Lancashire County Council

Health Scrutiny Committee

Tuesday, 4 March, 2014 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 14 January 2014**	(Pages 1 - 6)
4.	**Lancashire Teaching Hospitals Trust**	(Pages 7 - 48)
5.	**Report of the Health Scrutiny Committee Steering Group**	(Pages 49 - 74)
6.	**Recent and Forthcoming Decisions**	(Pages 75 - 76)
7.	**Minutes of the Joint Lancashire Health Scrutiny Committee**	(Pages 77 - 78)
8.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	

Lancashire County Council

9. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 22 April 2014 at 10.30am at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 14 January, 2014 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Steven Holgate (Chair)

County Councillors

M Brindle	Y Motala
Mrs F Craig-Wilson	B Murray
G Dowding	M Otter
N Hennessy	N Penney
M Iqbal	B Yates
A Kay	

Co-opted members

Councillor Brenda Ackers, (Fylde Borough Council Representative)
Councillor Jean Cronshaw, (Chorley Borough Council Representative)
Councillor Paul Gardner, (Lancaster City Council Representative)
Councillor Bridget Hilton, (Ribble Valley Borough Council Representative)
Councillor Julie Robinson, (Wyre Borough Council Representative)
Councillor Mrs D Stephenson, (West Lancashire Borough Council Representative)
Councillor M J Titherington, (South Ribble Borough Council Representative)
Councillor David Whalley, (Pendle Borough Council Representative)
Councillor Dave Wilson, (Preston City Council Representative)

1. Apologies

Apologies for absence were presented on behalf of County Councillor Alycia James and Councillors Liz McInnes (Rossendale Borough Council), Tim O'Kane (Hyndburn Borough Council) and Besty Stringer (Burnley Borough Council).

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None disclosed.

3. Minutes of the Meeting Held on 3 December 2013

The Minutes of the Health Scrutiny Committee meeting held on the 3 December 2013 were presented

Resolved: That the Minutes of the Health Scrutiny Committee held on the 3 December 2013 be confirmed and signed by the Chair.

4. Lancashire County Council's Public Health Responsibilities

The Chair welcomed Dr Sakthi Karunanithi, Director of Public Health, Adult Services, Health and Wellbeing Directorate.

Dr Karunanithi presented the report which explained that responsibility for the majority of public health services had transferred from the NHS to Lancashire County Council on 1 April 2013 providing a number of opportunities to more closely integrate public health interventions with other local authority services and to increase local democratic accountability for public health.

The report provided a brief overview of the County Council's public health responsibilities and highlighted key public health challenges to help inform the Health Scrutiny Committee about potential areas of public health for it to focus on.

Dr Karunanithi used a short PowerPoint presentation to further explain the role of public health, focusing on resources, how the County Council would work with its district council partners and the key challenges facing the county council. A copy of the presentation is attached to these minutes.

The Chair invited members to put questions to Dr Karunanithi, the main themes and points arising are summarised below:

Staff

- In response to a question whether staff in the Public Health team were now fully integrated in to the County Council, Dr Karunanithi explained that staff from three primary care trusts had come together into one Public Health unit, merging different cultures and ways of working. The primary objective had been for the County Council to understand what it had inherited and that the transition had gone smoothly.
- A named director would provide a link between Public Health and the other Directorates within the county council.

- It was relatively early days in terms of the new arrangements, not only for the County Council but for its partners too. There were also wider organisational changes to come to enable the County Council to adjust to significant financial pressures, and there would inevitably be a further period of change. Whilst it was difficult to give an end date by which Public Health staff would be fully embedded, Dr Karunanithi felt that it would take some 18-24 months.
- Dr Karunanithi believed that there was a good mix of skills within the Public Health team and also among other colleagues within the County Council and district councils with whom they would be linking. The approach would not be 'business as usual' and it was recognised that there would be a need to change and adapt to local needs.

Health Checks

- Members were concerned that the number of GPs who had signed up to deliver health checks was too low and that some of those who had signed up were not actually carrying them out. It was felt that Public Health had a duty to ensure that health checks were working as intended.
- Dr Karunanithi explained that health checks were a mandated public health service funded by the Public Health Grant; the County Council was responsible for commissioning the service that GPs provide.
- Public Health had a responsibility to ensure that people were being offered health checks; Dr Karunanithi confirmed that 85% of GPs had signed up to deliver health checks, but he acknowledged that monitoring performance presented a challenge.
- Health checks were a corporate priority, the county council was working closely with the NHS, and progress was regularly reported to the Cabinet Committee on Performance Improvement.
- It was hoped to improve uptake and there was to be an awareness campaign at the end of January.
- It was acknowledged that historically, people only went to see their GP when they were ill and it was necessary for Public Health to promote health checks as a 'wellness' service and to ensure that GP practices had appropriate support.
- It was suggested that there needed to be more control to ensure that GPs were actually carrying out the health checks that they had signed up to, and this was perhaps something that the Health Scrutiny Committee could look at in more detail.

Health Inequalities

- It was felt that there should be a whole-system approach to Public Health looking more at early intervention and prevention including matters such as planning, housing and the provision of open spaces, all of which have an impact on wellbeing.
- It was suggested that there should be some sort of inequality 'proofing' process in place and that a greater number of decisions taken within the County Council should be subject to a health and wellbeing impact

assessment. For example, the proposal to cut evening or weekend bus services would affect the least wealthy and could lead to social isolation.

- Dr Karunanithi acknowledged that successfully addressing and removing health inequalities was the ultimate 'holy grail' which would necessarily involve the private and third sectors also. He agreed that it was important to consider how to minimise the impact of decisions and how best to allocate resources. He made the point that health inequalities had not been successfully addressed in years of growth; the challenge was even greater in times of austerity and the social impact was now starting to show in areas such as employment, housing and relationships.
- One member suggested that employers were not considering people with long-term disabilities for employment because they were under increasing pressure to reduce absence levels.
- It was suggested also that employment brought health benefits and it was important to encourage businesses into the county who would employ local people.
- The importance of working with the district councils who could usefully contribute to the public health agenda was emphasised - South Ribble Borough Council had addressed the issue of health inequalities in its task group report 'Mind the Gap' and had identified areas within the borough where life expectancy and long term ill health were issues of serious concern.
- Dr Karunanithi agreed that health inequalities could not be addressed by just one agency and the role of the districts was vital. The solutions did not lie in providing more services, but in addressing the underlying determinants of health.
- In response to a question about provision of services for mental wellbeing, particularly psychosis and schizophrenia in young people resulting from use of cannabis, Dr Karunanithi confirmed that a lot of resources were being put into addressing substance misuse. He would report back to the Committee on this issue.
- It was noted that the list of performance challenges set out in the presentation did not include the issue of on-line grooming and sexual exploitation, which was a serious and growing problem. There had been recent examples of such cases in Lancashire. It was suggested that it was essential to tackle the common underlying causes of the challenges facing Public Health. Dr Karunanithi again assured the Committee that the need to address root causes in order to reduce the need for services further down the line was well understood. Addressing the wider determinants of health was a priority. Partnership working was being strengthened and, regarding the specific example of child exploitation, the Public Health team was working with a range of partners including Community Safety and the Health and Wellbeing Board.
- There was some concern that social landlords were not providing appropriate facilities for disabled tenants. Dr Karunanithi referred to the Disabled Facilities Grant which was part of the Better Care Fund – a joint pooled budget. He asked the councillor who had raised this point to refer any specific concerns to him outside the meeting.

Other

- One member raised a question about discrepancies in the population figures for Burnley; there was a difference of some 11,400 depending on the source referred to. This was a large discrepancy and she believed that it was important to ensure this figure was correct, particularly in a deprived area such as Burnley because it would affect funding and health service provision. It was also necessary to have reliable figures to be able to plan services for dementia care into the future. Dr Karunanithi undertook to look into this and get back to her. He explained that dementia had not been referred to on the slide headed 'Performance Challenges' because this list included only those issues that required improvement.
- In terms of procurement, Dr Karunanithi explained that it was important for the county council to understand what contracts it had inherited, what the public health needs were, and how resources were currently committed. There was no intention to simply re-commission services and, as contracts came to an end, there would be an opportunity to consider need and address services in a more joined-up, equitable way based on need and not history. Decisions would be published in the usual way for members and the public to see.
- It was suggested that good practice arising from 'Health Cities' be shared with the Committee, in writing initially (The Healthy Cities Network is a global movement that engages local authorities and their partners in health development through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects).

Following the discussion, it was suggested that to enable the Health Scrutiny Committee to best decide how it could contribute to the Public Health agenda it would be helpful for it to receive details of Public Health programmes, including the responsible officer, timescales, how objectives would be achieved, and how outcomes would be measured. The Committee could then take part in a half day workshop to consider what aspects of Public Health it could usefully scrutinise.

Resolved:

It was agreed that:

i. A list of programmes of work being undertaken by Public Health be provided to the Health Scrutiny Committee. The list to include the responsible officer, timescales, how objectives would be achieved; and how outcomes would be measured.
ii. A workshop be held to enable members of the Health Scrutiny Committee to consider the programme of work referred to at (i) above and identify topics for further scrutiny
iii. It be recommended that a greater number of decisions taken within the County Council be subject to a health and wellbeing impact assessment.

5. Report of the Health Scrutiny Committee Steering Group

On 8 November the Steering Group had met with officers from Lancashire Teaching Hospitals Trust to discuss the work and performance of the Trust. A summary of the meeting was set out at Appendix A to the report now presented.

On 29 November the Steering Group had met with the Chief Executive of Lancashire Healthwatch. A summary of the meeting was set out at Appendix B to the report now presented.

Resolved: That the report of the Steering Group be received.

6. Recent and Forthcoming Decisions

The Committee's attention was drawn to forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this could inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

Resolved: That the report be received.

7. Urgent Business

No urgent business was reported.

8. Date of Next Meeting

It was noted that the next meeting of the Committee would be held on Tuesday 4 March 2014 at 10.30am at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on 4 March 2014

Electoral Divisions affected:
All

Lancashire Teaching Hospitals Trust
(Appendices A, B & C refer)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
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Executive Summary

Representatives from Lancashire Teaching Hospitals Trust (LTHT) have been invited to attend Committee to provide members with information on:

- Performance
- Winter pressures
- Challenges facing the Trust

The Trust met with the Health Scrutiny Committee Steering Group on 8 November last year. A copy of the note of that meeting is attached at Appendix A.

The Care Quality Commission (CQC) also recently carried out an inspection of the Trust looking at the following standards:

- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Assessing and monitoring the quality of service provision
- Complaints

A report was produced in January and a copy is attached at Appendix B

In addition on 9 December, Monitor (the sector regulator that ensures Trusts are well led and are run efficiently) wrote to the Trust notifying them of their decision to open a formal investigation due to governance concerns. A copy of the letter can be found at Appendix C.

Recommendation

The Health Scrutiny Committee is asked to consider the information relating to the performance of the Lancashire Teaching Hospitals Trust and determine what further scrutiny may be required.

Lancashire County Council

Background and Advice

Following the attendance of officers from the Trust at the Health Scrutiny Committee Steering Group meeting on 8 November last year (a copy of the notes attached at Appendix A), members felt it would be beneficial for further scrutiny of the performance and financial management of the Trust to take place. Therefore it was agreed that the Trust to be invited to attend the Committee at the earliest convenience.

The Trust was informed that the areas of scrutiny would include:

- Performance
- Winter pressures
- Challenges facing the Trust

They were asked if they wished to provide supporting information for the members of the Committee but declined the opportunity and therefore in consultation with the Chair of the Health Scrutiny Committee, County Councillor Steve Holgate it was agreed that members should be provided with the latest CQC report and the current concerns of Monitor regarding the risk ratings of the Trust.

