



Lancashire Teaching Hospitals  
NHS Foundation Trust

Annual Report and  
Accounts 2020–21

Excellent  
care with  
compassion



# **Lancashire Teaching Hospitals NHS Foundation Trust Annual Report and Accounts 2020-21**

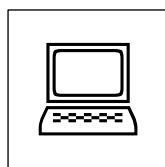
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This symbol indicates that more information is available on our website:

[www.lancsteachinghospitals.nhs.uk](http://www.lancsteachinghospitals.nhs.uk)

## Cover Illustration:

Some of our wonderful staff at Lancashire Teaching Hospitals

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## CHAIRMAN'S AND CHIEF EXECUTIVE'S WELCOME



The past year has been unprecedented in the history of the NHS. The Covid-19 pandemic has presented our Trust, like all others, with tremendous challenges. However, our colleagues made many personal sacrifices to rise to the challenge and continued to provide compassionate and high quality care and support to patients, their relatives and each other. On this note, it makes us extremely proud to share our Annual Report and Accounts which highlights our achievement, activity and performance during the financial year 2020-21 whilst setting out our vision and priorities for the future.

We must begin by saying a heartfelt 'thank you' to our colleagues, local health and care partners, governors and volunteers for their herculean efforts over the last 12 months.

This really has been a year like no other, but despite the pressures and sadness, there were some very special moments in which human spirit has shone through as brightly as all the buildings lit up to show support for the NHS.

We have also seen extraordinary generosity from the local public who have demonstrated unwavering loyalty and support towards our hospitals – this made a huge and much appreciated difference to us all. Our governors and volunteers have helped us in many ways during the pandemic and have truly been part of our extended Trust family.

We will never forget the way that our communities joined in the Clap for Carers at 8pm every Thursday evening from 26 March until 28 May. Local people, the Police, the Ambulance service and many others joined us at our hospitals to show solidarity. It was a very moving experience which really boosted morale for our staff who were dealing with what was a very new and frightening virus. Rainbows became symbolic with the NHS fight against the virus and our Local Authority partners painted these on the tarmac at the entrances to our hospitals raising much needed spirits as staff arrived for long and gruelling shifts.

Alongside this emotional support, we were inundated with gifts such as hot food and cold food, flowers, toiletries and financial donations to our Charity. You can find out more about how we have spent your donations on [our Charity website](#).

Like many charities we have struggled to fundraise in the traditional ways this year but we have been fortunate to benefit from the fundraising efforts of the late great Sir Tom Moore. We will be looking at ways of creating a lasting memorial to Sir Tom within our hospitals and look forward to sharing updates with you as we move forward through the year.

As part of our response to the pandemic, we temporarily reconfigured our services which involved moving all of our acute respiratory medicine from Chorley and South Ribble Hospital to Royal Preston Hospital.

On 1 April 2020 we also temporarily closed the Emergency Department and Critical Care unit at Chorley so that the teams could work on one site to tackle the virus. This move allowed us to utilise all of our available resources to deal with acutely ill Covid-19 patients on a single site within the larger of our Intensive Care units, in order to provide better care. In addition, this reduced the risks associated with transporting infectious patients between locations. Our Chorley site continued to run a 24/7 Urgent Care and Minor Injury service.

We promised that this would be a temporary measure and in line with this commitment to the local community, Chorley Emergency Department re-opened on a reduced hours, adults only basis on 2 November 2020. It returned to its pre-Covid-19 opening hours of 8am to 8pm on 15 March 2021.

The Covid-19 pandemic has affected our lives in ways which nobody could have foreseen. The tragic loss of life, coupled with isolation and separation from many of our loved ones, has had a profound effect on everyone concerned.

Throughout the year we have provided our staff with access to mental health and emotional support and this will be a continued focus for the year ahead. Our Bereavement team and Patient Advice and Liaison Service (PALS) have continued to provide support to patients and their families through some very difficult moments and our wonderful ward staff have done everything they can to keep families connected despite the necessary restrictions on face-to-face visiting.

Over the winter period a number of measures were put in place to help ease pressures on our hospitals and help people return home in a timely way. The Avondale Rehabilitation Unit opened its doors in December, providing intensive support to those who need two or more staff to move them, enabling people to get home more quickly and with better outcomes. Partners across our health and care system took part in Home for Christmas and Home for Easter campaigns which had the multiple benefits of unblocking barriers to discharging patients, reducing lengths of stay and the individual risks of nosocomial infections and improving flow within our hospitals at traditionally busy times of the year.

We have also had to adapt many of the regular services that we provide to our patients such as creating drive-through clinics to help protect the vulnerable in our society and outpatient appointments, where possible, taking place by video consultation. These innovations have proved more convenient for patients as well as more cost effective and will be part of our offer to the public as we move into the new financial year.

Equally, as a workforce we have also had to adapt the way we communicate. Microsoft Teams meetings have become the new normal – who would have thought our most regular sayings would be ‘you are on mute!’. Agile working has now become commonplace for a large percentage of our workforce and we are pleased to say that an Agile Working Policy has been approved and is here to stay.

The NHS nationally provided Trusts with resources to help cope with the pandemic. However, growth in demand for all services, along with rising costs and workforce shortages, means we remain in financial deficit. We will not compromise the quality and safety of care we provide but instead are very much focusing on improving efficiency so that we deliver better value for money and reduce waste.

We continue to work in partnership with Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council and our local Commissioners to change the way we work and provide care and treatment more effectively and closer to home.

The Government's New Hospitals Programme is providing us with a once in a generation opportunity to develop new hospital facilities and a programme of engagement is underway with a consultation expected in spring 2022. We continue to develop our own workforce of the future, by supporting a wide range of apprenticeships across many departments, and The Health Academy continues to lead the way in training and developing our current staff but also the clinical staff of the future.

During the year we were excited as a Board to launch our second Continuous Improvement Strategy which articulates how we take a collaborative and consistent approach to improvement and change across our organisation. The proposed approach is fully aligned to the Continuous Improvement methodology that is being adopted across our Integrated Care Partnership (ICP). As we further develop our Continuous Improvement capability, we have placed a particular focus on developing leadership and the culture for improvements to flourish and measuring impact and outcomes, maximising opportunities for improvement and celebrating successes together. Continuous Improvement for our organisation and wider system is about embedding a shift in culture and applying a consistent and clinically-led approach to improvement and transformation. We are achieving this by working with colleagues across multiple teams, including Organisational Development, Digital and Business Intelligence teams and with front line staff from across our organisation, to co-design and test improvements to build reliable systems, reduce unnecessary variation and design improved ways of working that will positively impact on both quality of care and patient outcomes.

Our Continuous Improvement Strategy sets out the principles and improvement methodology at all levels, from system (macro) level such as Urgent and Emergency Care Patient Flow and Always Safety First; pathway (meso) level improvement for clinical pathways such as colorectal cancer, frailty and sepsis; and local (micro) level improvement, which can be applied to individual wards and departments. We have this year launched our Lancashire and South Cumbria Flow Coaching Academy and our local Microsystem Coaching Academy.

2020-21 was the second year of our strategy ('Our Big Plan') which has detailed metrics to enable us to measure how we are fulfilling our mission and strategic objectives. Given the circumstances, some of our metrics have been amended during the year and we will be relaunching a refreshed version of Our Big Plan on 20 April 2021. This will highlight some of the excellent progress made over the past twelve months across many areas.

Royal Preston Hospital was one of the first fifty hospitals to establish a vaccination hub and the first in the North West to vaccinate a patient. 81-year-old volunteer Doreen McKeown received the first vaccination at the Royal Preston Hospital vaccination hub at 7.20am on 8 December 2020, and soon afterwards we set up a similar hub at Chorley and South Ribble Hospital. Many thousands more people have now been through our doors to have their jab and we have had roving vaccinators visiting wards and have worked in partnership with the Lancashire and South Cumbria Integrated Care System (ICS) to establish a mass vaccination centre at St John's Shopping Centre in Preston City centre. This activity has been part of a combined national effort that by March 2021 had seen more than half of the adult population of the UK vaccinated against Covid-19.

In addition to physical building works to make both our hospitals Covid-19 secure, we saw the completion of the new Birth Centre at Chorley, meaning we can now offer women four choices as to where they wish to give birth. Work is underway on the Ophthalmology Centre at Chorley which will be a centre of excellence for Lancashire and Cumbria and is due to open in October 2021. In March 2021, we also completed the final phase of our Critical Care Unit which provides a state of the art environment for patients, staff and relatives from across Lancashire and South Cumbria.



Our commitment to drive innovation through world-class research continues to go from strength to strength with our Clinical Research team. Since April 2020, over 3,000 patients and staff have taken part in research studies within the Trust. Many of those have been urgent public health studies often cited by Government advisors and are playing an important part in the country's fight against Covid-19.

Following guidance from the National Institute for Health Research (NIHR), we suspended a large number of studies to focus on Covid-19 research. Over the course of the year, we have gradually reopened studies and currently have 68% of all studies reopen to recruitment. This provides us with a balanced portfolio of Covid-19 and non-Covid-19 studies.

Throughout March, we celebrated colleagues who had achieved the remarkable milestone of 25 years of service to Lancashire Teaching Hospitals and the NHS. Their dedication and service is not taken for granted and they can be proud to know that they have contributed to the care of many, many people over the course of a quarter of a century.

Talking of long and distinguished NHS service, after 40 years in the NHS, of which 11 have been spent as Chief Executive at the Trust, in January 2021 Karen formally announced her intention to retire at the end of year, in order to allow the maximum time possible for the recruitment of her successor. This process is underway and we will keep our stakeholders updated – and of course some are involved in the selection process.

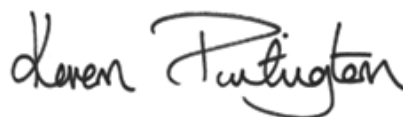
As we move forward our message to the public is: 'Your local NHS is here for you – together we will get back on track.' We are currently working on a comprehensive restoration of services plan across the Lancashire and South Cumbria ICS so that patients across our region have equitable access to services and treatment. However, it is more important than ever that patients make every effort to attend their scheduled appointments so that we can get them the care they need as quickly as possible and make our processes as efficient as they can be. By reducing the numbers of missed appointments we will also be able to reduce our waiting lists which have grown substantially during the last year.

We have implemented strict infection prevention and control (IPC) protocols to help keep our staff and patients as safe as possible and nobody should feel that they need to put off having medical treatment.

Please continue to follow the latest Government guidance and take care. Thank you once again for your overwhelming support.



**Professor Ebrahim Adia**  
Chairman  
10 June 2021



**Karen Partington**  
Chief Executive  
10 June 2021

Lancashire Teaching Hospitals NHS Foundation Trust

**PERFORMANCE REPORT**  
2020-21

## OVERVIEW OF PERFORMANCE

**The purpose of this report is to inform the users of the Trust's performance and to help them assess how the Directors have performed in promoting the success of the Trust.**

This report is prepared in accordance with sections 414A, 414C and 414D Companies Act 2006, as interpreted by paragraphs 5.2.6 to 5.2.11 of the Treasury's Financial Reporting Manual. For the purposes of this report, we have treated ourselves as a quoted company. Additional information on our forward plans is available in our operational plan on our website. Information on any mandatory disclosures included within this report is provided on pages 86 to 90.

The accounts contained within this report have been prepared under a direction issued by NHS Improvement under the National Health Service Act 2006.

### Who we are

Lancashire Teaching Hospitals NHS Foundation Trust was established on 1 April 2005 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983

We are one of the largest acute Trusts in the country, providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.7 million people across Lancashire and South Cumbria.

Our mission is to always provide excellent care with compassion which we do from three facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- the Specialist Mobility and Rehabilitation Centre (based at Preston Business Centre)

We are a values driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- **Caring and compassionate:** We treat everyone with dignity and respect, doing everything we can to show we care.
- **Recognising individuality:** We respect, value and respond to every person's individual needs.
- **Seeking to involve:** We will always involve you in making decisions about your care and treatment, and are always open and honest.
- **Team working:** We work together as one team, and involve patients, families, and other services, to provide the best care possible.

- **Taking personal responsibility:** We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

We believe that to provide the best care, we need to continually improve the way in which we provide services. If we are to be the best, we need to continually seek improvement and embrace change, empowering our teams to develop ideas and drive them forward. In order to do this, we have adopted a Continuous Improvement approach and developed a strategy to support this.

Our strategic objectives are:

- To provide outstanding and sustainable healthcare to our local communities
- To offer a range of high quality specialised services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training and research

The delivery of excellent services to our local patients through the provision of district general hospital services is at the core of what we do. To achieve this we need to ensure we focus on meeting key quality and performance indicators so our patients can be assured of safe and responsive services.

As well as providing healthcare for our local patients, we are proud to be the regional centre for a range of specialist services. These services include:

- Adult Allergy and Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system diseases)
- Renal (kidney diseases)
- Specialist vascular surgery

Our portfolio of services will continue to develop as the strategy for the provision of services across our region is developed by our Commissioners, but the delivery of specialist services will remain at the heart of our purpose and the decisions we take in our day-to-day activities will be taken in the context of ensuring we remain as the region's specialist hospital.

When we were established in 2005 we were the first Trust in the county to be awarded 'teaching hospitals' status. We believe that developing the workforce of the future is central to delivering high quality healthcare into the future. We know we are a regional leader in respect of our education, training and research and as the only NIHR Clinical Research Facility in the region, and a leading provider of undergraduate education, we will continue to drive forward the ambitions described in our education and research strategies.

## **Our business model**

The governance structure of a Foundation Trust is prescribed through legislation and is reflected within our Constitution. All Foundation Trusts are required to have a Board of Directors and a Council of Governors as well as a membership scheme, which is open to members of the public and staff who work at the Foundation Trust. Members vote to elect governors and can also stand for election themselves. The Council of Governors is responsible for representing the interests of NHS

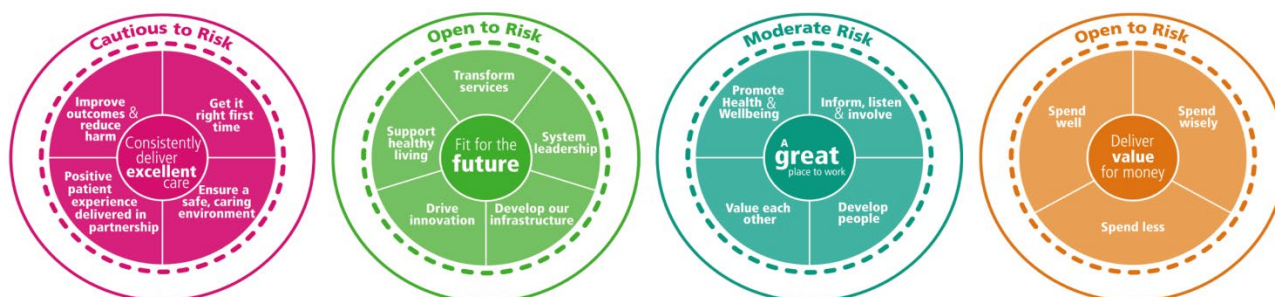
Foundation Trust members and the public and staff in the governance of the Trust. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the organisation. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Board of Directors retains the overall responsibility for decision-making within the organisation, except where the Council has statutory responsibilities. The Board does, however, work closely with the Council in formulating its forward plans. A schedule of matters reserved to the Board is in place and this document details the matters reserved to the Board, as well as providing more detailed information on the respective roles of the Council of Governors and the Board of Directors.

## Our strategic framework

We have three equally important strategic objectives:

1. To provide outstanding healthcare to our local communities
2. To offer a range of high quality specialist services to patients in Lancashire and South Cumbria
3. To drive innovation through world class education, training and research

These strategic objectives are underpinned by our four ambitions, which together provide the framework for our strategy and business planning processes.



Our strategic objectives, together with our four ambitions, provide the focus and drive for performance, clinical quality and safety, financial delivery and the long term sustainability of services in the context of system working.

Our Strategy (Our Big Plan) was launched in April 2019 and identifies clear delivery outcomes for each of its three years. The detailed metrics within the plan are refreshed annually to ensure they remain current in the context of both national and local changes.

This year, however, has been an exceptional one and the Covid-19 pandemic has impacted significantly on the continued relevance of a number of performance metrics within our strategy. In August 2020, the Board agreed a process for refreshing Our Big Plan in light of the issues that have impacted on the NHS over the last 12 months.

The Board has undertaken a full review of Our Big Plan in the last quarter of the year and a refreshed and updated strategy will be published on 1 April 2021.

## Developing an Integrated Care Partnership (ICP) in Central Lancashire

Partnership working has been more fundamentally important in 2020-21 than ever before, as partners from across the patch have come together to support our residents and patients by joining

up and co-ordinating services and supporting each other through the pandemic. Our history of partnership working in Central Lancashire has enabled us to rise to this challenge and further developed our relationships and successes.

From an ICP delivery perspective, we have supported key elements of the central Lancashire pandemic response, including the weekly ICP Executive Covid-19 Command and ICP Vaccination co-ordination meetings which have been a real success story for partnership working. These have brought together all key partners on our patch involved in the delivery of health and care services to work in collaboration and across organisational boundaries to plan and deliver a co-ordinated response to challenges such as delays in transfer of care, vaccination capacity and provision, communications, planning and workforce redeployment. Other key groups have come together such as the ICP Discharge Groups, ICP Clinical Forums – which in the first wave of the pandemic supported the coming together of clinicians from across primary care and secondary care to make decisions and remove barriers to support patient care – this has been formalised and continues to make progress.

In terms of development of the ICP itself, we have made great progress this year in mobilising a new structure to enable us to accelerate collaborative working across central Lancashire; at both a strategic and directional level through our Committees, and at an operational level through our System Delivery Boards (SDBs). The governance structure is all encompassing through both the member representation at the ICP and through our focus on delivering health and care services across all settings, whilst maintaining a strong focus on reducing the impact of health inequalities and wider determinants of health and keeping our population well. The ICP People Board was added to our structure in January 2021 to ensure the voice of our combined workforce is heard and to act as the primary forum for workforce leadership, advice and challenge.

The Committees and Boards each have a trio of leaders; a Senior Responsible Officer, a Clinical Lead to ensure our partnership is clinically-led, and a Senior Lead to bring operational acumen. In addition to these leaders, we are developing 'Functional Lead' roles to focus on enablers to collaborative working such as performance, planning, communication and engagement. This approach means that we are starting to create a model of leadership where key individuals from any organisation take a lead on an area on behalf of the whole ICP. Through this approach, we have seen the approval of an ICP Continuous Improvement strategy which will provide a consistent framework through which we will deliver against 2021-22 collective priority areas. Our performance colleagues have developed an ICP Covid-19 dashboard to enable our senior leadership team to review and monitor progress, with plans to expand this to encompass performance against key ICP priorities in the coming year. The ICP Core Team provides dedicated strategic and logistical support as our partnership Committees and Boards continue to mature to ensure a consistency of approach, reporting and accountability.

A clinically and professionally-led priority setting process is underway for 2021-22 led by our Clinical and Professional Forum. This has been informed by disease profile data, specific to our ICP, developed by the Determinants of Health SDB. This process will result in a small number of priorities for each SDB to focus on during the year ahead, which will have been endorsed by our clinical and professional leaders. Further work is planned to tailor our health and care services and interventions at a 'place' level to enable us to target and improve our population's wellbeing and health and to tackle health inequalities.

Throughout this year we have also worked with our ICP and ICS colleagues to develop a common ICP strategic narrative which sets out what an ICP will do in Lancashire and South Cumbria in the future. This then led to the development of an ICP Maturity Matrix and an associated peer review

process as a means of assessing progress against this narrative and the developmental achievements and requirements of each of the five health and care economies within the Lancashire and South Cumbria ICS. The coming year will see us transition from ICP mobilisation to a focus on development utilising this Maturity Matrix as a framework. The recent ICP Peer Review process (March 2021) provided some great feedback for central Lancashire with particular accolades for our operating model using the new governance structure and outcomes achieved as a result.

## **Developing an Integrated Care System (ICS) in Central Lancashire**

Healthier Lancashire and South Cumbria is a partnership of Local Authority, Public Sector, NHS and voluntary and community organisations working together to improve services and help the 1.7 million people in Lancashire and South Cumbria. The Trust is committed to working with all partners across Lancashire and South Cumbria as a key part of the ICS.

Key ICS priorities for strategic working include:

- The continued development of the ICS as a whole-system partnership
- The development of strategic commissioning arrangements for Lancashire and South Cumbria
- The continued development of provider collaboration
- The acceleration of work to develop place-based partnerships

The ICS Clinical Strategy has set three key aims which are to:

- Improve the health and wellbeing of local communities
- Deliver better, joined-up care, closer to home
- Deliver safe and sustainable, high quality services

## **Our principal issues and risks**

The Trust continues to identify potential risks to achieving its strategic developments as part of our good governance processes. The Board Assurance Framework is used to identify these strategic risks alongside actions being taken to mitigate such risks. This enables the Board of Directors to evaluate whether we have the systems, policies and people in place to operate in a manner that is effective in driving the delivery of the Trust's corporate objectives.

The principal organisational risks for 2020-21 are:

- The inability to consistently deliver excellent care, provide a positive patient experience and demonstrate sufficient responsiveness in the organisation's recovery and restoration plans due to a shortage of suitably trained staff and high occupancy levels further impacted by Covid-19 and the requirement to configure services differently to accommodate infection status. To mitigate this, the Trust continues to execute novel and targeted recruitment and retention campaigns, expand and develop relationships with community leaders and partners with increased focus on reducing health inequalities, reduce inefficiencies in internal processes and strengthen system wide partnerships to enhance the flow of patients in and out of the hospitals.
- Sustainability of complex services within an ageing estate and with continued reliance on temporary workforce leading to continued financial pressures. System wide solutions are being sought to adopt optimum service configurations and improve operational efficiencies including through the New Hospitals Programme.

- The inability to be a great place to work due to the potential burnout of staff and the increasing psychological impact of the Covid-19 pandemic on staff resilience, coupled with local and national workforce shortages and an ageing estate. To alleviate this, the Trust has increased the provision of psychological support for staff, identified innovative ways of engaging with staff and enhanced its focus on equality, diversity and inclusion.
- The inability to be fit for the future including modernising system delivery due to evolving system working impacting on the ability to develop and implement key change programmes within required timescales. Despite this, we continue to successfully drive change through the Trust's Our Big Plan Strategy, Governance and Risk Maturity Programme, Continuous Improvement Strategy and a number of other key programmes of work, including research.
- The inability to drive innovation through world class education and training due to the impact of the pandemic on social distancing, the need to utilise education facilities for the Covid-19 vaccination programme and the consequences of continuing international travel subsequently impacting the ability to provide face-to-face education. This is currently being mitigated through virtual, original and hi-tech solutions.

All the principal risks listed are reported to the Trust Board and appropriate Committees of the Board for reviewing, monitoring and reporting the effectiveness of controls and mitigation plans identified to achieve the risk target as determined by the risk appetite approved by the Trust Board.

The Annual Governance Statement, contained within this report, further outlines the Trust's approach to risk and how it manages these. The Trust has developed a clear risk mitigation strategy to deal with the recovery and restoration of services post pandemic and the evolving external environment and will continue to engage and strengthen relationships with patients, staff, public and strategic partners to ensure long term sustainability in the delivery of its strategic objectives.

The Trust's culture is built on trust, openness, transparency and empowerment with clear lines of accountability and responsibility underpinned by continuous learning and improvement. The Annual Governance Statement also includes the Trust's system of internal control which is designed to manage risk for the organisation. The Trust continues to perform well against objectives, regulatory requirements and targets and is confident in delivering these going forward.

## **Our performance**

The NHS faced unprecedented times in 2020-21 and, like all other NHS Trusts across the country, Lancashire Teaching Hospitals NHS Foundation Trust has been significantly challenged by the Covid-19 pandemic. As a result, performance across the board, both emergency and elective, has been significantly impacted with operational pressures experienced throughout the year resulting in non-compliance in relation to a number of key standards. The performance position is outlined in the Performance Analysis section on page 13.

## **Going concern**

The accounts have been prepared on a going concern basis which the Directors believe to be appropriate for the following reasons.

New guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concern unless there are ongoing discussions at departmental level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.



The Trust recorded a significant deficit for 2019-20 and was expecting to enter 2020-21 with a plan for a further large deficit. However, the Covid-19 pandemic has resulted in emergency funding arrangements being put into place by the Department of Health and Social Care. These have had the effect of ensuring that the Trust will receive sufficient funding for the duration of the pandemic, effectively to achieve breakeven for this period. Currently these arrangements continue to be in place from 1 April 2021 to 30 September 2021 and guidance will be published in due course about how the plan for the remainder of the 2020-21 financial year will be prepared and implemented.

