptly isolated preventing spread and therefore reducing potential outbreaks across the organisation.

The rapid test has also facilitated the closure of affected bays as opposed to ward closures as Norovirus can be rapidly excluded in patients with diarrhoea in unaffected bays on the ward. Unaffected bays are therefore not inappropriately regarded as part of the outbreak. Due to this, 3 of the 4 reported Norovirus outbreaks reported in 2022-23 resulted in 0 bed-days lost with one outbreak on the Acute Frailty Unit resulting in 12 bed-days lost, of which 1 day was due to maintenance issues in the bay.

Table 22 The number of positive Norovirus patients per location

Ward	12	15	23	24	25	5	8	8A	ED RPH	AFU	BRIN	CCL	ED CDH	MAU CDH	CrCu	FELL	GYN	HAZ	MAU RPH	NSUA	RWA	RWB	SAU	SDEC
Norovirus GI: ***POSITIVE***							1		18	1			1				1		1	1				
Norovirus GII: ***POSITIVE***	1	1	4	2	1	1	4	1	25	6	1	6	4	1	1	6	2	1	4		1	1	6	1
Grand Total	1	1	4	2	1	1	5	1	43	7	1	6	5	1	1	6	3	1	5	1	1	1	6	1

Source: LTHTR data

Influenza

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses cause seasonal epidemics in winter in temperate climates, as in the UK. There are 2 groups of Influenza virus, Influenza A and Influenza B which cause infection in humans.

The epidemiology of Influenza is unpredictable as Influenza viruses continually change and evolve, which is why a new vaccine is developed for each season. Influenza is usually self-limiting in healthy individuals, with recovery in 3-7 days. Elderly people, children under 6 months old, pregnant women and people with chronic conditions or immunosuppression are at increased risk of complications of Influenza. Influenza vaccination is offered to people at risk of complications and increased Influenza exposure, as well as to young children, who are efficient infection spreaders.

Transmission of Influenza occurs mainly by droplets, which can travel up to 2m through the air and by direct and indirect contact. Aerosol-generating procedures such as bronchoscopy and non-invasive ventilation can produce small particles which can travel further than droplets and remain in the air for longer.

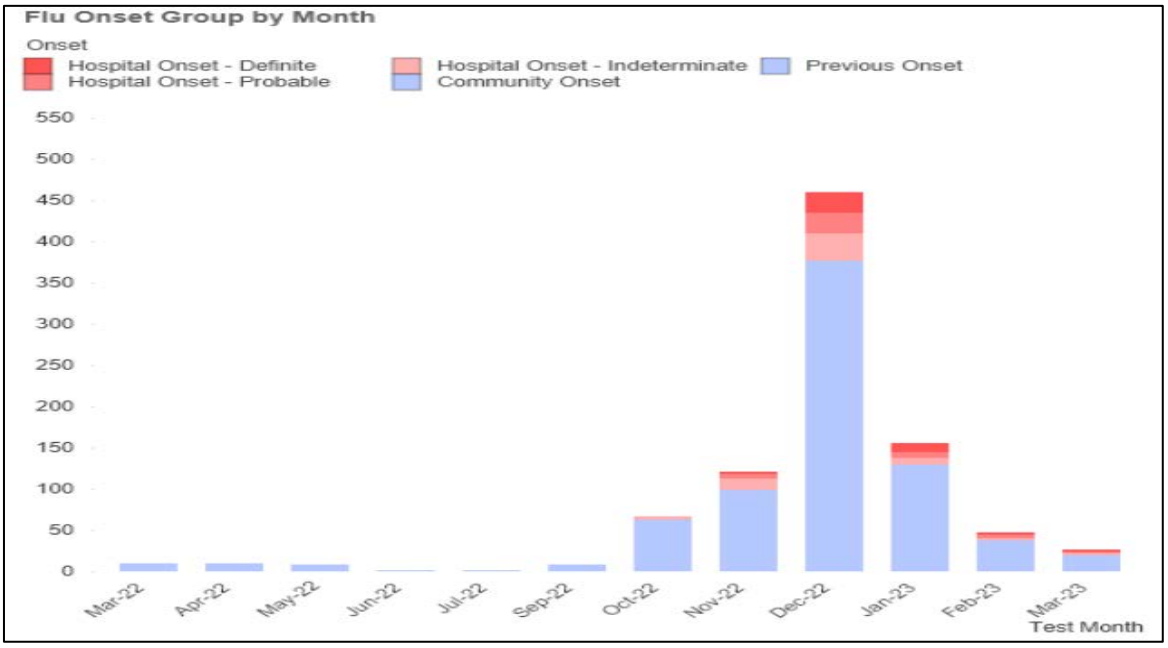
Prevention of Influenza is by vaccination and basic hygiene including hand hygiene and cough/sneeze etiquette. Isolation in single rooms and use of appropriate personal protective equipment (PPE) for suspected and confirmed Influenza cases is also key to preventing Influenza transmission in healthcare. When the number of single rooms exceed the single room capacity, cohorting Influenza cases can be implemented by subtype.

In temperate climates, the incidence of Influenza is seasonal and peaks in winter usually between January and March.

Influenza season 2022-23

The year 2022-23 has seen the first Influenza season since before the COVID-19 pandemic began in 2020. The Influenza season in the Trust for 2022-23 started at the end of October 2022 in line with the national pattern and peaked in December 2022. Influenza A was the most predominant strain with a small number of cases of Influenza B.

Figure 27 Influenza positive patients by Nosocomial Onset



Source: LTHTR data

Figure 27 above shows the total number of Influenza cases diagnosed in the Trust including both patients who were admitted and those who were not admitted broken down into nosocomial onset. The high number of cases in 2022-23 is consistent with national reporting. Point of care testing was continued to differentiate between Influenza and COVID-19 with both having similar symptoms. The rise in Influenza cases along with COVID-19 cases proved difficult in terms of capacity and isolation leading to the cohorting and boarding of patients.

Mpox National Outbreak

Mpox is a viral zoonotic disease that until May 2022, was primarily identified in Central and West Africa. There are 2 historical clades of Mpox – a Central African clade with a reported mortality of 10% and a West African clade with a reported mortality of 1% from epidemiological cluster and outbreak reports from Africa. Prior to 2022, it was occasionally identified in other countries related to travel from endemic areas in Central and West Africa.

From 13 May 2022, cases began to be reported in multiple countries that do not have endemic Mpox virus in animal or human populations, including countries in Europe, North America, and Australasia. This represented community transmission (particularly in men who have sex with men) in multiple non-endemic countries.

At the beginning of the epidemic, the Trust IPC leads met with colleagues in the ICS and led in the development of robust community clinical pathways which avoided the need for patients to come to hospital for investigation. Although an Infection Prevention and Control policy was developed, if this should occur, the Trust never needed to manage an actual case of the infection.

Group A strep / iGAS

Group A streptococcus (GAS), also referred to as Strep A is a common bacterium. Many people carry it in their throats and on their skin and it does not always result in illness. However, GAS does cause a number of infections, some mild and some more serious.

Milder infections caused by GAS include scarlet fever, impetigo, cellulitis and pharyngitis. These can be easily treated with antibiotics. The most serious infections linked to GAS come from invasive group A strep, known as iGAS.

These infections are caused by the bacteria getting into parts of the body where it is not normally found, such as the lungs or bloodstream. In rare cases an iGAS infection can be fatal.

Whilst iGAS infections are still uncommon, there was a national increase in cases in 2022-23, particularly in children under 10 with a small number of deaths.

We saw an increase in community iGAS cases in the Trust following the national increase however all patients were managed accordingly and there was no nosocomial spread or outbreaks identified.

Mortality Surveillance and Learning from Adult, Child & Neonatal Deaths

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

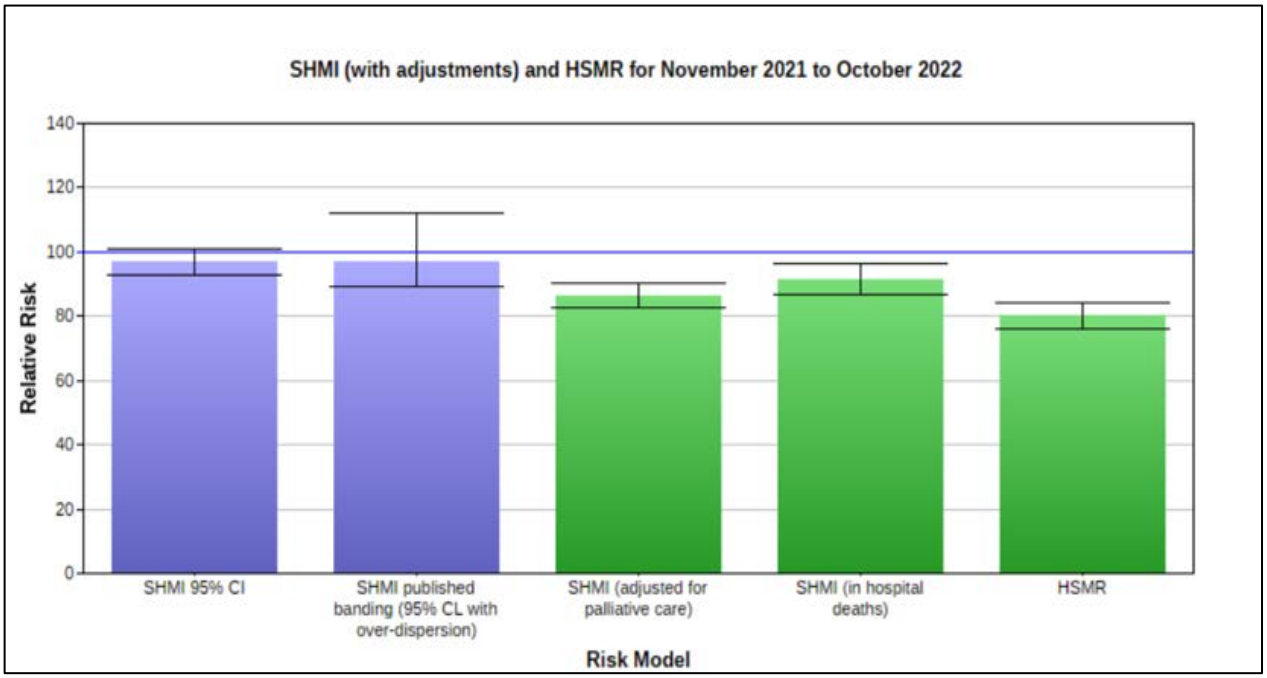
Mortality Surveillance

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

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

The SHMI for the most current period available at the time of report writing is for the 12-month period from November 2021 to October 2022, is 96.84 and remains within the expected range. When the SHMI is adjusted for palliative care, it is 86.25 and for in hospital deaths 91.54 both of which are lower than expected.

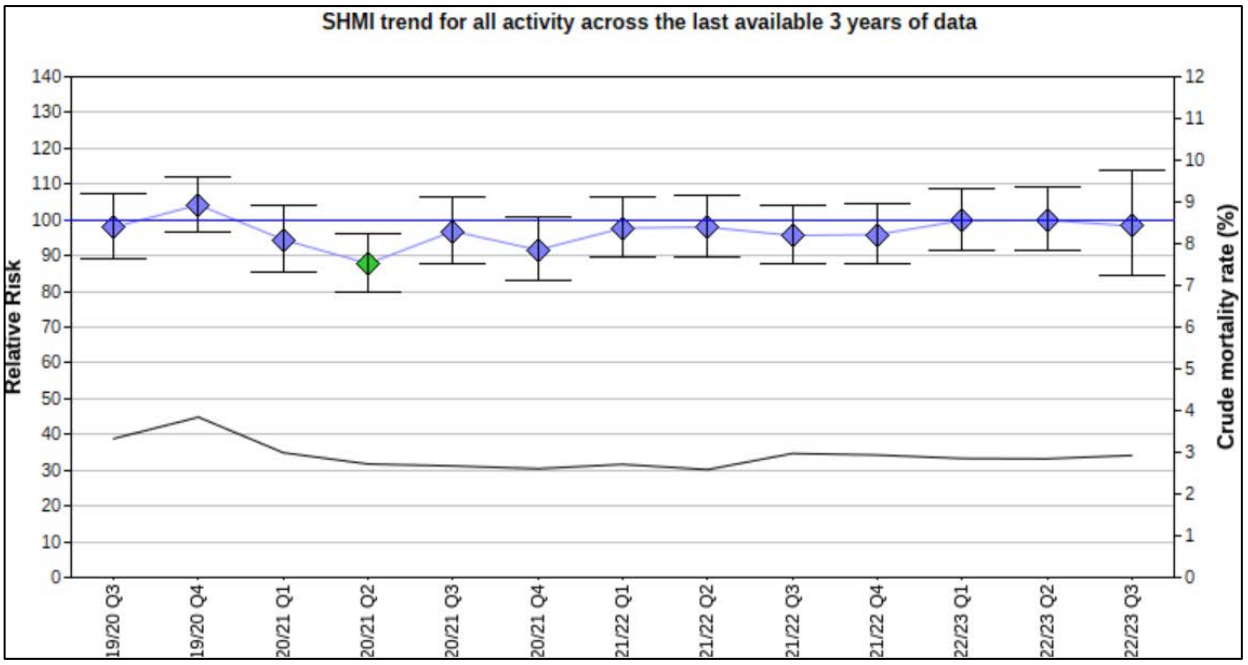
Figure 28 Summary Hospital Mortality Indicator (SHMI) – November 2021 to October 2022



Source: Dr Foster Intelligence

The SHMI trend for the last three years is presented below, it demonstrates a within expected position for most quarters, apart from quarter 2 of 2020-21, which was significantly lower than expected at 87.89.