The latest CQC report identified that 3 out of the 5 inspection areas indicated 'action needed'. These areas were:

- Care and welfare of people who use services
- Staffing
- Complaints

A copy of the report is provided at Appendix B and can also be found via the following link: CQC report - 8.1.14

Additionally as a Foundation Trust, LTHT is subject to continual assessment by Monitor, who has created a risk-based system of regulation which informs the intensity of the monitoring. It is designed to identify actual and potential financial and non-financial problems.

They publish two risk ratings for each NHS foundation trust:

- **financial risk rating** (rated 1-5, where 1 represents the highest risk and 5 the lowest); and
- **governance rating** (trusts are rated green if no issues are identified and rated red where they are taking enforcement action).

Where they have identified a concern at a trust but not yet taken action, they will provide a written description stating the issue at hand and the action they are considering. Foundation trusts' risk ratings are updated each quarter. They also update risk ratings in 'real time' to reflect regulatory action they take.

Financial risk rating (1- 5)

1. highest risk - high probability of significant breach of authorisation in short-term, e.g. <12 months, unless remedial action is taken
2. risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action
3. regulatory concerns in one or more components. Significant breach unlikely
4. no regulatory concerns
5. lowest risk - no regulatory concerns

Governance rating

- Red - where they are taking enforcement action
- Green - no evident concerns
- *Where they have identified a concern at a trust but not yet taken action, they will provide a written description stating the issue at hand and the action they are considering.*

Monitor have identified the Financial Rating for the Trust as **3** and the Governance Rating is subject to further action required due to concerns at the Trust, following breaches of the Referral to Treatment (RTT) target and the C.difficile target.

Monitor wrote to the Trust on 9 December (Appendix C) to inform them of their intention to open a formal investigation.

Further information can be found via the following link: Monitor - LTHT risk ratings

Consultations

N/A.

Implications:
This item has the following implications, as indicated:

Risk management
This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Appendix A

NOTES

Health OSC Steering Group
Friday 8 November– Scrutiny Chairs Room (B14a)
2.00pm

Present:
- County Councillor Steve Holgate
- County Councillor Mohammed Iqbal
- County Councillor Margaret Brindle
- County Councillor Fabian Craig-Wilson

From Lancashire Teaching Hospitals Trust:
- Karen Partington – Chief Executive
- Steve O'Brien – Associate Director for Quality
- Paul Havey – Finance Director

1. **Notes of last meeting**
   The notes of the Steering Group meeting held on 18 October were agreed as correct

2. **Lancashire Teaching Hospitals Trust**
   As part of the ongoing scrutiny of the Acute Trusts within Lancashire, officers from Lancashire Teaching Hospitals Trust (LTHT) had been invited to the Steering Group to talk to members about their current position.

   Members had been provided with a copy of an Intelligence Monitoring Report from the CQC and the response provided by the Trust, copies of which are appended to these notes.

   Karen, Paul and Steve attended the meeting and a general discussion about the work and performance of the Trust took place, the main points being:

   - Trust's response to the CQC report – context and how it's been pulled together
   - Issues relating to regulators that came out of the Mid Staffs review and how they would amend their inspection regime.
   - Quality and risk profile – been reviewed (over 150 indicators of quality) – 87 applicable to LTHT
   - There are 3 categories of risk – as per document
     - 80 no risk
     - 3 risk
     - 4 elevated risk
   - 6% rating of risk – placed all trusts in a banding – LTHT in band 2
   - Some indicators are less patient focused as not all data relates to patient care.
   - Coding takes time so use 'flex data' (how much activity has taken place but not necessarily coded) and 'freeze data' (all coded activity) – freeze data determines the payment that the Trust receive.
   - Felt that this process will mature in terms of what indicators are important and those that aren't.

- Felt that whistle blowing events should be seen as a positive rather than a negative.
- Management Team have been made aware of whistle blowing and tried to determine a solution, take it very seriously and they trigger an internal investigation – disappointed that this hasn't been reflected in the scoring
- Mortality alerts accumulate over time until they go through a threshold and trigger a target. – Trust look at it as a rolling 12 months (on a monthly basis) – use the same tools as the CQC. – Many ways of looking at the data, constantly monitor this area.
- Role of non-execs as champions to work alongside the data crunchers but need to clear about what's being looked
- HSMR -standardised mortality ratio to try to even out the playing field and be able to compare to other trusts. LTHT mortality rates has dropped year on year
- 27 mortality ratios - but HSMR is the one most recognised and used.
- Don't look at all patients but 56 diagnostic groups. They adjust the data in response to case mix (i.e. older patients, multiple conditions, at end of life) to get the ratio.
- In terms of coding the Trust feel they can be stronger (i.e. that they under code for complexity) – making steps to improve this. The first response is not to challenge the data but to determine the indicator of harm.
- Steve asked how many risk levels that the Trust currently use – didn't really answer the question instead they replied with the factors used i.e. age, conditions, what's wrong with you, gender and post code element of social deprivation. Trust said that they don't determine the level of risk, that's it's a national criteria set.
- What the Trust are going to do – looking at all in hospital deaths (were they appropriate/expected). Concentrating on and understanding avoidable deaths.
- Just because the Trust is meeting targets are they still striving for improvement? The safety/quality strategy document potentially addresses some of these issues. – e.g. should they be putting in percentage targets to reduce mortality year on year?
- Are they minimising harm, are they reducing avoidable harm – felt that this was the most important issue
- The Trust hasn't just waited for the CQC report to be produced but they have already been putting actions in place to address the issues raised.
- Data looked at weekly – in the past had a responsive attitude but now look at each individual death to see if there are any patterns. Some seasonal, some due to major trauma, found areas of improvement but no single incidence where a lapse in treatment has contributed to someone's death. Higher level of mortality over the weekend but feel it's not due to the interventions of the Trust
- The Trust argues that the data applied didn't seem to reflect the risk associated with a patient or take into account the community based services that could be asked. – expectation as per national pathways
- The hospital is the end point so quite often they are the recipient of the result of the health economy if there isn't an adequate patient pathway.
- Working with clinical senate – all Trust CEOs, LCC, CCGs and NWAS (in its early stages) – to work across pathways.
- Trust has an issue with social care and 7 day working – one of their biggest concerns is the period over Christmas when social care offices are closed.

- If hospitals are open 7 days the rest of the system needs to be too.
- How do we move towards a more integrated service? They feel that there should be more focus and responsibility for health onto local authorities – how are councils going about planning for an integrated service.
- £3.9billion is coming out of health in April 2015 – coming to LAs instead. Political argument as to how that money is used within councils' (public health) to prevent admissions. The conversation needs to start now so the trust can work out what it needs to stop doing.
- Staff morale – internal satisfaction survey pretty good (although this is not what the data says), under a lot of pressure, depends on where within the Trust that staff are – Karen is getting back in uniform and getting back to the floor.
- Feel that staff who want to answer do so but often it's those most satisfied and those most unsatisfied will respond – feel that they are doing lots to get out and about to give staff an opportunity to voice concerns.
- Have trackers – given to patients and staff to provide feedback (real time)
- When staff flag concerns full investigations are carried out – staff email Karen individually – admit that they don't have the communications right.
- Every staff group is represented in their internal survey and they are sampled. They do an email survey but the national staff survey is impendent
- What % of return - last year 60% for internal survey.
- Annual opportunity for every member of staff to feedback
- Having a special meeting of governing body to go through the figures next week. Want to reassure members that they are doing everything possible to address the issues re avoidable deaths.
- Specialised services - PCTs used to commission these services – now its NHS England LATs (and not CCGs) but the Trust want them to have significant influence over it.
- As Lancashire as a whole we are underprovided for renal services – but patients are presenting at hospital, not going to their GP first for referrals and its often not shown as the cause of death (its often down to heart failure as a result)
- Bear in mind that complex services need to be consulted upon in a very clear and plain manner – need to identify the benefits as a first point
- With regard to staff – it became us/them when 2 services combined and need to make sure this won't happen in the future – particularly important when you have 2 sites
- Finances – not hit the financial targets for 3 qtrs, relatively poor financial position, and drive to hit the targets impacting on their finances. At least 40 beds more in the system than needed, spending lots on A&E pressures, and spending to hit the 18 weeks targets.
- Reconfiguration of services –at very early stage, appointed a Strategic Director and will be done within a wide range of stakeholders – (if starting 6 months prior to a general election the NHS is instructed to stop anything that may become a political issue.)
- Using consultants to look at clinical priority and need, but clinical care will not be compromised.
- Chorley is not a trauma unit because Preston is the trauma centre. Chorley is where the majority of the elective orthopaedic work takes place
- The future of LTHT? – all options are being looked at, nothing will happen overnight, no surprises, full consultation will take place, proper

engagement. Trust have met with Chorley campaign group and agreed to meet with them again

- Want people to understand how good LTHT is and the complexity of Royal Preston – Liverpool and Manchester have their specialism's in separate hospitals
- Communication and clarity was requested so the Trust can explain clearly and more people understand – i.e. patient pathways, locations of services etc.
- Feel the Trust should be smaller if more services are provided within the community, shouldn't be an empire. Particularly interested in preventative measures through our public health role
- Specialised services - may be a desire to move services back to Manchester – Steve asked Paul to email him and CC Ali outlining their concerns re this as they are meeting with Lancashire MPs over the next few weeks. Paul will provide information to explain the nature and implications (they are saying access doesn't necessarily mean location)
- Trust provide superb services for cancer and are disappointed re knock on effect for staff. Christie may subcontract back to LTHT
- Given the public's expectations it's an opportunity to challenge the central decisions taken given we've got an ageing population. It's not about integrated provision but what do we want to spend on health in this country
- Buckshaw – do they get VFM?, 20 beds, quite often they're empty, problem finding the right type of patient, is there a monitoring of people who free up hospital beds, what's the re-admissions rate to the less intensive beds? Providers are not paid for re-admissions within 28 days; only 5% were as a result of something the Trust could have done better. 95% because not adequate support available in the community or residential sector
- Massive shortage of some specialities, Medicine is £2m overspent due to agency staff
- 'Case for Change' – within this Chorley has a significant role to play in the delivery of services but his hasn't been formulated yet for the future
- National shortage of nurses – as a result of Francis enquiry every Trust is looking to increase the number of nurses. Problem recruiting theatre staff, national shortage of A&E staff. Training numbers have been reduced
- Feel that CQC Intelligence Monitoring Report was harsh
- Will achieve a risk rating of 3 (Monitor), not where they want to be, have the plan but need the time to implement
- Have a cadet ship within the Trust, looking to expand. Bank staff can also be trained up
- Asked members to reiterate positive messages about the NHS as lots of negative press

3. Work plan and updates

Members considered future topics for Committee and Steering Group and discussed progress on previous issues considered.

4. Dates of future meetings

- 29 November – Leslie Forsyth, Chief Executive of Healthwatch
- 20 December – FWCCG: Development of the Health & Care Strategy
- 10 January – Domiciliary Care review
- 31 January - ELCCG

CareQuality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Royal Preston Hospital

Sharoe Green Lane, Fulwood, Preston, PR2 9HT

Tel: 01772716565

Date of Inspections: 18 November 2013
15 November 2013
14 November 2013

Date of Publication: January 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Standard	Result
Care and welfare of people who use services	✗ Action needed
Cleanliness and infection control	✓ Met this standard
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✗ Action needed

Details about this location

Registered Provider	Lancashire Teaching Hospitals NHS Foundation Trust
Overview of the service	Royal Preston Hospital is the largest hospital of Lancashire Teaching Hospitals NHS Foundation Trust. The hospital provides acute medical services to a local population of almost 400,000 people as well as specialist services to a wider population of people across Lancashire and Cumbria. There are a number of specialist services provided from the hospital including neurosurgery and neurology, cancer services and plastic surgery. The hospital has a busy accident and emergency department which includes a Major Trauma Unit.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 November 2013, 15 November 2013 and 18 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with other regulators or the Department of Health and talked with local groups of people in the community or voluntary sector. We were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

What people told us and what we found

This was an unannounced inspection carried out over several days. During the inspection we visited a variety of areas including the hospital's accident and emergency (A&E) department, the medical assessment unit (MAU), rapid assessment unit (RAU) and a number of medical wards.