The Trust's working capital loans were frozen as of 31 March 2020 and were replaced by Public Dividend Capital (DPC) as at that date, in a transaction that took place in September 2020. This means that the Trust no longer faces uncertainty regarding repayment of these previous temporary financing arrangements. The new arrangement also provides for further PDC advances rather than loans to Trusts in financial distress which gives greater confidence for the Trust's funding arrangements in coming years.

It is clear that outside of the pandemic response the Trust remains in a deficit position and will need to work with its partners across the local healthcare system to achieve efficiencies, maximise the use of its assets and sustainable financial balance. The Trust will work with NHS Improvement (NHSI) and its stakeholders to achieve this objective.

In addition to the matters referred to above, the Trust has not been informed by NHSI that there is any prospect of its dissolution within the next 12 months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with Commissioners.

Based on these indications the Directors believe that it remains appropriate to prepare the accounts on a going concern basis.

# PERFORMANCE ANALYSIS

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

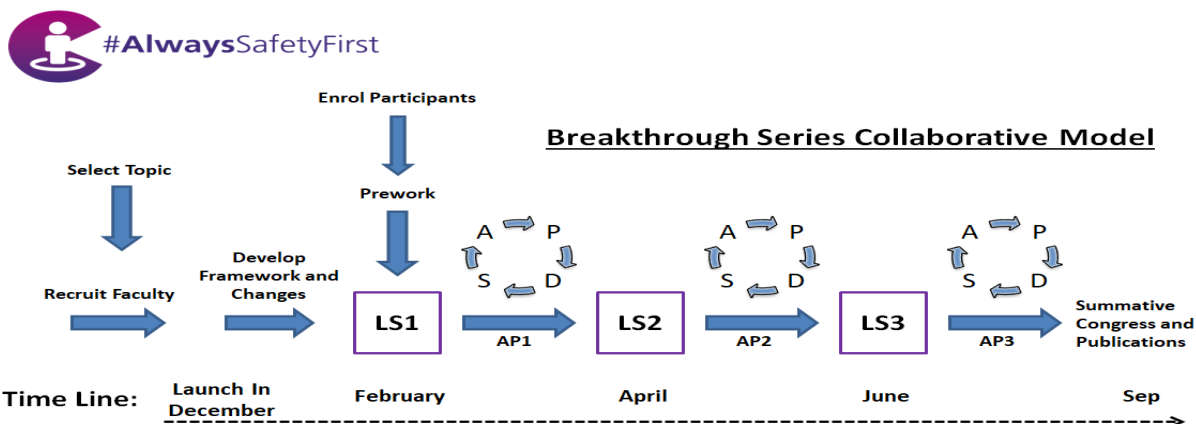
## Always Safety First

The Trust Board recognises the benefits of embedding a culture of continuous improvement across our organisation, supporting our staff to design, test, embed and sustain changes that benefit patients and our local population. To achieve a culture of continuous improvement in our patient safety metrics, we have developed Always Safety First, our long-term approach to transforming the way we deliver services for the better. Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialities and learning to improve. Our work is underpinned by a real time safety surveillance system, making our data visible from Ward to Board. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical staff.

## How is our Continuous Improvement in patient safety, access and patient experience delivered?

Our Continuous Improvement Strategy outlines our approach to enabling a culture of continuous improvement. This includes building the ‘will’ to change, programme design and delivery, learning and skills, measuring improvements and knowledge and evaluation.

The Always Safety First programme has a defined global aim which sets a safety precedence for the organisation and our commitment to improving safety for everyone. Our aim is ‘to deliver excellent service users safety by ensuring there are highly reliable and measurable systems in place to reduce avoidable harm, upholding the principles of ‘Always Safety First’ within Lancashire Teaching Hospitals’. To execute the delivery of such a large, ambitious safety programme across the organisation we have committed to using tried and tested improvement methodology and delivery models to achieve success in our programme, as well as building quality improvement capability amongst the participating teams. To achieve this we are delivering an Institute for Healthcare Improvement ‘Breakthrough Series (BTS) Collaborative’ which is a model favoured for the rapid delivery and spread of interventions or a package of change at scale. The BTS model is outlined below.



This model is structured around a number of collaborative learning sessions where all participating teams are brought together to learn about the interventions to be embedded, share learning and best practice, building improvement capability and actively participating, forming a positive continuous improvement culture. Teams are coached in improvement between learning session events and team testing, applying their improvement changes to build highly reliable systems and processes.

The NHS faced unprecedented times in 2020-21 and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has been significantly challenged by the Covid-19 pandemic. As a result, performance across the board in both emergency and elective activity has been significantly impacted with operational pressures experienced throughout the year resulting in non-compliance in relation to a number of key standards.

A whole health economy system pressures in response to Covid-19 demand resulted in high bed occupancy throughout the year with the need to focus primarily on Covid-19 non-elective activity, resulting in standing down non-urgent elective activity as mandated nationally for significant periods across the year.

A health economy system wide action plan is in place to address the urgent care system and pressures; with identified primary and social care initiatives and schemes delivering a level of sustainability across the health economy.

In addition, whilst the national planning guidance for 2021-22 is expected imminently, ICSs have been tasked with drafting system level elective recovery plans which clearly set out:

- dates for restoration of cancer and Priority 2 (P2) work to within current standards;
- dates to return to 100% of 2019-20 activity levels; and
- trajectory for the eradication of over 52-week waits

Since the beginning of the Covid-19 pandemic the Trust has put in place a range of measures including:

- Additional medicine bed capacity to meet increase in demand
- Re-zoning of our estate to meet IPC requirements
- Delivery of Same Day Emergency Care (SDEC)
- Secured winter monies from the Clinical Commissioning Group (CCG) to support the development of an integrated frailty model and a dedicated rehabilitation ward
- Additional Intensive Therapy Unit surge beds with additional staffing through redeployment
- Implemented digital health to reduce inappropriate admissions to hospital

These actions have all helped to support the Trust during these unprecedented times and enabled compliance to be achieved against a range of measures within the risk assessment framework. These include two of the national cancer waiting times standards and one of the IPC standards.

However, the Trust has failed to achieve its objectives in relation to the Emergency Department 4-hour care standard, the 18-week incomplete access target, and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both referral to treatment (RTT) and cancer pathways was directly impacted by Covid-19 and the need to cease all elective activity during the pandemic peak periods and prioritise only urgent elective activity as part of the elective restoration plan.

The table below shows the summary position detailing performance against key targets in 2020-21. Whilst monitoring of performance has continued, these have not been measured against usual achievement standards due to ongoing management of the pandemic.

Indicator	National Target %	Cumulative Performance	Current Period
A&E - 4 hour standard	86	85.56	% - Cumulative to end Mar 2021 Position includes both ED and UCC locations. Target based on agreed Trajectory to Mar 2020
Cancer - 2 week rule (All Referrals) - New method	93	88.0	% - Cumulative to end Mar 2021
Cancer - 2 week rule - Referrals with breast symptoms	93	52.8	% - Cumulative to end Mar 2021
Cancer - 31 day target	96	89.5	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	77.8	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment – Drug	98	97.9	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	97.7	% - Cumulative to end Mar 2021
Cancer - 62 day Target	85	64.0	% - Cumulative to end Mar 2021
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	57.3	% - Cumulative to end Mar 2021
28 day faster diagnosis standard – compliance	75	80.3	% - Cumulative to end Mar 2021
MRSA	0	0	% - Cumulative to end Mar 2021
C.difficile Infections	<84	100	Cumulative to end Mar 2021
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	79.2	54.2	% - sum of Apr-Mar 2020-21 Target based on agreed Trajectory to Mar 2020
% of patients waiting over 6 weeks for a diagnostic test	<1	43.12	% - Cumulative to end Mar 2021

*\*The MRSA indicator is no longer a national target associated with MRSA however we continue to report performance against this metric to the Board and show it as a compliant measure.*

## Our finances

### Income Generation

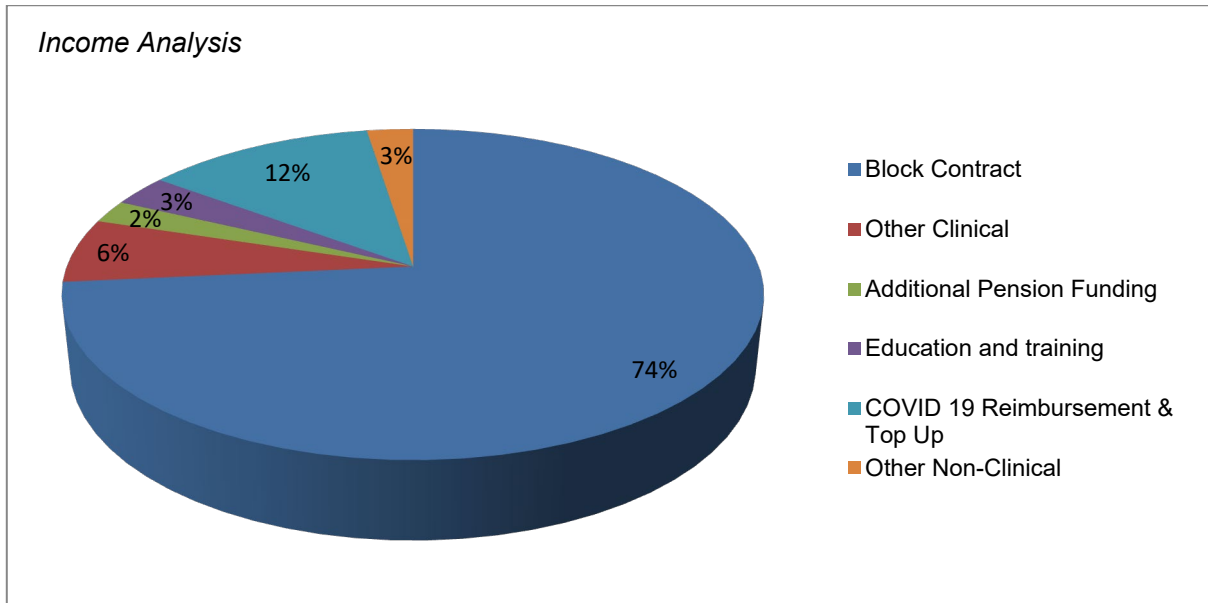
As a consequence of the Covid-19 pandemic there was a new financial regime to minimise the detrimental impact on the performance of the organisation.

Income from commissioners was received through a block contract basis to minimise the financial effect of reduced patient activity.

During 2020-21, the Trust generated income from patient care including through a block contract of £561m, an increase of 16% from 2019-20.

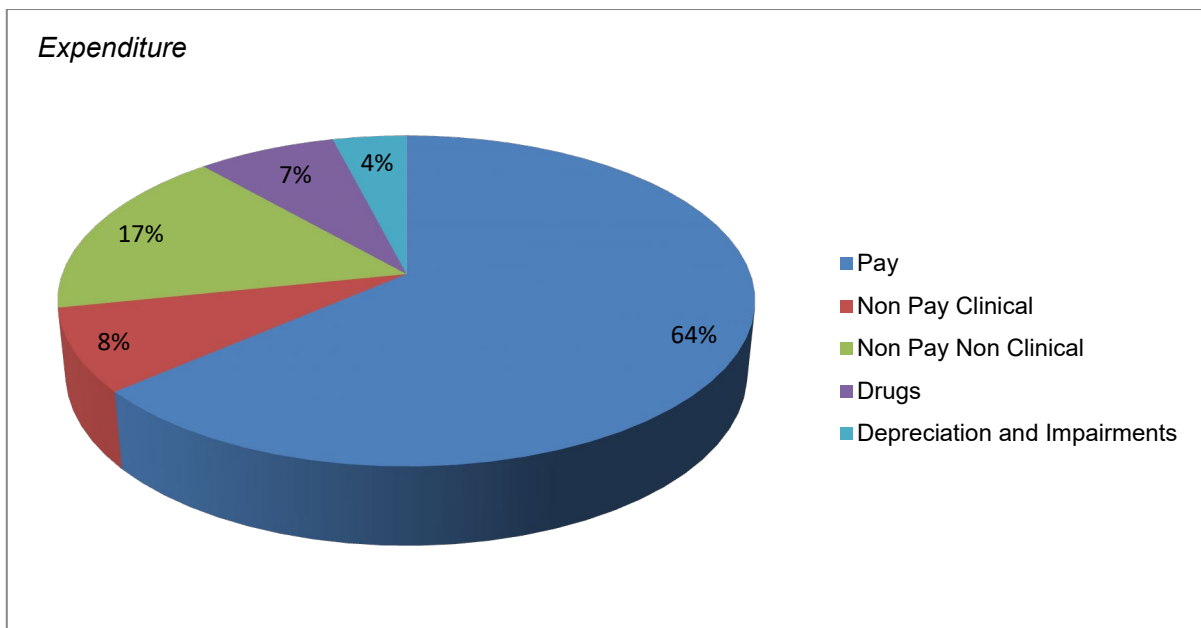
The Trust received reimbursement and top up funding of £85m to cover the additional costs associated with the Covid-19 pandemic.

A further £38m was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations.



**Expenditure**

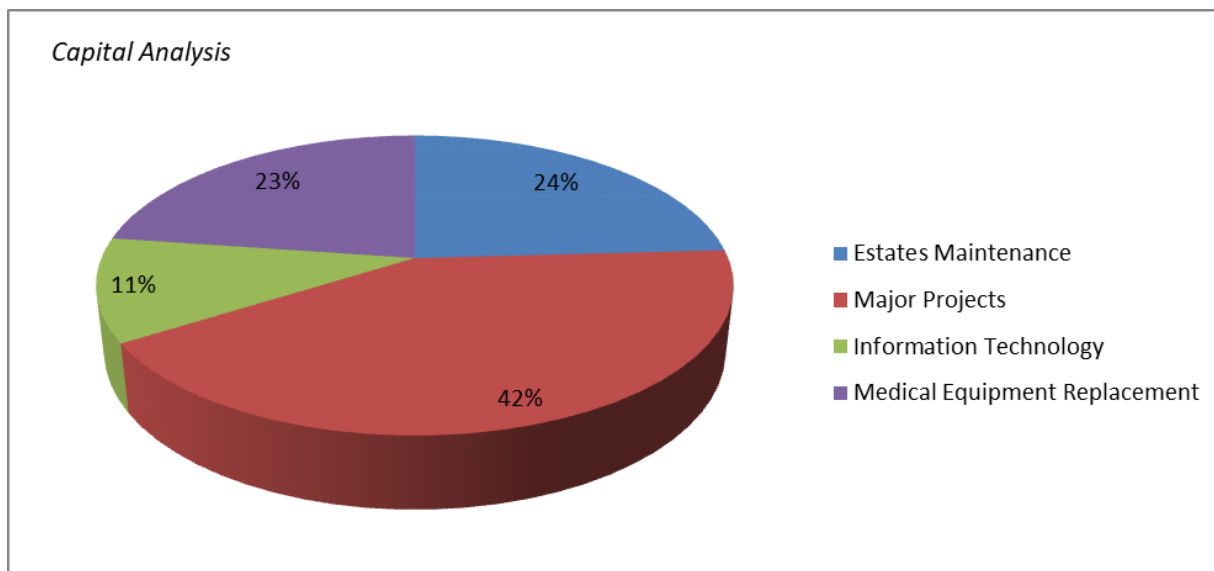
Operating expenditure (excluding impairments) for the year was £670m (2019-20: £587m), the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to the Covid-19 pandemic.



**Capital investment**

In 2020-21, £70m was invested in the Trust’s capital programme to maintain the asset base of the Trust as illustrated in the chart below. Major projects completed in year included the Birth Centre at Chorley and South Ribble Hospital and completion of the new Critical Care unit at Royal Preston Hospital. Also included in our major development programme are ongoing projects such as the new Ophthalmology unit at Chorley and the upgrade to Chorley theatres. The below table also includes over £10m being spent on the replacement of medical equipment.

The Trust received £13m of Covid-19 funding which supported the overall programme.



## Forward look

Prior to the onset of the Covid-19 pandemic the Trust had an underlying plan deficit position of £78m (before the application of provider sustainability funding or the equivalent) for 2020-21 which was to be managed through; the development, implementation and monitoring of cost improvement programmes across all areas of Trust activity, system working with the Central Lancashire ICP and medium term the review of hospital sites. Following the onset of the Covid-19 pandemic, NHS England and Improvement (NHSE/I) requested all NHS entities halt the development and formal reporting of cost improvement programmes as part of the wider financial planning suspension for 2020-21 in order that attention could be focused on dealing with the pandemic.

In order that we can build a financially sustainable Trust for the future, there will be a renewed focus on cost improvement during 2021-22. A cost improvement target of 3% for 2021-22 has been agreed with the ICS and the Trust has identified and allocated risk rated targets to divisions and activities, and will monitor performance using the cost improvement reporting mechanism. Performance against cost improvement will be reported monthly to the Finance and Performance Committee. The Trust continues to work in partnership with the ICS and central Lancashire ICP and is part of the New Hospitals Programme looking at site development in future years.

## Better Payment Practice Code (BPPC)

We aim to treat all suppliers ethically and to comply with the BPPC target, which states that we should aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. For 2020-21, we paid 95% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £	No.	Value £	No.	Value £
Invoices paid within 30 days	2,432	30,047,411.07	109,563	331,804,476.28	111,995	361,851,887.35
Invoices not paid within that 30 day period	1,138	7,528,826.69	4,567	11,930,289.33	5,705	19,459,116.02

<b>Total Invoices</b>	<b>3,570</b>	<b>37,576,237.76</b>	<b>114,130</b>	<b>343,734,765.61</b>	<b>117,700</b>	<b>381,311,003.37</b>
<b>BPPC</b>	<b>68.12%</b>	<b>79.96%</b>	<b>96%</b>	<b>96.53%</b>	<b>95.15%</b>	<b>94.9%</b>
<b>Total amount of any liability to pay interest</b>	0	0	1	893.92	1	893.92

## Reconciliation of underlying trading position for year ending 31 March 2021

In 2019-20 the Trust qualified for £11m of Support Funding - this was replaced with top-up and reimbursement funding in 2020-21 of £96.8m. The Trust achieved an accounting deficit for the year of £6.1m (2019-20: £49.9m). After adjustment for accounting movements relating to impairment charges and income and expenditure for donated assets received in response to the Covid-19 pandemic, the Trust achieved a revised trading surplus of £2.1m (2019-20 £58.4m).

	Group	
	2020/21	2019/20
	£000	£000
Deficit for the year pre Top-Up	(102,864)	(49,558)
Base Top-Up Income	68,329	-
Retrospective Top-Up Income	28,500	-
Deficit for the year	(6,035)	(49,558)
Add back I&E impairments	11,866	2,314
Remove net donated income	(1,390)	(133)
Remove DHSC centrally procured inventories (donated)	(2,342)	-
Remove support funding	-	(11,048)
Revised trading surplus	<b>2,099</b>	<b>(58,425)</b>

## Being a Good Corporate Citizen

The Trust works in a number of ways to control the impact it has on the environment and during the year a new group has been formed to drive forward the Trust's Green Plan, setting out our plans for sustainable development.

During 2020-21 we have:

- Continued to maximise the benefits of the Combined Heat and Power (CHP) plants on our two hospital sites. The Trust uses this equipment to generate over 60% of its own electricity on site. This reduces the cost of purchasing electrical energy from the National Grid, allowing the Trust to reduce its energy bill by around £1.25m per year.
- We continue to purchase renewable electricity from the National Grid for all of our sites, reducing our carbon footprint.
- Schemes to reduce water consumption are providing financial benefits and reducing the Trust's carbon emissions. We have invested in equipment to better monitor water usage, to help identify areas of excessive usage and assist in identifying leaks. This has seen a reduction in water consumption of around 30,000,000 litres of water over the last 12 months.
- Installation of efficient modern boilers has reduced our gas consumption, resulting in lower carbon emissions and reducing the overall cost to the Trust of purchasing gas.
- As part of our capital development programme we construct all new buildings and refurbish our existing estate to achieve higher levels of energy efficiency. For example we invest in

the use of low-energy light emitting diode (LED) lighting and install LED as standard in any new developments or refurbishment schemes.

- We have removed single-use plastics such as stirrers and straws across our catering services as part of the NHS-wide single-use plastics reduction campaign. A further range of single-use plastic items will be replaced with sustainable alternatives during the coming year.
- We continue to provide shuttle bus transport between our two hospital sites at a cost of around £100,000 per year, to help reduce the environmental impact of staff travel and car usage.
- We have implemented the WARP-IT resource redistribution system to enable the reuse or reallocation of unwanted furniture, equipment and other items. Use of this system has resulted in 45 tonnes of carbon being saved, along with 13.5 tonnes of waste avoided. A further benefit is that the Trust saves money buying new equipment and furniture.

We work collaboratively with other health organisations in Lancashire to share working practices which promote greater efficiency and enhanced saving opportunities across a range of areas including transport, energy and utilities.

### **Social, community and human rights issues**

Over the last 12 months, our widening participation agenda has been impacted by the Covid-19 pandemic. As a result, this has prompted us to think differently about how we have delivered some of our social and educational programmes. We have been able to continue to support students who have additional learning needs and disabilities, who would have attended our work familiarisation programme with career-inspiring activities that include virtual tours of departments, quizzes and interactive workshops via remote platforms. These students would normally attend local colleges including Midstream, Runshaw College, Cardinal Newman College and Sir Tom Finney Community High School, however we have been able to support the home schooling approach with our application of remote delivery. This programme continues to be very successful and well-received by all involved.

Our commitment to offer work experience placements has also continued throughout the pandemic. We have been able to offer virtual work experience opportunities via our social media platforms and we have delivered virtual careers events with over 3,500 participants.

We have run two pre-employment programmes over the last 12 months supporting people from our local community who have been long-term unemployed into employment at the Trust. Programmes have supported people into job roles within domestic services and healthcare. These programmes have been so successful that they will continue to run quarterly feeding into recruitment deficits across the organisation. This year we have supported 36 people to gain employment with us.

Since becoming a training provider for apprenticeships, the Trust continues to go from strength to strength. Each year since gaining our training provider status in 2017 we have exceeded in our achievement to meet the public sector target for new apprenticeship starts within the year. Our agenda for apprenticeships offers training opportunities to those who aspire to a career within the NHS and also to provide a training and development pathway for current employees. Ofsted, the Office for Standards in Education, Children's Services and Skills, is the external agency responsible for assuring quality standards for apprenticeships, however inspections were put on hold during the year due to the pandemic. We are anticipating a full Ofsted inspection during 2021-22 when the inspection schedule is reinstated. As part of the inspection we will be monitored on the four apprenticeship programmes delivered by the Trust; these are the Institute of Leadership and Management programmes for Level 3 Team Leader/Supervisor; Level 5 Operations Departmental



Manager; Level 3 Learning Mentor; and Level 3 Clinical Healthcare. We have experienced some interruptions to our apprenticeship programme delivery due to the pandemic, however the majority of learners are now back on their respective programme and are making good progress. Many of our completers this year have achieved distinctions, particularly across our clinical healthcare apprenticeships.

During 2020-21 we have been able to demonstrate financial sustainability by utilising the levy effectively and fairly, providing training and development opportunities across all divisions of the Trust. We are already starting to see the benefits of degree apprenticeships within our nursing division providing a much-needed pipeline of trained staff nurses into the Trust. This includes the new accelerated Registered Nurse apprenticeship, delivered in partnership with Northumbria University, which is a shortened pathway for existing Assistant Practitioners or other roles at a similar level.

We continue to deliver the Preston Widening Access Programme (PWAP) with our latest intake commencing in February 2021, supporting young people with advice and guidance aiding them through the application process into university to study medicine. A-Level students from colleges and sixth forms who meet widening participation criteria following an application process are allocated a place. This year we have accepted applications from East Lancashire and Greater Manchester as well as Preston and will be delivering the programme via a remote platform. Students will be guaranteed an interview at The University of Manchester to study medicine following successful completion of the programme. It is anticipated that these students will come back to Preston in the third year of medical school for their practical years. PWAP has been running for seven years seeing 40 students successfully gain a place at The University of Manchester as a direct result of the programme.

The LIFE (Learning, Inspiration, Future, Employment) Centre located at Chorley and South Ribble Hospital continued to see educational activity delivered throughout the Year. The Centre aims to inspire, educate and support a wide range of students from the age of five upwards to promote a career in healthcare with the NHS. The training of overseas nurses has continued under strict social distancing and infection control measures. We have also continued to provide training and skills development for our healthcare assistants.