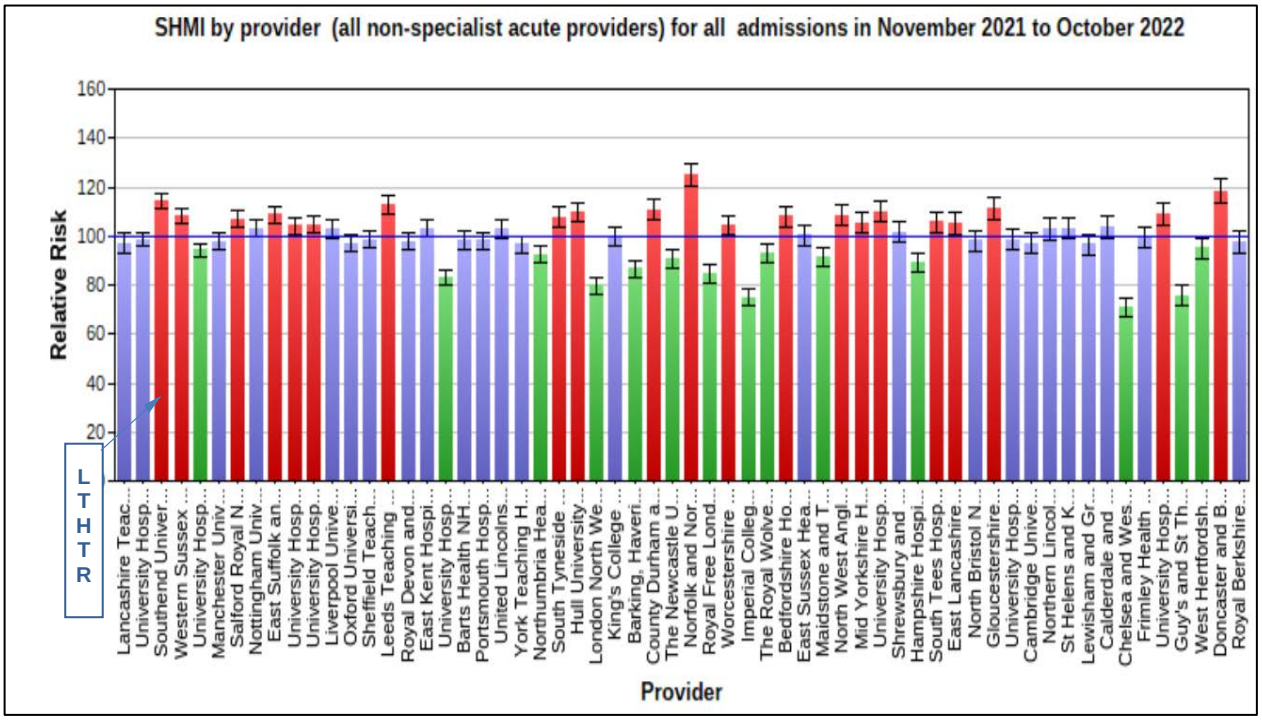
Figure 29 Summary Hospital Mortality Indicator 3 Year Trend



Source: Dr Foster Intelligence

The Trust can compare our SHMI with national peers and this is presented in figure 30 below, the Trust is the first organisation in the bar chart. Trusts featuring in blue are those within the expected range, green bars are lower than expected and those in red are higher than expected.

Figure 30 Summary Hospital Mortality Indicator Peer Comparison



Source: Dr Foster Intelligence

Hospital Standardised Mortality Ratio (HSMR)

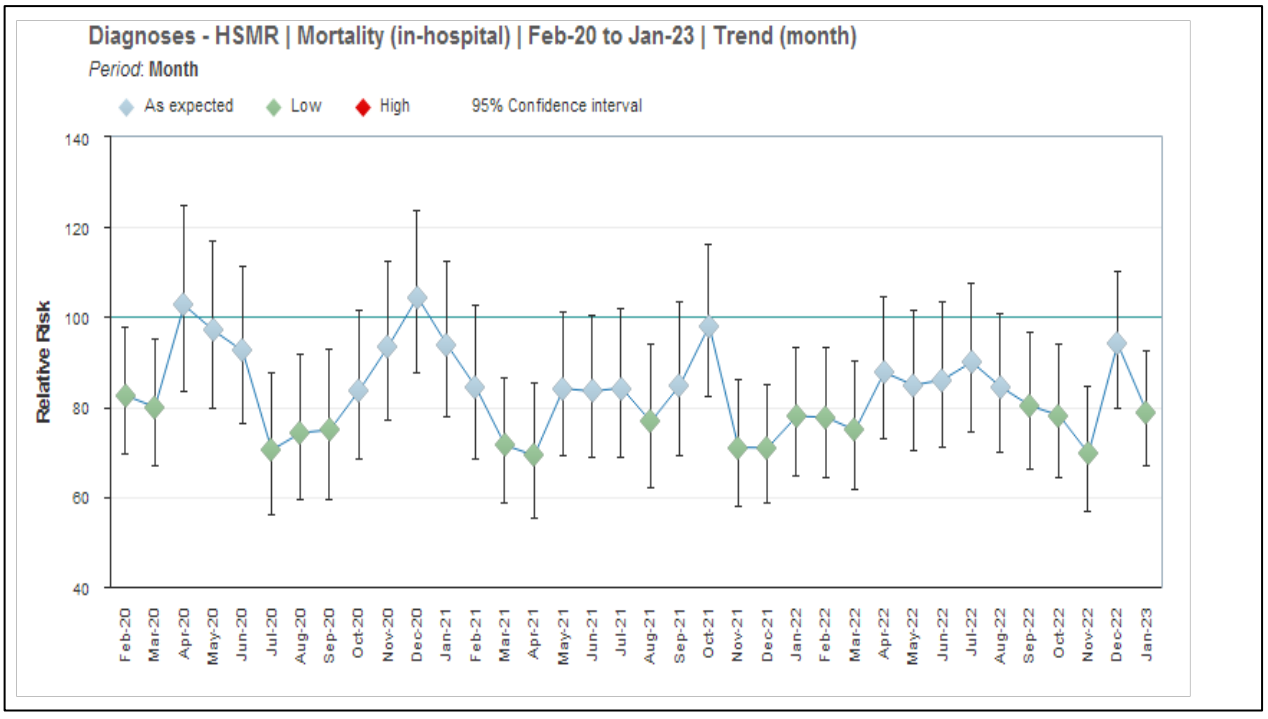
In addition to the SHMI the Trust monitors mortality rates using the HSMR which is derived from data based on 56 diagnostic groups, which account for approximately 80% of all hospital deaths. The data is adjusted to include a range of factors that can affect survival rates but that may be outside of our direct control such as age, gender, associated medical conditions and social deprivation. The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. A rate greater than 100 indicates a higher-than-expected mortality rate, whilst a rate less than 100 indicates either as expected or lower than expected.

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

The most current 12-month HSMR data relates to the period from February 2022 to January 2023, the figure is 82.0 and remains lower than expected. The HSMR for the same period between February 2021 and January 2022 was 79.4 and significantly lower than expected.

Our HSMR trend over the past three years is presented in figure 31 below and demonstrates the continued HSMR trend of mortality being either within expected or lower than expected range.

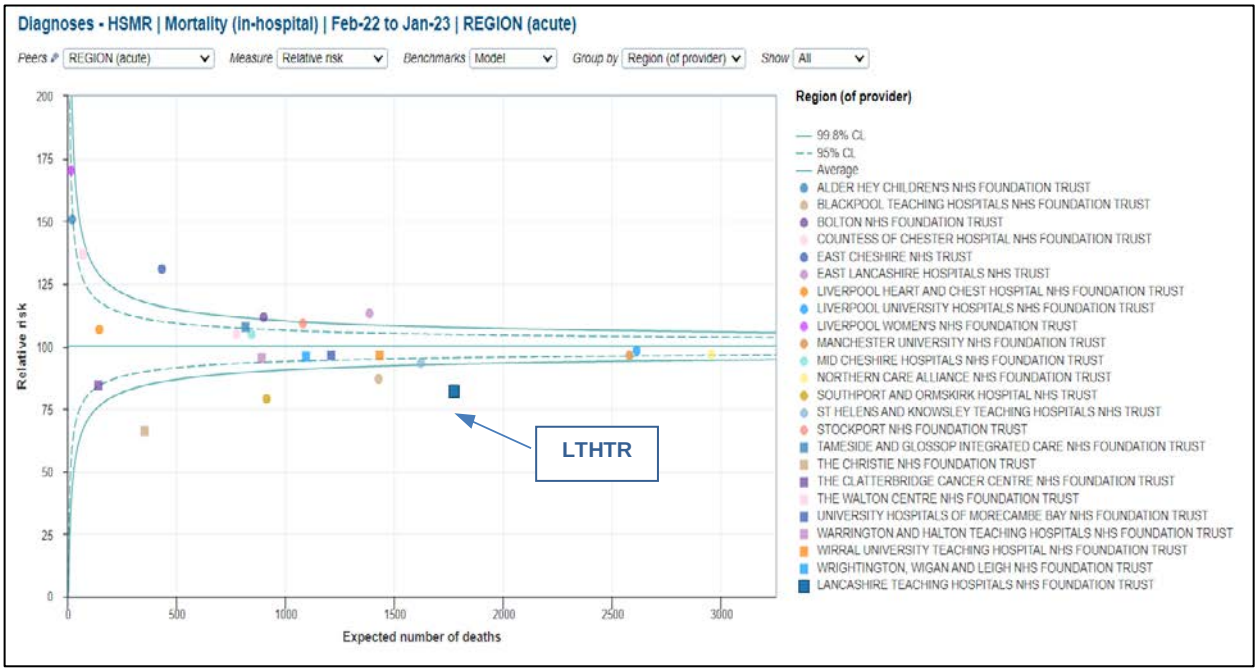
Figure 31 Hospital Standardised Mortality Ratio Feb 2020 – Jan 2023



Source: Dr Foster Intelligence

A comparison with other regional acute peers is also presented below in the funnel plot in figure 32, which shows the Trust has one of the lowest HSMRs in relation to our regional acute peers for the most recent data available.

Figure 32 HSMR Regional Acute Peers Benchmark Feb 2022 – Jan 2023

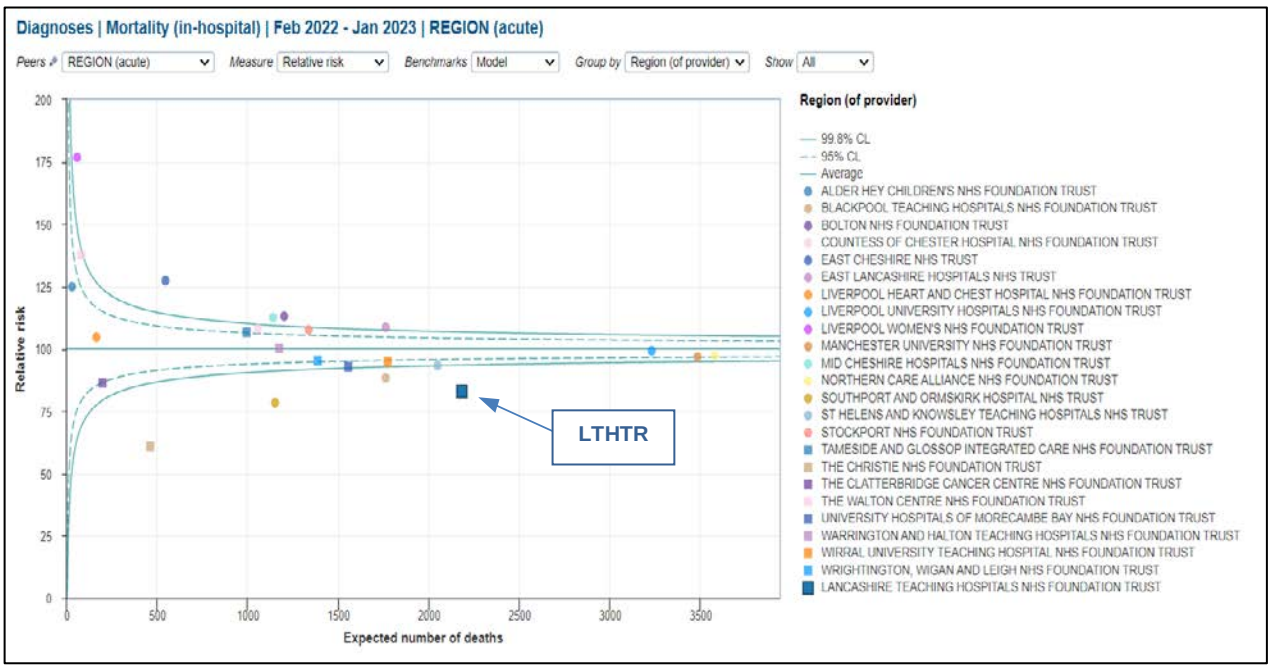


Source: Dr Foster Intelligence

Standardised Mortality Ratio – Relative Risk for All Diagnoses

The Trust also monitors the Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' and for the period February 2022 to January 2023 this was 82.8, which is lower than expected. The funnel plot in figure 33 below, demonstrates that again the Trust has one of the lowest relative risks compared to our regional acute peers.