We spoke to 31 people who were either using the service at the time of our inspection or had recent experience of it. We also spoke with over 40 staff members who included domestic assistants, nurses, health care assistants, doctors and senior managers.
The vast majority of discussions we held were very positive. Most people who were using or who had recently used the service, expressed satisfaction with their care and treatment. However, we did receive a small number of negative comments. The things people told us included:

"I have had absolutely first class care. They have all been brilliant!"

"The staff have been very kind and caring."

"I cannot thank them enough. They have been wonderful."

"The doctors have been fine and the nurses have been very friendly."

"The bay in A & E wasn't very private, people can hear everything!"

"They need to improve the way they communicate with patients!"

"I felt forgotten about while I was waiting but when I did see the consultant he was brilliant."

During the inspection we looked at the care people received and how their welfare was promoted. We found that the vast majority of patients received safe and effective care that met their needs. However, we also found people's experiences were variable in relation to having a lot of ward moves or not being on the correct ward to meet their needs.

We inspected the area of cleanliness and infection control and found the Trust had good arrangements in place to help ensure that people were cared for in a clean, hygienic environment and were protected from the risk of infection.

We assessed staffing levels. We found there were safe staffing levels in most areas and that the Trust had implemented a number of positive measures to maintain safe staffing levels. However, we did find that not all areas of the service used procedures for responding to unexpected, short notice requirements effectively.

Arrangements for the monitoring of quality and safety were assessed. We saw there were good processes in place that enabled managers to monitor standards, identify risk and respond appropriately to adverse incidents.

We looked at how the Trust enabled people to raise concerns and their processes for responding. We found this area was in need of improvement.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The majority of people who used the service experienced safe, effective care. However, there was potential for the quality of people's care to be compromised if they were being cared for in the wrong environment or experienced excessive or unnecessary ward moves.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Throughout this inspection we consulted 31 people who were either using the service, or had very recent experience of it. The majority of feedback we were given was positive and most people expressed satisfaction with the care and treatment they had received. People's comments included:

"They were excellent! They took her straight in to resuscitation and she was seen by a doctor straight away. They kept a strict eye on her and explained everything. I felt at ease after talking to the consultant and knew she was in good hands. Everyone who attended her was attentive. I couldn't have asked for a better service."

"They asked me all the right questions and made me feel at ease. I was given some painkillers to take there and then."
People spoke very highly of staff at the hospital and told us they had been treated with kindness and respect. One patient said, "Every nurse and doctor I have seen has been absolutely wonderful." Another commented, "I cannot fault the staff at all, they are so busy but always so kind and caring."

Where people expressed an element of dissatisfaction, there were two very clear themes. These were around ward moves and communication. A number of patients told us they had been moved around wards more times than they felt necessary. This was also a concern that had been raised with Healthwatch Lancashire, on several occasions.

Two people being cared for on the RAU (Rapid Assessment Unit) told us they had been moved late at night and had been transferred onto wards and then back to the RAU. One patient described being woken up at around Midnight. "I woke up to see people packing up

my things. I was very disorientated, a nurse told me they were moving me here. It's very frustrating."
Another person described his experience as 'being pushed from pillar to post'. He commented, "It is a bind when you just get settled and then have to move somewhere else." This patient went on to explain that he had paid ten pounds for a television card to allow him to watch television on his previous ward, which he had lost due to being moved back to the RAU.

We saw one patient arrive on the MAU (Medical Assessment Unit) with a porter. He was told by the sister that there was no bed available for him. Eventually the staff took him into one of the examination rooms, with another patient.

We spoke with managers about the concerns raised by some patients in relation to excessive ward moves. It was recognised that the transfer of a patient to an alternative ward was sometimes necessary and in their best interests. However, in some of the cases we looked at and following discussion with staff, there was no apparent reason for some of the moves. Unnecessary bed moves could result in a lack of continuity of care as well as potential discomfort and disorientation for the patient.

Managers told us this was an area that had been identified for development and a number of measures had been put in place to improve patients' experiences in terms of ward moves. However, it was apparent from our discussions with some patients, that these had not yet been fully effective.

One patient who was dissatisfied about being moved also felt staff had not communicated with him well. "I came by ambulance on Tuesday at Midnight. I was here first, then I went to MAU (Medical Assessment Unit) but the next day they brought me back down here. I don't know why, I wish someone would tell me what's going on. I was taken for an xray and I didn't know why. I had to ask the girl who was doing the xray. They need to improve in communication."

Whilst the inspection was ongoing, the Care Quality Commission received letters from three people raising concerns about a lack of communication from the Trust. In two of the cases, the people were waiting for outpatient appointments which had been cancelled. They had waited for several months and felt the Trust could have communicated with them better throughout this period.

However some patients we spoke with did feel staff had communicated with them well during their stay. One patient told us that staff had explained everything to him the previous day but because he had been disorientated, they had taken the time to go through things with him again. He commented, "It was all a bit of a blur yesterday, so they have explained everything again today."

Throughout the inspection, we visited a number of wards and observed how staff provided care and interacted with patients. The majority of our observations were very positive and we saw many examples of very good care being provided in a kind and caring manner. We observed staff responding to patients' requests in a timely manner and addressing them with patience and respect.

On one ward we visited, staff had arranged for an older couple who were both patients, to be admitted to the same ward. We spoke with some of their family members who told us they were 'absolutely delighted' with the care that had been provided at the hospital.

We spoke with staff carrying out a variety of roles including health care assistants, junior doctors and consultants who without exception, demonstrated clear values and commitment towards good patient care. One senior nurse commented, "I have worked all over the country and this is the best place for patient care that I have worked at."

However, we did identify some concerns through our observations. We saw that the majority of patients appeared clean and comfortable and had their call bells within reach. Although we did see three call bells out of patients' reach. We spoke to one of these patients, who was on the MAU, and asked her if she knew how to request help if she needed it. She was not aware of the call bell.

On the morning of our first visit we met a patient on the RAU who appeared quite confused. This patient was quite mobile and needed close monitoring as he was disorientated. Staff told us that the patient needed enhanced care (one to one monitoring) to keep him safe but we saw this was not always being provided. The patient was regularly attempting to leave the unit and staff told us they were struggling to support him safely.

We examined the care plan that related to this patient and found his assessment document had not been updated to take account of the recent deterioration and that his confusion had first been noted more than twelve hours before we first saw him. There was no evidence that this person's care and management had been altered as a result of his deteriorating condition.

On the morning of the first day of our inspection, the accident and emergency department had a fairly low number of people waiting to be seen and the flow through the department was good. We spoke to people in the majors area, all told us they had been seen quickly on arrival and been given adequate pain control, though one person did tell us that it had 'taken a while'. Other comments included:

"There were other people being treated and I saw some people waiting, but patients like my wife who required urgent treatment, got seen straight away."

"We were seen within minutes of arriving. I feel like he is in good hands."

Staff were also generally complimentary about the way patient flow was managed through the Accident and Emergency Department. One senior nurse told us, "It is very busy but there are good processes in place to move patients on as well as communicating with them while they are here."

We spoke to three paramedics who conveyed people to the department. They told us that 'the vast majority of the time' they found the process of bringing in patients straightforward. They said they felt staff communicated well and told us they worked effectively to escalate the most unwell patients through the system as a priority. One of the paramedics told us, "This is one of the better ones (emergency departments) in the area."

We examined the cubicles in the 'majors' and 'minors' area. These were clean and tidy, though staff told us that when the department was very busy, 'people had to wait in corridors' although they said this did not happen very often. Staff told us they tried to move people through the system quickly to make sure they did not wait for long.

Other processes to assist effective patient flow following their transfer from A&E included an electronic beds management system and daily staff huddles, during which full reviews

of bed availability would take place.

We examined the pathway for people who were referred by the GP because they had a condition that meant they could be treated and sent home. We were told the area where people were seen in these circumstances was the Rapid Assessment Unit (RAU). We spoke to people who were currently admitted to this ten bedded unit. We spoke to 5 people whose condition did not seem to fit the patient profile for the unit. Three people told us they had been previously admitted to the medical assessment unit (MAU) and then moved from there to the RAU.

When we spoke with staff, we found that some people had been moved from the majors area in the emergency department, up to the MAU, in preference to those people who had waited in the RAU for up to three days. It was unclear as to why this was the action taken.

We looked at a number of patients' care records to assess how their needs and risks to their wellbeing were managed. We found patients' records were quite well organised and contained a manageable amount of information to guide staff in providing care.

Various assessments were seen, which included assessment of risk in areas such as falling, pressure sores and nutrition. There were detailed risk assessments for areas of complex need such as mental state, agitation and confusion. The assessments were complete in most of the records we saw.

We spoke with one patient who was assessed as being at high risk from developing pressure sores. We saw that a special mattress had been provided to help reduce this risk and the patient was also able to confirm that she was provided with regular pressure relief. We also looked at the care plan of one patient who had been assessed as very high risk in the area of nutrition. Records showed that during his short stay, he had managed to gain some weight, demonstrating good nutritional support.

However, we did note some gaps in care planning which included that of a patient with diabetes. The patient's records were not complete in relation to the support he needed to manage his diabetes. He told us that the day before he had mistakenly eaten some jam which was high in sugar, as he assumed the staff member who gave it him was aware of his condition. He told us, "I should have managed it myself but I was really confused and disorientated." He was concerned that his blood sugar levels were 'through the roof.'

Staff we spoke with were generally complimentary about the risk assessment and care planning processes. One nurse told us, "The documentation is very good as it prompts you to take everything into account." The nurse also felt that the processes for recognising a patient's sudden deterioration were also very effective.

There was evidence in all the patients' records viewed that people had been seen by appropriate medical staff and/or referred to other professionals as necessary and in a timely manner. A number of nursing staff we talked with were highly complimentary about the support provided by consultants, particularly in the emergency department.

Records showed patients were supported by a variety of professionals such as dietitians and physiotherapists and we were told by staff on all units and wards that access to such professionals was readily available. One ward sister told us, "The team work is exceptional. It helps us to provide seamless care." A doctor in the emergency department commented, "We have a fantastic relationship with diagnostics which means people get all

the tests they need really quickly."

We were advised by managers of a new process, which had been implemented across the Trust to improve outcomes for patients, who had been in hospital for over 21 days or had experienced six ward moves or more. The process involved an enhanced approach to multi disciplinary care planning, to help ensure that any improvements that could be made to a patient's care and treatment plan were implemented.

There were procedures in place to help ensure patients' wellbeing and safety was maintained in the event of an emergency or major incident. In general, staff we spoke with demonstrated a good understanding of the procedures and said they were confident they would be effective if required.

There were processes in place to check emergency equipment on a daily basis, to ensure it was safe for use and working effectively. However, we saw that the cubicles in the majors area of the A&E department had some very dated ventilator equipment attached to the wall. The majors area is not often used for patients with such a high level of care requirement and we asked staff to explain why this equipment was there. We were told it was only to be used in case of a major incident where many people may require artificial ventilation. The equipment varied most significantly from the ventilators being used in the resuscitation area and this had the potential to cause confusion amongst staff.

Staff had organised for the equipment to be checked and serviced by an engineer, who had documented it was compliant by placing a yellow sticker on the device. Unfortunately, this sticker had been placed over a crucial oxygen gauge making it almost impossible for staff to use the ventilator effectively without removing the sticker. There was also no documentation to inform staff as to the circumstances in which this equipment should be used. We discussed our observations with managers at the time who agreed to deal with the equipment immediately. The provider may wish to examine processes for checking emergency equipment in light of these findings.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Appropriate guidance had been followed which helped to protect people from the risk of infection.