With a continuation of widening participation activity, the delivery of pre-employment programmes, the continuation of training and development opportunities for overseas colleagues and virtual career-inspiring activity, we have been able to maintain community engagement, aid social mobility and promote the Trust as an employer of choice.

### **Health and safety performance**

The Trust's policy is to safeguard the health and safety of all our employees, patients, visitors and anyone who may be affected by our activities by ensuring we are compliant with the Health and Safety at Work Act (1974). This is the primary legislation covering occupational health and safety in the United Kingdom (UK) and defines the fundamental structure and authority for the regulation and enforcement of workplace health, safety and welfare within the UK. To further strengthen the delivery of health and safety performance oversight and management, health and safety governance operationally has transferred to corporate governance whilst strategically remains in the portfolio of the Finance Director.

There are two key Committees that manage and contribute to health and safety across the Trust, these being:

- *Health and Safety Governance Group* – this group is attended by managers from all the Trust's clinical divisions and key corporate teams. The Health and Safety Governance Group reports to the Finance and Performance Committee and is chaired by the Associate Director of Governance. A Non-Executive Director has been identified to support the health and safety agenda and they are a designated member of the Group. The proactive stance taken towards health and safety has been further enhanced by the recruitment of a Health and Safety Manager to represent the estates division with a significant remit of reviewing and developing physical health and safety across the hospital sites.
- *Health and Safety Joint Consultative Committee (HSJCC)* – the Committee is a forum for engagement with staff representatives on safety matters, meeting the statutory requirements of the Safety Representatives and Safety Committee Regulations 1977 (as amended) and the Health and Safety (Consultation with Employees) Regulations 1996. The meetings are productive and create positive engagement from all. The Associate Director of Governance attends the HSJCC meeting and there is an elected staff side Health and Safety Officer who attends both the HSJCC and the Health and Safety Governance Group. This further supports engagement and involvement of staff representatives with the health and safety governance agenda.

During 2019 the Trust commissioned an independent external review of its performance against the NHS Workplace Health and Safety Standards (otherwise known as the Partnership for Occupational Safety and Health in Healthcare, or POSHH standards). The report was received by the Board and an action plan is in place to address the auditor's recommendations. A major recommendation is that relevant Managers undergo formal accredited training from a recognised external professional body. This is now in train and has included delivery of the Institution of Occupational Safety and Health (IOSH) health professionals training to the Executive Directors. The plan is to extend IOSH training to the Non-Executive Directors.

In addition, the Trust has a number of responsible officers whose role it is to co-ordinate and lead health and safety within their own particular area or service and these roles are supported with a programme and training to further upskill the Trust in health and safety management.

## **Security**

During 2020-21 the Security team was expanded to a complement of 28 full-time officers and four supervisors covering the Trust's two hospital sites. This has enabled a more proactive 24/7 security response and allowed the team to manage security incidents in a more effective manner. The positive work undertaken with the team on recruitment and training has resulted in a 41% reduction in assaults against our security staff compared with the previous year.

Security training regarding violence and aggression has been made available to Trust staff and has been initially targeted at those wards and departments experiencing the greatest challenges with regard to security incidents and assaults. This training has been well attended by staff and the feedback has been very positive. Certain areas have also received bespoke training to suit their particular requirements based on levels of risk.

A recent development has seen security staff undertaking the Emergency Department and Fire safety response role and this has shown a marked decrease in the number and seriousness of incidents that require security to attend. This is positive evidence of the benefits of de-escalation and conflict resolution skills that the Security team deploy and supports front line staff to concentrate on delivering clinical care.

## **Fire Safety**

Good progress is being made with maintaining fire safety standards across the Trust. A new full-time Fire Safety Manager has joined the Trust and we have added an additional Support Officer to the team. Other initiatives include:

- various training sessions available to staff including: Fire Warden training, practical fire extinguisher training, kitchen fire safety, evacuation and ski pad training (update of the online training package and a practical training session). There will soon be evac chair training and bespoke evacuation and practical fire extinguisher training for critical care and theatre staff.
- support for Fire Wardens has improved and we have introduced a monthly newsletter providing facts and guidance along with information as to what work is being undertaken by the Fire team and any other projects related to fire safety within the Trust.
- capital works have been undertaken to upgrade the Trust's fire alarm systems in several areas, including within our staff residential accommodation blocks.
- a process to fully review and update all fire risk assessments across the estate has been undertaken using a specialist external contractor.
- fire drills have taken place across the Trust for those areas who fully evacuate and a full schedule is in place to ensure all areas are completed in 2021 and yearly thereafter. All fire drills are logged with the use of an InfoPath form to ensure all relevant details are captured and action taken where needed.
- a fire evacuation scenario was completed on 7 January 2021 within the new critical care building; this has been recorded by the Blended Learning Team and will be available as a training pack in various locations including the Fire Safety Intranet page.
- a significant amount of work has been undertaken by the Fire Safety team to ensure we are taking every opportunity to educate people about minimising false alarms. This is done with contractors, at the start of project meetings, with staff during training sessions including Fire Warden training and also following a false alarm. Due to this work, there has been a significant reduction in false alarms at both our hospital sites.
- security has taken over the responsibility of meeting the Fire Service for fire alarm activations at Preston. Feedback from the Fire Service has been very positive and incidents are running smoother as a result of this.

## **Waste Management**

In order to support our ambition to be Fit for the Future and deliver against our Green Plan, robust waste management remains a critical factor. The general and domestic and confidential waste contracts have both been successfully extended with a number of improvements introduced. The Trust continues to recycle various waste streams, including cardboard, plastic bottles, confidential waste paper (once shredded), waste electrical and electronic equipment, wood, mattresses, batteries, fluorescent tubes, cooking oil, engine oil, IT consumables and scrap metal. Green garden waste at Preston is sent for composting. Food waste from our restaurant and café areas is recovered via anaerobic digestion. Domestic waste is sent to a materials recycling facility where obvious recyclables are removed and the residual then used as a fuel source which means none of this waste is landfilled. We also have a reuse portal called Warp-It where wards and departments can advertise usable items of equipment and stationery, for other areas to claim, free of charge.

The significant increase in clinical waste during the pandemic has been extremely challenging. Fortunately, waste collection and disposal has been well managed and the service from our contractor has been excellent. Disposal of large quantities of personal protective equipment (PPE) resulted in issues with storage and movement of waste, as well as increases in cost. Contingency

measures have been implemented several times over the preceding months and all have worked effectively. The Trust has also negotiated the provision of additional wheeled bins and collections to ease the pressure on this service.

Moving forward over the next several months, waste segregation will be further improved with the introduction of a new colour coding system for clinical waste. This will ensure waste is not over processed, help to reduce risk, provide cost reduction opportunities and ensure the Trust has more sustainable systems.

## **Emergency Preparedness**

In November 2019 a review of emergency preparedness, resilience and response (EPRR) was conducted by Mersey Internal Audit Agency (MIAA) in accordance with the requirements of the 2019-20 Internal Audit Plan approved by the Audit Committee. The overall objective of the audit was to review and evaluate the arrangements in place in relation to emergency planning, considering local and national guidance and the degree to which plans had been tested. The main fieldwork for the review was performed pre-Covid-19 (October to November 2019) and, as such, represented the position of the Trust at a point in time before the effects of the pandemic impacted on the organisation.

The findings from the review provided the Trust with limited assurance and indicated that there had been limited progress against the original recommendations made within the review undertaken in 2016-17. However, whilst in the process of closing out the audit review the Trust had to actively implement its emergency preparedness procedures in an unprecedented situation (Covid-19). The findings of the MIAA review were those at November 2019 and represent the Trust position before the pandemic hit and in some instances were overtaken by events.

To address the recommendations set out in the MIAA audit and in response to Covid-19, the Trust took immediate action and aligned both the accountability and delivery for EPRR under the Chief Operating Officer's portfolio in line with the learning in managing the Covid-19 response.

A significant amount of work took place between May 2020 and March 2021 to address the recommendations set out by MIAA. One of the recommendations highlighted concerns around the lack of evidence to support business continuity plans (BCP) being in place within the Trust. The EPRR team worked closely with all divisions across the Trust to ensure up-to-date BCP's were put in place for all critical functions. A central location has been created on the Trust's Intranet site to allow for ease of access to the plans, for all staff. Processes have been put in place to allow for the plans to be exercised over the coming year and reviewed annually to ensure that the plans are robust and continue to be fit for purpose.

In January 2021, an interim EPRR Lead was recruited to address the departure of the Trust's EPRR Officer, to support the creation of a new EPRR team and to ensure, in respect of learning from audits conducted in 2019 and 2020 by MIAA that the Trust is compliant with the NHS England core standards for acute Trusts moving forward. The interim lead was recruited for a six month period and will be replaced at the end of the contractual period by a substantive EPRR Manager.

The interim EPRR Lead found that significant work had been undertaken to address the nine recommendations raised in the MIAA audits with all areas being addressed and that the Trust is in a good position with regard to meeting the majority of the core EPRR standards. A further six remaining areas of improvement were identified by the interim EPRR Lead on recruitment and have since been addressed, these being:

- improved governance arrangements for EPRR within the Trust;
- training for the existing members of the EPRR team (Head of EPRR and patient flow and Operational Services Manager for EPRR) and staff involved in a major incident response;
- simplification of the Trust's EPRR major incident response plans;
- gathering and storing evidence to support the self-assessment of compliance with NHS England core standards;
- Assurance relating to the physical resources required to support a major incident response; and
- creation of a dedicated EPRR budget Trust-wide to fund training, physical resource management and incidental costs.

The Trust will be in a position to declare substantial compliance with the core standards audit in 2021-22 as the work detailed above is fully addressed.

The Trust is on target to achieve full compliance with the core standards within three to four years of this date, following the annual work plan and maintaining the improvements since 2019.

#### *Datix – Health and safety incidents*

The management of health and safety incidents, including incidents that affect staff, is undertaken with the same rigour as for clinical incidents and in line with the risk management strategy. This ensures that the Trust investigates, mitigates and learns when things go wrong that affect not only our patients but our staff also. A comprehensive health and safety incident report is presented to the bi-monthly Health and Safety Governance Group. In addition all health and safety incidents are reported to the weekly Safety and Learning Group with actions tracked as indicated.

#### *Risk Register*

Datix has the facility to extract risk entries across a number of different headings including those that are related to health and safety issues to support management and mitigation of risks. A series of risk management workshops have taken place to support staff in reviewing risk registers. It is particularly pleasing to see that the estates and facilities division, risk owners for a large percentage of health and safety risks, has made significant progress with their risk registers.

#### *Prohibition or enforcement notices*

The Trust has not received any prohibition or enforcement notices during the year.

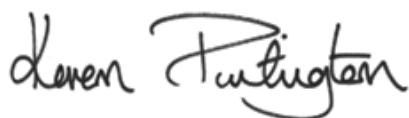
#### *Overseas operations*

The Trust does not have any subsidiaries overseas.

#### *Political Donations*

The Trust has neither made nor received any political donations during 2020-21.

This Performance Report is signed on behalf of the Board of Directors by:



**Karen Partington**  
**Chief Executive**

10 June 2021

**ACCOUNTABILITY REPORT**  
2020-21

# DIRECTORS' REPORT

**The Directors present their annual report on the activities of Lancashire Teaching Hospitals NHS Foundation Trust.**

This Directors' report is prepared in accordance with:

- sections 415, 416, 418 and 419 Companies Act 2006 (section 415(4)-(5) and sections 418(5)-(6) do not apply to NHS Foundation Trusts)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008. All the requirements of schedule 7 applicable to the Trust are disclosed within the report
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by NHSI in its Annual Reporting Manual

## Our Board of Directors

Our Board of Directors is a unitary Board, and has a wide range of skills with a number of Directors having a medical, nursing or other health professional background. The Non-Executive Directors have wide-ranging expertise and experience, with backgrounds in finance, audit, IT, estates, commerce, quality and service improvement, health and social care, risk and governance, and education. The Board is balanced and complete in its composition, and appropriate to the requirements of the organisation.

Please note that (I) indicates that the Non-Executive Director is considered independent.

### **Professor Ebrahim Adia (Chairman) (I)**

Appointment: 2 December 2019 to 1 December 2022

Ebrahim is currently Pro Vice-Chancellor at the University of Central Lancashire and a member of the Senior Executive Team.

Previously, Ebrahim served as Vice-Chair of a Primary Care Trust and as a Non-Executive Director of an NHS Foundation Trust. He has also served as Deputy Leader of Bolton Council and is currently an Elected Member.

### **Tim Watkinson, Vice Chairman (I)**

Appointment: 1 April 2016 to 31 March 2022

Tim is a qualified accountant with over 25 years' experience in senior audit positions in the public sector. He was previously the Group Chief Internal Auditor for the Ministry of Justice and prior to that was a District Auditor with the Audit Commission, including terms of office in Lancashire County Council, Preston City Council and Chorley Borough Council. Tim has led national teams and taken a lead role for the Audit Commission in the development of methodology for improving the performance of local authorities. Tim has experience of working in major accountancy firms providing audit and consultancy services to the public sector including the NHS. He has also been employed as an accountant and a Chief Internal Auditor within the NHS.

Tim is the Vice Chairman of the Trust and the Chair of the Trust's Audit Committee. He is also the Non-Executive Board lead for Freedom to Speak Up and a member of the Rosemere Management

Committee. Outside the Trust, Tim is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee.

**Professor Paul O'Neill, Senior Independent Director (I)**

Appointment: 4 March 2019 to 3 March 2022

Paul is Professor Emeritus at the Manchester University and Consultant Physician with special interests in elderly care and stroke medicine. He has been the Head of School and Deputy Dean for the Faculty of Medical and Human Sciences. He received a National Teaching Fellowship and has published extensively in medical education and clinical research, as well as co-authoring six books. Internationally, Paul was a member of Faculty for the Harvard-Macy medical educators programme and acts as an education consultant internationally. On behalf of the Medical Schools Council, he led the work on devising a new selection system for the Foundation Programme implemented in 2012. He has an interest in patient and public involvement in medical education and established the Doubleday Centre for Patient Experience at Manchester. In 2013, he was awarded the President's Medal of the Academy of Medical Educators for his achievements. Paul continues to work extensively for the General Medical Council in quality assuring undergraduate and postgraduate medical education and is a Consultant at the Manchester University Foundation Trust. Paul is the Chair of the Trust's Education, Training and Research Committee.

Paul was appointed as Senior Independent Director on 31 August 2019.

**Geoff Rossington, Non-Executive Director (I)**

Appointment: 4 September 2017 to 3 September 2023

Geoff began his career as an industrial engineer after which he joined the North West Regional Health Authority (NWRHA) in its internal consultancy department specialising in performance improvement, value for money and market testing of support services. After 11 years at the NWRHA he joined PricewaterhouseCoopers and worked on complex change programmes resulting in organisational transformation, profitable growth and commercial improvement advising a portfolio of public and private sector organisations including the NHS, Ministry of Defence, FTSE100 and global companies such as Lockheed Martin. Since then he has advised a number of NHS clients on various transactions including transforming community services and the acquisition of a NHS Independent Sector Treatment Centre. He specialises in capital projects, business case development, transactions support and programme management. Recent examples include the recommissioning of community services on behalf of South Cheshire and Vale Royal CCGs and the repatriation of Pathology services for Cambridge University Hospitals. Geoff has recently taken up a position as Non-Executive Director of Origin Control Solutions Limited. Geoff is the Chair of the Trust's Charitable Funds Committee.

**Jim Whitaker, Non-Executive Director (I)**

Appointment: 3 July 2017 to 2 July 2023

Jim is an experienced Executive currently working at BT Enterprise, where he is Director of Project Management. During his career, Jim has led many large scale IT transformation programmes for customers in the UK and abroad; these have typically been high complexity and operationally critical in nature. He has worked with customers in many sectors including Government, Defence, Investment Banking and Retail. Jim is a Chartered IT Professional with the British Computer Society and holds project management qualifications, which include APM RPP, MSP and Prince 2. His areas of particular expertise are strategic planning, managing change, governance, and risk management. Jim is the Chair of the Trust's Workforce Committee.



### **Ann Pennell, Non-Executive Director (I)**

Appointment: 7 January 2019 to 6 January 2022

Ann has had a long Executive career in local Government including senior roles in children's services, corporate improvement and housing. She has held Non-Executive Director posts at Cheshire and Wirral Partnership NHS Foundation Trust and prior to that, she was Non-Executive Director and Vice Chairman at Southport and Ormskirk Hospital NHS Trust. Ann is the Chair of the Trust's Safety and Quality Committee and Non-Executive Director Lead for maternity safety and safeguarding.

### **Kate Smyth, Non-Executive Director (I)**

Appointment: 4 February 2019 to 3 February 2022

Kate is a chartered town planner and worked in planning and economic development for many years in local authorities across the North West. She then ran her own consultancy business for 25 years specialising in economic development and disability, and has extensive experience working in the public and community and voluntary sectors. From 2012 to 2019, she was the Lay Member (Patient and Public Involvement) at Calderdale CCG. Kate was also the equality lead and the lead for deprivation, poverty and housing. From 2010 to 2019, she was an independent Board member (latterly, the Deputy Chair) at Kirklees Neighbourhood Housing and the equality champion. She is currently a Lay Leader at Yorkshire and Humber Patient Safety Translational Research Centre and in 2019 was appointed to the North West Regional Stakeholder Network, established by the Cabinet Office Disability Unit.

In March 2021, Kate was elected as Co-Chair of the Disabled NHS Directors' Network.

### **Tricia Whiteside, Non-Executive Director (I)**

Appointment: 9 September 2019 to 8 September 2022

Tricia is a transformational leader with a wealth of financial services experience having held a number of senior leadership roles within large Fortune 500 and FTSE100 organisations. Her experience gathered over 25 years includes owning aspects of global control frameworks and assuring compliance to the expected standards of control, establishing Strategic Change Portfolios, operational delivery of integration programmes following organisational merges/acquisitions and lead upon significant business transformation. Over the last 10 years she successfully established her consultancy business which provided interim management support, with focus on setting up new operational functions and building sustainable internal capabilities, creating portfolios of strategic change to improve operational performance and financial stability, strengthening governance and control regimes, consulting on risk management strategies, and positively responding to increased regulatory scrutiny. Tricia is the Chair of the Trust's Finance and Performance Committee.

### **Karen Partington, Chief Executive**

Permanent post – appointment from 1 October 2011

Karen was appointed as Chief Operating Officer of Lancashire Teaching Hospitals NHS Foundation Trust in 2008 and became Chief Executive on 1 October 2011. A nurse by background, she has over 40 years' experience in the NHS, working in acute hospitals in Wales and the North West of England. Karen is Chair of the health economy wide Urgent Care Delivery Board, co-Chair of the Major Trauma and Critical Care Operational Delivery Network (ODN) and Chair of the ICS wide

People Board. She is also Chair of Quest, comprising 13 hospitals across England and Wales who work together on specific topics and quality improvement.

**Jonathan Wood, Finance Director / Deputy Chief Executive**

Permanent post – appointment from 1 August 2019

After graduating, Jonathan joined the North Western financial management training scheme in 1992 where he worked with a number of Health Authorities within Greater Manchester. Since qualifying he has worked for a number of NHS organisations, including Salford Royal, the North West Strategic Health Authority, East Lancashire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Foundation Trust. He has supported a number of hospital developments over the years and enjoys working with teams in resolving complex problems.

**Gerry Skales, Medical Director**

Permanent post – appointment from 1 March 2018

Gerry graduated from Guys Hospital in London and spent the early years of her medical training in London and the South Coast before moving to the Christie Hospital to undertake specialist training in Clinical Oncology. She was appointed as a Consultant at the Royal Preston Hospital in 1997 with an interest in treating lung and gynecological cancers. She has held a number of leadership roles within the Trust and North West region including Clinical Lead for the Lancashire and South Cumbria Cancer Alliance and Deputy Medical Director of the Trust. Gerry continues to work as a Consultant in Oncology undertaking a weekly Acute Oncology ward round and is actively involved in a number of the ICP and ICS Committees. Gerry was appointed as the Trust's full-time Medical Director from March 2018 and is also our Caldicott Guardian.

**Sarah Cullen, Nursing, Midwifery and AHP Director**

Permanent post – appointment from 1 August 2019

Sarah is a Registered Nurse with experience in a variety of nursing and operational roles in a broad range of specialties. Sarah has spent 18 years of her career at University Hospitals of Morecambe Bay and joined Lancashire Teaching Hospitals in 2017 as the Deputy Nursing, Midwifery and AHP Director becoming the Executive Nursing, Midwifery and AHP Director in 2019. Sarah is the Executive lead with responsibility for the hospital charity, governance, maternity, children and safeguarding. She is also a trustee of the post graduate education charity.

**Karen Swindley, Strategy, Workforce and Education Director**

Permanent post – appointment from 1 November 2011

Karen was appointed to the role of Director of Workforce and Education in November 2011 prior to this appointment, having previously worked as Associate Director of Human Resources Development in the Trust since 2001. Having been employed in the NHS for over 26 years, she has held a number of senior posts in education, training and organisational development both in the NHS and the private sector. She is responsible for the corporate strategy and strategic leadership and management of human resources, training and education and research. The role of strategy was added to her portfolio in December 2018 and the post title changed to reflect this. Outside of the Trust she is the Chairman and Trustee of Derian House Children's Hospice.

**Faith Button, Chief Operating Officer**

Permanent post – appointment from 1 May 2019

After graduating Faith joined the NHS and has worked in a number of acute Trusts in senior roles in London and the South with over 20 years' experience. She has a strong background in senior operational management and performance management having been a Director of Performance at her last two Trusts. She joined the Trust in 2017 having been the Deputy Chief Operating Officer and was appointed to Chief Operating Officer in May 2019.

### **Non-voting Board members**

#### **Ailsa Brotherton, Director of Continuous Improvement**

Permanent post – appointment from 1 December 2017

Ailsa joined the Trust in 2017 from Manchester Foundation Trust where she was the Director of Transformation for the Single Hospital Programme. Prior to this Ailsa was the Clinical Quality Director for the North of England with the Trust Development Authority/NHSI. She has also held a post-doctoral senior research fellow post, has a Masters in Leadership (Quality Improvement) from Ashridge Business School and is a Health Foundation Generation Q Fellow. Ailsa has extensive experience of designing and delivering quality improvement and large scale change programmes. During this year, Ailsa was awarded an honorary professorship in the School of Health and Wellbeing at the University of Central Lancashire and is working with our academic partners to ensure all our improvement programmes are evidence based and evaluated. She is a member of the Safety and Quality Committee, Education, Training and Research Committee and Workforce Committee and is a member of the national Improvement Directors' network.

#### **Stephen Dobson, ICP Chief Information Officer**

Permanent post – appointment from 1 April 2020

Stephen joined the Trust in April 2020 from Greater Manchester's Health and Care Partnership where he was the Chief Digital Officer. Prior to this Stephen spent eight years as Chief Information Officer for Wrightington, Wigan and Leigh NHS Foundation Trust. He has also spent over 10 years working for Pfizer Pharmaceuticals within the USA and UK within a variety of roles including Pharmacogenomics, Clinical Trials, Informatics and Knowledge Management. Stephen has a PhD in Molecular Genetics and extensive experience leading digital programmes. Stephen attends the Finance and Performance Committee.

#### **Gary Doherty, Director of Service Development**

Fixed-term post – joined the Trust in February 2020 (appointed to current role 1 December 2020)

Gary joined the Trust in February 2020 and is an experienced NHS leader having worked in operational and planning roles at a range of levels including Chief Executive. He has over 25 years NHS experience and has worked in both the English and Welsh NHS, mainly in hospital provision but also at a regional level for the Department of Health. Gary attends the Safety and Quality and Finance and Investment Committees.

### **Board members whose term of office ended during 2020-21**

There have been no Board members whose term of office ended during 2020-21.

### **Appointment and removal of Non-Executive Directors**

Appointment and, if appropriate, removal of Non-Executive Directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, a

Nominations Committee of the Council oversees the process and makes recommendations as to appointment to the full Council. The procedure for removal of the Chairman and other Non-Executive Directors is laid out in our Constitution which is available on our website or on request from the Company Secretary.

### Division of responsibilities

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures the Board has a strategy which delivers a service that meets the expectations of the communities we serve and that the organisation has an Executive Team with the ability to deliver the strategy. The Chairman facilitates the contribution of the Non-Executive Directors and their constructive relationships with the Executive Directors. The Chief Executive is responsible for leadership of the Executive Team and for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

### Declaration of interests

All Directors have a responsibility to declare relevant interests, as defined within our Constitution. These declarations are made to the Company Secretary, reported formally to the Board and entered into a register which is available to the public. The register is also published on our website, and a copy is available on request from the Company Secretary.