Figure 33 SMR Regional Acute Trust Benchmark Feb 2022 – Jan 2023

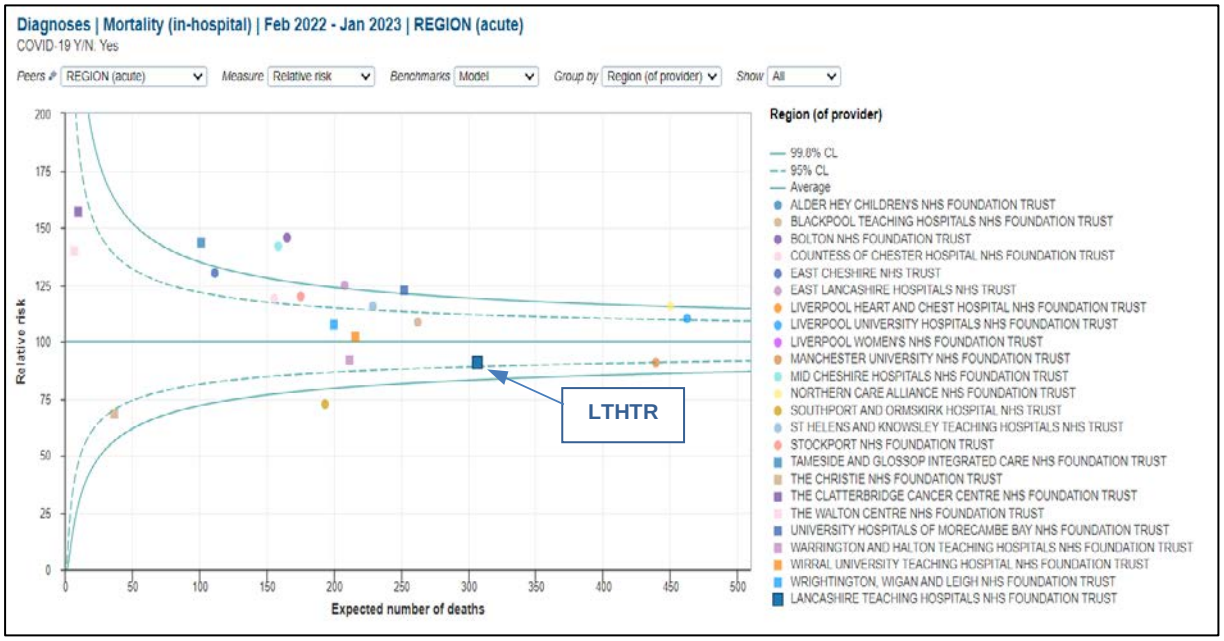


Source: Dr Foster Intelligence

COVID-19 Mortality Data Analysis

When only the COVID-19 data is analysed the funnel plot in figure 34 below, demonstrates that when compared to regional acute peers, the Trust was in the as expected range with the SMR being 90.8.

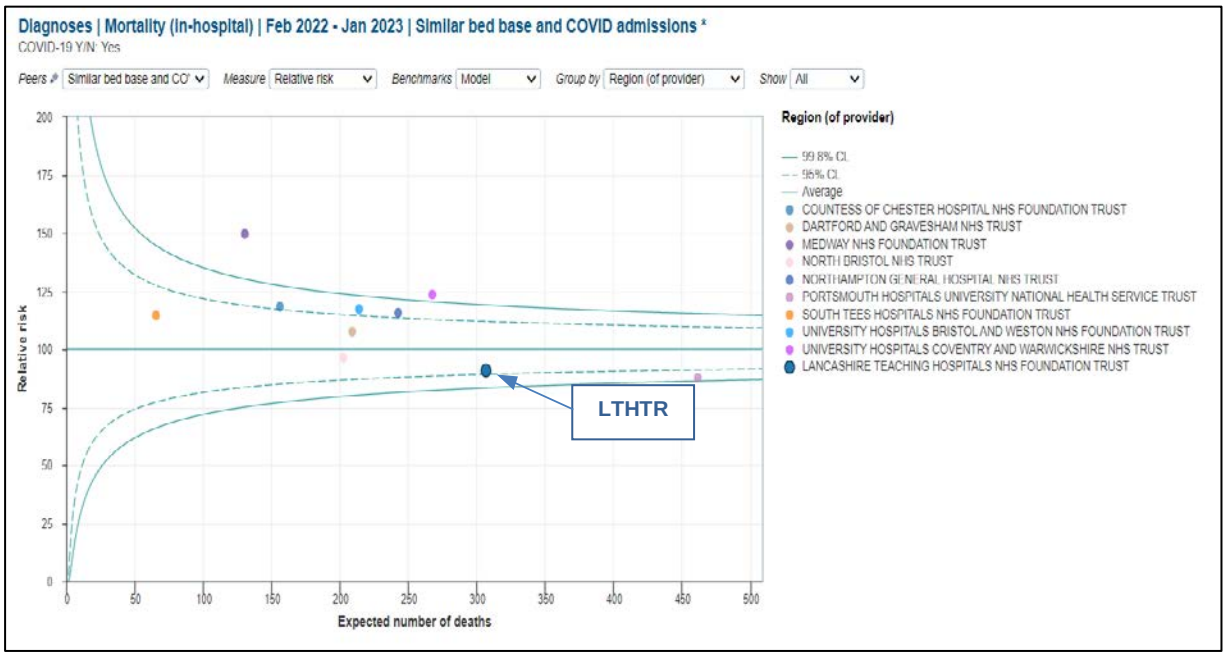
Figure 34 SMR Regional COVID-19 Benchmark Feb 2022 – Jan 2023



Source: Dr Foster Intelligence

The funnel plot in figure 35 below, compares the SMR with peers who have a similar number of beds and numbers of COVID-19 admissions. The data again demonstrates that the Trust had deaths within expected range, with an SMR of 90.8.

Figure 35 SMR COVID-19 Similar Bed Base Benchmark Feb 2022 – Jan 2023



Source: Dr Foster Intelligence

Learning from Adult Deaths

A summary of the learning from the SJRs is presented below. These are the key themes that have been identified from primary and secondary SJRs undertaken in 2022-23 and are areas for continual improvement:

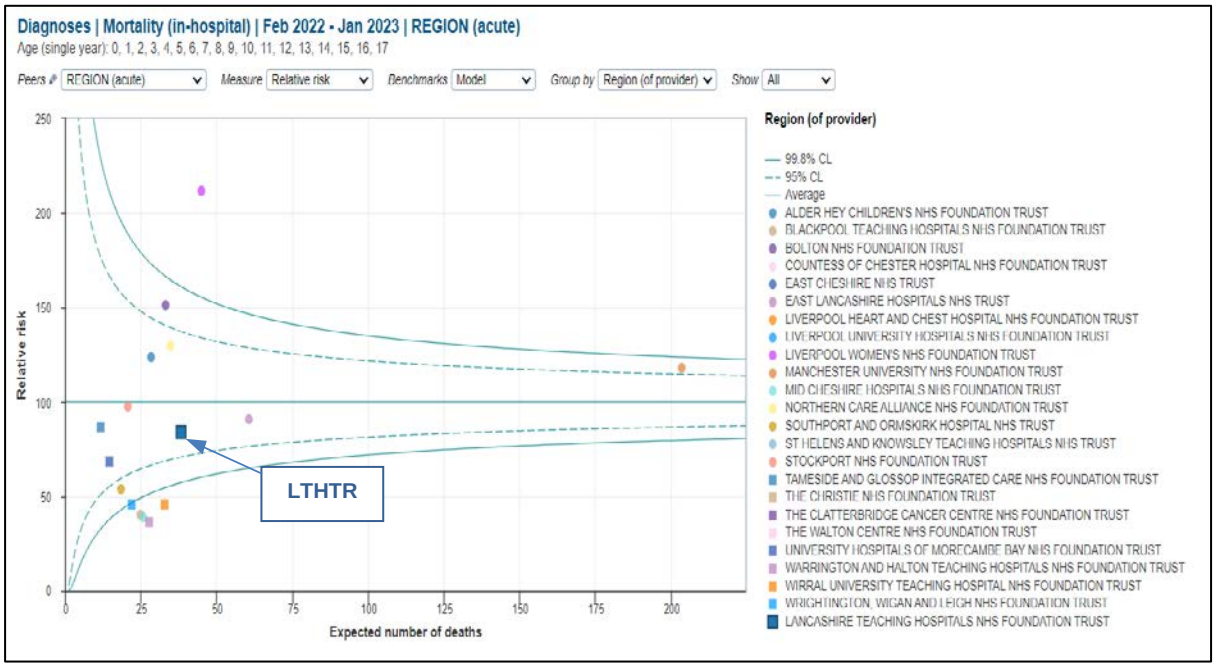
- Importance of early decision making and discussion of DNACPR with patients and families
- Importance of appropriate use of Alcohol Withdrawal Guidelines and correct documentation of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scores. CIWA is a tool to measure the level of alcohol withdrawal and informs medication
- Timely transfer of patients to specialty or higher level of care to avoid issues with transfer of patients who are acutely decompensating
- Education of management plans for intra cranial haemorrhage including observations, A-E assessments and blood pressure targets
- Accurate calculation and documentation of fluid balance
- Confirmation of prognosis from all relevant specialties for patients with active cancer to aid decision making regarding active treatment/palliation
- Patients undergoing active treatment should still have an individualised care plan if likely to pass away during current admission
- Importance of holistic review – in cases where there is false reassurance from an Early Warning Score (EWS) <4 but a single parameter is of concern
- Need for earlier recognition of patients nearing the end of life
- Improved communication with patients and families regarding decisions
- It is important to note that areas of good practice are also highlighted at primary and secondary review and key themes were:
    - Good quality MDT working.
    - Nursing care of patients.
    - Pre-emptive planning and discussions around DNACPR.
    - Communication and considerations well documented.
    - Co-morbidities influencing decisions to transition to conservative management and end of life care in a positive way.
    - Good discussions with family keeping them up to date and explaining the limitations to treatment and risk of deterioration.
    - Good pre-emptive planning and discussions around DNACPR.
    - Good end of life care with the family supported and updated including palliative care involvement.
    - Timely review and prompt admission to Critical Care.
    - Excellent end of life care.
    - The deaths reviewed of patients with Learning Disabilities had good to excellent care.

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

Child Deaths

The SMR for children for the 12-month period February 2022 to January 2023 (the most recent period available) is 83.8 which is within expected range as demonstrated in figure 36 below.

Figure 36 SMR for Children (<1 - 17 years)



Source: Dr Foster Intelligence

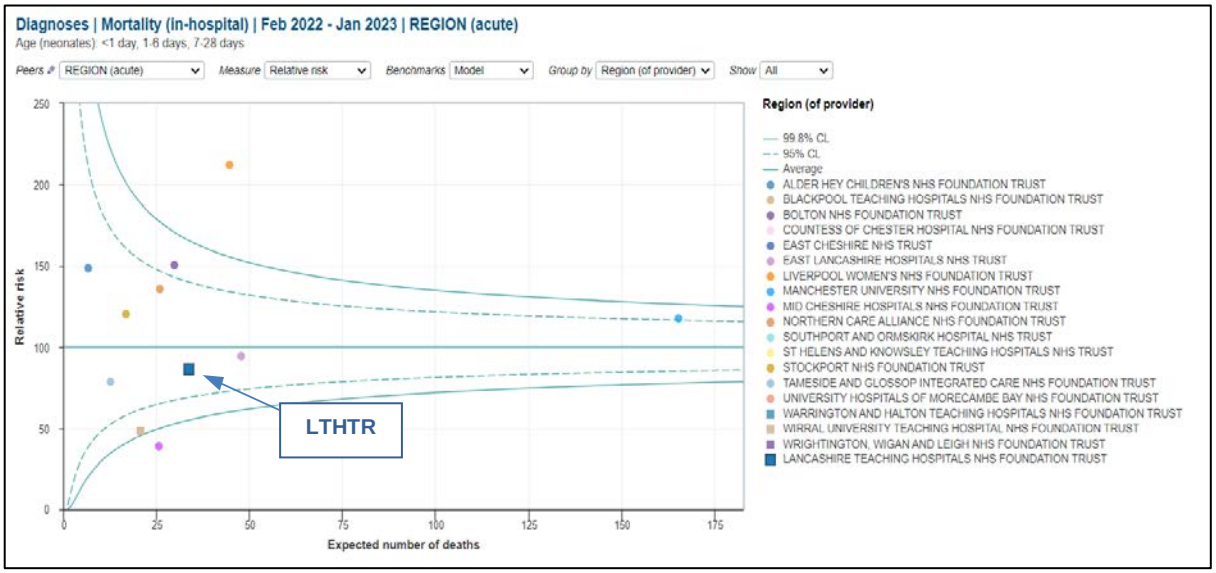
Reporting of child deaths is managed in line with local and national guidance. The Trust offers immediate support to parents and families and the Trust has a bereavement midwife available to support the parents of new born infants.