Reasons for our judgement

During this inspection we visited the Accident and Emergency (A&E) department and five wards. We noted that all the wards and departments we viewed appeared to be clean and in a good state of repair. Most areas viewed were clutter free and well organised. However, we did see some ventilators on the A&E department, which had single use oxygen tubing attached, some of which was unsealed and trailing along the floor. This represented an infection control risk to people and as such, was pointed out to managers, who agreed to deal with it immediately.

We saw that clinical waste was being disposed of in the correct manner and there were ample clinical and general waste bins provided, which were not overfilled. We also noted that bins for the disposal of needles and sharp medical devices were not overfilled.

There were sufficient hand washing facilities and paper towels available on the wards and hand gel dispensers appropriately placed at entrances to all wards and departments. Those we checked, were working properly and were adequately filled.
Staff members we saw throughout the inspection, were appropriately dressed, in accordance with the Trust's infection control policy. We noted that staff observed good hand hygiene practice in all the wards and departments we visited.

There was a good amount of information available for patients, staff and visitors regarding precautions they should take. This included clear signage to remind people to use hand gels when entering a ward or department. Information regarding cleaning schedules with a clear list of planned activities, was also posted in each area we visited.

We asked some of the patients and relatives we spoke with about their views of cleanliness and hygiene within the hospital. Without exception, they were very complimentary about this area. Their comments included, "They were particular with hygiene, they wore gloves and washed their hands all the time." And, "The place looked clean and really organised." Another patient who had been in hospital for several days said, "I see them cleaning all the time, they seem to always be doing something and from what I've seen, they always wash their hands."

We spoke with a number of staff throughout the inspection who carried out a variety of roles including doctors, nurses and domestic workers. Every staff member we asked about infection control procedures, demonstrated a clear understanding of the area and was able to confidently describe the processes they should follow. One junior doctor commented, "They are very hot on that here! Everyone knows it's an important issue." Nursing staff were very complimentary about the support provided in this area. They described frequent visits on their wards from infection control specialists and also explained that advice was available throughout the day and night if they needed it.

Records demonstrated that all staff were provided with training in the area of infection control at the start of their employment. There were clear systems in place for the induction and support of new staff in the domestic department, which included a mentoring and observed practice system. This helped to ensure staff worked in a safe and effective manner. It was pleasing to see agency staff employed within the Trust, were also provided with a similar induction.

Staff training was updated on an annual basis. However, we were advised there were processes in place to provide additional training to any staff member who required it and that the training could be adapted to support a staff member's particular development needs. Staff told us that they found the training in infection control useful and confirmed it covered sufficient detail. One domestic worker described being supported to complete national vocational training, as well as the Trust's own courses. She said, "The training is very good. It's not just the facts. They help you understand why it's important to do things in certain ways."

We were able to confirm that staff involved with patient care were provided with training which included aseptic non touch techniques (ANTT), a tool which helps to prevent infections in health care settings.

A domestic supervisor described his very detailed training portfolio and told us that the domestic role was a complex one, which he said 'wasn't just about cleaning'. He commented, "Our role has evolved but so has the training to support us." He was clearly very knowledgeable and competent in the area of infection control.

As well as routine cleaning schedules, we saw there were processes in place to respond to any unplanned requirements such as spillages or infection control incidents. There was a 24 hour response team in place, who were able to attend an area at short notice as well as provision for the completion of special, deep cleans where necessary. We were advised by managers that additional staff resources had been allocated to the response team as part of the Trust's winter plan.
There were clear protocols in place providing staff with guidance in supporting patients with infectious diseases. The Trust's dedicated infection control team were involved in all identified cases, carrying out daily visits to the patient and observing the procedures taken.

There were processes in place to monitor outbreaks of infectious diseases and where appropriate, detailed analysis was carried out to examine the cause and identify any incidents where correct procedures had not been followed. As part of the overall governance of the service, all outbreaks were reported to the head of patient safety, through the Trust's incident reporting system.

Following recent breaches of the Trust's national trajectory of Clostridium Difficile (C Diff)

cases, an action plan had been implemented. As a result, domestic services and cleaning systems had been reviewed. Audit processes had been strengthened and a peer review had taken place at the service, carried out by an external organisation. The action plan was being monitored by the Trust's Infection Control Committee, which was a group composed of Directors, Clinicians, Managers, Senior Nurses and experts in Infection Prevention and Control.

Comprehensive infection control audit processes were in place as well as a variety of systems for monitoring the standards of cleanliness within the hospital. A dedicated team were employed to carry out checks and observe standards. In addition, managers also carried out regular checks by visiting various wards unannounced and observing standards through initiates such as the 'Ward of the week' and the Trust's internal CQC style inspections. One domestic worker told us, "They monitor is all the time! They give us scores. I make sure I always get good scores!"

We were also able to confirm that where a shortfall in standards was identified, through the audit and quality monitoring standards, there were processes in place to ensure they were addressed. This included the requirement of an action plan by the ward and a revisit by the quality team, within a set timescale to ensure that necessary improvements had been made.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

Positive measures were in place to help maintain safe staffing levels but not all areas of the service benefitted from them.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

As part of this inspection we examined staffing levels within the service. We spoke with patients about their experiences and their views of staffing levels. The vast majority of patients told us they felt they had seen ample numbers of staff on duty. Their comments included:

"There are plenty of staff about. I'm surprised."

"There are definitely enough staff around."

"I'm more than happy. I've had really good care and never been left waiting for anything."

However, one patient, who was on the Rapid Assessment Unit (RAU) did express some concerns about the staffing levels there. He commented that another patient who was confused had been very unsettled. He complained that the patient had not been monitored carefully through the previous night. He said, "It's not their fault (the staff). There aren't enough of them to cope with all the people on here."

This patient's view was supported by our observations on the RAU. On the first day of our inspection we found the unit to be very busy with a number of people in beds and a large number of people in chairs who had been sent by their GPs. Staff on the unit appeared to be under pressure and two staff members told us they were struggling to cope. We asked one worker if this situation was normal and they said that it was, 'more often than not.'

We also noted that a patient who was in need of enhanced care because he was confused and frequently attempting to leave the unit, was not receiving this. We spent 20 minutes on the patient's bay observing. We saw that a staff member checked on him for a few minutes during this time, the rest of the time, he was unsupported.

We discussed the situation with managers from the Trust. There was a difference of opinion as to whether additional staff support had been provided to help support the

patient and we received conflicting information in relation to that point. However, we were able to confirm the patient was not receiving enhanced support when we carried out our observations there.

It was established that the RAU was not operating as it had originally been intended, which was as a short stay unit. Managers told us they had recognised this and changes to the way it operated were due to be implemented. Managers agreed to look at staffing levels in the interim, to ensure they were in line with the needs of patients being cared for on the unit.

In discussion, managers told us comprehensive staffing and skill mix reviews were carried out regularly across the service. This information was supported by staff who we spoke with. The A&E matron advised us that such a review had taken place within the department she managed and that as a result, staffing levels had been increased. We were advised some of the additional posts were still to be appointed.

The Trust have recognised challenges in relation to the increasing number of patients requiring enhanced care and large vacancy rates, which are issues for many services across the country. In response to these challenges, a number of measures have been introduced to help ensure safe staffing levels are maintained.

We saw such measures included a process whereby additional staff could be requested by a particular ward, to help support a patient requiring enhanced care because for example, they were at high risk of falling. However, some staff we spoke with told us these requests were not always met and this information was supported by notifications we had received from the service over recent months. We did note that requests for additional staff members and their outcome, were closely monitored by managers. We were advised at the time of our inspection, that approximately 66% of requests had been met in the previous quarter.

We were also able to determine that staffing levels across the Trust were closely monitored by senior managers through the Trust's incident reporting system and unannounced inspection on wards by managers. These inspections included examination of the area and discussions with staff and patients. During daily management meetings, the overall situation in terms of capacity and staffing, was monitored to help anticipate any potential problems.

Further measures taken to support safe staffing levels included considerable investment in additional nursing staff as well as pro-active recruitment activity by the Trust, such as their attendance at job fairs and overseas recruiting. Improvements to HR processes had also been implemented to help ensure staff who were selected, were able to start their posts as soon as possible.

The information provided by senior managers was supported by staff from most areas, who in general, felt staffing levels were adequate. Many staff members we spoke with felt that there had been recent improvements in staffing levels. Their comments included, "There have been a lot of new starters so numbers have come up." And, "I don't think we can say we are understaffed. The other thing is that if we have agency staff, they are usually the same faces. That helps a lot because they know how we do things."

Staff that we spoke with were also generally complimentary about the skill mix of staff and availability of senior clinicians. One staff member in A&E commented, "We have a strong

consultant presence. They are on site until midnight and then on call. This means junior medical staff receive a good level of support as well."

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of the service that people received.

Reasons for our judgement

All NHS organisations are required to have a comprehensive programme of quality monitoring and improvement in place. Trusts refer to the processes of quality assurance as 'governance'. We examined systems for monitoring the quality of the service and looked at how the Trust ensured that their governance arrangements resulted in the continuous improvement of patient care.

Arrangements were in place to monitor quality at ward and department level. In addition, there were processes that enabled senior managers to monitor performance across the Trust.

At ward level, various aspects of quality and performance were constantly monitored. Audits were in place that assessed safety, quality and performance in areas such as equipment, stocks and cleaning, as well as those areas directly related to the wellbeing of patients such as falls, pressure sores and nutrition.

We saw that all wards had performance boards describing their performance in relation to important areas of patient care, as well as information about complaints and feedback. In all the areas we visited, ward performance boards were up to date and highly visible.

There was a process in place, whereby unannounced inspections were carried out on wards. The inspections, which were conducted by senior managers, focused on the essential standards of quality and safety. In addition, they included gathering the views of staff and patients. We saw that following an inspection, a ward would be given a report and rating. Any areas identified as needing improvement would be addressed in an action plan. We also noted follow up inspections were carried out in all cases, to ensure improvements had been made.

In addition to the unannounced inspections, we were advised that executive directors carried out weekly walkabouts, during which they would visit wards on an unannounced basis and speak with patients and staff about their views of safety and quality.

Trust wide performance results were available to senior managers, which also enabled the user to drill down to specific areas. Action and improvement plans were monitored by the executive team, to help ensure required improvements were achieved.

The Trust's quality assurance processes included clinical audits. Clinical audit is a process of reviewing care and outcomes for patients against a set of criteria or standards. Some of these standards are nationally agreed and some are defined by the Trust. We saw that the Trust continuously monitored outcomes of clinical audits and responded quickly if audits indicated that an area needed to be investigated in more detail.

We saw evidence the Trust monitored mortality ratios and alerts using Dr Foster Intelligence's (DFI) information systems. Evidence was available to demonstrate that where risk was identified, the Trust were quick to respond by carrying out detailed reviews.

Patients were asked about their views of the service in a variety of ways including an electronic survey which examined their experience of using the service and the care they had received. The Trust patient feedback system included a requirement for ward managers to monitor performance and identify improvement actions for any serious negative responses.

We saw some examples of changes that had been made within the service as a result of patient feedback. Through the 'You said, We did' system various improvements had been made including an increase in the number of wheelchairs available for patients' use and a wider choice of sandwiches.

Effective learning from adverse incidents, near misses and complaints was evidenced. Governance arrangements had been reviewed to include three improvement groups. Their roles were to ensure lessons were learned and resulted in improved safety, effectiveness and patient experience.

We saw an example of improvements implemented as a result of learning from adverse incidents and complaints. The operation of the discharge lounge within the service had been completely reviewed and a number of improvements made. The changes had resulted in patients who were waiting to leave the hospital receiving a much improved standard of care and support.

A number of staff that we spoke with commented on recent improvements in the Trust's Datix system. This is a system used for reporting concern incidents and near misses. We were advised there had been some recent investment in the system which would enable managers to have clearer oversight across the service.

There are a number of national performance targets in place which most services are required to meet. In recent quarters the Trust had missed some of these targets, mainly in relation to waiting times, referral to treatment times and infection control targets. We discussed the areas with senior managers, who shared with us detailed action plans, which had been implemented as a result of the missed targets. These demonstrated that time had been taken to understand the performance issues and identify the necessary improvements. The effectiveness of the action plans was being monitored on an ongoing basis.