### Independence of Directors

The role of Non-Executive Directors is to bring strong, independent oversight to the Board and all Non-Executive Directors are currently considered to be independent. The Board is made up of a majority of independent Non-Executive Directors who have the skills to challenge management objectively. There is also a strong belief in the importance of ensuring continuity of corporate knowledge, whilst developing and supporting new skills and experience brought to the Board by new Non-Executive Directors.

Decisions on reappointments of Non-Executive Directors are made by the Council of Governors. A reappointment of a Non-Executive Director beyond six years is based on careful consideration of the continued independence of the individual Director and recognising the need to introduce new skills to the Board. Non-Executive Directors who are appointed beyond six years are always subject to annual reappointment, and the maximum term of office is nine years in aggregate, in line with the Trust's Constitution.

In recognition of our role as a teaching hospital, one of our Non-Executive Director posts is held by a University representative. This allows the post holder to use their detailed knowledge and their experiences within the field of academia to play a key role on the Board and this post is occupied by Professor Paul O'Neill, who was appointed on 31 August 2019 for a three-year term.

### Board meeting attendance summary 2020-21

PRESENT	02/04/2020	04/06/2020	06/08/2020	01/10/2020	03/12/2020	04/02/2021	A	B	Percentage of meetings attended
Ebrahim Adia	P	P	P	P	P	P	6	6	100%
Ailsa Brotherton	P	P	P	P	P	P	6	6	100%
Faith Button	P	P	P	P	P	P	6	6	100%

Sarah Cullen	P	P	P	P	P	P	6	6	100%
Stephen Dobson	P	P	Ab	P	P	P	6	5	84%
Gary Doherty					P	P	2	2	100%
Paul O'Neill	P	P	P	P	P	P	6	6	100%
Karen Partington	P	P	P	P	P	P	6	6	100%
Ann Pennell	P	P	P	P	P	P	6	6	100%
Geoff Rossington	P	P	Ab	P	Ab	P	6	4	67%
Gerry Skales	P	P	P	P	P	P	6	6	100%
Kate Smyth	P	P	P	P	P	P	6	6	100%
Karen Swindley	P	P	P	P	P	P	6	6	100%
Tim Watkinson	P	P	Ab	P	P	P	6	5	84%
Jim Whitaker	P	P	P	P	P	P	6	6	100%
Tricia Whiteside	P	P	P	P	P	P	6	6	100%
Jonathan Wood	P	P	P	P	P	P	6	6	100%

**Ab** = Absent | **B** = Meetings attended | **P** = Present | **A** = maximum number of meetings the Director could have attended

## Evaluating performance and effectiveness

In line with NHSI requirements that Trusts carry out developmental reviews of their leadership and governance, the Trust commissioned an independent review in 2020. The review was conducted in line with the Well Led Framework which consists of eight key lines of enquiry (KLOEs) and details descriptions of good practice that organisations and reviewers can use to inform their judgements. The eight KLOEs within the framework are as follows:

<b>1</b> Is there the <b>leadership capacity and capability</b> to deliver high quality, sustainable care?	<b>2</b> Is there a clear <b>vision</b> and credible <b>strategy</b> to deliver high quality sustainable care to people, and robust plans to deliver?	<b>3</b> Is there a <b>culture</b> of high quality, sustainable care?
<b>4</b> Are there clear responsibilities, <b>roles</b> and systems of accountability to support good governance and management?	<b>Are services well led?</b>	<b>5</b> Are there clear and effective processes for managing <b>risks</b> , issues and <b>performance</b> ?
<b>6</b> Is appropriate and accurate <b>information</b> being effectively processed, challenged and acted on?	<b>7</b> Are the <b>people</b> who use services, the public, <b>staff</b> and <b>external partners engaged</b> and involved to support high quality sustainable services?	<b>8</b> Are there robust systems and processes for <b>learning</b> , continuous <b>improvement</b> and <b>innovation</b> ?

The overall conclusion of the review is that Lancashire Teaching Hospitals NHS Foundation Trust is well led with the final report indicating a good level of awareness around the strengths of the organisation, as well as reflecting areas where greater improvement is required. The report noted

that there has been an ongoing focus on improving governance arrangements across the Trust, with examples including:

- The recent development of the revised approach to divisional governance and accountability arrangements to strengthen clarity of roles and expectations.
- The development of the approach to continuous improvement within the Trust.
- Continued emphasis on staff engagement, with a Staff Engagement Plan in place that aligns with the objectives in the Workforce and Organisational Development Strategy.

Further information on performance and effectiveness can be found in the Annual Governance Statement.

## Understanding the views of Governors and Members

Directors develop an understanding of the views of governors and members about the organisation through attendance at members' events, the Annual Members' Meetings, Council of Governors' meetings and workshops, linkages with the Council subgroups and an annual interactive forward planning session each year. The impact of the pandemic meant physical attendance at members' events and meetings during 2020-21 was not possible. As much activity as possible continued through the use of digital technology, introduced rapidly at the onset of the pandemic in March 2020 and embedded throughout the year to meet the requirement for safe working conditions.

A very successful virtual Annual Members' Meeting was held for the first time on 18 November 2020 with higher attendance levels seen from staff, Trust members and the general public. As part of the meeting there were two fantastic presentations delivered by Consultants Dr Mohammed Munavvar and Dr Aashish Vyas, covering '*Clinical Management and Covid-19 research trials*' and '*Treatment of respiratory failure in the High Care Unit*' which were both inspiring and thought provoking. A range of questions were posed during the meeting and any responses not covered were posted on the Trust's website.

During the year we continued to focus on improving the relationship between the Board and governors through a number of ways, including the following:

- (i) we encourage governor attendance at Board meetings (in the capacity of observer) and governor attendance is recorded within the Board minutes. Attendance has increased this year through the benefit of attending Board meetings using digital technology;
- (ii) there is Non-Executive Director representation at each of our core governor subgroup meetings;
- (iii) Board members are invited to every Council of Governors' meeting and Non-Executive Directors in particular are invited to comment on the Trust's performance and provide presentations to governors on their involvement in chairing each Board Committee. Governors have the opportunity to ask them questions and seek assurances that Non-Executive Directors are holding the Executive Team to account. A number of presentations have been delivered by Non-Executive Committee Chairs to provide insight into the role and responsibilities of the Committees of the Board.
- (iv) as part of the Trust's forward planning process, the Board and the Council of Governors have a joint interactive workshop every September where Board members and governors review the Trust's priorities for the year ahead and governors provide feedback from members and the wider public on such priorities;
- (v) there are joint Board and governor development sessions, for example during 2020-21 we held a joint development session on the Trust's strategy 'Our Big Plan' where

governors represented the views of their constituents for consideration as part of the strategy refresh. In addition, an interactive session was held to discuss the draft Case for Change for the New Hospitals Programme including the draft communications and engagement strategy; and

- (vi) there are joint visits and events around the hospital, such as Fab Feedback Friday visits which were held virtually during the year. These virtual visits allowed departments and teams to showcase their achievements and highlight issues which are important to them that may need support from the Board and/or governors to resolve.

## The Modern Slavery Act 2015

The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles. The summary below sets out the steps the Trust is taking to ensure that slavery and human trafficking is not taking place in our supply chains or in any part of our service:

- **Assessing risk related to human trafficking and forced labour associated with our supply base:** we do this by supply chain mapping and developing risk-ratings on labour practices of our suppliers to understand which markets are most vulnerable to slavery risk.
- **Developing a ‘Supplier Code of Conduct’:** we will issue our Supplier Code of Conduct to our existing key suppliers as well as those that are in a market perceived to be of a higher risk (for example, catering, cleaning, clothing and construction). The Supplier Code of Conduct will also be included within our tendering process. We will request confirmation from all our existing and new suppliers that they are compliant with our Supplier Code of Conduct.
- **Monitoring supplier compliance with the Act:** we will request confirmation from our key suppliers that they are compliant with the Act.
- **Training and provision of advice and support for our staff:** we are further developing our advice and training about slavery and human trafficking for Trust staff through our Safeguarding Team to increase awareness of the issues and how staff should tackle them.
- **Monitoring contracts:** we continually review the employment or human rights contract clauses in supplier contracts
- **Addressing non-compliance:** we will assess any instances of non-compliance with the Act on a case-by-case basis and will then tailor remedial action appropriately.

## Directors’ declaration

All Directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust’s auditor is aware of that information. All Directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Lancashire Teaching Hospitals NHS Foundation Trust, including our business model and strategy.

If you would like to make contact with a Director, please contact the Company Secretary by email: [company.secretary@lthtr.nhs.uk](mailto:company.secretary@lthtr.nhs.uk) , Tel: 01772 522010.



*Also available on our website:*

Register of directors' interests

Director biographies

Statement on the division of responsibilities between Chairman and Chief Executive



# Quality Improvement

Below highlights some of the key developments made by the Trust to improve service quality and an overview of the Trust's arrangements in place to govern service quality. Additional information on quality is available in our Quality Account on pages 131 to 258 and within our Annual Governance Statement on page 93.

## Major service developments

Despite the challenges of the Covid-19 pandemic, we are delighted to have made a number of significant service developments during 2020-21. This is testament to the hard work of staff and key partners whom, in their respective areas, have been on a journey of transformation while managing the impact of the virus.

Below we have set out some of the major developments that have been introduced, including those yet to come, but are well underway:

### Royal Preston Hospital's Critical Care Centre complete

In last year's annual report we outlined our building progress for the expansion and refurbishment of the Critical Care Unit at Royal Preston Hospital and we are delighted to announce that the works are now complete.

Phases one and two of the programme were completed in June 2020 and proved significant in helping in our challenge against Covid-19. Phases three and four of the development were completed in March 2021.



The 34-bed state-of-the-art unit now features facilities for both patients and staff and for the first time a dedicated reception area for relatives, featuring locker spaces, a kitchen area, and three counselling rooms that offer a calm and comfortable space to meet with clinicians away from the clinical setting.

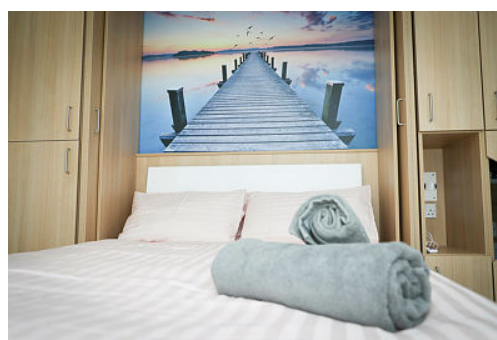
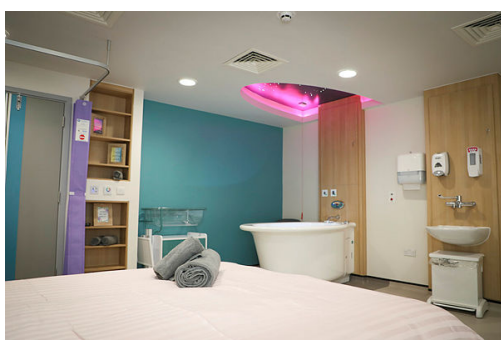
The unit also includes two ante-rooms that provide a negative-air chamber to isolate workspace from a patient. More about the development is available on the [Trust website](#).

### **Chorley Birth Centre re-opened**

In December 2020, the Trust was delighted to announce that the relocated and freestanding Chorley Birth Centre at Chorley and South Ribble Hospital had re-opened.

This came after the former Birth Centre had closed in February 2019 and services were temporarily relocated until the new Birth Centre was completed.

The new Centre offers an outstanding birth environment for women, with active birthing equipment and birthing pools in each of the birth rooms in addition to clinical assessment and education areas for expectant mums. The freestanding Birth Centre is now one of four places of birth options offered to all women booked within the Trust's care.



### **Same Day Emergency Care Unit**

To help improve patient flow and help improve capacity at Royal Preston Hospital, the Trust introduced a Same Day Emergency Care unit in May 2020.

The purpose of the unit is to filter medical patients away from the Emergency Department to help prevent unnecessary admissions into hospital beds.

The first year of the service has proven a big success, seeing and discharging over 5,000 patients who were streamed directly from the Emergency Department, NHS 111 and the North West Ambulance Service.

This has not only helped to improve patient flow but has helped to improve the patients' journey and experience with us.



## Trust provides vaccination hub

Also towards the end of 2020, the Trust was delighted to be one of the first hospital hubs in the country to administer the new Covid-19 vaccination to key priority groups.

The Trust's first vaccination went to 81-year old Doreen McKeown at 7:20am on the 8 December 2020 at Royal Preston Hospital making Doreen the first patient in the region to receive the Pfizer-BioNTech vaccine. Doreen is also one of the hospital's volunteers, making this extra special!



Following the introduction of the Oxford-AstraZeneca vaccine, the Trust opened a hub at Chorley and South Ribble Hospital and also created roving teams to move around each hospital's ward areas to provide patients with the vaccine. Staff have also been instrumental in the establishment and continued operation of the mass vaccination centre at St John's Shopping Centre in Preston. The mass vaccination site is set to expand which will make it the largest site of its kind in Lancashire.

## Avondale Rehabilitation Unit

In December 2020, the Avondale Rehabilitation Unit was opened to treat patients who need more intensive rehabilitation and two or more people to assist and support them.

The new 28-bed unit at Royal Preston Hospital supports intermediate care capacity for rehabilitation and enhances the current offer in existing community units.

Patients are referred from all inpatient areas of Preston and Chorley and the unit supports a wide range of people from those recovering from major trauma to lower-limb amputees and those with dementia.



Avondale is a therapy-led unit that has no age or time limit for patients who are treated depending on their individual needs.

## Chorley Day Case and Eye Unit



Construction of the Day Case and Eye Unit at Chorley and South Ribble Hospital continues to progress at speed and in line with the original programme.

The ground floor will provide staff support accommodation, and on the first floor will be the outpatient department for diagnostic, consultant and nurse-led clinics, Orthoptist service, Laser procedures and Macular Injection clinics. The day case theatre suite will be on the second floor and the third floor will house the plant room/building services and IT infrastructure provision.

## **Improvements on the way for kidney patients**

People with kidney disease on dialysis treatment in East Lancashire, North Lancashire and South Cumbria will see improvements to the service they receive following the award of a new contract to Diaverum Facilities Management.



The seven year deal will provide vital haemodialysis treatment to patients across the three areas with building work already underway at the site of a new centre in Ulverston for people being treated for kidney disease, due to open in July 2021.

The new arrangements will allow 94% of patients across Lancashire and South Cumbria to access haemodialysis within the national target of 30 minutes travel time from home. The current figure in South Cumbria is 65%.

## **Acute Frailty Assessment Unit**

On 10 August 2020, the Acute Frailty Assessment Unit at Royal Preston Hospital opened to provide specialist services for elderly and vulnerable people in Lancashire.

The new unit was established to cater for frail patients and make sure staff have the right pathways, specialist skills and equipment to deliver tailored care of the highest possible standard.

The unit provides specialist training in areas such as falls and pressure ulcer prevention, helping to get elderly and frail patients the care they need to return home or to care in the community.

The team will be measuring the outcomes of the trial unit to see what difference it will make to admission avoidance, length of stay, patient experience and outcomes for patients so we will provide further updates on this great initiative in due course.

## **Outpatient Digitalisation**

Work has been in progress for nearly two years to digitalise outpatient clinics at Lancashire Teaching Hospitals, with the last 12 months bringing a number of improvements for patients and clinicians alike.

The new digital systems, introduced across all core areas, improve outpatient appointments for clinicians, therapists and patients.

The system brings a number of benefits to clinicians, including instant access to patient records, better quality data, easier booking and scheduling and a paperless system – all of which will contribute towards a reduction in administrative errors and delays.

Meanwhile the patient will see improved waiting times, reduced travel and more flexibility to choose a convenient appointment around their schedule.

## **New Hospitals Programme**

The Lancashire and South Cumbria New Hospitals Programme presents us with a once in a generation opportunity to transform our region's hospitals by 2030.

We want to build on what our hospitals are already great at, while developing new cutting-edge hospital facilities that take advantage of new healthcare technologies and treatments to offer the absolute best in modern healthcare.

You can read more about the New Hospitals Programme on page 57.

## **Exciting project to transform Pathology Services**

As part of the transformation of Pathology services across Lancashire and South Cumbria, we are working in partnership with other local Trusts to ensure that our Pathology services remain at the forefront of diagnostics to the benefit of all staff, clinicians and patients.

More information about the Pathology Collaboration can be seen on page 54.

## **Research and Innovation**

Our strategic commitment to drive innovation through world-class research continues to thrive and we are again the top performing site in Lancashire and South Cumbria for patient and volunteer recruitment into research studies and innovation projects. We have been the first UK site to recruit participants in four studies, for one study recruited the first GLOBAL patient and have recruited over 3,100 new patients into studies and clinical trials. While assisted by the most unfortunate of backdrops, this is a record year for recruitment and a fitting testimony to the hard work of the Research and Innovation team. Not unsurprisingly, the vast majority of working hours spent on research and innovation in 2020-21 have been spent on gathering information, science around immunology and developing treatments in support of the battle against Covid-19. Indeed, over 90% of our recruits are from these studies.

As a teaching hospital we believe that developing the workforce of the future is central to delivering high quality healthcare into the future. We are a regional leader in respect of our education, training and research and as the only NIHR Clinical Research Facility (CRF) in the region and a leading provider of undergraduate education we will continue to drive forward the ambitions described in our respective education and research strategies.

In 2020-21 the Centre for Health Research and Innovation has continued to grow and develop in line with the ambitious three year strategy (2019-22) although some delays due to the pandemic have been noted and accepted by the Trust. Many new milestones have been reached and highlights include:

- The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2020-21, recruited to participate in research approved by a Research Ethics Committee, was circa 3,100 (circa 2,122 in 2019-20). This represents a huge increase in numbers of around 48%.
- In total there are currently now 217 active research studies recruiting patients at the Trust with a further 186 follow-up recruited patients.
- We have opened 37 new studies this year (62 in 2019-20) which is creditable given the staggering reduction in (non-Covid-19) NIHR portfolio studies opening in this period.

- The Trust has opened and run around 30 Covid-19 studies in this period and, while in the most unfortunate of settings, highlights of this performance-wide have been:
  - Developing three in-house studies (one alternative antibody focussed; one targeted treatment (radiotherapy); and one looking at long-term immunity)
  - UK REACH. This is a staff feedback study which aims to explore how ethnicity may affect Covid-19 outcomes across the UK and the impact of the pandemic on healthcare workers. The Trust with a nurse principal investigator (PI) was in the top five recruiters in the UK, recruiting 150 staff in only two weeks. The Leicester co-ordination team commented, ***'As one of the top five recruiting sites we will acknowledge your contribution to the study in publications arising from the work by including the study PI as a co-author on publications arising from this work.'***
  - In NoCOV-2 (a safety and efficacy trial of a nebuliser with product RESP 301), the Trust was the UK's first recruiter to the trial.
  - **Magnet4Europe**. The study aims to improve mental health and wellbeing amongst health care professionals by redesigning clinical environments in more than 60 hospitals across six European countries. The study will last for four years and there will be several initiatives that the Trust will be involved with over that time.
- Average occupancy in the NIHR Lancashire CRF stayed consistent at an excellent 40%. Given both the national fall in NIHR studies and the Covid-19 pandemic, this is very credible (given periods of no patient attendance) and is testimony to performing more high intensity experimental medicine studies.
- The NIHR Lancashire CRF continues consolidated cross-sectoral funding to secure its sustainability and growth while actively reviewing new partnerships and is running at an operating surplus.
- The NIHR Lancashire CRF initially founded on an 'in-reach hotel model' for studies from the Trust, Lancashire and South Cumbria NHS Foundation Trust (formerly Lancashire Care NHS Foundation Trust) and Lancaster University research groups, has initiated and run 21 new studies in 2020-21 across the partnership, bringing genuine newness in experimental medicine studies to Lancashire and South Cumbria. Again, this is creditable given the pandemic.
- Our NIHR Lancashire CRF team successfully recruited a patient into a First in Human (FiH) Phase 1 clinical trial. This is a historic moment in the history of experimental medicine at the Trust, which comes on the back of recruiting into three other Phase 1 trials. At the time of writing, the NIHR Lancashire CRF is also creating the processes and procedures to deliver the Trust's first ever Genetically Modified Organism (GMO) trial.
- In the 2020 NIHR North West Coast Research and Innovation Awards, the Trust's Clinical Research team was crowned winners of one award and highly commended in two further awards. The team won the **Award for Research Capacity Building** for the Clinical Academic Faculty, thanks to their partnership with the University of Central Lancashire. The Clinical Academic Faculty is a hub for clinical academic research advice and signposting, supporting the development of local clinical academic research and innovation.
- Publication highlights include involvement in the British Medical Journal from Dr Christian de Goede *'Covid-19 symptoms surveillance in immunocompromised children and young people in the UK: a prospective observational cohort study'*.
- Nichola Verstraelen, Clinical Team Leader for Research and Innovation, is participating in the second year of the NIHR 70@70 programme. This national programme of 70 outstanding senior nurses and midwives has the sole aim of embedding research into the clinical culture for nurses and midwives in the NHS.
- A Nursing, Midwifery and Allied Health Professions research strategy is in development with integration into the relevant clinical strategies. As part of this programme we now have 85 research champions across the divisions. Research notice boards are present in all areas to

showcase specific studies happening in different clinical areas. Research is now included in all the quality audits across the organisation. As a large teaching hospital we are looking at developing educational programmes to enhance knowledge and skills around research for the clinical divisions.

- Stephanie Cornthwaite, one of our senior Research Nurses, has consolidated her national Cancer Research UK Clinical Research Nurse Advisory Group role. The group ensures that activities, content and resources as part of the Excellence in Research Programme continue to meet the professional and educational needs of research nurses working on cancer clinical trials. Due to the pandemic the main focus has been group liaison on study restart of cancer research. The members have also reflected on lessons learned and impacts this has had on a professional level for nurses working in cancer research.
- We have been the first UK site to open and recruit in three commercial studies and one non-commercial study over the last year.
- While somewhat interrupted by Covid-19, the Trust continues to attract commercially sponsored trials demonstrating steady increases year-on-year, especially of earlier phase studies that are utilising the NIHR Lancashire CRF. Looking at studies coming through the pipeline, and notwithstanding further waves of the pandemic, this trend is set to continue into the coming year with an ongoing focus on device trials.
- Our Industry Lead, Nina Vekaria, has built our close links with the NIHR Clinical Research Network and Office for Clinical Research Infrastructure and we are also seeing many direct approaches from industry sponsors. Early phase Oncology studies has seen an increase in expressions of interest mainly attributed to experienced investigators with strong relationships with leading industry sponsors and we have developed a reputation for meeting recruitment targets, fast set up and early UK recruitment.

## Patient care

We have continued our efforts to improve patient experience through a variety of methods, overarched by our Patient Experience and Involvement Strategy and Nursing, Midwifery, Allied Health Professionals (AHP) and Care Giver Strategy which are now both in their third year of implementation.

We listen to our patients to gather their feedback to help improve services and we do this in many ways, including:

- through our governors and Foundation Trust members
- through PALS
- by reviewing the complaints and compliments we receive
- by listening to patient experience feedback from public websites, consultation and dedicated virtual focus group events
- participation in national patient surveys
- through our Friends and Family Test (FFT) results
- through our Safety Triangulation Accreditation Review (STAR) quality assurance framework
- through our Patient Experience and Involvement Group

Our Patient Experience and PALS team work with clinical and departmental staff to try to resolve concerns at the earliest opportunity in order to avoid escalation to the formal complaints process wherever possible. The team do this by:

- providing information to patients, carers and relatives
- resolving problems and concerns before they escalate

- providing data about the experiences of patients, their relatives and carers to inform improvements in the quality of services
- informing people about the complaints procedure and how it can be accessed
- acting as an early warning system for the Trust
- working in partnership with the PALS teams of other healthcare providers

## Complaints and concerns

The Patient Experience and PALS Team have dealt with over 1,436 concerns which could have the potential to become formal complaints and resolved these with a reasonable outcome for patients. This is a positive reflection of the move to locally resolve concerns supporting the organisation's Big Plan and ensuring a positive patient experience.

For the year 2020-21 we received 361 complaints, a decrease of 96 compared to 2019-20.