All child deaths are reported to HM Coroner unless the death is expected, and this has previously been agreed with HM Coroner. The statutory requirements for reporting child deaths to the CDOP are followed with this panel providing an independent multi-disciplinary review with the purpose of identifying lessons and preventing future deaths. In addition to reviewing children who have died in the Trust a case review is undertaken for any children known to the children's services at the Trust for example those transferred to Paediatric Critical Care or children who have died unexpectedly at home.

Neonatal Deaths

The SMR for Neonatal deaths for the 12-month period February 2022 to January 2023 (the most recent period available) is 86.3 which is within expected range and is demonstrated in figure 37 below.

Figure 37 SMR for Neonatal Deaths (<1 - 28 days)



Source: Dr Foster Intelligence

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

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

A summary of the learning from the child and neonatal deaths is presented below

Reviews identified opportunities for improved communication including always:

- ensuring good quality clinical documentation of care being delivered.
- completing death notification on the corporate form so that families receive appropriate Trust communications.
- provide comprehensive clinical documentation of escalation processes and immediate actions are put in place.
- ensuring nursing documentation has appropriate level of detail including Paediatric Early Warning Score (PEWS) and pain scores when undertaking observations and effective escalation plans developed.
- showing the ‘Safer Sleeping’ advice video prior to discharge from the postnatal ward and performing an assessment for every postnatal check and to ensure a safer sleeping assessment undertaken on community primary visits and handing over outcomes to health visiting services.
- optimising temperature control within clinical areas

Perinatal Mortality & Perinatal Mortality Review Tool

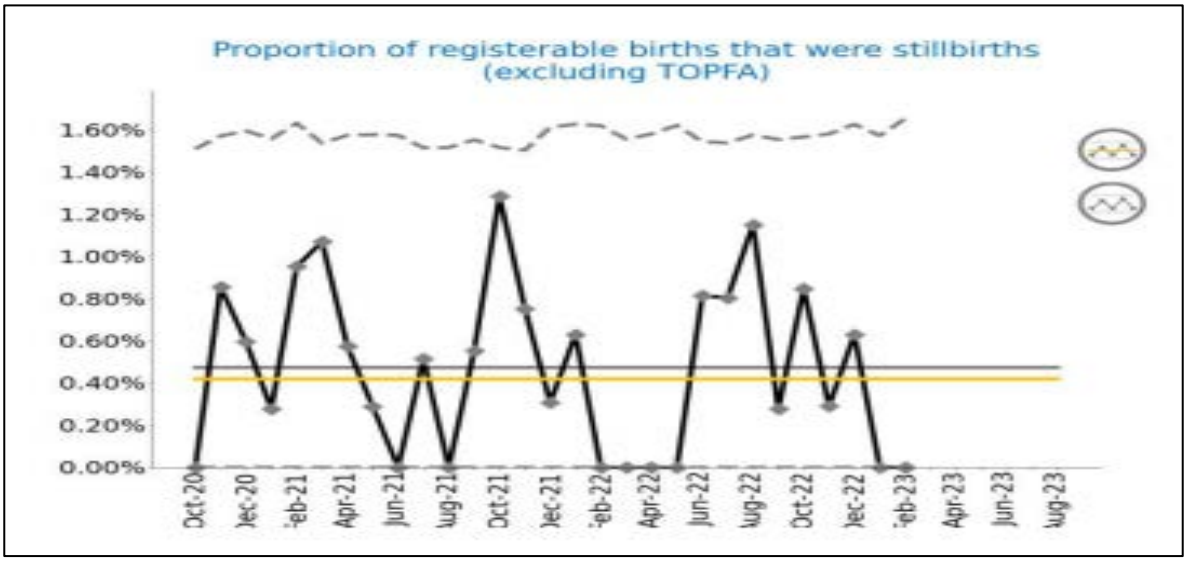
The Trust uses the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. This includes a comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth, excluding termination of pregnancy and those with a birth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

The Trust also shares a summary report of all cases at the Maternity Safety Champions meetings held bi-monthly. Formal reporting is provided to the Trust Board bi monthly as part of the Maternity Service Update Report. Between April 2022 and March 2023, the Trust reported 27 deaths that met the defined threshold for reporting using the PMRT

Stillbirths

The stillbirth rate is monitored monthly by maternity Safety and Quality Committee. The maternity service has recently moved from a traditional Red, Amber and Green (RAG) rated maternity dashboard to statistical process control (SPC) analysis. The SPC analysis, as shown in figure 38, shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. Currently the mean stillbirth rate is below the national average of 4.9 per 1000 births.

Figure 38 Maternity SPC analysis - Incidence of Stillbirths (per 1000 births)



Source: LTHTR Data

A cluster of stillbirths were identified in quarter three of 2022-2023. Local review of the cases did not identify any concerning features, themes are taken from reviews and align with national areas of work in this area, however, an external review of the cases by the regional chief obstetrician has been requested for assurance. The outcome of the review is awaited. The maternity service continues to closely monitor the incidence of stillbirth and the MBRRACE real time monitoring tool is utilised to closely track cases.

Medical Examiner Service

The Medical Examiner (ME) service was introduced nationally in response to:

- Recommendations in the 2003 Home Office Fundamental Review of Death Certification and Investigation
- The Shipman Enquiry
- Recommendations of Robert Francis in the Investigation into Mid-Staffordshire NHS Foundation Trust
- The Kirkup Review of Deaths at Morecambe Bay Hospitals

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

The MEs undertake the following tasks:

- Review the last admission episode
- Review the cremation forms
- Review the certified cause of death and discuss with the responsible clinical team if there are queries or causes of concern
- Speak to families and resolve any potential concerns
- Consider potential Coronial cases
- Review all deaths and escalate cases for Primary SJR Mortality Review or in cases of concern for a Rapid Incident or Serious Incident Review
- Facilitate early detection of any clinical governance issues through this additional layer of scrutiny into the review of deaths

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

Table 23 Medical Examiner Service Performance 2022-23 data

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

Source: LTHTR Data

The Coroner's Officers hold conversations with the bereaved when the death is referred to HM

Coroner and out-of-hours the families are supported by the General Office team and bereavement service.

The Registration Service has reported a reduction in the number of certificates rejected due to inaccurate or inappropriate causes of death. This rejection would normally result in the family having to seek a new MCCD from the hospital or a referral to HM Coroner's service.

It has also been reported that there has been a significant decrease in inappropriate cases being referred to HM Coroner. ME discussions with attending practitioners have resulted in clarity around the causes of death which has led to fewer patients being referred due to 'no cause of death identified.' Some cases have been referred to HM Coroner as a direct result of ME scrutiny. These include cases where concerns have been raised by families, substandard care has been identified or more commonly aspects of the events around death have meant that it is necessary to refer.

A second MEO has been recruited which has allowed for more support for the Lead ME and cover for annual leave. The increased capacity has also facilitated scrutiny of cases at Chorley and South Ribble Hospital. The national ME database system was introduced in April 2021 which replaced the current AMaT proformas. Resources have also been secured to start scoping the ME scrutiny of non-acute/community deaths, which it is hoped will result in the recruitment of two additional MEOs.

Review of Quality Performance – Experience of Care

Patient Experience Performance Report 2022-23

Patient care

Improving patient experience is a key ambition for the Trust underpinned by the mission to provide 'Excellent care with compassion.' Acquiring and acting upon the feedback provided by our patients, families and carers on their experience is an important component to achieving that ambition. This year, the Trust coproduced a new three-year Patient Experienced Involvement Strategy for 2022 to 2025. This strategy was developed and co-produced with our patients, families, carers, governors and staff. We have actively sought the views of patient groups who represent those people who have protected characteristics and recognise the importance of intersectionality when considering this feedback. The Patient Experience Involvement strategy closely links to a number of Trust strategies including Equality, Diversity and Inclusion, Leadership and organisational development, Mental Health, Learning Disability and Autism, Dementia and the Always Safety First strategy. The actions within our strategy are monitored through the Patient Experience and Involvement Group, which is a diverse group consisting of governors, patient representatives, carers, voluntary sector organisations and staff members and provides assurance to the Trust Safety and Quality Committee.

The strategy is divided into 3 sections. Insight - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information. Involvement – to equip our patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system. Improvement - to design and support improvement programmes that deliver effective and sustainable change.

The outcome measures that will evidence the delivery of the strategy include:

- Reduction in complaints.
- Improved recommendations via friends and family feedback.
- Increased response rates to Friends and Family Test (FFT).
- Increased compliments improved outcomes in our National Patient Surveys.
- Improved response time to concerns and complaints.
- Reduced number of second complaints.
- Increased evidence of patient co-production and improve training, metrics, communication and patient experience and Patient Experience and Patient Advice and Liaison Service (PALS) with early resolution.

Our PALS team work alongside colleagues, patients/carers and other stakeholders in a responsive way. The team do this by:

- Providing information to patients, relatives, and carers.
- Resolving problems and concerns before they escalate to become complaints.
- Providing data about the experiences of patients, their relatives, and carers to inform improvements in the quality of services.
- Informing people about the complaints procedure and how it can be accessed.
- Acting as an early warning system for the Trust.

- Identify opportunities for learning from the experiences of patients, relatives, and carers.
- Working in partnership with the teams of other healthcare providers and partner organisations.

Complaints, Concerns and Compliments

Table 24 Comparator data for Complaints 2020 to 2023

Year	Complaints received	Increase/reduction
2020-21	361	-96
2021-22	580	+219
2022-23	487	-93

Source: LTHTR Datix

During 2022-23 the Trust received 487 formal complaints, a decrease of 93 from 2021-22. The decrease represents a percentage of 16%. In the previous year there was a substantial increase in complaints, following the COVID-19 pandemic. The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below:

Table 25 Trend of ratio of complaints per patient contact 2020 to 2023

Year	No of complaints	Total episodes (inpatient/outpatient)	atio of complaints topatient contacts
2020-21	361	717,213	1:1,987
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744

Source: LTHTR Datix

Of the 487 complaints received between April 2022 to March 2023, 417 (86%) related to care or services provided at the Royal Preston Hospital (RPH), 68 (13.9%) to care or services provided at Chorley and South Ribble Hospital (CDH) and 2 (0.4%) to care or services provided by Preston Business Centre. In addition to the 487 complaints received, the Patient Experience and PALS team also responded to 7 cases which were deemed to be outside of the 12 month timescale set out under the NHS Complaints Procedure.

Table 26 Number of Complaints by Division – April 2022 to March 2023

Division	Number (%)	Division	Number (%)
Medicine	189 (40%)	Women and Children's Services	80 (16%)
Surgery	172 (35%)	Diagnostics and Clinical Support	31 (6%)
Estates and Facilities	6 (1.2%)	Corporate Services	9 (1.8%)

Source: LTHTR Datix

During this financial year there were 516 cases due to be closed. The outcome of these can be broken down into the following outcomes 44 (8%) of the complaints had been upheld. 310 (60%) were partly upheld and 127 (25%) had not been upheld. The 1 (0.5%) remaining record was withdrawn, and 34 (6.5%) cases currently remain open.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 97% of complainants received an acknowledgement within that timescale where complaints were received into the

Patient Experience and PALS team.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2022 and March 2023 we received 29 second letters.

During the period 1 April 2022 to 31 March 2023 555 complaints were closed. 70% of complaints received in 2022-23 were closed within the internal set target of 35-day timescale. This is reported to Safety & Quality Committee monthly. The Patient Experience and PALS Team have dealt with a total of 2,413 concerns and 4,727 enquiries.