Detailed plans had been put in place to enable the service to cope with the increased

demand for their services in the winter months, that had been anticipated. These included increased GP support and improved utilisation of community services. In addition, increased consultant led ward rounds and enhanced social care services had been implemented to help in achieving effective patient flow and discharge.

A senior staff member from each department made up the Winter Intensive Support Team. This team met on a daily basis to review demand and capacity and ensure that services continued to be delivered safely and effectively.

The majority of staff we spoke with felt there was good communication from senior managers at the Trust. People told us they felt their opinions were valued and described them in ways such as 'approachable' and 'supportive.' One senior nurse commented, "This Trust is very supportive to nurses. My experience of the managers has been very positive so far."

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

Improvements were required to help ensure that people who made complaints received satisfactory support and were provided with appropriate responses.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with some patients about their understanding of the Trust's complaints procedure. Very few patients had enquired as to the processes they needed to follow to make a complaint, although the majority told us they knew where to find the information should they require it.

When touring the hospital we looked for information about complaints in the form of posters for example, but did not see any in the wards or departments we visited. We spoke with managers who told us complaint information was included in bedside packs for patients. However, people using outpatient or A&E services would not have access to these.

We had discussions with some people who had used the Trust's complaints procedure. For some people, their experiences had been less than satisfactory and they had felt that they had not received adequate communication from the Trust while waiting for a response. In one example, we saw that a complainant had waited eight months for a response. We noted that the issues raised were very complex and had required detailed investigation. However, this contact showed us a record of calls and emails they had made throughout their wait, to the Trust's customer care department, some of which, they had not received a response to. They told us that they would have found the process much less stressful if the Trust had updated them on a monthly basis while they were waiting for a formal response.

Another person that we spoke with had wished to make a complaint and contacted the Trust's complaints department. They explained that the department had advised her that they needed to make their complaint in writing. They were unable to do this due to their disability and contacted the Care Quality Commission for advice. We talked with the head of customer service about this person's experience. It was acknowledged that the advice they had been given was not acceptable and agreed to reiterate to all staff, the importance of providing adequate support to enable people to raise their concerns.

The majority of staff we spoke with were able to describe the Trust's complaints procedure

and tell us how they would support a patient to raise concerns. However, we were aware of one example where a staff member had failed to follow the correct procedure when responding to a verbal complaint. This had resulted in the complainant receiving a very poor response to the concerns they had raised. This had been identified by the Trust who had taken action to help ensure the situation did not occur again.

We were advised that all complaints received at the Trust were risk assessed so any urgent issues relating to a patient's welfare could be referred through the correct safeguarding channels. However, during the inspection, we noted one such example of a complaint received by the Trust that was not referred through safeguarding procedures for a period of two weeks. This meant there was a delay in investigating the urgent issues relating to the patient's care.

Senior managers we spoke with advised us that the area of complaints management had been identified as being in need of improvement. It was acknowledged that the experiences of people using the process had been variable, as had the standard of some of the responses provided.

At the time of our inspection, an updated procedure had been presented to the Trust's board for approval, which included a number of improvements in relation to how complaints were to be investigated and how the Trust would communicate with complainants.

Managers were also able to provide evidence that extra investment had been made in the area, including the recruitment of additional staff to support people making complaints and to help ensure they received timely communication and responses.

We saw there were processes in place to ensure all complaints were monitored so that any themes or trends in relation to a specific area or department for instance, could be identified. Senior managers told us this monitoring took place so there could be greater emphasis on lessons learned and the communicating of such lessons to staff throughout the Trust.

This section is primarily information for the provider

✖ Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Not all service users were protected against the risks of receiving unsafe care or treatment. Regulation 9(1)(a)(b)(i)&(ii)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not always sufficient arrangements in place to ensure sufficient staff were available to safeguard the health, safety and welfare of service users. Regulation 22.
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met:

This section is primarily information for the provider

Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	The system for receiving, handling and responding to people's complaints was not always effective which resulted in unsatisfactory outcomes for some people who made complaints. Regulation 19(1)&(2)(a)(b)&(c)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✗ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✗ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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9 December 2013

Mr Stuart Heys
Chair
Lancashire Teaching Hospitals NHS Foundation Trust
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

Dear Stuart

Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") - Notification of decision to open a formal investigation

1. Further to our discussion with Karen Partington on 3 December 2013, I am writing to inform you of Monitor's decision to open a formal investigation into the Trust's compliance with its licence. This investigation has been opened due to governance concerns arising out of the Trust's self-certified failure to meet the Referral to Treatment (admitted) 18 week target ("the RTT target") and the number of cases of C.difficile exceeding the maximum threshold for three successive quarters at Q3 2013/14. We also have concerns about the Trust's performance in relation to the A&E four hour wait target and cancer targets, as set out below.

2. The purpose of this letter is to:

   2.1 State the issues which have led to our concerns; and

   2.2 Confirm the process Monitor will adopt in assessing the extent of these concerns, whether there is a breach of the Trust's licence, and what, if any, regulatory action may be appropriate in consequence.

3. We expect you to share the content of this letter with the Board and the Trust's Lead Governor.

4. **Monitor's concerns**

   4.1 Monitor is concerned that the Trust will have failed the RTT target for the third successive quarter at Q3 2013/14. This is an indicator of governance concerns under Monitor's *Risk Assessment Framework*. We understand that pressures experienced over the 2012/13 winter resulted in the Trust reaching agreement with Commissioners to breach the RTT admitted target in Q1 2013/14 while it

addressed resultant waiting list backlogs. The Trust's expected date of return to compliance has subsequently continued to slip and the Trust has reported that it does not anticipate recovering the RTT position to compliance until the end of Q4 2013/14.

4.2 The Trust will also breach its C.difficile trajectory for the third successive quarter in Q3 2013/14, reporting 32 cases at the end of November against a cumulative trajectory of 31 cases in Q3. This is also an indicator of governance concerns under Monitor's *Risk Assessment Framework*.

4.3 The Trust also breached the A&E four hour wait target in Q4 2012/13 and Q1 2013/14 and the Trust has reported that this target continues to be under pressure during Q3 2013/14. The Trust has also reported that cancer targets have continued to come under pressure, with the 31 day surgery and 62 day urgent GP referral targets breached in Q4 2012/13 and the 2 week waits from referral to date first seen (symptomatic breast patients) target breached in Q2 2013/14.

4.4 Monitor is concerned that these issues could be indicative of governance failings at the Trust, indicating a potential breach of the Trust's licence.

4.5 Monitor also has concerns that there is risk to the Trust's financial position. The Trust only had around £240k headroom to an FRR 2 at Q2 and may be impacted by the financial position of the CCG.

5. Monitor's process to determine whether there is a breach of the licence and what, if any, regulatory action is appropriate

5.1 Monitor will consider all relevant factors in assessing what, if any, regulatory action is appropriate in relation to its concerns, including:

- information gathered from the Trust and relevant third parties;
- Monitor's published guidance relating to the requirements of the licence; and
- the factors set out in Monitor's *Enforcement Guidance*.

As part of the above, we will consider, amongst other things, the evidence provided as a result of the Trust's work with the NHS Intensive Support Team ("the IST") on RTT and Cancer; the Trust's plans to address underperformance against the C.difficile target; and the Trust's response to the other concerns, including A&E and Cancer targets.

5.2 As part of the investigation, we will also seek further information from the Trust and may consider relevant information from third parties such as the Care Quality Commission ("CQC"), the Trust's commissioners and the Lancashire Area Team.

5.3 Following our consideration of relevant information, we may explore our concerns relating to Board governance at a meeting with you and other members

of your Board. The purpose of this is to help us consider whether the matters outlined in section four above could indicate a breach of the Trust's licence and, if so, what, if any, regulatory action is appropriate in response.

6. **Next Steps**

6.1 We will publish the Trust's revised Governance Risk Rating. The rating will change from its current narrative to the following narrative: "Monitor is investigating governance concerns at the Trust, following breaches of the Referral to Treatment (RTT) target and the C.difficile target."

6.2 We will notify the Quality Surveillance Group, Lancashire Area Team and Clinical Commissioning Groups of our decision to investigate.

6.3 We will speak to the Trust's Lead Governor to explain the action we are taking and provide an opportunity to speak to us directly.

6.4 The Trust should provide the information requested in Appendix A by 5pm, Monday 6 January 2014.

6.5 Following receipt of this evidence and initial consideration, we will be able to confirm potential next steps and associated timings. Should formal enforcement action be considered, the Trust will be afforded further opportunity for engagement or representations as appropriate, in line with our *Enforcement Guidance*.

6.6 Monitor expects the Trust to continue to work at pace to progress the work with the IST, and address the concerns identified in relation to the breaches of the targets referred to above.

6.7 The Trust's Governance Risk Rating will be 'narrative' until the investigation has concluded.

7. If you have any queries relating to the matters set out in this letter, please contact your relationship manager, Kate Sutherland, on 020 7340 2519 or by email Kate.Sutherland@monitor.gov.uk.

Yours sincerely

Robert Davidson
Regional Director – North

cc.: Ms Karen Partington, Chief Executive
Mr Paul Howard, Trust Secretary

Appendix A

Information requested from the Trust by 6 January 2014 (5pm)

1. The key reasons, in the Trust's view, underlying the target breaches set out in the letter, the reasons why the target breaches were not prevented, and any steps taken by the Trust to rectify any deficiencies in Board governance identified as a result of these target breaches;

2. Timetable detailing work with the IST, results of the work with IST and the latest version of the actions plan to address issues identified;

3. Details of work planned to reduce cases of C.difficile;

4. A copy of the latest action plan in place to address findings in the KPMG Urgent Care Services review;

5. Any governance reviews commissioned by the Trust from 2012/13 to date;

6. Copies of reports from any external assurance reviews commissioned around operational issues from 2012/13 to date;

7. All Board and Board sub-committee papers relating to operational issues in relation to RTT, C.difficile, A&E and cancer targets from 2012/13 to date; and

8. Any other information considered relevant by the Trust Board. Where the Trust provides other information please provide an explanation of what it is and the reason for providing it to us.

Health Scrutiny Committee
Meeting to be held on 4 March 2014

Electoral Divisions affected:
All

Report of the Health Scrutiny Committee Steering Group
(Appendices A and B refer)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

On 20 December the Steering Group received an update on the Health & Care Strategy from Fylde & Wyre CCG and an update on the Domiciliary Care Review from the Adult, Community Services and Public Health Directorate. A summary of the meeting can be found at Appendix A.

On 31 January the Steering Group met with East Lancashire CCG to discuss their system to gather soft intelligence. A summary of the meeting can be found at Appendix B.

Recommendation

The Health Scrutiny Committee is asked to receive the report of the Steering Group.

Background and Advice

The Scrutiny Committee approved the appointment of a Health Scrutiny Steering Group on 11 June 2010 following the restructure of Overview and Scrutiny approved by Full Council on 20 May 2010. The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Liberal Democrat Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of the increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

- To act as the first point of contact between Scrutiny and the Health Service Trusts;

Lancashire County Council

- To make proposals to the main Committee on whether they consider NHS service changes to be ‘substantial’ thereby instigating further consultation with scrutiny;
- To liaise, on behalf of the Committee, with Health Service Trusts;
- To develop a work programme for the Committee to consider.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the full Committee for consideration and agreement.

Consultations

N/A.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

N/A.

Reason for inclusion in Part II, if appropriate

N/A.

Appendix A

NOTES

Health OSC Steering Group
Friday 20 December– Scrutiny Chairs Room (B14a)
2.00pm

Present:

- County Councillor Steve Holgate
- County Councillor Mohammed Iqbal
- County Councillor Margaret Brindle

Apologies:

- County Councillor Fabian Craig-Wilson

Notes of last meeting

The notes of the Steering Group meeting held on 29 November were agreed as correct.