### Comparator data for Complaints 2015 to 2020

Year	Complaints received	Increase/reduction
2015-16	575	-4
2016-17	595	+20
2017-18	553	-42
2018-19	710	+157
2019-20	457	-253
2020-21	361	-96

*Source: LTHTR Datix*

This demonstrates a 21% decrease in complaints since 2019-20 for the same reporting period. When considered in terms of the ratio of complaints to patient contact, we received a complaint for every 1:1,292 inpatient and outpatient episodes between April 2020 and March 2021. The trend in the ratio of complaints to patient contacts over the past four years is detailed in the table below:

### Trend of ratio of complaints per patient contact 2016 to 2021

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2016-17	595	790,696	1:1,329
2017-18	553	789,643	1:1,428
2018-19	710	815,607	1:1,148
2019-20	457	576,447	1:1,261
2020-21	361	821,526	1:1,292

*Source: LTHTR Datix*

Of the 316 complaints we received between April 2020 and March 2021, 292 (81%) related to care or services provided at Royal Preston Hospital; 65 (18%) to care or services provided at Chorley and South Ribble Hospital; and four (1%) to care or services provided off-site by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre.

### Number of Complaints by Division – April 2020 to March 2021

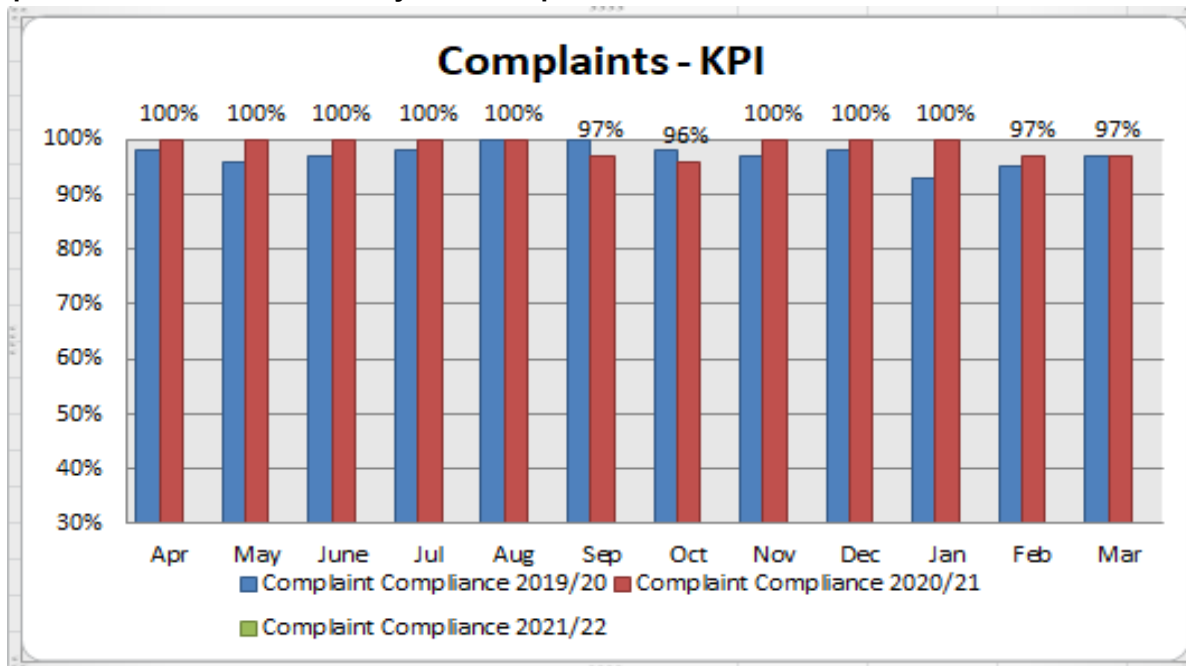
Division	Number (%)	Division	Number (%)
Medicine	166 (46%)	Women and Children's Services	34 (9%)
Surgery	131 (36%)	Diagnostics and Clinical Support	19 (5%)
Estates and Facilities	5 (1.3%)	Corporate Services	4 (1.1%)

*Source: LTHTR Datix*



Of the 361 cases received between April 2020 and March 2021, 321 cases due for closure during this period were achieved.

**Complaints Answered within 35 days Period April 2020 to March 2021**



**Source: LTHTR Datix**

Investigations that were undertaken into the 321 closed complaints concluded that 38 (12%) of the complaints had been upheld. 188 (58%) were partly upheld and 93 (28%) had not been upheld. The seven (2%) remaining records were cases that were withdrawn.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 100% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

Second letters may be received as a result of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2020 and March 2021 we received 15 second letters.

Between April 2020 and March 2021 there were no cases where the Parliamentary and Health Service Ombudsman (PHSO) determined that the outcome would be upheld; one case was partially upheld; and one case was not upheld. A further six cases are ongoing and no final decision has yet been reached.

At the start of the Covid-19 pandemic, NHSE/I permitted NHS organisations to pause the complaints process as long as complainants were informed of the reason. However, we decided to continue with normal ways of working as far as possible and complaints were managed as part of day-to-day business.

We are always aiming to improve our services and in February 2021 all complaint response letters started to contain a link to a satisfaction survey for complainants to complete. The outcome of the survey will enable our Patient Experience and PALS team to analyse the feedback and make changes in the future to improve the complaints process.

Work is also currently in progress to develop an e-Learning package which aims to promote complaints being supported initially through local resolution and how complaints should be responded to. The e-Learning package will be launched by August 2021 to support ongoing achievements, quality of responses and learning from concerns and complaints.

## **Patient experience feedback**

Improving patient experience is a key priority for us and is central to our aims and ambitions, underpinned by our mission to provide excellent care with compassion.

Patient experience and feedback forms the bedrock of our service provision and provides opportunities for the organisation to reflect on practice to ensure developments are consistent and appropriate to meet the needs of our service users and carers. Our Patient Experience Improvement Strategy 2018-21 is aligned to the Trust's ambitions and values to enable staff to embed best practice in relation to patient experience, whilst ensuring that at every level of care and treatment this is taken into account. The four aims of the strategy are to:

1. deliver a positive patient experience
2. improve outcomes and reduce harm
3. create a good care environment
4. improve capacity and patient flow

Governance of the strategy is monitored through the Patient Experience and Involvement Group and the Safety and Quality Committee where complaints and feedback are discussed.

Our Patient Experience and Involvement Group consists of over 40 people from the local community; governors; patient representatives; carer organisations and staff. The Group provides an opportunity for input from a fully diverse representation of the communities served across Chorley, Preston and South Ribble and is an open and honest reflection of the local community. The Group oversees the feedback that we receive in relation to several areas, including:

- FFT results and feedback
- National Patient Surveys
- Complaints, concerns and compliments

The FFT is a key indicator to gather information in relation to patient experience. This enables us to identify how services meet the needs of patients and how improvements in the future can be made. A performance threshold of 90% of patients recommending the ward or department for inpatients and 85% for Emergency Department patients has been established.

From April 2020 the national FFT data no longer requires NHS Trusts to gather information in relation to response rates at the point of discharge although organisations are encouraged to gather feedback more widely on patient experiences. Information is obtained from key areas – inpatients; outpatients; day case treatment; our Emergency Department and Maternity services, as well as our Neonatal and Children and Young People's services.

FFT performance is monitored on a monthly basis and reported through our Safety and Quality Committee. Our reports have been adapted to ensure a true reflection and analysis of the feedback that is recorded and reported. A more in-depth quarterly report is also provided to the divisions.

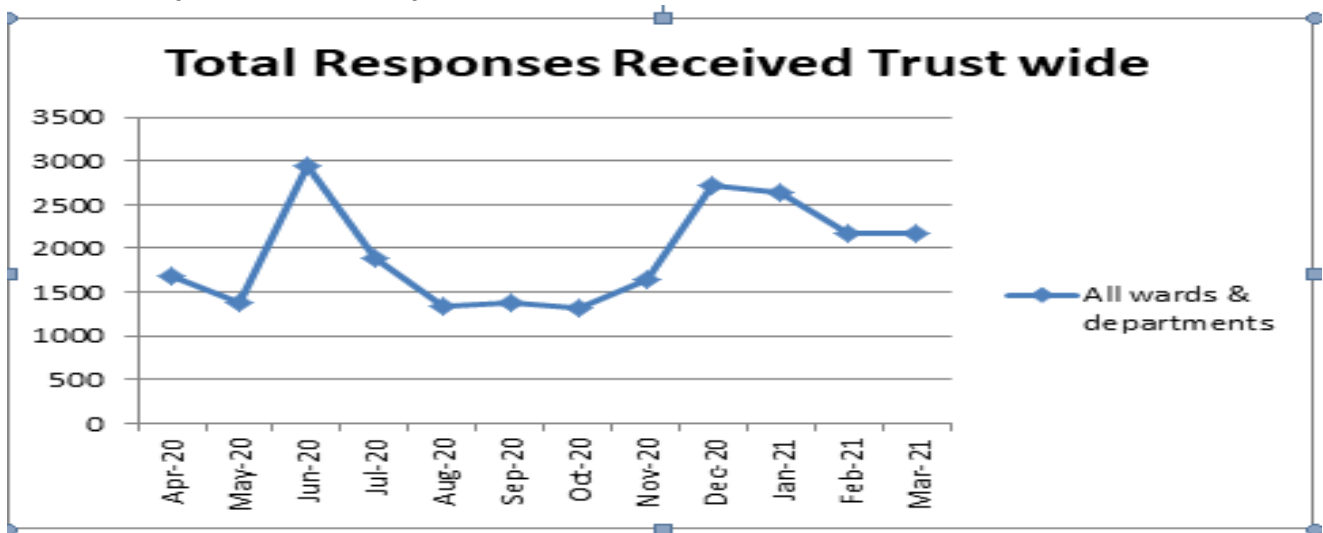
Work is currently ongoing to combine FFT, complaints, concerns and compliments so that all the patient experience information is triangulated for the divisions.

A new provider was introduced in April 2020 to facilitate gathering FFT data. This has provided an opportunity to cleanse the data provided and reconfigure the hierarchy information contained in the FFT IT system. The new arrangement will allow information to be shared across the organisation in a consistent way.

We have standardised our promotion of FFT by using the national branding. We have also produced materials in British Sign Language (BSL) as a way of further enabling the deaf community to provide feedback more effectively.

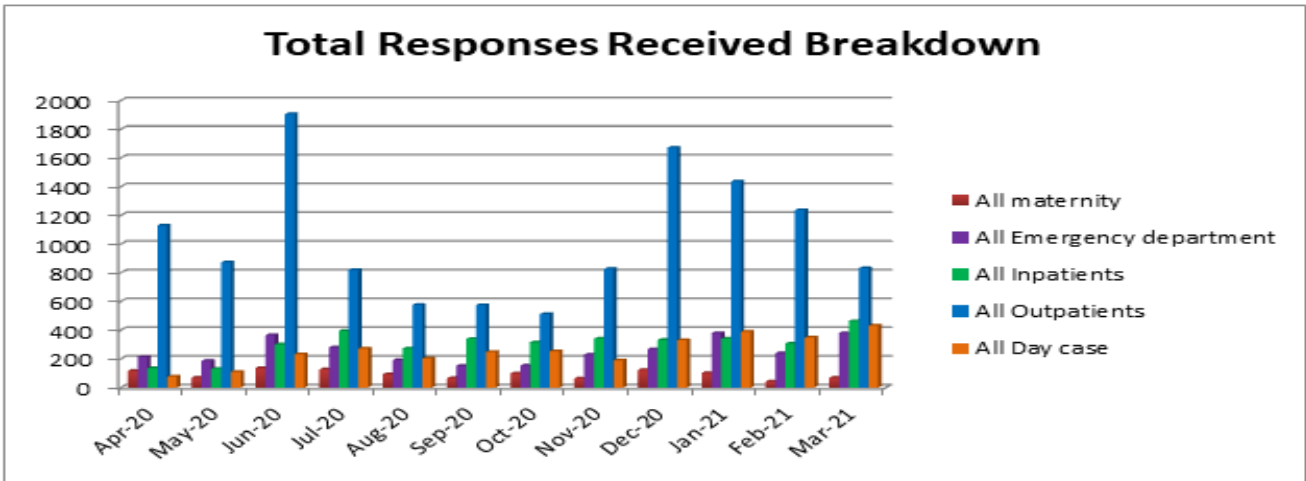
The Covid-19 pandemic has proved to be particularly challenging in relation to gathering FFT feedback. At the start of the pandemic we were required to remove the option of paper-based postcards due to IPC measures and all departments were advised to remove the postcards from circulation. The advice given by NHSE/I at the start of the pandemic was to pause the process and they removed the requirement to report nationally until January 2021. However, we took the decision to continue to gather feedback on a monthly basis and considered alternative methods of collecting the information. We introduced quick response (QR) codes on posters into over 200 clinics across the organisation and these linked specifically to the clinics where patients were attending for treatment. The responses received ranged from approximately 1,400 to 3,000 per month between April 2020 and March 2021 as shown in the graph below.

**Total FFT responses received April 2020 to March 2021**



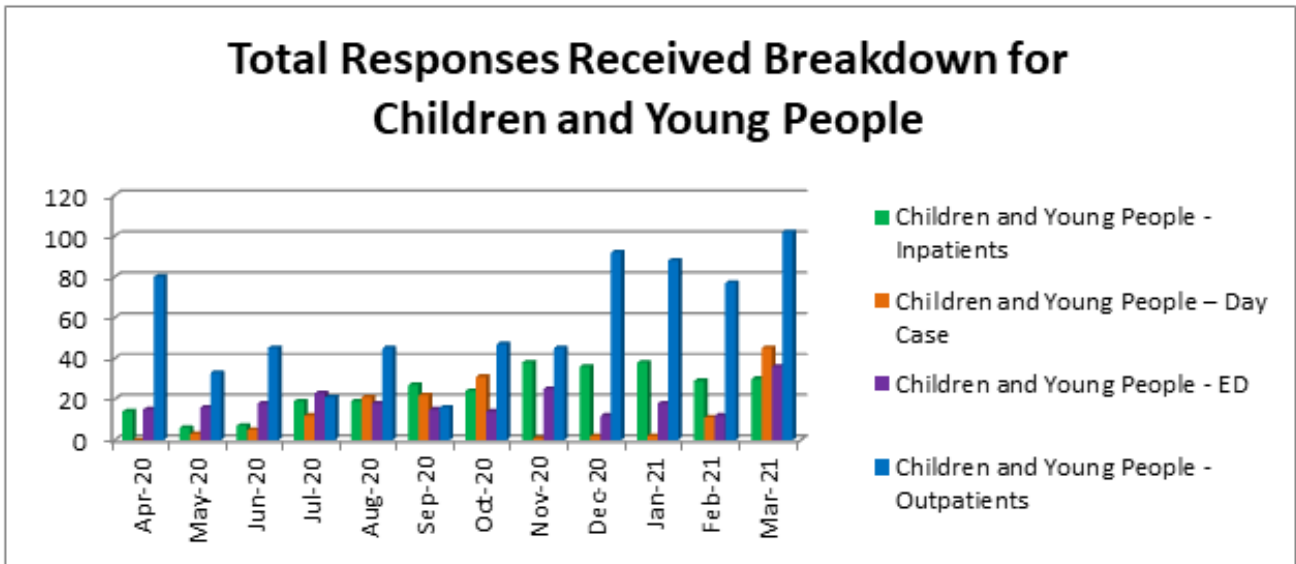
Source: FFT data

**FFT responses by areas April 2020 to March 2021**



Source: FFT data

**FFT responses for children and young people by areas April 2020 to March 2021**



Source: FFT data

Whilst there has been an overall improvement from previous years in the data gathered, in the coming year we will focus on improving the number of responses received. As described above, the Covid-19 pandemic has had a significant impact on facilitating the feedback. The Trust has an average 91% rating for satisfaction with the services provided.

**National Surveys**

During 2020-21 the national surveys were postponed due to the Covid-19 pandemic. As a result, the survey information held by the organisation remains largely the same this year as reported in the Annual Report and Quality Account for 2019-20.

The organisation was, however, given the opportunity to participate in the new mothers’ experience of care survey and the results are included within this section. It should be noted that the survey was optional and therefore should be treated with some caution in terms of benchmarking across other organisations. The 2019 cancer patient experience survey was also received and published and an overview of the results is provided in this section.

**New Mothers’ Experience of Care Survey**

The NHS maternity survey 2020 was cancelled due to the Covid-19 pandemic. Organisations were asked if they wanted to participate in the new mothers' experience of care 2020 survey as an alternative to the maternity survey. We welcomed the opportunity to participate in this survey and the results are presented below.

Picker administered the survey on behalf of only 12 acute Trusts who participated. The survey was based on a sample of mothers who gave birth in February 2020. A total of 345 new mothers from our Trust were eligible for the survey of which 78 returned a completed questionnaire, giving a response rate of 23%.

The new mothers' experience of care survey overall ratings for the following three statements in particular are:

- Treated with respect and dignity – 99%
- Had confidence and trust in staff (during labour and birth) – 99%
- Involved enough in decisions about their care (during labour and birth) – 94%

When comparing the average results received across the 12 areas surveyed we ranked best in the following areas:

- Felt concerns were taken seriously – 94%
- Offered NHS antenatal classes or courses – 82%
- Received support or advice about feeding their baby during evenings, nights or weekends – 83%
- Found partner was able to stay with them as long as they wanted – 86%
- Received help and advice from health professionals about their baby's health and progress – 94%

This is a new survey and therefore there is no comparison data from previous surveys. Consequently, this data will be the benchmark for any future new mothers' experience of care surveys in which we participate.

### **Cancer Patient Experience Survey**

The national cancer patient experience survey provides analysis of the experiences of all adult patients with a primary diagnosis of cancer, discharged from an inpatient stay or day case attendance in the months of April, May and June 2019.

A total of 1,357 patients responded to the survey from our Trust giving a response rate of 65% against a national response rate of 61%.

A total of 52 questions were used in the 2019 survey, which was comparable to the number of questions that were asked in 2018. Views from the survey about our Trust demonstrated the overall rating of care was 8.9 compared to the national average of 8.8. Our results below are above the national average:

- 83% of respondents said they were definitely involved as much as they wanted to be in decisions about their care and treatment
- 93% of respondents said they were given the name of a Clinical Nurse Specialist

- 87% of respondents said that it had been quite or very easy to contact their Clinical Nurse Specialist
- 87% of respondents said that overall they were always treated with dignity and respect
- 93% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

The Trust continues to perform well compared to peers in cancer patient experience.

## **Compliments**

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2020-21 a total of 2,311 compliments and thank you cards were received by wards, departments and through the Chief Executive's office.

## **Details of serious incidents**

Serious incidents in healthcare are adverse events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. The Trust Board holds the primary responsibility and accountability for effective serious incident management in the organisation ensuring that the Trust has the necessary systems, tools, policies and procedures (underpinned by appropriate behaviours of openness and transparency, a just culture and continuous learning and improvement) to prepare for and respond to serious incidents. Further details are contained in the Risk Management Strategy which is approved by the Board and published on the Trust's website.

The management of serious incidents is devolved to the Safety and Learning Group with reporting to the Safety and Quality Committee through quarterly serious case review reports. Executives may review and scrutinise individual incident investigations providing constructive challenge to the quality of recommendations and actions to ensure improvements to safety. They may also commission thematic reviews or external investigations as necessary. The Board receives detail of serious incident management through the Safety and Learning Group Chair's report. In addition, when an incident occurs that requires immediate notification to the Board, this is provided through an internal Trust Board briefing.

## **Patient and public involvement activities**

We are in the final year of our Patient Experience and Involvement Strategy 2018-21 and this year with the pandemic we have had to work a little differently to ensure involvement is continued with our patients and public to ensure their engagement in any major changes or service redesigns.

We have ensured inclusion by creating instant access language apps for all areas and digital BSL for our deaf community with clear masks for lip readers. Translation and interpretation services have evolved to ensure communication is key. Using our Trust website we have ensured vital pandemic information is kept up-to-date via BSL video links and likewise with languages. Our up-to-date and ever changing Covid-19 information is also published with illustrations and easy read documentation to aid our diverse communities. This work has been produced with engagement with other health providers, charities such as Deafway and communities that incorporate different faiths. The Trust's comprehensive website provides the public with instant access to information across all areas of Trust activity. We have also increased engagement on social media which has played a huge part in getting our messages across this year.

During this time some of our focus centred on our inpatients and the emotional struggles of families who were not permitted to be with their loved ones when they wanted to support them the most. We created a Multi-Faith and Spiritual Forum reaching out to the wider communities and their different faiths and focused on issues raised with our black, Asian and minority ethnic (BAME) colleagues and patients. We created a multi-faith clergy covering numerous different faiths who, after Covid-19 safety training and using our on-call system, presented themselves to any patient who required their assistance, be it end of life, communicating home via the iPads we installed in all areas or being a listening ear and emotional comfort. Our Chaplaincy have played an important role providing pastoral support for all staff, patients and visitors, including helpline numbers, email contact and platforms for our BAME communities. This way we could also share news including videos advising the facts around vaccination in their own languages. Again, social media helped enormously to channel this information out.

We also enrolled to the Hidden Disabilities campaign thus ensuring our patients that fell into this category could collect a lanyard or facemask identification exemption badge at point of entry to our sites.

Patient involvement in our organisation has never been as important as during the pandemic. We continue to focus on inclusive communication, mental health, encouragement, support and involvement to ensure patients and the public have a voice and express what matters most to them. With over 25 patient forums now in place and partnership working with other NHS health providers, charities, support groups, our public governors and Healthwatch, we will continue to provide an opportunity for patients, carers and visitors to really engage.

## **Volunteers**

We are so very proud of the contribution made by our 650-plus volunteers who provide invaluable support to many areas across our two hospital sites. A number of our volunteers have not been able to come on site during the year due to shielding. We have fully risk-assessed all our volunteers who were able to continue supporting us during the pandemic to ensure their safety.

Those volunteers who have continued to support the Trust have contributed in a number of ways, especially in our Covid-19 mass vaccination hub. In relation to Covid-19 vaccination support alone, our volunteers have given us over 1,500 hours of volunteering time during the last four months of the year.

We have invested time this year to audit our volunteer records and work to ensure we have up-to-date information on our electronic staff record system. This source of information is invaluable to the Trust to analyse the demographic of our volunteers and review numbers we have in the various posts across the Trust. Having this information readily available has also enabled us to mobilise our volunteers at short notice with a 'call to action' around Covid-19 support.

To support the pandemic response we created a number of new roles, including:

- Volunteer Marshalls – our Marshalls have played such a fundamental part in the smooth running of the vaccination hub. We have over 15 volunteers covering 19 different shifts over seven days. They play an important role in keeping our staff and patients safe, cleaning, triaging and directing patients. Excellent feedback has been received from patients and staff involved in the vaccination hub.
- Our volunteers have supported with mask distribution at entrances to our hospitals.



- Our volunteers have participated in the 'Connected Hearts' scheme (see illustration on the left). The scheme was put in place to connect patients and relatives who cannot be with their loved ones during the pandemic, both receiving a knitted heart to keep with them at all times.
- Our volunteers have provided Chaplaincy support for patients unable to receive visitors.
- Additional volunteers have been deployed on our Information Desk to provide increased support and information to our patients.
- Our 'Pets as Therapy' dogs have continued to come on site to visit patients.

We also ensured our volunteers were vaccinated as soon as we were able. Here is Doreen McKeown receiving her vaccination on 8 December 2020, our first day of providing vaccinations.



## Engagement

We worked hard to keep in touch with all our volunteers over the last 12 months. We have been in touch via telephone and email to check in where we can, particularly for those we know live alone or are perhaps a little more vulnerable. We also sent regular updates along with the Chief Executive's communication brief to ensure our volunteers were able to keep in touch with the latest news. Most volunteers have expressed a wish to return to site working as soon as Government guidelines allow and we are working on a recovery plan to support this.

We have also contacted the volunteers who were due to receive their Long Service Award and delivered those to their homes if they preferred to receive them this way.

## Recruitment

At the present time we have around 40 volunteers ready to start with us in 2021 and our recruitment plans continue at pace. We have been working with our nursing teams to identify new roles which will be helpful to our wards at this busy time. Some new tasks have been identified as follows:

- Distraction therapy and dementia teams
- Discharge support
- Paediatric audiology and clinic support
- Extending the role of ward support volunteers

We are also exploring:

- Virtual volunteering to enable more volunteers to work safely or to continue volunteering whilst shielding.
- Introducing new methods of recruitment. Creating links to careers events and open days through video and digital platforms such as Zoom. We recently recorded a video for the University of Central Lancashire to promote the benefits of volunteering for younger people.
- Working with partners and the Local Volunteer Partnership to broaden the ways we advertise our voluntary roles.



We have been sharing good practice through video meetings with other local Trusts across the country through the National Association of Voluntary Services Managers (NAVSM) network, NHSE, Lancashire Volunteer Partnership, Job Centre Plus and the website Future NHS Collaboration. This has enabled us to discuss service improvements and new volunteer roles and to reach out to more diverse communities.