Top 3 Themes from complaints by Division

Diagnostic Clinical Support

1. Consent, confidentiality or communication
2. Clinical assessment
3. Nursing care

Womens and Children's

1. Treatment/procedure
2. Consent confidentiality or communication
3. Staff behaviour or attitude

Medicine

1. Consent, confidentiality, or communication
2. Clinical assessment
3. Nursing care

Surgery

1. Consent, confidentiality, or communication
2. Treatment/procedure
3. Clinical assessment

The Parliamentary Health Service Ombudsman

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1 April 2022 to 31 March 2023 there were 4 cases referred to the PHSO; 1 was not upheld and 3 are ongoing. During this period, the PHSO sent final reports for 3 cases which were opened prior to April 2022 and the outcome of these were that 1 was not upheld and 2 were partly upheld. In addition, there was 1 other case opened prior to April 2022 which the PHSO closed as premature (Trust to undertake further local resolution). There are a further 2 cases referred to the PHSO prior to April 2022 which are still under investigation by the PHSO, and a final decision is yet to be reached. Also, during this period a further 2 cases have been referred to the PHSO which are being actioned through the PHSO's local dispute resolution process; 1 has been resolved, 1 is ongoing with a view to a meeting date is to be arranged.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2022-23 a total of 2,664 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been an increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions.

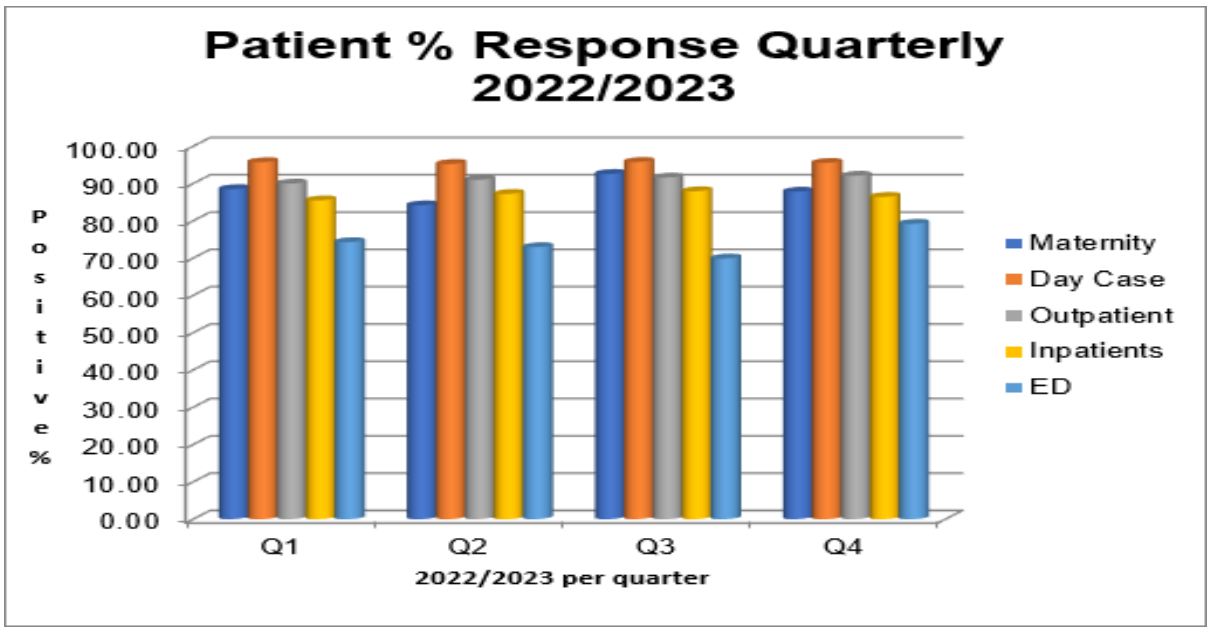
Patient experience feedback

Friends and Family Test

The FFT is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. FFT is reported at departmental level, and also reported to Safety and Quality Committee and through to Trust Board. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- ED

Figure 39 – Quarterly percentage of positive responses Friends and Family

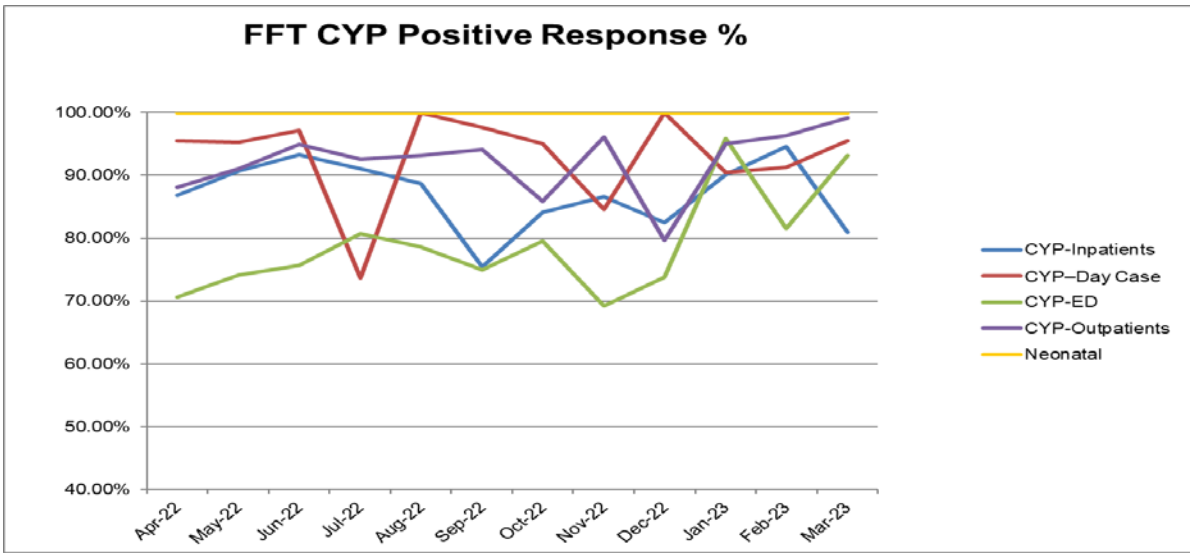


Source: FFT data CIVICA

Historically, a target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the ED. Maternity has achieved this in Q3, Day case have consistently achieved in excess of 90% in all four quarters, outpatients have achieved this for the past three quarters with inpatients and the ED under the target percentage in all four quarters. A redesign of the ED is taking place to address the number of patients in the department and the number of patients spending extended periods of time in the ED. This

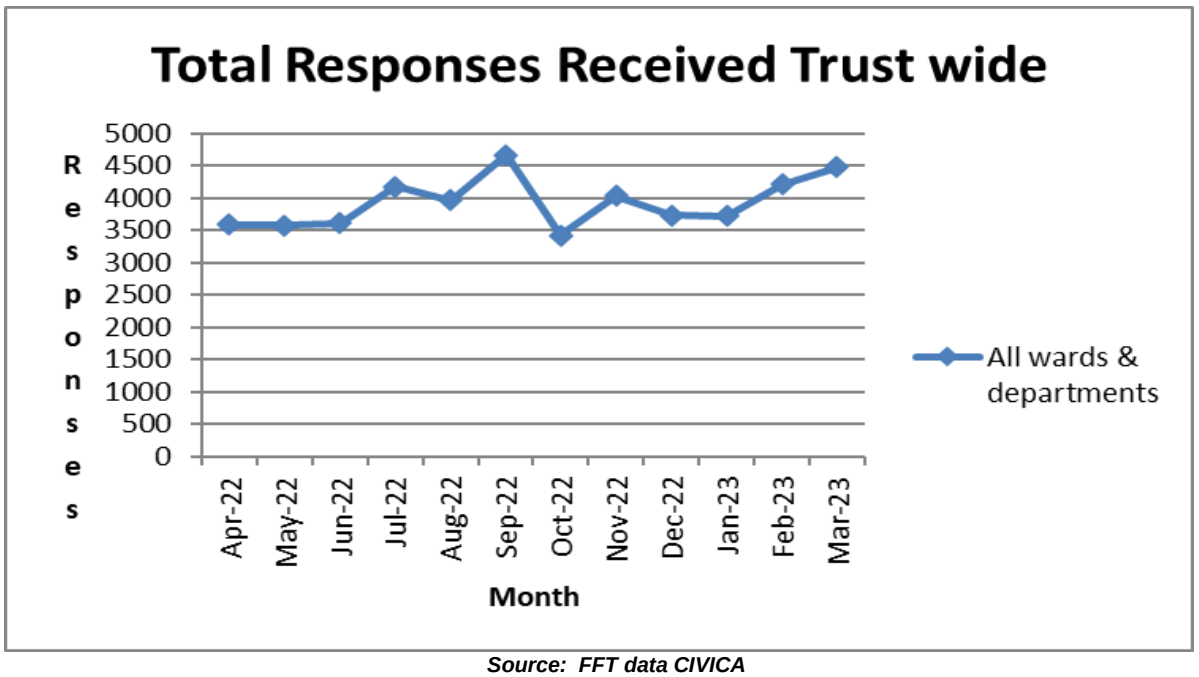
is aimed to improve overall experience for patients and families. Although not a national requirement, the Trust undertakes surveys in Children and Young People's (CYP)Services to ensure an equitable approach to measurement of experience. Positive increases in CYP ED experiences have been demonstrated in 2022-23, continued work to improve the experience of families and children in the children's inpatient area continues and the neonatal service has maintained a sustained performance of 100%.

Figure 40 CYP Quarterly % of positive responses FFT



Source: FFT data CIVICA

Figure 41 FFT % Response



Source: FFT data CIVICA

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

- Since April 2021 – March 2022 we have received 1468 surveys completed using the QR codes/on line links, 2829 paper surveys, 3684 telephone surveys and 36,128 SMS surveys.

- Since April 2022 – March 2023 we have received 2905 surveys completed using the QR codes/on line links, 6788 paper surveys, 4421 telephone surveys and 37,070 SMS surveys.

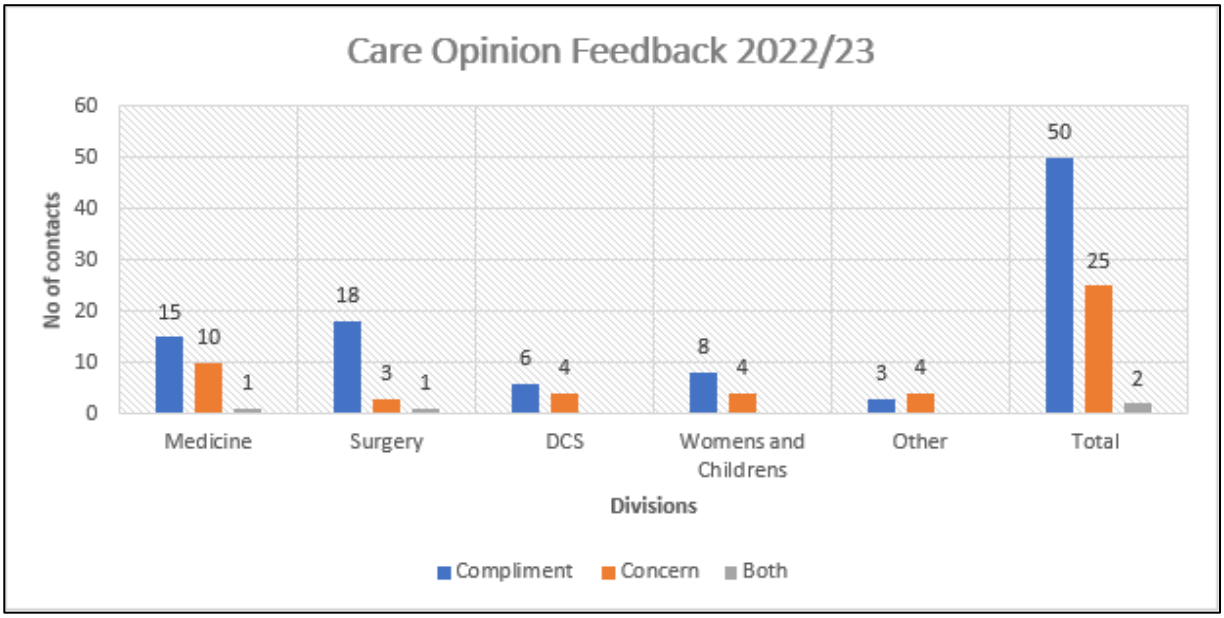
We are actively training staff to use the system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded using CIVICA. Monthly reports are being sent to all governance and divisional leads to ensure the results are being reviewed and shared throughout the trust.

Care Opinion website (www.careopinion.org.uk**)**

Care Opinion is a place where patients can share their experience of health or care services and help make them better for everyone. It provides patients with the ability to post reviews for both Royal Preston (which includes Preston Business Centre) and Chorley and South Ribble Hospitals.