Fylde & Wyre CCG – Health & Care Strategy

Peter Tinson, Chief Operating Officer and Dr Adam Janjua (GP Fleetwood and Acting Chair) from Fylde & Wyre CCG attended Steering Group to discuss the development of the CCG's Health and Care Strategy

A discussion took place between officers and members the main points being:

- Last time the CCG attended Steering group they had just started the process of developing the strategy
- Want to plan for a 17 year period (to 2030) – same time frame as local authority colleagues
- Manifesto for Change poster is a summary of all the high ,level challenges the CCG is facing – Peter to provide an electronic copy of the poster to share with members
- CCG accused of being too ambitious but they feel if they would be less ambitious and fail it would be worse than aiming for the stars
- Approx £200m to spend each year – most of this is allocated to acute trusts so the amount of money to spend on developing new services is quite small.
- Retention issue for staff on Fylde coast so has led to an increase in health expenditure.
- Ageing population but the NHS is a victim of its own success as making people live longer through improved health services - Shame that the public don't take more responsibility for their own health
- The CCG intend to make a sustainable plan – several engagement events taken place already with local councils, HW, etc. - Several groups looked at different pathways, done with stakeholders and they came up with a rough strategy. JSNA and Public Health played a huge part in the strategy. Hoping to make it future proof (regardless of changes in political power)
- Challenge to get patients and service users to think strategically rather than concentrate on individual issues
- Engagement/communications plan that starts January and intend to have the strategy ready by April next year.

- Stakeholder engagement has been a huge part of the content of the strategy
- A lot of the strategy is based on neighbourhood models and integration – particularly important with elderly population and long term conditions.
- Recognition that's there a lot of detail to be worked out over the next few months.
- Communication is key to be clear about what can and can't be done
- Implemented a care co-ordination model – asked practices to identify at least 20 patients most at risk of admission to hospital. Started this Oct 2012 and has saved countless admissions by identifying the needs of those people before hand – integrated services at a very local level at an early stage. Been a big success
- Fylde coast advisory commissioning board – social services, CCGs, acute trusts etc. – ahead of lots of other areas in terms of planning. This could be used as a model of good practice
- Engagement plan – how can they manage expectations – due to budget constraints? How will they manage the wish list? Obviously if there is outrage about the reduction/loss of a service it will have to be reviewed. But just because the public isn't happy with something doesn't mean it's not a good services.
- People still see the NHS as physical buildings rather than services in the community.
- Need for public health to work together in the future – need to make people aware of choices and the consequences of lifestyle choices.
- Prevention of ill health – what type of liaison do they have with public health e.g. immunisation of children? Tends to fall under the remit of NHS England but will from 2014 become a responsibility of the GPs. – what role will health visitors do in the future? –should they be more involved in wider public health education and issues?
- The CCG has a public health specialist from LCC that is involved in the work of the CCG. Feels though that more needs to be done with the general public, more campaigns on a local level.
- NHS health checks – issue of accurate data of eligible population numbers particularly due to the transfer from PCTs to CCGs/Public Health teams. Having to coax people into a health check – takes up a lot of nurse time, involves a second visit by the patient (these are often people who don't normally visit the doctor). Not sure that an individual would be happy telling pharmacist or workplace about health issues – amount they drink, family history etc.
- The CCG have had real trouble about getting patient identifiable data – have to get it either from NHS England or the LSU not the GP direct. Still having problems accessing data – impacts on decision making. National issue which would require legislation. The CCG has to justify the data required on every single occasion. Can transfer info between NHS.net emails but if using another email address requires special permissions to access info. Lots of issues without any obvious solutions being identified.
- Integration appears to be the best solution and a focus on health and well being – but this creates issues in terms that the NHS is geared up to fix unwell people rather than working with the well to keep them well.
- GPs reputations need to be maintained to ensure that people will want to go to a GP rather than A&E – reputation can be tarnished by emphasis on GPs only doing things for money.

- A concern with HWB is that they need to be able to listen to the local data and not just make blanket Lancashire policies. Start planning now
- All CCGs meet monthly and if this is a shared view it needs to be communicated to both the HSC and the HWB
- Draft strategy to be shared with SG in late Jan for comments and further input.
- Members appreciated the candour of the officers in speaking about the issues important to their local area.

Domiciliary Care Review Update

Following on from the Steering Group meeting on 6 September Tony Pounder, Head of Commissioning and Steve Gross, Executive Director - Adult, Community Services and Public Health Directorate attended to provide members with an update on the progress of the domiciliary care review.

Tony recapped what was discussed on 6 Sept and reminding members that it was, at the time very much a work in progress. He explained that a number of options went out to providers in late October for their comments and then in early November he wrote to everyone in receipt of domiciliary care.

He is presenting a report to Executive Scrutiny Committee on 7 January which will then go to Cabinet.

The recommendations of the report and additional comments made during discussions with Steering group members are below:

Recommendations

The Cabinet Member for Adult and Community Services is recommended to:

(i) Approve proposals for Recommissioning and Procuring Home Care services which place an emphasis on:

- Commissioning Home Care Services which:
    - Promote Personalisation;
    - Become more outcome focussed and maximise independence;
    - Support integrated working with other Health and Social Care services and organisations;
    - Ensure the dignity of individuals and safeguards those who are vulnerable;
    - Incorporates human rights obligations into decision making and commissioning and contracting practices - **when it comes to national minimum wage compliance it should be clear that the providers cannot ignore the issue. Uncertainty around whether private providers have to abide to human rights obligations has resulted in specific reference made within the contract.**
- Investing in and developing Lancashire's home care workforce by:

- Ensuring all Home Care agencies are contractually obliged to follow compliance guidance from Her Majesty's Revenue and Customs (HMRC) on paying National Minimum Wage (NMW);
- Setting prices on the Home Care Framework on the basis that
  - the use of zero hours contracts (ZHC) in the Home Care sector is minimised;
  - Hourly rates stretch towards the "Living Wage" to be paid to all home carers during the lifetime of the new contracts';
  - National Minimum Wage Compliance
- Endorsing the principles contained in Unison's "Ethical Care Charter for Home Care";
- Working with workforce and employers' representatives to draft a 'Lancashire Charter for Home Care', detailing annually updated commitments to:
  - National Wage Compliance at all times; **- should be pretty obvious but needs to be explicit due to recent issues identified nationally – everyone who bids on the framework must comply**
  - Minimising the use of Zero Hours contracts; **- more aspirational than mandatory, cannot abolish them legally but if that is the default employment approach then you risk having a workforce with no commitment or loyalty. Current staff turnover rate in home care is approx 37% so aim to reduce this substantially. Acknowledge that majority of staff will be part time (due to the nature of the work). Want to give a strong message to providers. Issue regarding pay increases for staff on working tax credit as this will reduce if their wages increase so they will be no better off. There will always be people who will not benefit but the majority should do. Pay wards will be an attempt to upgrade the status of the job role. Staff have been made aware by LCC writing out to interested bodies (such as Unison) so aimed to access all staff but cannot guarantee it. There is the principal about valuing the profession rather than treating care staff as unvalued workers. LCC hope to underwrite a minimum number of total hours for the provider so they can pass this guarantee onto staff.**
  - Hourly wage rates which stretch towards the 'Living Wage'; **- Reality is that LCC cannot specify what a contractor pays its staff as long as it complies with national minimum wage. Providers feel it's not a level playing field but we will be saying that there is a strong morale case for paying a living wage. Hopefully we can get providers to sign up to say they will work towards it.**
- Inviting Home Care Providers who are secure places on the Framework to sign up to this 'Lancashire Charter for Home Care', and supporting its use as a vehicle for promoting their reputation, partnership working and the sustainable growth of their businesses; **- use this as a reputation marketing vehicle, community pressure for all to be consistent. Didn't want to just make general aspirations but also didn't want to be too prescriptive**

by identifying a figure at the beginning. As there will be so many partners they will want to work with us we will need to be much more proactive in how we deal with problems. 46 current providers in Preston – difficult to have meaningful talks with this number of providers. If go for 5 (as an example) they would have 20% of the market each – some of the smaller ones can't achieve this so services would be delivered by the larger companies. This would disadvantage the smaller, growing organisations that are delivering a good service but not yet in a position to expand rapidly so have decided that a way forward is to ask providers what share of the market they can effectively deliver. Message will be that unless an organisation can grow or merge into a consortium they are unlikely to get a contract. Developing consortia however is more challenging to achieve within the private sector. The reality is that for some small providers they would need to look at the personal budgets or self-funder market instead – there is growth in what CCGs are commissioning and also the self funders market. New legislation is on the horizon relating to self funders but they can use which ever provider they want even if they are known to deliver a poor service

  - Adopting a strategic approach to training in the sector, analysing the workforce National Minimum Dataset, working with Skills for Care, and levering its investment in Lancashire Workforce Development Partnership to ensure delivery of training to Home Carers is in line with local priorities and takes account of CQC regulations, the Cavendish report, and the guidance under development by National Institute for Clinical Excellence (NICE);

- Changing the Council's approach to contracting so that:
  - Providers are clear about their responsibilities to act compatibly with the Human Rights Act 1998, and contracts would give users of contracted services a direct right of redress against the provider in the event that their human rights were breached;
  - There is a greater emphasis on quality over price in evaluating bids from providers;
  - Providers are expected to support the principles of Self Directed Support and take greater responsibility in supporting individuals to exert choice and control over the use of their Personal Budgets;
  - Adoption of a clear and robust approach to quality based on service user derived standards and Key Performance Indicators, reliable monitoring and incentives to continually improve;
  - Designing the new 'Framework' for Home Care providers to offer on minimum guaranteed hours of business the level of which is subject to periodic negotiations and reset according to predicted demand*;
  - Reviewing our approach to Electronic Time Monitoring Systems, with the intention of presenting a business case for investment in a centralised system to enable more effective monitoring and audit of key cost and quality indicators;
  - Extending the length of contracts offered to providers for up to 7 years on the basis of an initial 3 years with the option of yearly extensions for a maximum of 4 years subject to satisfactory

progress and performance and in order to encourage investment in workforce and systems and to reduce procurement costs; - **what happens regarding poor performance within the first 3 years? If identified early (within first year) would work with them to improve. At the moment no real understanding about who is good or bad as it may come down to an individual staff member.**
  - Building in flexibility to the contracts to enable the introduction of new approaches and innovations in service delivery and payment mechanisms;
  - Redesigning internal County Council arrangements for quality and contract management to ensure consistently high performance is rewarded, mediocre or poor performance is swiftly challenged and consistently poor performance leads to contract termination.

- Shaping the Market including:
  - Significant reductions in home care provider numbers operating under contracts from the County Council allowing for a more collaborative approach to working with commissioners and other providers, encouraging investment in systems and workforce development, reducing the proportion of provider sector's spend on management and overheads; and reducing transaction costs for the County Council; - **United Kingdom Home Care Assoc and Unison both felt that too many providers enable too different working practices and exploitation of staff through poor wages and zero hours contracts. The trade off is that whilst some businesses may become unsustainable the remaining ones will have staff with better terms and conditions which will enable them to provide a better service to clients. Increasing demand will be built into the contracts – reduction in hospital stays and integration of services. Currently the home care system cannot contribute to community based services as there are too many of them. Great opportunities for the future. This will enable improved opportunities to monitor contracts and manage the commissioning of services. Bigger organisations will probably be in a better position to offer training and support to staff as opposed to the smaller companies.**
  - Offering lots for home care business in specified 'Zones' to promote more efficient working across the system and closer integrated working with Neighbourhood Teams;
  - Allocation of new business to providers to secure a balanced and sustainable market in each zone by the end of the transition period, and then using competition to ensure focus on maintaining standards and continual improvement for the duration of the contract term;
  - Small Home Care providers can bid for smaller lots within zones to maintain variation in the market place and reducing the business risk for successful but newer businesses growing from a smaller base;

- Limiting market shares for any one providers to ensure the sector's longer term sustainability while ensure healthy competition and choice;

(ii) Note the details of the consultations undertaken with Home Care Providers and service users and the main findings detailed in Appendices 'B' and 'C' and the Equality Analysis contained at Appendix 'D'; Refers to EA being Appendix A below

(iii) Endorse establishment of a Home Care Business Transitions Project Team to ensure the efficient, safe and timely management of changing from the current configuration of services to those set out in recommendation (i) above;

(iv) Recommend that the Deputy Leader of the County Council approves a waiver of Procurement Rule 6.1 of the County Council's procurement rules to enable the County Council to extend the Framework for an initial 6 month period from 1 April 2014? with the option for the County Council to extend on a month by month basis for a further period of up to one year at the end of that period.