As part of our Equality and Diversity strategy, we will be directly targeting areas where we feel we are under-represented and looking at new ways to share details of the roles we have available to people of all ages and backgrounds. We have invested in our social media channels and have activity on Facebook, Instagram, LinkedIn and Twitter to share details of all our volunteer roles.

### **Priorities for 2021-22**

Our Volunteer strategy forms part of our Trust Workforce and Organisational Development Strategy 2021-22. Some of our key areas of focus over the next 12 months are:

- Develop and deliver a Volunteer Service Recovery Plan to return our volunteers to the roles they love as well as continuing to attract and recruit new volunteers from all backgrounds and communities.
- Launch a Volunteer Handbook and monthly newsletters.
- Continue to cleanse and update records and investigate new methods of recording volunteer movement and attendance, including rostering so we can provide better visibility of our volunteer demand, contribution and the impact our volunteers continue to make.
- Develop the profile of volunteers across the Trust which will include the development of a new intranet site with information for our managers. Update our existing external internet site with emphasis on the promotion of volunteer roles. We want to reach out to a more diverse population, making it easier and simpler to engage with us and find more opportunities.
- Continue engagement with staff around new roles such as support for winter pressures. Extend the roles on wards to include more dining companions and dementia volunteers. We will continue to increase the number of volunteers in our Emergency Department to provide support to clinical staff and housekeepers.
- Increase the positive celebration of volunteering through case studies, awards, tweets, posters and communications for an immersive and uplifting culture of volunteering.
- Develop a volunteer action plan as a result of Big Conversation feedback. Conduct a bespoke volunteer engagement survey and implement actions as a result.

### **Stakeholder relations**

During the Covid-19 pandemic, stakeholder relations have been even more important than in previous years and the Trust has engaged proactively in working collaboratively with an extensive range of stakeholders to improve patient care. These are too numerous to outline in full detail so examples are outlined below:

#### **Command and Control Cell Structures**

During the Covid-19 pandemic the NHS has functioned in a command and control structure which has seen the establishment of a number of 'cell' structures at an ICS level, including a hospital and out-of-hospital cell. The Executive team and senior clinical leaders have engaged extensively in the cell structures with partners to ensure that excellent care has been provided to our local population. This work included the introduction of a formal request for mutual aid and our healthcare systems have benefited significantly from the ability to request mutual aid from neighbouring organisations.

This has ensured the continued supply of workforce, equipment (including PPE) and critical services such as critical care beds and diagnostics.

### **New structures within the ICS**

The development of new structures at an ICS level has supported stakeholder relations and the Trust has engaged proactively in the new Committees and Programme Boards, including the Provider Collaborative Board, which has been established to support collaborative working between provider organisations. This collaborative approach has enabled us to continue to focus on the delivery of significant improvements in our priority programmes of work, including stroke and cancer as well as the establishment of new transformational forums (such as the Elective Care Recovery Group, which is chaired by our Director of Service Development) in response to the increased demands following the pandemic. The ICS People Board is chaired by our Chief Executive and attended by our Strategy, Workforce and Education Director.

### **Stakeholder relations at an ICP level**

The Trust has also been instrumental in contributing to the design of collaborative working at an ICP level. Working with system partners a new System Delivery Board and governance structure has been established with clear processes to align our planning framework, clinical priorities, transformation programmes and continuous improvement programmes. Working together has enabled us to remove duplication and waste from our system and to deliver improved care through integrated working. This work has also ensured the adoption of integrated functions at an ICP level including performance and business intelligence, discharge and system flow, continuous improvement and planning. Our senior leaders are involved in the ICP Senior Leadership Team, ICP Board, ICP System Delivery Boards and the ICP Committees, with both managerial and clinical involvement. We have taken a lead on some of the functional developments on behalf of the ICP, such as workforce and organisational development, performance and digital, continuous improvement and discharge. Full details of the achievements of the ICP over this year are contained in a separate section of the annual report.

### **National networks**

The Executive team members have joined the relevant professional networks throughout the year to ensure partnership working at a professional level. These include the Medical Directors' network, the Chief Nurses' network, the Chief Operating Officers' network, the Human Resources Directors' network, the Finance Directors' network, the Improvement Directors' network and the Communications Directors' network. This has enabled shared learning nationally to adopt best practice for our local population and included shared learning with the wider networks from innovation and best practice adopted within our Trust.

### **Clinical education, research and innovation**

The Trust works in partnership with the University of Lancaster and the Lancashire and South Cumbria NHS Foundation Trust to deliver the NIHR Clinical Research Facility, delivering an ambitious and highly successful research programme. There is also significant partnership with the University of Central Lancashire including joint and honorary appointments at professorial level.

The Trust continues to have positive stakeholder relationships with Manchester Medical School, other local Academic Institutions and the Innovation Agency and is leading work at an ICS level on training Nursing Associates to Registered Nurse level, on behalf of the system involving all of the local Trusts.

There continues to be a priority focus on innovation and the Trust is benefiting from close working relations with the University of Central Lancashire to develop our innovation pathway, linking with

small and medium-sized enterprises. Research collaborations with pharmaceutical companies and industry collaborations and trials continue to be a high priority for the organisation which has included many successes in the field of Covid-19 research participation.

### **Clinical professional forum and Ethics Committee**

During the pandemic, a clinical professional forum has been established connecting local clinical leaders from a range of stakeholder organisations to ensure clinical priorities are identified and integrated pathways of care are developed. The Ethics Committee has ensured a priority focus on clinical decision-making and compliance with national guidance, especially in relation to end of life decisions.

### **Continuous improvement**

Our Continuous Improvement team has launched two new academies – the Lancashire and South Cumbria Flow Coaching Academy and the Microsystem Coaching Academy – in partnership with stakeholders in improvement networks. The Flow Coaching Academy programme, which is a nationally funded Health Foundation programme, has enabled the Trust to build stakeholder relations with 12 organisations who form the national Flow Coaching Academy network. This has facilitated shared learning between organisations and supported the delivery of improvements in care for our local population. This work has also included building excellent stakeholder relations with local partners as a number of the Big Rooms (for example frailty, colorectal cancer, inflammatory bowel disease and discharge) require many system partners to work together and during the year a number of steering groups and operational groups have been established with representatives from across our local partnerships to work together to enable integration of pathways of care.

### **Anchor Institutions**

As an anchor institution the Trust is rooted in its community. We aim to positively contribute to our local area beyond providing healthcare. Anchor institutions aim to work with partners and their community to increase diversity, reduce inequality, improve access to work, purchase more locally and reduce their environmental impact. We will choose to invest in and work with others locally and responsibly to positively impact on the wider factors that make us healthy. Our supporting social value framework will outline our ambitions in the short, medium and longer term.

### **Procurement and Pathology Collaborations**

We have made some great strides this year with respect to working with our partners through the continued development of the Procurement Collaboration, the Pathology Collaboration and shared medical staff bank.

The Trust has been working with Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust and University Hospitals Morecambe Bay NHS Foundation Trust to design a single pathology service which is high quality, clinically effective and cost-effective. The programme investment objectives are:

- Clinical and financial sustainability
- Investment in technology to produce a more effective, efficient and resilient service for the future
- Investment in research and development and quality standards
- Investment in workforce and education
- Investment in estates and infrastructure

A hub and spoke framework has been chosen with the pathology hub processing all non-urgent tests and essential service laboratories remaining on each hospital site to turn around tests needed for emergency and urgent care.

A robust and transparent process was put in place for choosing a location for a pathology hub. A purpose-built environment will bring together highly qualified clinical and scientific staff to drive the adoption of new technology, maximise future investment and increase the ability to continue providing a high quality service. The outline business case has been developed and is going through an endorsement process through all four Trust Boards prior to submission to NHSE/I. Staff, partners and stakeholders will continue to be fully engaged, informed and involved as the project moves forward.

### **Cancer Alliance**

The Lancashire and South Cumbria Cancer Alliance includes representation from hospital Trusts, CCGs, Specialised Commissioning, Public Health and National Cancer Charities across Lancashire and South Cumbria. The Cancer Alliance took a system leadership role across the ICS in response to the pandemic. Both clinical and operational oversight groups were rapidly set up to implement all appropriate guidance, develop bespoke reporting tools and ensure consistency across all localities. A Surgical Prioritisation Group was developed to maintain oversight of the cancer waiting list and ensure equity of access.

A successful capital bid secured over £6m of investment to endoscopy services which has allowed rapid expansion of services to support recovery of waiting lists. Whilst current backlogs remain significantly higher than before the pandemic, the proactive work of the Alliance means that plans for restoration include specific, measurable and achievable targets for 2021-22.

In response to the national trend of falling cancer referrals during the Covid-19 pandemic, the Cancer Alliance encouraged local people not to ignore the various cancer symptoms. Media releases, social media toolkits and videos all carried the message that it was safe to come in for tests if recommended after an initial virtual consultation. Campaigns were aligned with various national awareness dates and a number of targeted messages signposted to support people who were shielding whilst undergoing cancer treatment.

### **Digital**

Clinical and digital experts across the ICS collaborated to develop a Clinical Systems Roadmap which will enable speciality clinical system consolidation, a shared Electronic Patient Record and a data orchestration environment. Together these will reduce ICS digital complexity, enable collaboration, support cross ICS workflow and accelerate innovation.

In March 2021 Lancashire Teaching Hospitals NHS Foundation Trust was the first to 'go live' with a Maternity Specialist System, the first system on this roadmap, enabling mothers to see their own records and supporting cross organisational care. Learnings will be shared as each Trust prepares for their launch.

Lancashire and South Cumbria partners offered iPads to care homes in the region to improve access to remote consultations and healthcare services, and to help residents maintain contact with loved ones. The devices went to homes that were at least partially NHS or local authority-funded, with priority given to those that lacked good digital infrastructure. NHSX funded the project, which was co-ordinated by the ICS Digital team and Regulated Care sub-cell. These iPads further support the Digital Health programme, a collaboration with Tameside Hospital NHS Foundation Trust to

provide care homes with emergency care advice through video, preventing ambulance conveyance to hospital and reducing GP contacts.

Advice and Guidance (A&G), the locally developed digital communications tool, has been rolled out to all acute providers in Lancashire and South Cumbria. This gives GPs rapid access to advice from specialists in secondary care and has been used over 15,000 times between April 2020 and January 2021. Early feedback suggests a potential reduction in the number of patient journeys and in waiting times for certain appointments. More than 97% of GPs say the system is easy to use and rated the information they obtained as either useful or really useful.

A Data Science Forum was initiated in early 2020-21 to enable clinicians and others to better understand the value of their data and has initiated several collaborations with academia.

Working with Central Lancashire and Blackpool CCGs the Trust now has access to a virtual ward capable of supporting patients at home with pulse oximetry and providing early warning of deterioration. This enables both step-up and step-down of vulnerable patients. Funding for this service has been provided by NHSE.

The Digital and Health Informatics Technical Services team has established partnerships with Blackburn with Darwen Borough Council and the University of Central Lancashire to enable cost effective Data Centre Service provision. Over time, the Trust's technology will migrate to these organisations' purpose-built datacentres removing the need to invest in expensive capital replacement programmes within the hospital.

### **Communications**

Consistent messaging has been essential throughout the pandemic and to this end the Communications team has been involved in activity at a national, regional ICS and local ICP level. The Trust has taken part in numerous television, radio and press interviews as well as a major documentary about clinical care during the pandemic. Our social media activity has substantially increased and the Chair and Chief Executive have both produced videos for the public as well as producing a regular stakeholder briefing document.

### **Disabled NHS Directors' Network**

Kate Smyth, Non-Executive Director, co-founded the Disabled Network in October 2020 which is open to Executive and Non-Executive Directors with disabilities on the Boards of NHS Trusts, CCGs, ICSs, NHS Arms-Length Bodies and Community Interest Companies and Public Sector Mutuals providing NHS services. Kate was also elected as co-Chair of the Network alongside Peter Reading, Chief Executive of North Lincolnshire and Goole NHS Foundation Trust with effect from 15 March 2021. The Network set out to raise the standards of disability across all NHS Boards, raise awareness of the benefits of diversity in leadership positions, provide a supportive environment for members to share issues and lobby for improved selection processes for Non-Executives and Lay Members to ensure more accurate representation of the communities that Boards represent – especially in relation to disabled people. Patient and governors are key stakeholders and are covered in separate sections within the report.

### **Our Health Our Care (OHOC) programme update**

Over the past year we continued to work with the CCG on the OHOC programme which set out to transform health services within Chorley and South Ribble. The original plan was to work towards a public consultation taking place this summer.

However, the timetable was affected by the pandemic and it has now been agreed that the ICS will focus on providing improved hospital facilities through the Government's New Hospitals Programme (NHP). The extensive clinically-driven work undertaken as part of the OHOC programme will be used to inform the NHP.

### **New Hospitals Programme**

We are working together with the Government to build new, centrally-funded hospital facilities locally. This will result in brand new, world-class facilities for local people as part of the Government's plan to build 40 new hospitals by 2030.

The programme will see the Trust and University Hospitals of Morecambe Bay NHS Foundation Trust work with other Trusts and health organisations across Lancashire and South Cumbria to develop ideas and proposals.

The opportunity that this programme presents is significant; a once-in-a-generation chance to address long-standing problems with existing buildings and create an environment that staff can be proud to work in and where we can provide the best quality care and facilities for all our patients.

The Government funding will be used to refurbish and build new, world-class hospital facilities to reduce health inequalities and help local people live longer, healthier lives.

We are currently working with our clinicians and patients to agree the details of why change is needed and what possible options we might be able to propose for new hospital facilities and refurbishment.

We will use the expertise of clinicians, backed by input from staff at all levels and from all teams – clinical and non-clinical – to develop options aimed at transforming patient treatment and care. We will also seek the views of patients, staff and local communities. As ideas begin to emerge, these will be built into proposals which will be the subject of public consultation. This is the opportunity for our stakeholders to have a say and work together in planning a happier, healthier future for our local communities.

## REMUNERATION REPORT

The NHS Foundation Trust annual reporting manual requires NHS Foundation Trusts to prepare a remuneration report in their annual report and accounts. The reporting manual and NHSI requires that this remuneration report complies with:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422 (2) and (3) do not apply to NHS Foundation Trusts
- Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium- sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) (“the Regulations”)
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHS Improvement in the reporting manual
- Elements of the NHS Foundation Trust Code of Governance.

### REMUNERATION COMMITTEES

There are two Committees which deal with the appointment, remuneration and other terms of employment of our Directors. The Nominations Committee, as a Committee of the Council of Governors, is concerned with the Chairman and other Non-Executive Directors. The Appointments, Remuneration and Terms of Employment (ARTE) Committee, as a Committee of the Board, deals with the pay and conditions of senior Executives.

#### Nominations Committee

The Committee comprises the Chairman (except where there is a conflict of interest in relation to the Chairman’s role, when the Vice-Chairman, Senior Independent Director or other nominated Non-Executive Director will attend), three elected governors and one appointed governor. The elected governors have a nominated deputy who attends in their place if they are unable to attend themselves, as does the appointed governor representative. The Company Secretary and the Strategy, Workforce and Education Director provide support to the Committee as appropriate, and the Chief Executive is invited to attend all meetings.

The Council of Governors appoint the members of the Nominations Committee for a two-year period and elections are held to replace any Committee member who ceases to be a governor following the governor elections or retirement of a governor in-year.

The composition of the membership during 2020-21 is detailed in the attendance summary below.

#### Nominations Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Ebrahim Adia, Chairman	3	3	100%
Rebecca Allcock, Staff Governor	3	3	100%
Alistair Bradley, Appointed Governor	3	2	66%
Steve Heywood, Public Governor	3	3	100%
Mike Simpson, Public Governor	3	2	66%
<b>Substitutes</b>			
Pav Akhtar, Public Governor	0	0	-
Eddie Pope, Appointed Governor	0	0	-
Alison Slater, Staff Governor	0	0	-

*A = maximum number of meetings the member could have attended*

*B = number of meetings the member actually attended*

## Work of the Committee

During 2020-21, the Committee met on three occasions which enabled it to:

- Receive, consider and recommend the re-appointment of a Non-Executive Director
- Receive, consider and recommend Non-Executive Directors' remuneration in line with national guidance
- Receive the outcome of the Chairman's and Non-Executive Directors' annual appraisals
- Receive the Non-Executive Directors' 360 degree survey results undertaken by the Executive Directors

At the Nominations Committee meeting on 21 July 2020 consideration was given to the re-appointment of Geoff Rossington as Non-Executive Director for a further three year term, which was formally endorsed by the Council of Governors on 30 July 2020.

There have been no new Non-Executive Directors appointed this year.

## Appointments, Remuneration and Terms of Employment Committee

All Non-Executive Directors are members of the Committee. The Chief Executive and Strategy, Workforce and Education Director are normally in attendance at meetings of the Committee, except when their positions are being discussed. The Strategy, Workforce and Education Director also attends meetings as appropriate to provide advice and expertise and the Committee has the option to seek further professional advice as required. During 2020-21 the Committee did not use any independent advice or services from any Director of the Trust to materially assist in consideration of any matters.

## Appointments, Remuneration and Terms of Employment Committee attendance summary



Name of Committee member	A	B	Percentage of meetings attended (%)
Ebrahim Adia	4	4	100%
Paul O'Neill	4	2	50%
Ann Pennell	4	3	75%
Geoff Rossington	4	3	75%
Kate Smyth	4	3	75%
Tim Watkinson	4	4	100%
Jim Whitaker	4	4	100%
Tricia Whiteside	4	3	75%

*A = maximum number of meetings the member could have attended*  
*B = number of meetings the member actually attended*

### Work of the Committee

During 2020-21, the Committee met on four occasions which enabled it to:

- Receive, consider and approve a proposal for the appointment of a Director of Service Development (fixed term)
- Receive and consider options for an Executive Management team restructure
- Receive the annual report on Executive Directors' performance reviews
- Receive, consider and approve the process for appointment of the Chief Executive following confirmation of retirement at the end of December 2021
- Receive and consider remuneration for the Chief Executive
- Undertake the selection of a Recruitment Search Agency for replacement of the Chief Executive

As part of its cycle of business every three years the Committee undertakes a benchmarking exercise to review the baseline salaries of senior managers for which it is responsible. A review of salaries also takes place when a post becomes vacant in order to ensure that when the post is being advertised, the salary level is competitive within the current market.

During 2020-21 the Committee approved two Executive Director appointments – a substantive Chief Information Officer across the ICP and a Director of Service Development on a fixed term basis.

### ANNUAL STATEMENT ON REMUNERATION

At Lancashire Teaching Hospitals, we understand that our Executive remuneration policy is key to attracting and retaining talented individuals to deliver our business plan, whilst at the same time recognising the constraints that public sector austerity measures bring.

The Trust policy for the remuneration of very senior managers (VSM) identifies that the Trust will apply a pay award to VSM posts in line with the national pay award applied to staff on Agenda for Change (AFC) terms and conditions. This has been applied annually since the policy was agreed. The annual uplift of 1.03% was applied again in year.

Save for the application of the national pay award to the VSM posts in line with the national pay award for staff on AFC terms and conditions, there have been no other changes to remuneration of senior Executives.

A handwritten signature in black ink, appearing to read 'Ebrahim Adia', with a stylized flourish at the end.

**Professor Ebrahim Adia**  
**Chairman, Appointments, Remuneration and Terms of Employment Committee**

## SENIOR MANAGERS' REMUNERATION POLICY

As detailed in the Chairman's statement above, the remuneration policy is designed to attract and retain talented individuals to deliver the Trust's objectives at the most senior level, with a recognition that the policy has to take account of the pressures on public sector finances.

This report outlines the approach adopted by the ARTE Committee when setting the remuneration of the Executive Directors and the other Executives who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting this criterion by the Committee and are collectively referred to as the senior Executives within this report:

### Executive Directors

- Chief Executive
- Finance Director/Deputy Chief Executive
- Nursing, Midwifery and AHP Director
- Medical Director
- Chief Operating Officer
- Strategy, Workforce and Education Director

### Other Executives

- Director of Continuous Improvement
- Chief Information Officer for the ICP
- Director of Service Development (fixed term post)

Details on membership of the ARTE Committee and individual attendance can be found on page 59 of this report.

### Our policy on Executive pay

Our policy on the remuneration of senior Executives is set out in a policy document approved by the ARTE Committee. When setting levels of remuneration, the Committee takes into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. In addition the Committee takes into account the need to ensure good use of public funds and delivering value for money. The maximum of any component of senior managers' remuneration is determined by the ARTE Committee.

Each year, the Chief Executive undertakes appraisals for each of the senior Executives, and the Chairman undertakes the Chief Executive's appraisal. The results of these appraisals are presented to the Committee and they are used to inform the Committee's discussions. The Committee considers matters holistically when considering Executive remuneration, such as the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. A revised process for senior Executive appraisal was implemented in 2019-20.

The remuneration package for senior Executives comprises:

**Salary:** As determined by the ARTE Committee and reviewed annually

Senior Executives do not receive any additional benefits that are not provided to staff as part of the standard AFC contract arrangements. No senior Executives have tailored arrangements outside of those described above.

The remuneration package for Non-Executive Directors comprises:

**Salary:** As determined by the Council of Governors and reviewed in line with the national guidance on remuneration of Non-Executive Directors. Current rates are:

- £12,791.00 p.a. for Non-Executive Directors
- £1,535.00 p.a. as additional responsibility payment payable to the Audit Committee Chair and Vice-Chair
- £50,500 p.a. for the Chairman

**Additional benefits:**

- Gym membership discounts with NHS identification
- Access to NHS staff benefits offered by retailers
- Onsite therapies at discounted rates
- Salary sacrifice schemes

There is no provision for bonuses to be paid to any senior manager within the Trust.

All senior Executives are employed on contracts with a six-month notice period. In the event that the contract is terminated without the Executive receiving full notice, compensation is limited to the payment of salary for the contractual notice period. No additional provision is made within the contracts for compensation for early termination and there is no provision for any additional benefit, over and above standard NHS pension arrangements, in the event of early retirement. In line with all other employees, senior Executives may have access to mutually-agreed resignation schemes (MARS) where these have been authorised.

Our Non-Executive Directors are requested to provide three months' notice in the event that they wish to resign before their term of office comes to an end. They are not entitled to any compensation for early termination.

During the year no Executive Director, Non-Executive Director or Very Senior Manager received a payment for loss of office.

## ANNUAL REPORT ON REMUNERATION

Details of the total number of Board members in post during 2020-21 are included on pages 26 to 30. Details of our Council of Governors are included on page 117, together with information on expenses paid to them in 2020-21.

### Business expenses

As with all staff, we reimburse the business expenses of Non-Executive Directors and senior Executives that are necessarily incurred during the course of their employment, including sundry expenses such as car parking and transport costs such as rail fares.

The expenses paid to Directors during the year were:

	<b>2019-20</b>	<b>2020-21</b>
Total number of Directors in office as at 31 March:	16	19
Number of Directors receiving expenses:	9	4
Aggregate sum of expenses paid to Directors (£00s):	£84	£258

### **Salary and pension contributions of all Directors and senior Executives**

Information on the salary and pension contributions of all Directors and senior Executives is provided in the tables on the following pages. This information in these tables, and in the remainder of this remuneration report, has been subject to audit by KPMG LLP. Additional information is available in the notes to the accounts.

Each of the Chief Executive's, the Finance Director's and the Medical Director's salary is above £150,000 per annum but within or below the national average, when benchmarking against other Trusts. In order to ensure the level of remuneration paid by the Trust is reasonable, on an annual basis we carry out a rigorous process of benchmarking against all other Trusts (including Trusts with comparable income, with comparable headcount, by Trust type and by region). We also take into account the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. Furthermore, we consider the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. Taking such factors into account, the ARTE Committee considers the remuneration for the Chief Executive, the Finance Director and the Medical Director to be reasonable.