The Care Opinion website is monitored and responded to on a regular basis by the Patient Experience and PALS Team. All reviews are responded to in order to acknowledge them, provide assurance that their feedback will be shared and provide the Patient Experience and PALS contact details for those who wish their concerns to be raised or looked into further. All feedback and compliments are logged on the Datix Governance reporting system and share with the relevant divisions and staff. A quarterly report is provided from the reviews left on Care Opinion and shared with the Trust Corporate Governance team.
It is difficult to establish themes due to the low numbers provided. During the past financial year, there have been a total of 77 reviews posted on the website consisting of 50 compliments, 25 concerns and 2 with a mix of both complements and concerns.

Figure 42 Care Opinion Feedback 2022-23



Source: Care Opinion Website

National Survey Results

Maternity Survey 2022

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 19th out of 65 Trusts in 2022 surveyed by Picker. This is compared to the 2021 survey, where the Trust was ranked 11th out of the 66 Trusts surveyed. The response rate to the Maternity survey of 44% was lower than the national average of 48%.

There were no areas identified where the Trust was significantly worse than the 2021 survey.

There were 2 areas identified where the Trust was significantly better than the 2021 survey:

- Partner/companion involved (during labour and birth) – 95% compared to 86% in the 2021 survey
- Found partner was able to stay with them as long as they wanted (in hospital after birth) – 94% compared to 36% in 2021

We were significantly better that the national Picker average on the following five questions:

- Offered a choice of where to have baby – 93% compared to Picker average of 81%
- Partner/companion involved (during labour and birth) – 95% compared to Picker average of 91%
- Found partner was able to stay with them as long as they wanted (in hospital after birth) – 94% compared to Picker average of 41%
- Involved enough in decisions about their care – 96% compared to Picker average of 92%
- Not left alone when worried (during labour and birth) – 82% compared to Picker average of 73%

We were significantly worse that the national Picker average on the following two questions:

- Provided with relevant information about feeding their baby – 73% compared to Picker average of 82%
- Given information/advice on risks of induced labour – 47% compared to Picker average of 64%

Overall, the results for our Trust showed:

- 97% treated with respect and dignity (during labour and birth)
- 95% had confidence and trust in staff (during labour and birth)
- 95% involved enough in decisions about their care (during labour and birth)

Children and Young People's Survey 2020

We have seen an increase for the year 2020 in satisfaction of the parents, children and young people surveyed based on the 2018 survey. The Trust is ranked 31st out of the 67 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 58th out of 66

Trusts surveyed. Parents rated experience of care as seven out of 10 or more and this is at par with the Picker national average.

We were significantly better than the last survey on the following seven questions:

- Parents had new members of staff introduce themselves – 97% compared to 92% in 2018
- Parent felt that Wi-Fi was good enough for child to do what they wanted – 81% compared to 57% in 2018
- Parent kept informed by staff about what was happening – 90% compared to 92% in 2018
- Parent had access to hot drinks facilities in hospital – 84% compared to 74% in 2018
- Parent felt that staff were available when child needed attention – 97% compared to 93% in 2018
- Parent felt hospital room or ward was clean – 99% compared to 96% in 2018
- Child felt hospital was quiet enough to sleep – 86% compared to 68% in 2018

We were significantly worse than the last survey on the following question:

- Parents felt that there was not enough for their child to do – 73% compared to 91% in 2018

We were significantly better than the Picker average on the following two questions:

- Parent had access to hot drinks facilities in hospital – 84% compared to 78%
- Parent able to prepare food in hospital – 70% compared to 41%

We were significantly worse than the Picker average on the following question:

- Parent rated overnight facilities as good or very good – 50% compared to 69%

Overall, the results for our Trust showed:

- 93% parent felt well looked after by staff
- 93% child felt well looked after in hospital
- 94% parent felt staff agreed a plan with them for child's care

Urgent and Emergency Care Survey 2020

Lancashire Teaching Hospitals is ranked 34th out of 66 trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 47th out of 69 Trusts surveyed. This shows an improvement on the previous survey.

We were significantly better than the last survey on the following 3 questions:

- Waited under an hour in the ambulance – 97%, compared to 89% in 2018
- Waited under an hour in A&E to speak to a doctor/nurse – 90%, compared to 82% in 2018
- Staff helped control pain – 90%, compared to 84% in 2018

We were significantly worse than the last survey on the following question:

- Right amount of information given on condition or treatment – 74%, compared to 83% in 2018

Significantly better than the Picker average on the following 5 questions:

- Understood results of tests – 99%, compared to 97%
- Saw the cleaning of surfaces – 82%, compared to 74%
- Saw tissues available – 83%, compared to 78%
- Did not feel threatened by other patients or visitors – 96%, compared to 93%
- Staff discussed transport arrangements before leaving A&E – 61%, compared to 50%

Significantly worse than the Picker average on the following question:

- Spent under 12 hours in A&E – 88%, compared to 94%

Overall, the results for our Trust showed:

- 88% rated care as 7/10 or more
- 97% treated with respect and dignity
- 95% doctors and nurses listed to patient

Adult Inpatient Survey 2021

The Trust is ranked 55th out of the 73 Trusts surveyed by Picker. This is compared to the 2020 survey where the Trust was ranked 61st out of 71 Trusts surveyed. This demonstrates an overall improvement.

We were significantly better that the last survey on the following two questions:

- Did not have to wait a long time to get a bed on ward - 78% compared to 69% in 2021
- Was involved in decisions about care and treatment – 82% compared to 75% in 2021

We were significantly worse that the Picker average on the following 9 questions:

- Did not have to wait long time to get to bed on ward – 69% compared to Picker average 74%
- Not prevented from sleeping at night – 48% compared to Picker average 47%
- Food was very good or fairly good – 48% compared to Picker average 69%
- Always or sometimes enough nurses on duty – 86% compared to 90%
- Was involved in decisions about care and treatment – 75% compared to Picker average 80%
- Felt involved in decisions about discharge from hospital – 71% compared to Picker average 76%
- Knew what would happen next with care after leaving hospital – 80% compared to Picker average 84%
- Told who to contact if worried about discharge – 70% compared to Picker average 75%
- Asked to give views on quality of care during stay – 8% compared to Picker average 13%

Overall, the results for our Trust showed:

- 80% rated experience as 7/10 or more
- 97% treated with respect or dignity
- 97% had confidence and trust

National Cancer Patient Experience Survey

The 2021 National Cancer Patient Experience survey (NCPES) involved all adult patients confirmed with a primary diagnosis of cancer who were discharged from an inpatient episode or day case attendance for cancer related treatment during the period of April - June 2021. The fieldwork was undertaken during period of October 2021 - February 2022.

The survey is designed to:

- Monitor national progress on cancer care,
- Provide information to drive local quality improvements,
- Assist providers and to inform the work of the various stakeholders supporting cancer patients,
- Understand what patients think about their cancer care.

The survey reflects the views of 1,233 patients with a response rate of 56%, which is lower than the previous year response of 65% but just above the national rate of 55%. Most of the respondents completed the survey by paper and were white British aged over 55. Only 3% of respondents were ethnic minority background. The distribution between male and females' responses were almost equal and responses from males were more positive overall.

Trust areas of good practice with teams achieving 100% score:

- The patient has a main contact - Upper Gastro-Intestinal (UGI) team
- The patient found advice from their main contact very helpful - Head & Neck (H&N) and UGI teams
- Review of care plans with patients - all teams except Gynaecology team
- The patient received all the information about diagnostic tests - Gynaecology team.
- Patients receiving easily understandable information - H&N team (all other teams scored well)
- The patient was given information regarding side effects - UGI team
- Patients were given enough information regarding radiotherapy - H&N and Colorectal teams
- Information given regarding progress with radiotherapy treatment - Colorectal team

Trust areas to improve care

- To improve information regarding referral particularly with the lung and gynae pathways
- Finding out the patient has cancer in lung and gynae pathways
- Discussing treatment options
- Supporting information for families and loved ones on how to care for patient at home
- Respect and dignity whilst an inpatient
- UGI and Prostate scores were lower regarding inpatient care

The positive results of the survey and many positive patient comments regarding the care of cancer patients at Lancashire Teaching Hospitals cancer centre show the dedication and effort of our staff to provide a highly specialised service with patient care at the centre of our work.

Major Service Developments and Improvements

Despite significant challenges across the Lancashire and South Cumbria healthcare system due to winter pressures and the restoration of activity following the COVID-19 pandemic, we continued to implement a number of major service developments during 2022-23 which have benefitted both patients and colleagues, with some working to help alleviate demand on our Emergency Care pathways and improve flow across our sites.

These developments are testament to the resilience of our hard working and dedicated colleagues and key partners who have remained committed to enhancing services available to our patients and improving the experience they received. The major service developments during the past year are outlined below.

Nightingale and Cuerden Ward

In June 2022, the Nightingale demountable facility at Royal Preston Hospital officially closed its doors after over five months in service. The facility cared for around 1,000 low acuity patients who were nearing discharge with the additional bed base allowing the system to improve flow during exceptionally busy winter and spring periods.
The facility was originally erected by NHSE to deal with a potential surge of the COVID-19 Omicron variant but it was agreed with that Preston's Nightingale Surge Hub would open in January 2022 to help alleviate sustained and severe pressures and high bed occupancy across the Lancashire and South Cumbria ICS.
Both clinical and non-clinical staff were involved in the set-up, delivery and take-down of the facility and all colleagues can be proud of the part they have played in ensuring its success.
Following its closure, elements of the new Cuerden Ward at Chorley and South Ribble Hospital opened to add some much-needed capacity back into the system to improve patient flow. The new ward created 24 additional beds and has provided additional capacity at the hospital to help care for diabetes, endocrinology and general medical patients.

Renal services across Lancashire and South Cumbria

Lancashire Teaching Hospitals is responsible for renal services across Lancashire and South Cumbria.

In September 2022, the Laurie Solomon Renal Centre was opened by the Trust, as part of a programme of improvements to renal facilities across the local healthcare system.

The new centre, which was purpose-built on the site of Royal Blackburn Hospital, provides 24 haemodialysis stations and outpatient clinic facilities for patients from across the region and was named in honour of a doctor who recently celebrated 50 years with the NHS.

The opening follows new centres being unveiled in Ulverston (July 2021) and Burnley (November 2021).

Finney House – Lancashire Community Healthcare Hub

Our new Lancashire Community Healthcare Hub at Finney House in Preston has been hugely successful in helping to improve flow across our acute hospital sites. The Trust officially opened the Hub on 30 November 2022, having become the CQC registered provider of services two weeks earlier following a lease agreement with L&M Healthcare.

Alongside the care of around 30 residents, Lancashire Teaching Hospitals currently manages 64 beds within the facility. The beds are aimed at caring for patients who are medically fit for discharge within our hospitals but do not yet have the current support in place to go back into their community setting. The facility is making huge strives in increasing flow across our hospitals, enabling us to manage patients care effectively and in an environment where they can best recover.

By 31 March, the facility had seen 550 admissions and over 490 discharges with an improving portfolio of services available to patients, including on-site rehabilitation. Its early success was documented in a special BBC feature for The One Show which highlighted how Lancashire Teaching Hospitals is one of the few Trusts nationally to step into this space to help improve discharges. By freeing up acute beds at a quicker rate, this is helping to reduce the waiting times and pressures within our Royal Preston Hospital's ED, giving both staff and patients a much better environment and experience. So far, feedback from patients has been extremely positive which is testament to the fantastic facilities the Trust offers and the work all colleagues are doing to increase flow across our hospital sites.

COVID-19 Vaccination and Testing Programme

After two years and eight months, the Royal Preston Hospital COVID-19 staff testing POD closed for use in November 2022, following changes to Government guidance for testing. Over that time, the team performed tens of thousands of Polymerase Chain Reaction (PCR) swabs for colleagues, system partners and initially immediate family members, helping to identify and confirm thousands of positive results to help avoid nosocomial infections within our hospitals.

A month later, Preston's largest vaccination centre, run by Lancashire Teaching Hospitals, and located in St John's shopping centre, also closed its doors for the final time in after vaccinating over 200,000 people to protect against the COVID-19 virus. The site opened in January 2021, but closed its doors following vaccinations moving to be delivered within Primary Care – either in GP surgeries or pharmacies.

Surgical Hub meeting top clinical and operational standards

In March 2023, Chorley & South Ribble Hospital was one of eight surgical hubs awarded GIRFT accreditation as part of a pilot scheme to ensure the highest standards in clinical and operational practice.

The scheme, run by NHSE's GIRFT programme in collaboration with the Royal College of Surgeons of England, assesses hubs against a framework of standards to help deliver faster access to some of the most common surgical procedures such as cataract surgeries and hip replacements.

Surgical hubs, which are separated from emergency services, are part of plans nationally to increase capacity for elective care with more dedicated operating theatres and beds. The hubs exclusively perform planned surgery and mainly focus on high volume, low complexity (HVLC) surgery across various specialties including ophthalmology, general surgery, orthopaedics, gynaecology, ear nose and throat, and urology.

Hubs bring together the skills and expertise of staff under one roof, with protected facilities and theatres, helping to deliver shorter waits for surgery. The hub beds are designated for patients waiting for planned surgical procedures, and are protected from emergency admissions, reducing the risk of short-notice cancellations.