Subject to the approval of recommendations (i) and (iii) the Deputy Leader of the County Council is asked to approve the waiving of Procurement Rule 6.1 and approve the extension of the existing Framework for an initial six month period from 1 April 2014? with the option for the County Council to extend for a further period of up to one year on a month by month basis at the end of that period on the terms as set out in the report.

Another major challenge is the transitional phase from what we've got now to where we need to be – this will take place over a period of months. Issues may arise when providers realise they do not have a new contract but still need to deliver services until their existing contract expires. Also potential problems in the handover of client details from company to company. Also TUPE issues will need to be managed.

A team will be created to deal with these issues and members welcomed this approach

Feedback has been that zone based recruitment events should take place to enable staff to meet employers in the area they live/will work.

Dates of future meetings

- 10 January – cancelled
- 31 January – ELCCG
- 21 February – Sakthi Karunanithi, Director of Public Health
- 14 March – Dr Jay Chillala - Diabetes

NOTES

Health OSC Steering Group
Friday 31 January 2014

Present:
- County Councillor Steve Holgate
- County Councillor Mohammed Iqbal
- County Councillor Margaret Brindle
- County Councillor Fabian Craig-Wilson

Notes of last meeting
The notes of the Steering Group meeting held on 20 December were agreed as correct

East Lancashire CCG
Jackie Hanson, Chief Nurse from East Lancs CCG attended the meeting to discuss how the CCG collect and analyse soft intelligence. This is a follow up to when the CCG attended full Committee in September.

Jackie outlined what topics she would discuss with members and handed out a presentation (copy attached). The main points were:
- She's been in post since Sept last year and her remit is the professional lead in terms of nursing, quality and patient experience.
- Francis report came out this time last year re what happened at Mid Staffs and the CCG went through it and determined what it meant for the CCG. They decided they wanted to approach it differently and they produced a number of pledges (see presentation)
- Part of the issue what that staff and other 'knowledge' in the system knew the problems but didn't have a mechanism to express their concerns adequately. The CCG recognised they didn't have a way to collect the anecdotal evidence and patient stories. They branded their soft intelligence system as Connect.
- Soft intelligence will help improve service and will be collected on any provider who delivers services (all sectors)
- Started to pull together a system of info from different sources, NHS choices website, formal complaints and comments, local media, elected members, listening and engagement events etc.
- Reps from CCGs will go out to listening events to talk to the public about what is and isn't working and asking for ideas to improve the services.
- Have contract monitoring with all of the providers
- Public events appear to have been well attended so far – one issue identified was that there was no Parkinson's Nurse in Rossendale, as a result the CCG have worked with partners and from April a new nurse will be in post.
- Sometimes people have bad experiences but have not complained about it formally so this is a way to capture this type of information.
- Current problem is that the CCG are not allowed to hold any patient identifiable data to enable them to track the progress of a concern raised – this is a national issue that has been flagged with Government

- Weekly meetings to go through the data received and risk rate the issues (any serious issues are escalated through the relevant process – ie safeguarding)
- Will either escalate or trend issues which can then identify patterns of problems, trended on providers, service and theme
- 3 trends have already been raised with ELHT so far– eg, hygiene, A&E as a Department and discharge processes in a specific department (eg Ophthalmology)
- Currently the analysis and risk rating is done manually by the team – hopefully this will be automated soon, working with CSU who use a system in Staffordshire and progress is being made to implement this.
- Issues from out of area will be forwarded onto the lead commissioner for that provider
- Timeframe – response asked within 2 weeks, some providers struggle with this and some have their own system to flag issues up.
- Capacity issues – where else could people go though, some providers have strict financial constraints, others have vacancies/gaps in the system.
- ELHT in particular have responded positively to the challenge to deal with these concerns in a timely manner.
- Jackie's team will track the soft intelligence comments and follow those up with the provider. Any formal complaint will be tracked through the complaints system.
- Is providing the CCG with a good alternative source of information and assists with commissioning decisions and contract monitoring.
- Pathways and referrals – not crossing (consultants in same Trust write back to GP) so the Trust has amended its system as a result
- Poor quality care – tend to patient specific, generally the softer side e.g. dignity, privacy, nutrition rather than quality of nursing
- Discharge issues – across all acute Trusts.
- Service availability – OOH – if someone dies on Friday night, the registration would be held up until Monday. Jackie felt that Mortuary Services would be a good starting point to investigate.
- Now that the CCG see value in the system and that it provides them with a richer source of info need to progress to a more automated system
- Listening events are very generic at the moment, town centre based. Looking at more focused events in different venues and different age groups and communities
- Members acknowledged that there are some communities that are very insular
- Looking at how they can join up with neighbouring CCGs and acute Trusts for the listening events.
- Does Jackie feel there is a point at which the model can be shared with other CCGs (to roll out across Lancashire) - LNCCG have created a very formal data system so across the board there are many opportunities to capture intelligence. If confident in the software/computer system then the plan would be to run a similar system throughout the county.
- The non-execs and Chair of the CCG are very supportive of the system.
- Time intensive but worthwhile, this is new for providers as they are used to a more formal process.
- Don't want to duplicate but do want to share.

- Data peaked at the beginning when the system went live and then should even out after that. All issues, even the positive ones, are recorded and forwarded to the provider.
- Healthwatch/CQC – Jackie has regular meetings (both formal and informal) with the CQC and discusses the issues identified. The CCG informs the CQC what trends and themes they raise with the providers.
- Ongoing issues raised within care home settings and the CCG is working with the local authority to clarify roles around these issues.
- Jackie asked for specific groups that members knew of that would take part in a listening event. Could the listening events be tagged onto existing public engagement events – Jackie to investigate
- How are the CCG and PHL working together – Steve referred to the Better Care Fund and wanted to know Jackie's views on this. Her opinion was that the relationship works well, her main engagement was around infection control and after a shaky start it is now progressing well.
- Integration agenda – massive, strategic intention as a CCG is this, both organisations need to be clear and realistic about what can be delivered and identified steps to achieve this. Challenging and CC Holgate felt that the missing link was NHS England who are key players but seem to be isolated from the process.
- Although the contracts for GPs is with NHS England the responsibility for improving primary care lies with the CCGs – feels as if the system is improving after a slow start.

Update on the progress of ELHT Action Plan and new governance arrangements

Jackie also provided the Steering Group with an update on the progress being made by ELHT (from a Commissioners perspective)

- Keogh review and original risk summit in the summer
- The plan developed by the Trust and the Trust Development Agency (TDA) so the CCG developed an assurance framework
- Working with TDA and ELHT to see where they are – NHS England LAT hold quality surveillance groups and these have taken place
- Another risk summit is due but unsure whether this will take place
- New chief exec – Jim Burrell (interim)
- New chair – Prof. Eileen Fairhurst
- ELHT have made progress in all areas but some progress is a bit slow – CQC have done several inspections since then and whilst there are still issues things are improving and it's a more positive outlook. On the right track, still a long way to go.
- Jim would welcome the SG to visit the Trust to receive an update and progress report.
- The CCG now have access to more info than they have ever had before.
- The recent performance is improving (even though they will not meet their target), their pathways have improved and also decision making.
- The systems and processes in place are having a positive impact on patients. Addressing their medical gaps with agency/locums and will remain so until the Trust stabilised.

Actions from previous Committees
Members to received an update on all the outstanding actions from Committee which included a visit to NWAS control centre at Broughton and the response from CC Tony Martin to the Care Complaints task group.

Work Plan
Members discussed the work plan and topics for future consideration. Now that the dates of future Steering Group meetings have been agreed invitations can be offered to address the topics identified.

In response to a query raised by CC Dowding regarding the provision of medical reports by GPs for DLA claimants, it was agreed that CC Iqbal would email her to request that she investigate the issue further and report back to Steering Group.

Dates of future meetings
- 21 February – Sakthi Karunanithi, Director of Public Health
- 14 March – Dr Jay Chillala – Diabetes & F&WCCG long term strategy development update
- 4 April – Janice Horrocks on behalf of SOHT re Care Closer to Home

Annex A

East Lancashire
Clinical Commissioning Group

East Lancashire Clinical Commissioning Group

NHS East Lancashire CCG have considered the findings and recommendations made in the Francis Report. We accept the report in its entirety and the recommendations in principle.

We are committed to serving our local population in each of our localities and ensuring they receive safe, committed, compassionate and caring services. We will do this by:

Fulfilling our commitment to listen to patients

We will proactively seek the views and feedback of patients through a number of methods such as locally based listening & consultation events, thematic discussions using different media and individual patient stories.

We will plan regular visits by Governing Body members to all our services and public places during the year, so people can meet us and speak to us personally.

We will put patients and how they experience health care at the heart of our meetings and reports by regularly using patient case studies describing how they have reported to us their experience of the services we commission.

Preventing Problems

We will ensure the patient is the priority in everything we do.

We fully accept our responsibility for setting and monitoring standards & we will contribute to the national programme of setting fundamental standards.

We will support the National Commissioning Board in developing enhanced quality standards and will monitor local services against these standards.

We will lead the local health economy by defining developmental standards setting our long term goals required of our local service providers.

Local clinicians are in positions of leadership for commissioning and this represents a fundamental change which will drive better alignment with the safety and effectiveness of patient care.

Reviewing culture, ensuring we & all of our Providers are putting patients first

We will refresh our Quality Strategy by September 2013 which will demonstrate our vision and the action to be taken in response to the Francis report and beyond, to drive improvements in standards of care throughout the health economy.

As the leaders of the local health economy we will ensure we model the correct behaviours, create an empowering culture and have the right skills and values to successfully deliver what is required of us.

We will ensure we apply the values of transparency, honesty and candour within our own organisation and how we operate.

We will provide leadership to the local health economy and require all service providers to assure us that they apply the values of transparency, honesty and candour.

Once developed we will promote and encourage the use of the culture of care barometer.

Three practical actions we will take in the short term:

We will establish and publicise a CCG Contact system by the end of June which will enable patients and carers to share with us their experience of care in East Lancashire and ideas for service improvement via letter, email, twitter, Facebook and face to face local events.

We will work with our member practices to set up an early warning system by the end of July so we can start receiving soft intelligence about quality of services received by our patients from our GPs.

We will organise an annual programme of listening events in each locality commencing in September 2013.

Taking Action Promptly

We are developing our Early Warning Systems and proactively seeking out and acting on patient feedback; positive and negative, about all providers of healthcare (including primary care).

We will ensure providers of services clearly advertise to patients how to complain and that they respond in a timely manner to any complaint made. Service providers will also be asked to provide more detail on their reports to us about the complaints and compliments they receive and the action they have taken.

Developing our capacity to address the Quality agenda

We have established a Quality & Safety Committee which dedicates time to detailed scrutiny of patient experience, safety and performance information, and generating key summary information about quality for the Governing Body.

We will aim to bring the energy and flavour of the subcommittee to the Governing Body so everyone is fully engaged in quality.

We will compare, contrast & align information we receive with regard to quality from patients, providers and regulators to challenge as appropriate; driving up standards of care.

We will proactively collaborate and share information with regulatory and local commissioning bodies of any concerns we have about our providers & the services they provide.