## Remuneration disclosures: Senior Executives

Name	Title	2019-20				2020-21			
		Salary and Fees (bands of £5,000)	Taxable Benefits (to the nearest £100)	All pension related benefits (bands of £2,500)	Total of all items (bands of £5,000)	Salary and Fees (bands of £5,000)	Taxable Benefits (to the nearest £100)	All pension related benefits (bands of £2,500)	Total of all items (bands of £5,000)
		£'000	£	£'000	£'000	£'000	£	£'000	£'000
Karen Partington	Chief Executive	180-185	200	2.5-5.0	185-190	180-185	0	10.0-12.5	195-200
Faith Button	Chief Operating Officer	130-135	0	0	130-135	135-140	0	37.5-40.0	170-175
Jonathan Wood	Finance Director / Deputy Chief Executive	110-115	0	110.0-112.5	220-225	165-170	0	140-142.5	305-310
Geraldine Skailes	Medical Director	170-175	5,400	0	175-180	170-175	0	42.5-45.0	210-215
Sarah Cullen	Nursing, Midwifery and AHP Director	120-125	1,900	0	120-125	130-135	0	62.5-65.0	190-195
Karen Swindley	Strategy, Workforce and Education Director	130-135	0	82.5-85.0	215-220	130-135	0	27.5-30.0	160-165
Ailsa Brotherton	Director of Continuous Improvement	105-110	100	17.5-20.0	125-130	105-110	0	22.5-25.0	130-135
Stephen Dobson	Chief Information Officer	0	0	0	0	105-110	0	0	105-110
Gary Doherty	Director of Service Development (from 1 December 2020)	0	0	0	0	55-60	0	0	55-60
Ebrahim Adia	Chairman	10-15	100	0	10-15	40-45	200	0	40-45

Tim Watkinson	Vice Chairman	15-20	0	0	15-20	15-20	0	0	15-20
Ann Pennell	Non-Executive Director	10-15	100	0	10-15	10-15	0	0	10-15
James Whitaker	Non-Executive Director	10-15	0	0	10-15	10-15	0	0	10-15
Geoff Rossington	Non-Executive Director	10-15	400	0	10-15	10-15	0	0	10-15
Kate Smyth	Non-Executive Director	10-15	0	0	10-15	10-15	0	0	10-15
Paul O'Neill	Non-Executive Director	10-15	200	0	10-15	10-15	0	0	10-15
Tricia Whiteside	Non-Executive Director	5-10	0	0	5-10	10-15	0	0	10-15

**Notes:**

*All members have been in post for the whole year unless otherwise stated  
Non-Executive Directors do not receive any pensionable remuneration*

## Pension benefits

Non-Executive Director remuneration is not pensionable and therefore it is only the senior Executives in the table above who are members of the pension scheme at the balance sheet date who are included in the table below.

	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value (CETV)	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Karen Partington Chief Executive	0.0-2.5	5.0-7.5	90-95	275-280	2,103	67	2,232	0
Jonathan Wood <sup>(1)</sup> Finance Director / Deputy Chief Executive	7.5-10.0	12.5-15.0	65-70	145-150	1,064	132	1,238	0
Geraldine Skailles Medical Director	2.5-5.0	0	80-85	200-205	1,626	61	1,739	0
Sarah Cullen <sup>(2)</sup> Nursing, Midwifery and AHP Director	2.5-5.0	2.5-5.0	30-35	55-60	366	35	426	0
Ailsa Brotherton Director of Continuous Improvement	0.0-2.5	0	55-60	0	740	26	793	0
Karen Swindley Strategy, Workforce and Education Director	0.0-2.5	0	45-50	100-105	865	31	930	0
Faith Button <sup>(3)</sup> Chief Operating Officer	2.5-5.0	0.0-2.5	35-40	80-85	570	29	628	0
Stephen Dobson Chief Information Officer	20.0-22.5	0	20-25	0	0	283	283	0



## Notes

- (1) Jonathan Wood opted out of the NHS Pension Scheme on the 31 December 2019 and then opted back into the scheme on 1 April 2020
- (2) Stephen Dobson joined the Board in April 2020 and his accrued pension benefits at that point are not available, therefore the increases in benefits cannot be calculated

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

The “cash equivalent transfer value” (“CETV”) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which this disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

The “real increase in CETV” reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Details of off payroll arrangements for any senior managers are included within the Staff Report. There are no current off payroll arrangements for Board level posts.

We are also required to disclose the relationship between the remuneration of the highest-paid Director in our organisation and the median remuneration of our workforce. The banded remuneration of the highest paid Director in the financial year 2020-21 was £180,000 – £185,000 (2019-20 was £180,000 – £185,000). This was 6.1 times (2019-20 – 6.4 times) the median remuneration of the workforce, which was £30,269 (2019-20 £28,965). In 2020-21, no employees (2019-20, one employee) received remuneration in excess of the highest-paid Director. In 2020-21 remuneration ranged from £852 to £184,862 (2019-20 the range was £2,642 to £189,559). Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

This Remuneration Report is signed on behalf of the Board of Directors by:

A handwritten signature in black ink, appearing to read 'Karen Partington', written in a cursive style.

**Karen Partington**  
**Chief Executive**

10 June 2021

# STAFF REPORT

## Our people

As at 31 March 2021, we employed 9,007 substantive members of staff. This number is broken down as follows:

Staff Group	Headcount
Additional Clinical Services	2,098
Additional Professional, Scientific and Technical	283
Administrative and Clerical ( <i>including Non-Executive Directors</i> )	1,722
Allied Health Professionals	527
Estates and Ancillary	889
Healthcare Scientists	266
Medical and Dental ( <i>excluding Lead Employer Doctors</i> )	750
Nursing and Midwifery Registered	2,472
<b>Total</b>	<b>9,007</b>

A comparison of our workforce over the past three financial years is provided in the table below, and our staff turnover can be accessed via the information published by NHS Digital using the following link: [NHS workforce statistics - NHS Digital](#).

	2018/19 HC	% of Total HC	2019-20 HC	% of Total HC	2020-21 HC	% of Total HC
<b>Age (yrs)</b>						
Under 17	2	0.02%	26	0.31%	61	0.68%
17 – 21	158	1.95%	131	1.54%	131	1.45%
Over 21	7,943	98.03%	8,322	98.15%	8,815	97.87%
<b>Ethnicity</b>						
White	6,660	82.19%	6,859	80.89%	7,184	79.76%
Mixed	105	1.30%	114	1.34%	138	1.53%
Asian or Asian British	1,002	12.37%	1,140	13.44%	1,282	14.23%
Black or Black British	120	1.48%	135	1.59%	167	1.85%
Other	134	1.65%	145	1.71%	162	1.80%
Not Stated	82	1.01%	86	1.01%	74	0.82%
<b>Gender</b>						
Male	1,757	21.68%	1,881	22.18%	2,077	23.06%
Female	6,346	78.32%	6,598	77.82%	6,930	76.94%
<b>Recorded Disability</b>	242	2.99%	271	3.20%	342	3.80%

As at 31 March 2021, the gender split of our Board of Directors (including Non-Executive Directors) was six male and eight female. The gender split of our senior Executives, as defined by the Appointments, Remuneration and Terms of Employment Committee, was three male and six female.

As an organisation we are required to publish our Gender Pay Gap report annually – here is the link to our Trust website where the Gender Pay Gap report is housed:

<https://www.lancsteachinghospitals.nhs.uk/equality-and-diversity>.

## Attendance management

Sickness absence data is reported on a calendar year basis (January to December 2020):

<b>Figures Converted by Department of Health to Best Estimates of Required Data Items:</b>	
Average FTE 2020	7,507
Adjusted FTE days lost ( <i>to Cabinet Office definitions</i> ) measure)	92,068
Average sick days per FTE	12.3
<b>Statistics published by NHS Digital from ESR Data Warehouse:</b>	
FTE days available	2,772,736
FTE days recorded sickness absence	151,049

**Source:** NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse

**Period covered:** 01 January 2020 to 31 December 2020

**FTE definition:** Full-time equivalent

The 12-month average sickness absence rate for the period 1 January to 31 December 2020 was 5.48%, compared to 5.50% in the previous year. Although this is only a marginal improvement it is positive that we have been able to maintain absence at these levels, given to context of the Covid-19 pandemic. Other forms of absence related to Covid-19 have, however, compounded the staffing gaps with the impact of shielding, isolation and quarantine equating to an annual loss of 3.05% FTE. Staff testing has been a vital tool in IPC and minimising unnecessary absence, with polymerase chain reaction (PCR) and lateral flow testing processes established in year; and Loop-Mediated Isothermal Amplification (LAMP) testing due to be implemented in spring 2021.

There has been an increase in the proportion of sickness absence attributable to mental health with the Trust's highest ever rate (1.64%) being observed in May 2020. This is not unexpected as people have been faced with sudden changes enforced on their working and home lives, amidst uncertainty of the pandemic's longevity and concern for their own or loved ones' health.

Recognising the need to support staff, we have invested in psychological services over the last 12 months with the establishment of a psychological wellbeing helpline, introduction of group therapies and support sessions; and new training modules for managers to increase their skills and confidence in supporting mental health at work. Individualised risk assessments have also been undertaken for all staff at higher risk of serious illness from Covid-19 due to risk factors including health, age, gender, ethnicity and pregnancy.

Our 2020 flu vaccination campaign was our most successful yet, with uptake of 83.7% amongst frontline healthcare workers; and in December 2020 we became one of the first two sites in Lancashire and South Cumbria to offer the Covid-19 vaccine to the national priority cohorts. To date, 82% of our workforce has received their first dose vaccination.

Our broader health and wellbeing offer has also expanded with the introduction of an Employee Assistance Programme and a particular focus on improving rest and recreation areas for staff. Through generous donations from local businesses and fundraising support from our Charities team we have been able to progress a scheme to provide sleep pods for staff and we have launched a 'Break Room Refresh' competition with the first four winning teams currently being supported to plan the refurbishment of their local rest areas. Junior doctor mess facilities are also being upgraded.

Supporting the health and wellbeing needs of our workforce will be a long-term priority and a key element of our organisational restoration and recovery strategy. The appointment of our Chief Operating Officer as Wellbeing Guardian signals our Board-level commitment to this and a new three year health and wellbeing plan will be published in April 2021. Key highlights for the next 12 months will include the introduction of wellbeing conversations for all staff, commencement of Schwartz Rounds and Workplace Wellbeing Charter reaccreditation.

## **Equality and diversity**

We want every colleague to feel able to bring their whole selves to work and to also feel valued for who they are and what they bring to our organisation. Equality, diversity and inclusion remains a priority for our organisation as we know that the better the experience of our workforce, the better the quality of service delivery to our patients.

We set out our commitments for equality, diversity and inclusion through our People Plan driver 'to be inclusive and supportive' these are to:

- Ensure our workforce is representative across all levels
- Develop a culture which supports the Trust values so our people are not subject to discrimination, harassment or bullying at work
- Develop staff engagement and development opportunities for marginalised groups
- Ensure all our workforce is supported so everyone has opportunity to reach their full potential

Over the past year our work plans have had to adapt to accommodate the impact of Covid-19; some scheduled pieces of work had to be put on pause, some elements of work have been delivered virtually, and other previously unscheduled pieces of work were undertaken in response to the emerging impact of the pandemic. Activity was focused on listening, understanding and responding to the experiences of colleagues from diverse, vulnerable groups throughout the pandemic, continuing to engage with (and grow) the inclusion forums, providing support in respect of psychological health and wellbeing and continuing to educate colleagues through raising awareness of diversity and inclusion-related topics.

From a workforce and organisational development perspective, achievements include the following:

- Over 3,000 colleagues have now pledged their support to the National Rainbow Badge scheme which was designed to show we offer open, non-judgemental and inclusive support

and care for all, regardless how people identify themselves. Colleagues pledge their support to reducing inequalities and to signpost appropriate support to LGBTQ+ patients or colleagues. The Hidden Disability (Sunflower) scheme pin badge was launched for colleagues who are living with a hidden disability and who wish to signpost to others they may need a little extra time, consideration or support.

- A series of Listening Events were held with colleagues who were shielding, in addition to our BAME colleagues, to understand their experiences of work throughout the pandemic, to learn lessons for the future, understand what is working well and to take actions to improve further. We undertook a number of promotional campaigns in line with our inclusion calendar of events to educate our workforce, for example Black History Month; South Asian History Month; World Hearing Day; World Down Syndrome Day; Transgender Awareness; Pride; and Ramadan.
- Trialled two virtual Living Library events where people with lived experience of discrimination act as the 'books' and share their experiences with 'readers' in order to challenge stereotypes and reduce discrimination.
- We continued to fly the Pride flag across both hospital sites through the months of February (to mark LGBT History Month) and September (to mark Preston Pride) which further demonstrates our support to our LGBTQ+ colleagues and our wider community.
- Refreshed our mandatory training in respect of equality, diversity and inclusion incorporating elements such as supporting disability in the workplace, Access to Work, and inclusive language.
- We have continued to grow attendance at our Inclusion Ambassador forums; LGBTQ+; Living with Disability; and our more recently established BAME forum. The forums have been instrumental in helping to shape some of our workforce policies and in supporting our promotional campaigns as well as helping identify areas of focus to help us become consciously and intentionally inclusive.
- Further improved our ranking in the Inclusive Employers Top 50 from 21 in 2019 to 19 in 2020.

In addition to the above, a number of work streams continue to be revisited which include:

- Analysis of the staff survey results and development of associated actions with regard to discrimination, harassment, bullying or abuse and protected characteristics.
- Annual equality impact assessment of the disciplinary, grievance and bullying and harassment policies and procedures, the purpose of which is to analyse if the policies have negatively impacted on any particular category of a protected characteristic and to ensure the policies are also accessible and utilised by staff across all protected characteristics.
- Proactively engaging with areas where informal concerns are raised in respect of discrimination.
- Supporting colleagues to raise concerns in respect of inclusion through the Head of Diversity and Inclusion, the Equality Champions and the Freedom to Speak Up Champions across a range of professions and bands.

Plans for the next 12 months include, the launch of an 'Inclusive Leadership @ Lancs' programme for minority groups in bands 5-8a supporting their career progression and growing our talent pipeline; development of an Allies programme for leaders and colleagues; introduction of a Reciprocal Mentoring programme across the organisation; a refresh of our Equality, Diversity and Inclusion plan co-designed with colleagues from the inclusion forums; further developing our Trust

values to make expectations in respect of inclusive behaviours more explicit; a review of recruitment and selection processes (with the introduction of equality representatives or cultural ambassadors); including health, wellbeing and inclusion conversations in appraisal; work with the inclusion forums to improve confidence in respect of speaking up and speaking out; developing two new Values Plus films specifically in respect of diversity and inclusion to clearly illustrate how our people can be inclusive through living our Trust values; and developing stronger mechanisms of governance and measurement of progress.

Ensuring equality, diversity and inclusion of services is a priority within our organisation we have continued to work towards the Patient Experience and Involvement Strategy. We are now in our final year and have made some significant improvements over the last 12 months. Our proactive strategy is centred on giving our patients a voice and the ability to shape our services, to exceed expectations and identify areas for change. Our overall ambition is to deliver excellent care with compassion and wrap around this a positive patient experience. Patient forums have been slightly affected by the pandemic, however, most are still active and involve our communities in developments within our services and to aid this more working partnerships have been created across our ICS, such as:

- *Multi Faith and Spiritual Forum* – this new forum is made up of multi faith clergy from across Lancashire, including local Trusts, governors, chaplaincy, patient experience and equality, diversity and inclusion staff. It also includes Bereavement and Donation teams and workforce and is chaired by the Bishop of Lancaster and the Patient Experience Lead within our Trust. The aim is to share ideas across the wider network and produce ideas that will aid patient experience during these difficult times. New actions focus on a meditation slot available on the Trust's Hospital Radio so inpatients can listen free and get involved with the breathing exercises and relaxation techniques and talks around spiritual care. During the pandemic our main focus has been the mental health of not only our staff but our patients. One of our big successes this year was putting together a multi faith volunteer clergy. As face-to-face visiting was restricted during the pandemic to ensure the safety of our patients, visitors and staff, work was carried out within this area to focus on patient and staff wellbeing.
- *Multi Faith Volunteer Clergy* – this is a group of volunteers from different faiths who have agreed to come into the Trust during the pandemic and see to the needs of our patients, mainly centred around the patient's faith, although that is not always the case. They provide spiritual care, end of life support and also pay visits to wards to help patients with virtual contact with families through tablet devices. This service provides a listening ear and general companionship during these difficult times and frees up the ward staff to care for patients. We have also employed two part-time Imams who have worked in many areas including the production of a vaccine video in three different languages which has been shared for staff and made available on social media platforms to help relay the facts to the community around the vaccine and its benefits. We are also in the process of putting in place two female Imams who will help in areas, especially our women and children's division, as from listening to the community it was felt to be a key advantage for female Muslims when it came to their health care. Improvement work is also being carried out within our chaplaincy areas, prayer rooms and ablution facilities to ensure gender considerations are given when visiting for prayers.
- *BSL and language translation* – at the onset of the pandemic we anticipated that face-to-face translation could be an issue with the increased risk of companies sending their interpreters

into the hospitals. With this in mind, we added services to ensure staff and patients had no barriers with communication, which included:

- Instant access to language translation – all tablet devices have had an App installed that provides on-demand language through video interpretation. Face-to-face interpretation has still been possible when needed for certain appointments or as specifically requested.
- BSL was updated to provide 24/7 access to an interpreter using video link. Our current provider also ensures that face-to-face interpreting services are available when necessary.

In summary, translation and interpreter services are now available through a range of formats providing more access than ever – via telephone, video and face-to-face depending on the needs of the patient; written translation either digitally or through paper copy literature; and using BSL services either face-to-face or through video link. We also continue to use 'Browsealoud' which translates our entire website into different languages, larger font for the visually impaired, and audio for the visually/hearing impaired.

- *Patient Information Group* – following feedback from patients regarding our information being difficult to understand with format issues and accessibility problems, we re-established this group back in late 2019. The group is made up of patients, governors, staff from library services, clinical areas, pharmacy, governance, clerical staff and external organisations such as Healthwatch. Each month leaflets produced by staff are ratified by the group, comments and thoughts sent to leaflet authors and ideas shared on the production of information. A policy and procedure were put in place to streamline the process and we now have a structured service which incorporates:
  - Accessible information with language, audio and font facilities to help service users (available in digital or paper format)
  - Print control using one supplier with monthly audit of spend and supply
  - A reader group who approves and helps develop information that is understandable to all
  - Easy read documents for people with a learning disability
  - Videos in BSL
  - A Trust website with all information leaflets in one place for patients
  - Audits by STAR quality assurance and, in the near future, the Trust's governors to ensure information is current and up-to-date

The cancer team has a separate Patient Information Group and they are now mirroring this process and building a web page to ensure their patients can find the information they require.

Work is also in progress to ensure our patient information and other resources are non-gendered and inclusive of all bodies and identities. This is a significant move forward in inclusive maternity care and is also a much needed step to see this integrated. Links are also being established with local transgender support groups so we can learn, develop and ensure inclusion.

- *Carers Forum* – we have also focused on carers who we know play a huge part in our patients' care. We have updated our Carers Charter, introduced carers' lanyards and work has started in collaboration with Lancashire and South Cumbria NHS Foundation Trust and



their carers service to promote a joint Carers Forum, available digitally or accessible via telephone, to provide support and links to the hospital should carers need help or advice.

- *Assistance Dogs* – we are now in the final stages of producing the assistance dog policy, delayed due to the pandemic, following further involvement from patients who have experience in this area
- *Navigation Guides* – now that volunteers are slowly coming back into the Trust, we hope to start the roll-out of Navigation Guides who will be available to escort patients and visitors to appointments or services when required. The Guides will assist patients with visual impairments, learning disabilities or people who just need that little bit extra support.

## **Staff engagement and consultation**

Improving staff experience continues to be a high priority for us, particularly given the operational challenges the organisation has experienced during the Covid-19 pandemic.

Organisations that have higher levels of staff engagement deliver better care and so improving staff engagement remains essential to help us deliver high quality and sustainable services, achieve financial plans, deliver organisational change and transform services. The Staff Engagement Plan recognised that staff engagement is not achieved through one-off initiatives rather through a systematic, evidence-based approach to building a culture of engagement. Therefore, the plan focuses on the following:

- To continue to embed the staff survey as a whole systems approach to give staff a voice, measure staff experience and action plan for improvement
- Improve team engagement and increase staff involvement through the team engagement and development programme (TED) tool
- Create more opportunities for our Board to be involved in the staff engagement agenda
- Build a sense of team and community across the Trust
- Celebrate our achievements, reward and value staff

Two-way communication with staff is a key priority and over the last year we have continued to offer a number of staff engagement and communication mechanisms which include but are not limited to:

- The annual staff survey and subsequent focus groups with staff
- Quarterly staff friends and family test feedback survey
- The TED approach which gives teams a voice
- Inclusion forums: Living with Disability, LGBTQ+, multi-faith and spiritual (joint workforce and patients), and BAME
- Freedom to Speak Up Champions
- Fab Feedback Friday, an opportunity for teams to share with senior leaders their successes, challenges or ideas for improvement via team showcases
- Additional opportunities for staff engagement and communication with senior leaders were introduced in 2020-21 which include: Senior Operations Group (SOG) debrief meeting, which explores the main talking points and pressures from SOG as well as providing an opportunity for staff to ask questions, and 'In conversation with....the Executive Team', a forum where staff can ask questions about the issues that matter to them

- Additional written corporate communications to support staff engagement were introduced in 2020-21 which include: twice weekly CEO briefings and a weekly Monday Message from the Chief Executive.

### Other staff engagement mechanisms

In addition to this, a range of channels and mechanisms that promote staff engagement, communication and awareness of wider issues including financial and economic matters, continue to be used including:

- Our Big Plan events
- Valuing Your Voice channel to suggest ideas, ask questions or raise concerns
- Annual planning events
- Governors' listening events for members
- Staff intranet
- Social media
- Use of multimedia methodology such as video, animation and blogs
- Email accounts
- Staff magazine 'Connect'
- Joint Negotiating and Consultative Committee
- Local Negotiating Committee (for doctors and dentists)

Formal negotiating and consultative arrangements with staff organisations are in place and regular meetings are held.

### Staff survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020-21 survey amongst Trust staff was 50% (2019-20 was 49%). Scores for each indicator, together with that of the survey benchmarking group (Acute and Acute and Community Trusts), are presented below:



	2020/21		2019/20		2018/19	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
<b>Equality, diversity and inclusion</b>	9.2	9.1	9.1	9.0	9.1	9.1
<b>Health and wellbeing</b>	6.1	6.1	5.9	5.9	5.9	5.9
<b>Immediate managers</b>	6.9	6.8	6.9	6.8	6.7	6.7
<b>Morale</b>	6.3	6.2	6.1	6.1	6.0	6.0
<b>Quality of care</b>	7.6	7.5	7.4	7.5	7.4	7.4
<b>Safe environment – bullying and harassment</b>	8.2	8.1	8.1	7.9	8.0	7.9
<b>Safe environment – violence</b>	9.4	9.5	9.4	9.4	9.4	9.4
<b>Safety culture</b>	6.7	6.8	6.7	6.7	6.6	6.7

<b>Engagement</b>	7.0	7.0	6.9	7.0	6.9	7.0
<b>Team working</b>	6.7	6.5	6.7	6.6	6.6	6.6

50% of our colleagues shared their views via the staff survey, an improvement from 49% the previous year and above the national average of 45%. Response rates have increased from 35% (2015) and have now been maintained and demonstrate a strong level of engagement.

The staff survey provides us with vital feedback about the experience of our workforce, enabling us to build on what is working well for them and learn from and address the areas that are causing dissatisfaction.

Two of the questions that contribute to our staff engagement score are those which are mirrored in the patient Friends and Family Test – recommendation of the organisation as a place to work and recommendation of the organisation as a place to receive care. Both of these measures have improved as presented in the table below and these results are now only slightly below national average, which is an improved benchmarking position compared to previous years.

Theme		2018	2019	2020
Advocacy	If friend / relative needed treatment would be happy with the standard of care provided by organisation	66%	63%	69% 
	Would recommend organisation as a place to work	59%	58%	63% 

At an organisational level there has been a statistically significant improvement in 6 out of 10 themes, with other areas remaining the same. No themes have deteriorated.

We perform slightly better than the national average in most areas and we perform worse in relation to: safe environment, violence and safety culture. Health and wellbeing and morale are our lowest scoring themes with 44% of staff saying they have experienced work related stress, a theme reflected nationally in other NHS organisations. Improvements are still required to enhance the experience of BAME staff and staff with a disability. Experience is significantly worse for staff who prefer to self-describe their gender, those who describe their sexuality as bisexual, other or prefer not to say and, lastly, those staff who prefer not to disclose their religion.

### Utilising the results

Following the publication of the 2020 staff survey results in March 2021 we will explore these results further through Big Conversation focus groups and our Inclusion and Ambassador forums, which seek to explore staff experience from an inclusion and diversity perspective.

The Big Conversation focus groups are led by Board members and facilitated by the Leadership and Organisation Development team. These focus groups are an opportunity for staff to find out the results, find out more about progress being made to improve staff experience and discuss their ideas about how to make the organisation a better place to work. Feedback from these focus groups along with the staff survey results informs the annual staff survey action plans and workforce and organisational development plans.