International nurse recruitment

An extensive international nurse recruitment programme has continued during 2021-22.

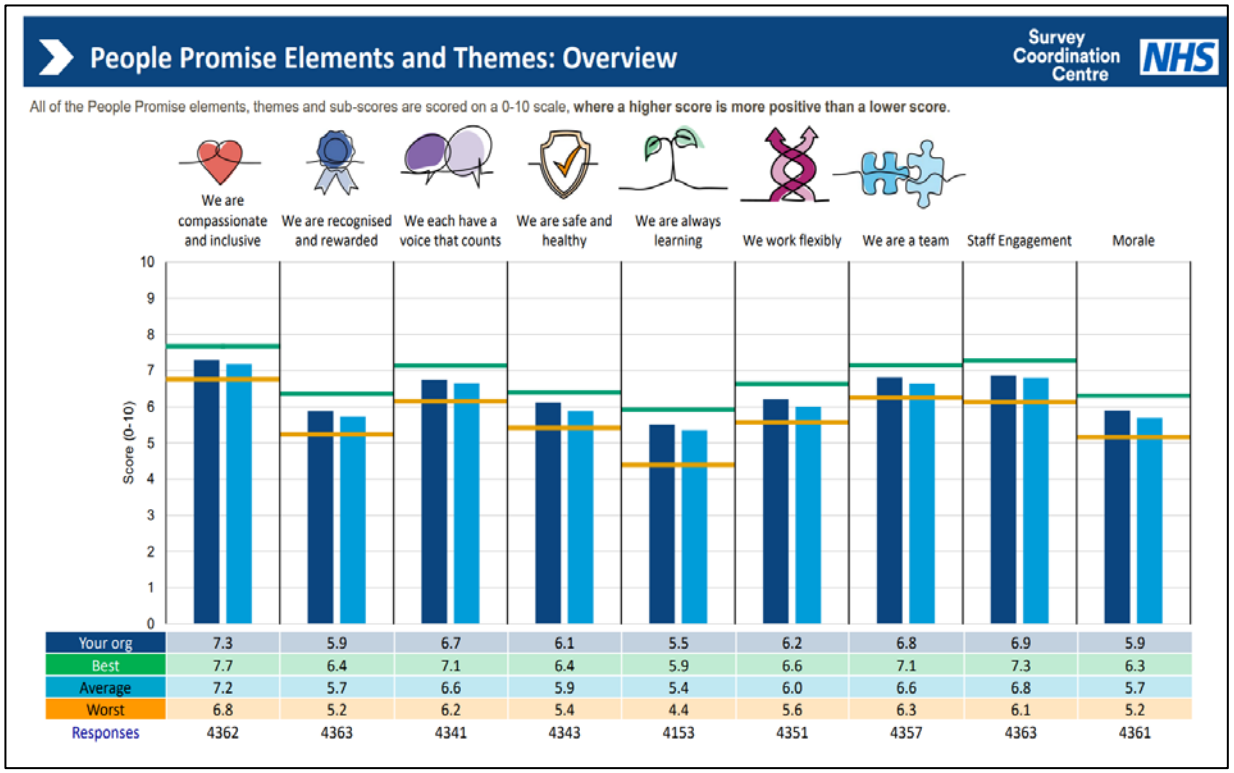
To date over a 4 year period almost 600 international nurses have joined our organisation. The aim is to improve the experience of colleagues working with team members who are part of their team, reduce the loss of registered nurses by improving staffing fill rates and having team members who are familiar with the environment they work in and therefore deliver better care to our patients. The added advantage is that this also reduces the reliance on high cost agency spend. The aim is to reach a zero registered nurse vacancy position by August 2023.

Staff Survey and Recommendation of Our Care

Annual National Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The Trust's response rate to the 2022 survey was 47%. This is a 10% increase from the 2021 survey (37%) and is above the national average (44%) in our benchmarking group (Acute and Acute and Community Trusts). Scores for each indicator together with that of the survey benchmarking group are presented below.

Figure 43 Annual National Staff Survey

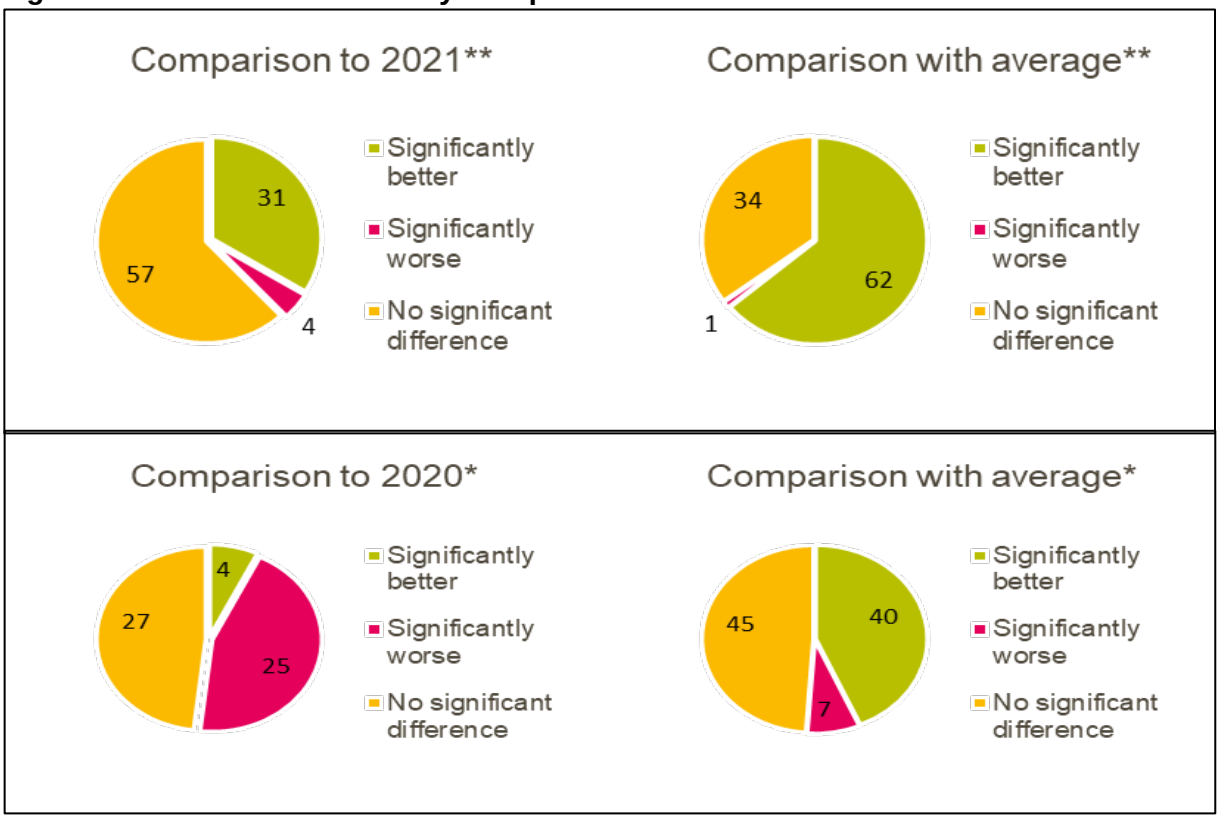


Source: National Staff Survey

As indicated in the summary above, against the nine elements, we have performed above the national average for all of the people promise elements in 2022. This is the first time we have achieved this and whilst the results still show us where are areas for improvement are, we can see we are continuing to make progress towards our aspiration of being the 'best' in the NHS.

In summary a total of 117 questions were asked in the 2022 survey, of these, 112 can be compared to 2021 and 97 can be positively scored. The pie charts below show how our 2022 scores have compared against how we performed in 2021 against the Picker average.

Figure 44 National Survey Comparisons



Source: National Staff Survey

Staff Engagement

The scores below detail the overall staff engagement score for 2022 and the breakdown of scores for items which measure the 3 facets of team engagement, namely motivation, involvement and advocacy. The results compare our scores against our 2020, 2021 results and the national average for this year.

The table below shows that for staff engagement we have seen improvements in all except two questions which have slightly deteriorated and one that has stayed the same in comparison to both our 2021 results and the national benchmarking average.

Table 27 Staff Engagement Results and Comparisons

Description	Organisation 2020	Organisation 2021	Organisation 2022	National Average
MOTIVATION	**7.2**	**7.0**	↑ **7.1**	**7.0**
I look forward to going to work.	56.8%	51.8%	↑ 55.2%	52.5%
I am enthusiastic about my job.	74.1%	68.7%	↑ 70.2%	66.7%
Time passes quickly when I am working.	77.2%	75.5%	↓ 74.5%	72.5%
INVOLVEMENT	**6.8**	**6.9**	↑ **7.0**	**6.8**
There are frequent opportunities for me to show initiative in my role.	73.6%	74.8%	↑ 75.7%	72.8%

I am able to make suggestions to improve the work of my team / department.	76.5%	73.6%	↑ 74.6%	70.9%
I am able to make improvements happen in my area of work.	55.5%	53.7%	↑ 56.5%	54.7%
ADVOCACY	**7.0**	**6.6**	6.6	6.6
Care of patients/service users is my organisation's top priority.	78.8%	72.6%	↑ 72.8%	73.5%
I would recommend my organisation as a place to work.	63.6%	56.2%	↑ 57.2%	56.5%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	69.1%	61.9%	↓ 59.9%	61.9%
OVERALL STAFF ENGAGEMENT SCORE	**7.0**	**6.8**	↑ 6.9	6.8

To summarise the staff engagement findings:

- In the majority of areas, our results show that we are making improvements and are now above or on the national average benchmarking data.
- Whilst our overall staff engagement score has only slightly increased since 2021 by 0.1 point, we are again, slightly above the national average.
- When we look at the engagement questions relating to motivation, we can see some encouraging increases in relation to looking forwards to going to work (+3.4%) and feeling enthusiastic about work (1.5%) which both above national average. This shows us important progress after our 2021 results had seen declines in both these questions.
- When we look at the engagement questions relating to involvement, we can see improvement here for all three questions in comparison to our 2021 results and when looking this in comparison to the national average, this can see this is an area of strength in our results.
- When looking at the engagement questions relating to advocacy, we can see this remains an area of focus for us. Whilst overall we have remained stagnant in this sub theme, there is work to be done to improve how colleagues feel regards to if they would recommend the organisation as a place of work and if a friend or relative needed treatment, they would be happy with the standard of care with both these questions being below the national average for our benchmarking group.

Future priorities and targets

The 2022 results show us where we are making progress to improve our overall staff experience and they help us to understand our priorities and key areas we need to pay attention to over the next 12 months. Many actions will continue to be delivered by the Workforce and Organisational Development team as outlined in Our People Plan 2023-26 which identifies our key strategic aims and deliverables.
Alongside this our three priority areas include:

- Colleagues experiencing physical violence, bullying, harassment or abuse from patients/public or from other colleagues.
- Resolving health, safety and building issues raised, as well as colleagues' lack of access to adequate materials, supplies and equipment to do their work.

- Improvements to the way colleagues feel able to raise concerns and their need to be updated on what action has taken, so they know they have been heard and listened to.

Finally, as indicated in the data above our results showed a 2% decrease in the number of colleagues who would be happy with standard of care provided by organisation if friend/relative needed treatment and a 1% increase in colleagues saying they would recommend our organisation as place to work. We know we can do better to improve these areas and our corporate level action plan will detail the actions we will be taking to make improvements to these areas. Progress against our priorities and measurement of impact will be reported to the Workforce Committee through the regular cycle of business.

Medical and Dental Workforce Rota Gaps

Our Workforce Department monitor vacant posts and as part of the 'Guardian of safe working' requirements provide a quarterly vacancy gap analysis as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b.

An overview of Trust wide vacancies per grade are presented in Table 28 below.

Table 28 Medical and Dental Vacancies (March 2023)

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

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

Source: LTHTR data

Our Workforce Business Partners provide monthly reports to the Divisional Workforce Committees which includes the detailed status of each vacant post.

The team use this information to work closely with Clinical Directors and departmental managers to source vacancies and agree recruitment strategies for new and hard to fill posts, some of which are shown below:

- Reviewing job descriptions and creation of promotional activity, aligning job descriptions to the new employment brand and elements to make posts more attractive for example rotations and dedicated time for audit, research and teaching.
- Promoting vacancies through social media, relevant journals and websites, through the British Medical Journal (BMJ) website.
- Sourcing doctors (where required) through international placement agencies.