Providing System Leadership

We will regularly challenge our providers to demonstrate how they are creating a culture of compassion & how are they incorporating the 6Cs into their nursing strategies.

We will scrutinise patient experience feedback and surveys and will drive our providers to aspire to be the top providers of healthcare in the country. We will expect them to regularly report how they are engaging with their workforce to genuinely change their culture and enabling staff to raise their concerns freely.

We will scrutinise our provider's staff surveys and will not allow poor results to remain unattended to.

We will push our providers to aspire to be the best employers in the country, supporting and developing the whole workforce, both qualified and unqualified staff.

Our providers will be held to account on their contractual duty of candour.

Service providers will be required to assure us that their staff have been fully involved in developing and owning their organisations core values and standards, demonstrating they are acting to embed them.

East Lancashire
Clinical Commissioning Group

Connect

Using soft intelligence to monitor care quality

- Commitment to quality on behalf of patients.
  - Reinforced by patients' views + Francis, Keogh, CQC, TDA, Monitor and
- Lead commissioner for East Lancashire Hospital Trust (in special measures post Keogh)

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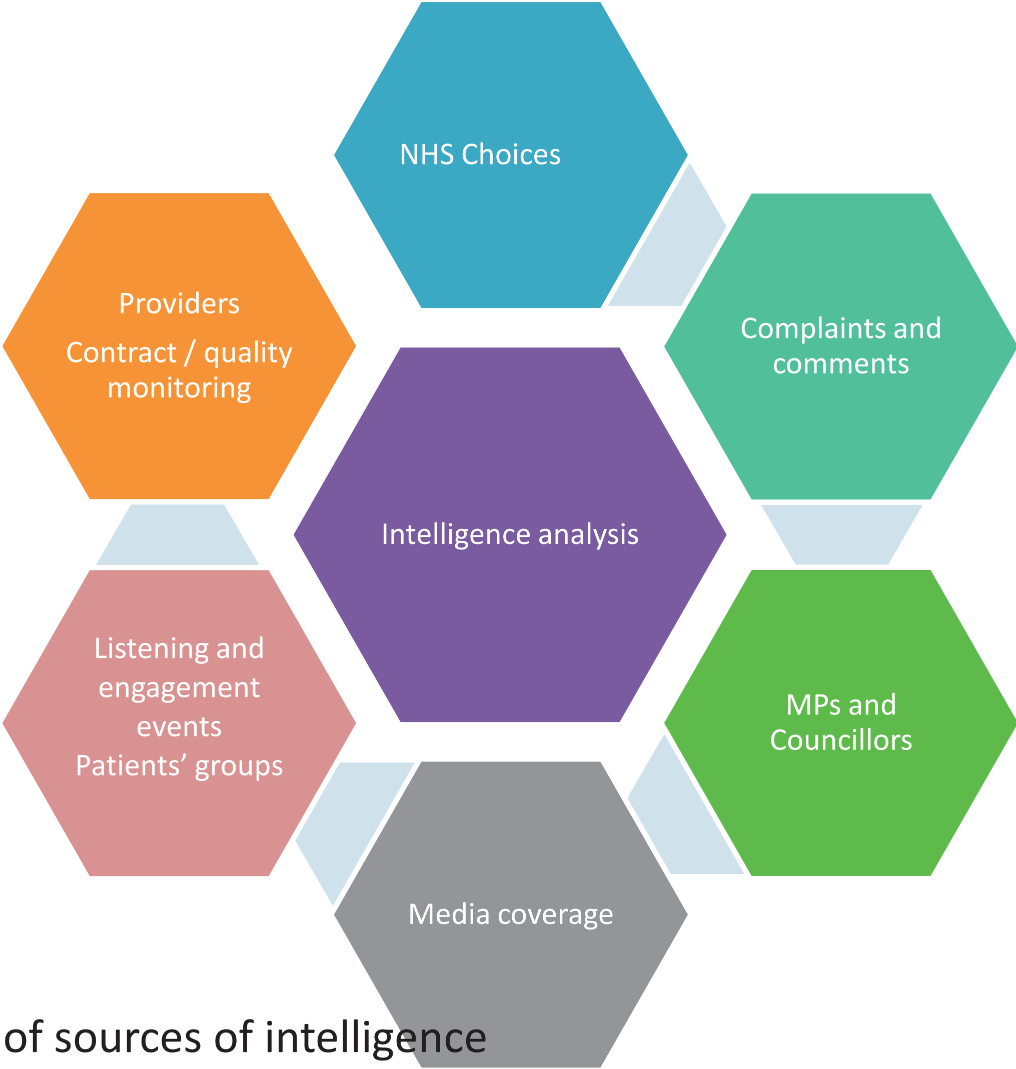

Bigger range of sources of intelligence

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Public listening events

- Saturday mornings

- Locally based

- Not Us v Them … a different approach

- Patient stories/voices (with privacy and support)

- Actively creating face-to-face opportunities

HEALTH

Patients at heart of better NHS services

■ New era is ushered in as area's health bosses hold a listening event

By LAWRENCE DUNHILL
Health reporter

A NEW era of putting the patients at the heart of improving NHS services in East Lancashire was ushered in at the weekend.

At least that's the idea. It is too early to tell whether newly-styled 'listening events', such as the one held in Rawtenstall on Saturday, will make any real difference, but health chiefs are at least talking a good game.

Bosses at East Lancashire Clinical Commissioning Group [CCG] spend most of their time analysing high-level data at their grand headquarters in Nelson, but have now begun meeting patients face-to-face to find out how services are delivered on the ground.

> We would like to see emergency services returned to Burnley
> **Tariq Mahmood**

The meetings, which will also be held in Hyndburn, Ribble Valley, Pendle and Burnley, are a response to damning evidence from across the NHS of patients' concerns being brushed aside by managers.

This was not only exposed in the Stafford Hospital scandal, but also in Sir Bruce Keogh's July report into failings at 14 hospital trusts, including that at East Lancashire's.

There was a steady stream of people at the first event at Rossendale Primary Health Care Centre, with both positive and negative comments.

Sheila Huxley-Birt, 61, from Waterfoot, had complained that East Lancashire was one of just 12 NHS areas in the country not to have a specialist Parkinson's nurse.

Her brother John suffers from the condition. Although often admitted to Fairfield General Hospital in Bury, he is not allowed care from the specialist nurse in that area, as he lives in Newchurch, Rossendale.

Tariq Mahmood, the secretary of the Rossendale Anglo Pakistan Society, said his members were mostly happy with the NHS, but would like to see emergency services returned to Burnley General Hospital, which is easier to access.

Photographer Karen Howard, 48, from Balladen, said that she was given 'fantastic' care at Blackburn and Burnley when diagnosed with breast cancer last year through an early screening programme.

A general view of the event

Above, Dr Diane van Ruitenbeek, chair of CCG governing body, and lead nurse Jackie Hanson. Right, Karen Howard

Sheila Huxley-Birt and Alan Huxley gave their views

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Initial steps in developing soft intelligence system

- Easy intelligence recording for GP practices
- Dedicated email address connect@eastlancsccg.nhs.uk
- EMIS template (to manage risks of patient identification)
- Initial safeguarding / risk check
- Weekly meeting to analyse and action, identify trends & review feedback

September 2013 to January 2014

168 items logged, risk rated and actioned

From a wide range of sources

- GP practices (increasing)
- Locality Listening events
- MPs' letters
- NHS Choices
- Weekly reputation tracker (media, complaints etc)

Related to:

- East Lancashire Hospital NHS Trust (108)
- Airedale Hospitals Trust (20)
- GP practices/services (17)
- Lancashire Care Foundation Trust (2)
- BMI (4)
- Fairfield (4)
- Out of area or no service identified (13)

East Lancashire
Clinical Commissioning Group

Main trends identified so far:

- Pathways issues and referrals (e.g. consultant to consultant)
- Poor quality care
- Discharge procedures & communication
- Service availability, e.g. out of hours
- A & E issues e.g delays/ attitude/ staffing
- Hygiene issues
- Ophthalmology issues

Identifying priority actions – informing commissioning decisions

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Connect

We want to know what you think about local health care services. Have your experiences been good, bad or mixed?

Your views can help us to make sure those services are of high quality and are the services you and your family need to help you to keep well and treat you if you are ill.

The more views we have – the more your voice can influence health services.

Healthcare

Contact us on our **online feedback** address
Connect@eastlancsccg.nhs.uk

Freephone: 0800 032 2424 • Telephone: 01772 777 952
Textphone: 01772 227 005

Expansion

- Plans to engage with hard to hear communities e.g travellers
- Considering how to extend across health economy
- Connect brand expanded

Connect

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Worth noting

- Time intensive (but worth it!)
- Can be difficult to identify individual cases for provider feedback
  e.g. NHS Choices
- Potential overlap with provider intelligence gathering – how do we join up?
- Extend to health economy or wider?
- Potential new IT system which will analyse information from incidents, complaints, compliments and soft intelligence automatically.

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Questions?

Health Scrutiny Committee
Meeting to be held on 4 March 2014

Electoral Division affected:
None

Recent and Forthcoming Decisions

Contact for further information:
Wendy Broadley Office of the Chief Executive, 07825 584684
wendy.broadley@lancashire.gov.uk

Executive Summary

To advise the committee about recent and forthcoming decisions relevant to the work of the committee.

Recommendation

Members are asked to review the recent or forthcoming decisions and agree whether any should be the subject of further consideration by scrutiny.

Background and Advice

It is considered useful for scrutiny to receive information about forthcoming decisions and decisions recently made by the Cabinet and individual Cabinet Members in areas relevant to the remit of the committee, in order that this can inform possible future areas of work.

Recent and forthcoming decisions taken by Cabinet Members or the Cabinet can be accessed here:

http://council.lancashire.gov.uk/mgDelegatedDecisions.aspx?bcr=1

The County Council is required to publish details of a Key Decision at least 28 clear days before the decision is due to be taken. Forthcoming Key Decisions can be identified by setting the 'Date range' field on the above link.

For information, a key decision is an executive decision which is likely:

(a)to result in the council incurring expenditure which is, or the making of savings which are significant having regard to the council's budget for the service or function which the decision relates; or

(b)to be significant in terms of its effects on communities living or working in an area comprising two or more wards or electoral divisions in the area of the council.

Lancashire County Council

For the purposes of paragraph (a), the threshold for "significant" is £1.4million.

The onus is on individual Members to look at Cabinet and Cabinet Member decisions using the link provided above and obtain further information from the officer(s) shown for any decisions which may be of interest to them. The Member may then raise for consideration by the Committee any relevant, proposed decision that he/she wishes the Committee to review.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

There are no significant risk management or other implications

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
N/A		

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee
Meeting to be held on 4 March 2014

Electoral Divisions affected: All

Minutes of the Joint Lancashire Health Scrutiny Committee

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

Minutes of meetings of the Joint Lancashire Health Scrutiny Committee for information.

The Joint Lancashire Health Scrutiny Committee last met on 28 January 2014. The agenda and minutes of that meeting and previous meetings may be viewed via the following link to the county council's website:

http://council.lancashire.gov.uk/mgCommitteeDetails.aspx?ID=684

Recommendation

The Health Scrutiny Committee is asked to note the report.

Background and Advice

The scope of the Joint Lancashire Health Scrutiny Committee is to consider any future and proposed health service changes that will directly affect all three upper tier local authorities covering the pan Lancashire area. Members from Cumbria County Council are invited to attend meetings of the Joint Committee on those occasions when consideration is given to any planned or proposed health service matter that would be likely to directly affect the citizens in the Cumbria County Council area.

The agenda and minutes for meetings of the Joint Lancashire Health Scrutiny Committee are available to view via the following link:

http://council.lancashire.gov.uk/mgCommitteeDetails.aspx?ID=684

Consultations

N/A.

Lancashire County Council

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Agenda and minutes	14 January 2014	Janet Mulligan, OCE, 01772 5-33361

Reason for inclusion in Part II, if appropriate

N/A.