- Sourcing doctors through the Trust new Overseas Registrar Development and Recruitment (ORDER) program. This program is designed to fill middle grade gaps across all specialties and is aimed at international doctors. This program provides them a 2-year post which includes a university qualification. For posts doctors recruited through this route the Trust will sponsor them for their General Medical Council (GMC) registration. This has been launched in June 2023 and the first posts have just been advertised with a view to doctors starting in September 2023.
- Sourcing doctors through the Medical Training Initiative program in liaison with the Royal Colleges and the Trust has seen success particularly in the Critical Care Unit.
- Utilising our medical and dental in-house banks to reduce reliance on agency workers, reduce cost and improve quality of care. There are currently approximately 120 medical bank workers working regular shifts.
- Working with the lead employer to improve rotation information to ensure early identification of vacant posts where possible.
- Continued recruitment to the medical intern program in partnership with the University of Manchester and the University of Mansoura in Egypt. A total of 10 interns were appointed to start in August 2023 and a further 9 are currently completing their first year, moving into year 2 in August 2023. These posts fill vacant junior clinical fellow gaps and where required vacant Foundation Year 2 (FY2) and Speciality Trainee 1 (ST1) posts.

In addition to these strategies the Trust is also looking at ways to retain doctors and the following strategies have been applied:

- Development of Trust induction to meet GMC standards tailored for international doctors with a view to providing these doctors a structured and development focused introduction to the NHS.
- Continue to run an annual round for the Lancashire Teaching Hospitals (LTH) Associate Consultant post. This is an internal development post open to all speciality and speciality grade (SAS) doctors, the appointment round takes place every January. This post aims to support doctors wishing to progress their career who are working at a very senior, autonomous level with the aim of retaining these highly skilled doctors by providing career progression. We currently have 12 Associate Consultants currently in post who were appointed between 2018 and 2023.
- Development of quality job planning to ensure it is fully reflective of activity with an updated job planning policy being published in March 2023 and a new job planning system being implemented in January 2022.
- Foundation Year 3 (FY3) program and focused recruitment to junior posts for FY2 doctors not joining regional training.

Quality Assurance

Our Quality Account has presented the data, information and assurance required by NHSI. The Trust has provided information related to the statutory core performance indicators and assurance on our data quality. The Trust has presented progress with our key priorities for 2022-23 which were stated in the 2020-21 Quality Account and highlighted new priorities for 2022-23 which align to Our Big Plan. The Trust has presented a review of activity in relation to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

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

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

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

Our Governor involvement in the New Hospitals Programme has been hugely valued and much appreciated by the Trust. Our governors also continue to offer valuable challenge and assurance as well as contribute to significant environmental improvements for patients through use of their charitable fund. Our Quality Account for 2022-23 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care, and excellent experience.

Annex 1:

Statements from External Stakeholders

Statement from the Lancashire County Council Health Scrutiny Committee re: Quality Accounts for 2022-23

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

As such the following is entered as their response to the LTH 2022/23 Quality Accounts:

“Although we are unable to comment on this year’s Quality Account, we are keen to engage and maintain an ongoing dialogue throughout 2023/24. ”

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

Healthwatch Lancashire
Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 22-23

Introduction

We are pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts for 2022-23.

Chief Executive's Statement

A comprehensive statement commenting on the challenging continued effects of the pandemic. It was pleasing to read that as a result of the pandemic, this has strengthened partnership and collaborative working across local partners.

2.3 Freedom to Speak Up

There is a clear process in place which encourages staff to raise concerns any concerns they may have and an option to speak with a FTSU guardian should they feel that their concerns haven't been addressed. The account addresses the reduction in responses from staff and priorities have been put in place to strengthen and embed FTSU across the trust, including e-learning for all staff. It is pleasing to read that this has been acknowledged and the trust recognises the importance of staff speaking up and listening and responding to those concerns.

Review of Quality Performance

Of note is the co-production of the Trusts new three-year Patient Experience Involvement Strategy which has been developed with patients, families, and carers. We know processes and systems are more successful when they involve people as fully as possible.
We also commend the reporting that the number of complaints received has reduced this year and there has been an increase in the number of compliments received.

National Survey Results

Patient experience of care is a key part of the role of Healthwatch and we are particularly interested in patients feedback which has been obtained from the national surveys.
We would like to commend the results of the Maternity Survey, particularly that 97% of patients felt that they were treated with respect and dignity, however we are looking forward to learning how the trust plans to ensure that information is provided on risks of induced labour.

Summary

In accordance with the current NHS reporting requirements, mandatory quality indicators requiring inclusion in the Quality Account, we believe that the Trust has fulfilled this requirement. The quality indicators, results and supporting narrative are clear and well laid out.
Overall, this is a fair and well-balanced document which acknowledges areas for improvements and actions being taken to further improve patient treatment, care and safety.
We welcome these and as a Healthwatch we are committed to supporting the Trust to achieve them.

Jodie Ellams, Manager- Healthwatch Lancashire

NHS Lancashire and South Cumbria Integrated Care Board Response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2021-22

Our ref: DA/JR/LTHQA2223

Please contact: Jacquie Ruddick

Email: Jacqueline.Ruddick@nhs.net

NHS
Lancashire and South Cumbria
Integrated Care Board

Chorley House
Lancashire Business Park
Centurion Way
Leyland
PR26 6TT

Tel: 01772 214232
www.lancashireandsouthcumbria.icb.nhs.uk

19 June 2023

Christine Morris
Associate Director of Safety and Learning
Lancashire Teaching Hospitals NHS Trust
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

Dear Christine

Re: ICB Response to Lancashire Teaching Hospitals NHS Trust Quality Account 2022/23

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

The ICB acknowledges that Infection Prevention and Control (IPC), and most notably Clostridioides difficile (C. difficile which is an anaerobic bacterium that is present in the gut) was a key priority for the CCG, ICB and Trust last year. It is recognised that in 2022-23 the Trust had a 48% increase (196 compared to 132 in 2021/22) in cases. However, the ICB is aware that there has been a national increase in C. difficile infections across a significant proportion of Trusts nationally and that the UK Health Security Agency and NHSE are currently undertaking a study to understand the reasons for the national increase. It is observed that this remains a key priority for the organisation and that the Trust continues to undertake Post-Infection Reviews which are monitored through the C. Difficile Infection Panel on a monthly basis.

The Trust's Care Quality Commission (CQC) overall rating has remained as 'requires improvement' since November 2019. In March 2022, the CQC commenced an urgent care system inspection in Lancashire and South Cumbria, involving the Trust alongside GPs, Northwest Ambulance Service, nursing homes, urgent care, mental health, and acute hospital providers. This report, published in July 2022, highlighted that Urgent Care Services are under increasing demand. For Lancashire Teaching Hospitals NHS Foundation Trust, the Urgent and Emergency Services at Royal Preston Hospital remains 'requires improvement'; inspectors provided a 'good' rating for being effective, caring and well-led; with an 'inadequate' rating for being safe and responsive. The ICB also recognises that there remain 3 outstanding actions from the 2019 CQC inspection, which are being monitored through the Risk Management process and require significant investment of time and resource to resolve.

In 2022/23, Trust performance in relation to NHS Constitutional targets was again adversely impacted by the residual effects from the pandemic as well as industrial action. The move to elective restoration, with an aim for zero 104-week waits by January 2023 and zero 78-week waits by end of March 2023. The Trust did not meet the target dates, but it is noted that by the end of March 2023 there were zero 104-week waits which demonstrates a commitment to the recovery plan, despite the additional pressures on

the Trust.

The ICB would also like to recognise all the challenging work that has been undertaken during 2022/23.

- Compliance with the 10 safety actions for maternity services;
- Successful reduction in 104-week waiters in 2022-23 with progress towards zero 78-week waiters in early 2023-24;
- 100% participation of each directorate in the annual risk governance maturity programme (assessed by external audit);
- Ensuring services were able to be safely operated whilst supporting staff during a period of continued industrial action, which impacted on services;

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

- A number of schemes undertaken through the Continuous Improvement Strategy, including "Flow Coaches" and "Big Rooms" for areas under pressure, such as colorectal or Urgent Care. These schemes provide multi-disciplinary staff with an opportunity for discussion, review and focused approaches for shared learning and identifying improvements for patient care and outcomes;
- Working in partnership with the Engineering Design Centre at Cambridge University partners to improve services across the Integrated Care System for people living with frailty and who have respiratory conditions;
- Working towards implementation of the PSIRF and LPSE national directives for improving Trust investigation management; future plans include addressing areas of concern from incident trends, such as pressure ulcers or Never Event incidents;
- Safety Triangulation Accreditation Review (STAR) visits. Out of 126 clinical areas registered for these visits, 124 were completed by the end of March 2023. 103 areas achieved silver or gold stars, equating to 82%. The ICB has been invited to participate in the STAR visits during 2023-24;
- The Laurie Solomon Renal Centre was opened in September 2022 as part of a programme of improvements to renal facilities across the healthcare system;
- The Trust has recruited almost 600 international nurses over the last 4-years; this supports the Trust aim to have no nurse vacancies by August 2023.
- The Trust have developed a new LTH ORDER programme, designed to fill middle-grade doctor gaps across all specialties. This programme will be fully launched in June 2023, with a view to recruits commencing with the Trust in September 2023.
- In January 2023 the Trust identified 2 Never Events relating to incorrect connection to air ports. As part of the investigation and audit process, a previous Never Event was identified from January 2022 and was also reported. Whilst it is disappointing that this was not identified at the time, it is positive to note that the audits and checks are in place to identify these retrospectively where needed. The ICB has seen the action plans and is assured that learning has been implemented and systems put in place to mitigate the risks identified.

The Trust acquired Finney House in November 2022 to enable the Trust to improve patient flow by providing 64 out-of-hospital health-led community bed capacity, reducing medicine bed capacity in hospital as a result. This is equally supported by the introduction of Virtual Wards, additional Home First capacity and crisis hours to support people to stay safe at home and to expedite timely discharge from hospital. The ICB recognises the actions being taken to improve overall patient flow and support collaborative system working across the health economy.

The Trust co-produced a new three-year Patient Experienced Involvement Strategy for 2022 to 2025 in collaboration with patients, families, carers, governors and staff. It is positive to note that this strategy links closely to a number of existing Trust strategies including: Equality, Diversity and Inclusion; Mental Health; Learning Disability and Autism; Dementia; and the Always Safety First strategy. Actions will be monitored through the Patient Experience and Involvement Group, which in turn provides assurance to the Trust Safety and Quality Committee.

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

experience including:

- Dietetics and SLT services now have an electronic inpatient referral systems;
- Creating an open and accountable reporting culture where staff are encouraged to identify and report issues;
- In March 2023 Chorley Hospital was 1 of 8 surgical hubs awarded Getting It Right First Time (GIRFT) accreditation as part of a pilot scheme run by NHSE/I;

- An increase in completed FFT surveys (44,109 in 2021-22 and 51,184 in 2022-23). Most services were over 90% for some or all quarters, with the exception of ED which was consistently under the target. A re-design of ED is taking place to address the number of patients in the department and the number of patients waiting extended periods of time;
- The Trust was ranked 19th out of 65 Trusts in 2022, with 2 areas identified where the Trust was performing better than the previous year: partner/companion involvement; and partner was able to stay with them as long as they wanted.

The ICB appreciates that the Trust Quality Account for 2022/23 acknowledges that there are a number of areas where the Big Plan metrics were not met but some have been carried forward into 2023/24. It is positive to note the continued focus on these areas:

- Achieve 62-day cancer target;
- Reduce pressure ulcers by 10%;
- Deliver the C. difficile measure within nationally set trajectory;
- Reduce sickness absence to 4%;
- Reduce vacancies by a further 5%;
- Reduce number of patients waiting greater than 12 hours in Emergency Department (ED).

To conclude, 2022-23 was a challenging year for the Trust in terms of the operational and workforce challenges, including through industrial action, financial pressures within the NHS and restoration recovery plans to reduce waiting lists. The ICB notes that these will continue into 2023-24 in terms of restoring services to full capacity and addressing the back-log of patients still waiting for treatment.

We look forward to working closely with the Trust with the 2023/2024 priorities and further developing our collaborative partnerships to continue to improve the quality of care to our patients.

Yours sincerely,

Professor Sarah O'Brien
Chief Nurse

Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account: Feedback from Council of Governors Meeting on 2 May 2023

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 2 May 2023, governors were invited to consider and input into the two Quality Indicators for inclusion in the 2022-23 Quality Account.

The agreed topics which support putting patients are at the heart of what we do and are carried over from the Quality Account 2021-22 to continue as year two indicators are as follows:

- Inclusive end of life care and advanced care planning.
- Patient experience including PALS and complaints resolution.

Annex 2:

Statement of directors' responsibilities for the Quality Account

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2022-23 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2022 to March 2023.
    - Papers relating to quality reported to the Board over the period April 2022 to March 2023.
    - Feedback from Integrated Care Board date to be added
    - Feedback from Healthwatch date to be added
    - Feedback from Overview and Scrutiny Committee date to be added
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2022-23.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHSI's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Professor Paul P O'Neill
Interim Chair Date: 16.6.2023

Kevin McGee OBE
Chief Executive Date: 16. 6. 2023

List of Tables

List of Figures

Glossary of Abbreviations

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

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

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

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

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

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