As an organisation the key areas of focus for us over the last year and that we will continue to seek to improve are communication, team work, manager support, health and wellbeing, safe working, rest and recuperation, and supporting colleagues to have the resources to work remotely and agilely. We will also place greater focus on improving our culture with a new equality, diversity and inclusion strategy, a new 'on-boarding' experience so colleagues feel part of the team from day one, an early reconciliation approach to work place issues and implementation of a just culture to help staff work in a blame free, psychologically safe working environment where we hope to bring about change.

These areas will be addressed through our Workforce and Organisational Development Strategy and we have comprehensive action plans in place to improve staff experience in relation to equality, diversity and inclusion and health and wellbeing. We will further shape our plans following involvement with staff and create 'You Said, We Did' communications to respond to staff feedback.

### **Improving staff experience across the organisation**

Whilst large parts of our plans to improve staff experience are implemented corporately, a significant part of staff experience is affected by their local working environment, experience within the team and relationship with, and support from, their manager. Therefore, the following plans are in place:

- All divisions, directorates and specialities have received their local results along with a manager toolkit and action plan templates to support them to explore experience in their team and plan actions to bring about improvements locally.
- Manager briefing sessions will be held to further support managers to understand their data, identify trends and feel more able to hold conversations with their teams.
- Each division will agree their own approach to sharing results in their area and hold focus groups with staff to explore experience and identify local solutions to bring about improvements. Support has been provided by the Workforce and Organisational Development team to facilitate focus groups and formulate local action plans.
- A number of additional measures have been put in place to strengthen the accountability and governance of divisions delivering their staff engagement improvement plans:
  - Each team has been set a staff engagement improvement target in line with the organisation's Our Big Plan.
  - A regular performance review of staff engagement will take place at the Divisional Improvement Forums.
- Teams are supported to explore experience at a team level and improve their team working through the TED programme.
- We are introducing a team engagement measure to enhance monitoring and reporting of staff experience at a team level.

### **Learning and Development**

Mandatory training compliance has fluctuated during 2020-21, largely due to the impact of Covid-19 service pressures. In line with national guidance, the Trust has worked to release training hours for direct patient care. During 2021-22 there will be a key focus on delivering robust plans across all divisions to ensure compliance across the core skills topics.

The Clinical Skills Education team supports the Trust to meet its legal obligation of ensuring our staff and students have the right knowledge, experience and skills to deliver safe, effective and compassionate care for our patients and to ensure our students successfully achieve their curriculum outcomes through the delivery of high quality clinical skills sessions. During 2020-21 there has been a critical focus on delivering training to equip staff with the knowledge and skills to care for patients with Covid-19. As key examples, the team has delivered the following training:

- Mask fitting for over 9,000 staff including refitting occurrences
- PPE donning and doffing
- Covid-19 specific training, such as proning, managing cardiac arrests, intubation, Covid-19 patient transfer
- Critical care upskilling programme utilising the European Society for Intensive Care Medicine training packages
- In-situ Covid-19 drills and simulation exercises
- Life support training sessions

In addition the team has maintained delivery of core activities including all clinical skills teaching sessions for students, our healthcare assistants' induction programme and the preceptorship programme.

The Student, Trainee and Placement Support team are the link between learners, placement areas and education providers. During 2020-21 the team has worked with colleagues from the Workforce and Organisational Development team to deploy around 350 student nurses into paid employment and 52 interim Foundation Year medical students to support service delivery. Medical students have also been effectively deployed to support service pressures and have taken an active role supporting proning teams, cannulation and venepuncture and also trained as vaccinators to support the Covid-19 vaccination programme.

Our placement expansion programme has been ongoing with the key aim of supporting universities to deliver growth in student numbers and thus grow our future workforce. This is an important development to support the national target of an additional 50,000 nurses to alleviate critical workforce shortages. Our continued rollout of the Collaborative Learning in Practice (CLiP) model has been successful and a key enabler to increasing our placement capacity and we are now the first Trust in England to have all ward areas operating CLiP. We have successfully secured £100,000 investment to enable further placement expansion across nursing, midwifery and allied health professions.

We have been selected as a case study site for the Reducing Pre-registration Attrition and Improving Retention (RePAIR) programme which is led by Health Education England. This programme is focused on key themes that will ultimately enhance the student experience and thus improve retention. As part of this programme, we have successfully secured funding to develop a pilot programme in 2021-22 which is intended to offer step-down employment options into student supervision and assessment for clinical staff who would otherwise have retired.

The Professional Education team supports the development of innovative professional (non-medical) workforce supply solutions and also delivers teaching on a number of programmes including:

- The Nursing Associate Apprenticeship continued to be delivered in partnership with the University of Central Lancashire. Our first cohort qualified in June 2020 and we have since recruited to intakes in January, March and September 2020 and March 2021.
- Pre-registration nurse training is delivered in partnership with the University of Bolton. Seven cohorts have now qualified since the start of this partnership generating 134 newly qualified nurses. There are currently eight cohorts still completing their training with 131 students on programme.
- A new Degree Nurse Apprenticeship programme was launched this year for Assistant Practitioners (or similar level of nurses) to complete the final 18 months of their nurse training and qualify as Registered Nurses, supported via an apprentice salary. We have successfully recruited 24 apprentices to this programme and have funding for a further 14 to start in September 2021.
- In January 2021 the Nursing and Midwifery Council (NMC) opened up the Test of Competence examination to Return to Practice nurses. This route to return to nursing entails a two-hour online examination known as the Computer-Based Test (CBT) and a two-and-a-half hour Objective Structured Clinical Examination (OSCE) as opposed to a six-month university programme and 100 hours of placement time. We have been promoting this programme since September 2020 and we have had one nurse who has so far successfully completed both the CBT and OSCE and regained her NMC registration code (PIN number).

In 2020-21 we have 24 overseas nurses who have passed OSCEs. We are committed to recruiting 291 international nurses over the next 12 months and to support this we have been awarded £400,000 for additional training and pastoral costs associated with the programme.

Although the Covid-19 pandemic has had far-reaching impact on our education activity with fluctuations in delivery throughout the 12 month period, the Education Team can demonstrate a significant number of achievements, some of which are highlighted as follows:

- Launch of The Health Academy's new website
- Launch of Education and Training Strategy 2020-23
- Rapid development and deployment of a range of digital technology solutions to support teaching delivery
- First cohort of Medical Intern Programme participants commenced
- Five-day NHS virtual careers event held
- Commenced Mandatory Training Skills Passport project on behalf of all Trusts in the Lancashire and South Cumbria ICS
- Enabled repurposing of educational space to support Trust priorities including staff changing facilities and Covid-19 vaccination programme
- Promoted home working for our staff wherever possible to ensure we met safe working guidelines
- Many of our staff have been redeployed to support Trust service pressures

### **Working time directive – junior medical staff**

All of our current junior doctor rotas remain both compliant with the European Working Time Directive, the 2016 terms and conditions (doctors in training) and the 2002 terms and conditions of service for NHS medical and dental staff (Trust-employed junior and senior clinical fellows).

All rotas are reviewed for compliance using an electronic e-Rota system and Trust doctors who have been engaged through 2002 national terms and conditions are also invited to monitor their working hours bi-annually.

Specialty Business Units continue to review the efficiency of rotas while at the same time ensuring that training needs are appropriately delivered alongside service developments.

The Trust has an established exception reporting process which has been agreed with both the Local Negotiating Committee and junior doctor forum. Exception reporting was introduced as part of the junior doctor contract (2016), a process whereby doctors report any variations to their contract. In terms of hours worked and educational opportunities, exception reports are overseen by the Trust's Guardian of Safe Working and the number of exception reports submitted forms part of the quarterly Guardian of Safe Working report presented to the Board. This report highlights any concerns raised relating to hours worked and any concerns relating to safe working. Exception reports raised are highlighted through divisional Workforce Committees on a monthly basis.

Significant challenges remain in filling gaps on medical rotas and the ongoing medical workforce strategy continues to address recruitment pressures.

## Occupational health

Our Occupational Health Service (Wellbeing Partners) has experienced significant operational change over the last year, with the pandemic driving a move to virtual consultations and Covid-19 associated recruitment activity leading to substantial increases in pre-employment screening. The service also provides a commercial service and the pandemic has affected the ability to generate income from contracts, so it is anticipated that 2020-21 will not enable income generation expectations to be met.

It has also been a year of strategic change as one of the three partners in the joint venture, Bolton NHS Foundation Trust, made the decision to withdraw from the partnership with effect from 1 April 2021. In consultation with our remaining partner, Wrightington, Wigan and Leigh NHS Foundation Trust, we have taken the opportunity to reflect on the future vision for Wellbeing Partners and decided to bring counselling and physiotherapy services for staff back in-house where they can be much more closely aligned with our health and wellbeing strategy. This will enable Wellbeing Partners to focus on providing core Occupational Health services for the two partners along with commercial growth.

## Staff costs

			2020/21	2019/20
	Permanent	Other	Total	Total
	£0	£0	£0	£0
Salaries and wages	302,880	28,275	331,155	291,815
Social security costs	28,671	2,602	31,273	28,247
Apprenticeship levy	1,454	132	1,586	1,454
Employer's contributions to NHS pensions	46,265	4,198	50,463	46,261
Pension cost – other	161	15	176	161
Other post-employment benefits	-	-	-	-

Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	19,274	19,274	13,937
NHS charitable funds staff	-	-	-	-
Total gross staff costs	379,431	54,496	433,927	381,875
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	379,431	54,496	433,927	381,875
Of which				
Costs capitalised as part of assets	-	-	-	-

Consultancy costs	
2020/21	2019/20
£0	£0
19,000	661,000

### Average number of employees (WTE basis)

	2020/21		2019/20	
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	870	64	934	901
Ambulance staff	2	-	2	1
Administration and estates	1250	69	1319	600
Healthcare assistants and other support staff	3,671	593	4264	2,734
Nursing, midwifery and health visiting staff	2,087	310	2397	2,234
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	699	12	711	929
Healthcare science staff	236	3	239	238
Social care staff	-	-	-	-
Other	23	-	23	-
Total average numbers	8838	1051	9889	7,637
Of which:				
Number of employees engaged on capital projects	-	-	-	-

### Pensions/retirement benefits and senior employees' remuneration

Accounting policies for pensions and other retirement policies and details of senior employees' remuneration are set out in the notes to the accounts and on pages 65 to 68 of this report.

### Off-payroll arrangements

We have a policy to ensure when the Trust enters into off-payroll arrangements we have a robust process in place to ensure HMRC regulations are met. As part of the staff report we are required to provide information in the following tables for our highly paid and/or senior off-payroll engagements:

Table 1: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months:



<b>Number of existing engagements as of 31 March 2020</b>	0
Of which:	
Number that have existed for less than one year at time of reporting	N/A
Number that have existed for between one and two years at time of reporting	N/A
Number that have existed for between two and three years at time of reporting	N/A

All off-payroll engagements are subject to an IR35 assessment and those deemed within IR35 the Trust makes relevant tax and National Insurance deductions as required by HMRC regulation.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between April 2020 and March 2021, for more than £245 per day and that last for longer than six months:

<b>Number. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020</b>	0
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	N/A
Number for whom an IR35 was conducted	N/A
Of which:	
Deemed inside IR35	N/A
Deemed outside IR35	N/A

Table 3: For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021:

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

### Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,000 - £25,000	0	1	1
£25,001 - £50,000	1	0	1
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
<b>Total number of exit packages by type</b>	<b>1</b>	<b>1</b>	<b>2</b>
<b>Total resource cost</b>	<b>£40,794.38</b>	<b>£11,259.67</b>	<b>£52,054.05</b>

## Exit packages: non-compulsory departure payments

	Agreements Number	Total Value of Agreements  £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	£0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	1	£11
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	£0
<b>Total</b>	<b>0</b>	<b>£0</b>

## Value of special severance payments approved by NHS Improvement

Minimum value	£0
Maximum value	£0
Median value	£0

## Trade Union Facility Time

<b>Relevant union officials</b>	
Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
33	28.21
<b>Percentage of time spent on facility time</b>	
Percentage of time spent on facility time during the relevant period	Number of employees
0%	16
1-50%	15
51-99%	0
100%	2
<b>Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period</b>	
Total pay bill	£352,244,000
Total cost of facility time	£54,835.55
Percentage of pay spent on facility time	0.0001557%
<b>Paid trade union activities</b>	
Hours spent on paid facility time:	3026
Hours spent on paid trade union activities	381.5
Percentage of total paid facility time hours spent on paid TU activities	12.61%

# DISCLOSURES SET OUT IN THE NHS FOUNDATION TRUST CODE OF GOVERNANCE

**The purpose of the code of governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice, but requires a number of disclosures to be made within the annual report.**

The NHS Foundation Trust code of governance contains guidance on good corporate governance. NHSI, as the healthcare sector regulator, is keen to ensure that NHS Foundation Trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a ‘comply or explain’ approach.

Lancashire Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is committed to the principles of the Code, which is supported by its robust internal governance arrangements, meets the statutory disclosure requirements in this annual report and also adheres to all other ‘comply or explain’ requirements.

## Comply or explain

NHSI recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This ‘comply or explain’ approach has been in successful operation for many years in the private sector and within the NHS Foundation Trust sector. In providing an explanation for non-compliance, NHS Foundation Trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a ‘comply or explain’ basis, there are other disclosures and statements (which we have termed ‘mandatory disclosures’ in this report) that we are required to make, even where we are fully compliant with the provision.

## Mandatory disclosures

Code ref.	Summary of requirement	See page(s):
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the board of directors.	8, 31, 116
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	26 – 28, 31, 32, 58 – 60, 128, 129

<b>Code ref.</b>	<b>Summary of requirement</b>	<b>See page(s):</b>
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	116, 117
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	117, 118
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	26 – 28
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	26 – 28
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	26 – 28, 30, 31
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	30, 31, 59
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	NOT APPLICABLE
B.3.1	A Chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	26
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	33, 34, 77, 116 – 118
FT ARM	If, during the financial year, the governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.	NOT EXERCISED
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	32, 33, 59, 60, 62
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	32, 33, 97
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	34, 91, 94, 101, 102, 111

Code ref.	Summary of requirement	See page(s):
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	93 – 95, 102, 107, 112, 113, 124 – 127
C.2.2	A trust should disclose in the annual report:  (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	127 – 128
C3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	NOT APPLICABLE
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: <ul style="list-style-type: none"> <li>▪ the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;</li> <li>▪ an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and</li> <li>▪ if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.</li> </ul>	124 – 129
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	NOT APPLICABLE
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	33, 49, 50, 76 – 79, 118, 120 – 123
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	120 – 123
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.	34, 119, 123
FT ARM	The annual report should include: <ul style="list-style-type: none"> <li>▪ a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;</li> <li>▪ information on the number of members and the number of members in each constituency; and</li> <li>▪ a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.</li> </ul>	120 – 123

Code ref.	Summary of requirement	See page(s):
FT ARM	The annual report should disclose details of company Directorships or other material interests in companies held by governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	31, 116

*'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the code of governance.*

### Other disclosures in the public interest

NHS Foundation Trusts are public benefit corporations and it is considered to be best practice for the annual report to include 'public interest disclosures' on the Foundation Trust's activities and policies in the areas set out below.

Summary of disclosure	See page(s):
Actions taken to maintain or develop the provision of information to, and consultation with, employees.	76, 77
The foundation trust's policies in relation to disabled employees and equal opportunities.	52, 56, 71 – 74
Information on health and safety performance and occupational health.	20, 21, 82
Information on policies and procedures with respect to countering fraud and corruption.	95, 124 – 128
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.	17, 18
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	N/a
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	N/a
Any other public and patient involvement activities.	49, 50, 103, 109
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 5.2 to the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 2.5 to the accounts
A statement that the NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.	6
Sickness absence data.	71
Details of serious incidents involving data loss or confidentiality breach.	110

### Voluntary disclosures

We have also included a number of 'voluntary disclosures' (as defined by the Foundation Trust annual reporting manual) in this report. These can be found as follows:

<b>Summary of disclosure</b>	<b>See page(s):</b>
Sustainability / environmental reporting	18 – 20
Equality reporting	71 – 74
Slavery and human trafficking statement (Modern Slavery Act 2015)	34

# STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

## Statement of the Chief Executive's responsibilities as the accounting officer of Lancashire Teaching Hospitals NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHSI.

NHSI, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Lancashire Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Lancashire Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

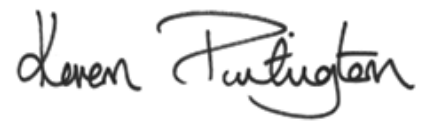
- observe the Accounts Direction issues by NHSI, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.



To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

A handwritten signature in black ink that reads "Karen Partington". The signature is written in a cursive style with a large, sweeping initial 'K'.

**Karen Partington**  
**Chief Executive**  
10 June 2021

# ANNUAL GOVERNANCE STATEMENT 2020-21

## Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

### Leadership and Accountability

The Chief Executive, with overall responsibility for risk within the Trust, ensures the work of the Committees of the Board, including sub-groups, is reviewed by the Board of Directors. The Chief Executive has overall responsibility for having effective risk management systems in place within the Trust, and for meeting all statutory requirements and adhering to guidance issued by NHSI and other regulatory bodies in respect of risk and governance.

The Trust ensures it has capacity to handle risk achieved through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation of Powers and the Risk Management Strategy, both documents being approved by the Board of Directors. The Strategy outlines the Trust's approach to risk, accountability arrangements and the risk management process including identification, analysis, evaluation and approval of the risk appetite.

The accountability arrangements for risk management in 2020-21 involved the following:

- a) the Board of Directors has overall responsibility for ensuring robust systems of internal control, encouraging a culture of risk management, routinely considering risks and defining its appetite for risk;

- b) the Committees of the Board undertake the detailed scrutiny of those risks that fall within their terms of reference on behalf of the Board of Directors, recommending new or revised risks to the Board as appropriate;
- c) the Audit Committee on behalf of the Board of Directors ensures that the Trust's risk management systems and processes are robust;
- d) the Executive Management Group reviews risks relevant to its remit and advises all Committees of the Board on potential/existing strategically significant risks, as well as liaising with the Divisional Management Boards to ensure the consistency of risk reporting and also overseeing the Trust's Risk Register;
- e) the Chief Executive, as the Trust's Accountable Officer, has overall responsibility for the risk management processes and Risk Management Strategy;
- f) the Nursing, Midwifery and AHP Director, supported by the Director of Governance, advises the Trust Board on all matters relating to governance, risk and quality;
- g) each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios;
- h) the Executive Finance Director (Deputy Chief Executive) has responsibility for ensuring that the Trust had sound financial arrangements that were controlled and monitored through financial regulations and policies;
- i) the Chief Information Officer is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs reporting;
- j) The Director of Governance is the Nominated Individual with the CQC.

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to various internal and external reviews. The Trust's strategic intentions, policies, procedures, Board Assurance Framework and supporting documentation are openly accessible via the intranet for all staff to reference.

The existing organisational management structure and Risk Management Strategy illustrates the Trust's commitment to effective governance and quality governance including risk management processes. As Accounting Officer, I have overall accountability for risk management within the Trust, however our Risk Management Strategy describes the responsibility of every member of staff to recognise, respond to, report, record and reduce risks while they are undertaking work for the Trust.

### **Training and learning**

Trust policies are available on the Trust's intranet and internet and relevant staff are encouraged to participate in the consultation of new and updated policies. Newly approved policies are published through a network of policy leads and also in the monthly briefing issued to staff.

To ensure that the Trust's approach to risk management is successfully implemented and maintained, staff of all levels are appropriately trained in key elements of risk management. All staff are required to regularly update their knowledge and skills and maintain their personal awareness of their responsibilities for risk management via an ongoing training programme which includes adverse incidents, health and safety, fire safety, infection control and prevention, safeguarding children and vulnerable adults, information governance, moving and handling, conflict resolution, complaints handling, care, fraud awareness, and equality and inclusion. This training is mandatory for all staff and is identified via a training needs analysis that is reflected in the Trust's Induction and Mandatory Training Policy.

Through a comprehensive training programme, which includes governance and risk management awareness, all staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis.

Monitoring of training compliance and escalation arrangements are in place via the Workforce Committee and the Divisional Improvement Forums to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level, for example bank staff. Where performance is below expected levels, the Trust Executive Team oversees tailored support for the Divisions and Corporate Teams in line with the Accountability and Oversight Framework to underpin sustainable improvement and delivery of plans, objectives and required outcomes.

To support continuous improvement during 2020-21 a series of risk maturity workshops were held across the Trust's Corporate Services as well as the four clinical divisions. The purpose of these workshops was to support an improvement in the quality of operational risks on the risk register, including staff understanding of controls, assurances and connectivity of operational risks registers with strategic ambitions and the Board Assurance Framework.

The Trust also delivers additional risk management training and development to Board members (both Executive and Non-Executive Directors). During 2020-21 a series of risk maturity workshops has taken place with Executive and Non-Executive Directors and as a result of these the Board has developed a revised risk appetite statement.

## **The risk and control framework**

### **The management of risk**

The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:

- a) overarching strategic aims for risk management;
- b) the Trust's Risk Management Strategy;
- c) the Trust's Risk Management Policy;
- d) the organisational process for risk identification and analysis;
- f) a definition of significant risk and acceptable risk within the organisation;
- g) organisational risk management structures;

- h) the development and application of risk registers within the organisation;
- i) incident reporting;
- j) the accountability and responsibility arrangements for risk management; and
- k) the Board Assurance Framework.

Throughout the reporting period the Safety and Quality Committee, the Finance and Performance Committee, the Workforce Committee and the Education, Training and Research Committee were the Committees in place for scrutinising the arrangements in place for specific areas of risk.

They are supported by a number of sub-groups including:

- Divisional Management Groups
- Health and Safety Group
- Infection Prevention and Control Committee
- Medicines Governance Committee
- Safeguarding Board
- Mortality and End of Life Care Committee
- Safety and Learning Group
- Capital Planning Forum
- Information Governance Forum
- Emergency Preparedness, Resilience and Response Committee

These arrangements are supported by the work of the Audit Committee which receives assurances on the effectiveness of the risk management framework annually by receiving the Head of Internal Audit Opinion. This is based on a robust Internal Audit Programme which tests key aspects of the Trust's governance arrangements through a series of reviews undertaken throughout the year which are also reported to the Audit Committee.

### **The Risk Management Strategy**

The Trust's Risk Management Strategy provides a framework for managing risk within the Trust and outlines the objectives of risk management; the structure in place to support the management of risk across the organisations; and the systems and processes to ensure identification, management and control of risk.

The strategy defines risk in the context of clinical, health and safety, organisational, business, information, financial or environmental risk and also provides a definition of risk management. It details the Trust's approach to:

- The provision of high-quality services to the public in ways aimed at securing the best outcome for all involved. To this end, the Trust ensures that appropriate measures are in place to reduce or minimise risks to everyone for whom we have a responsibility;
- The implementation of policies and training to ensure that all appropriate staff are competent to identify risks, are aware of the steps needed to address them and have authority to act;
- Management action to assess all identified risks and the steps needed to minimise them. This comprises continuous evaluation, monitoring and reassessment of these risks and the resultant actions required;

- The designation of Executive Officers with responsibility for the implementation of the strategy and the execution of risk management through operational and monitoring committees, as described in the risk management strategy;
- Action plans to maintain compliance with the requirements for CQC registration, which contribute to delivery of the risk control framework and registration standards assurance; and
- The process by which risks are evaluated and controlled throughout the organisation. In support of the risk management strategy, a range of policies exist that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents on behalf of patients, visitors or themselves.

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the strategy. The risk assessments are rated and this information is utilised to populate the relevant divisional risk register via our online system. Responsibility for the management and control of a particular risk rests with the division concerned.

Risks are escalated to the Executive Management Group when an action to control a particular risk falls outside the control or responsibility of that division, or where local control measures are considered to be potentially inadequate, require significant financial investment or the risk is 'rated high'. The Group may escalate a particular risk to the appropriate Committee of the Board for further consideration when required.

The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts: the **Strategic Risk Register**, those risks that threaten the delivery of the strategic objectives and are not likely to change over time and the **Operational Risk Register**, those risks that sit on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

During 2020-21, following recommendations from Deloitte, who carried out a developmental review of leadership and governance using the well-led framework in 2018, a review of Divisional Risk Maturity by MIAA in 2018 and two CQC inspections in 2018 and 2019, the Trust undertook a comprehensive programme of work to develop its Risk Maturity and refine the Strategic Risk Register. The following improvements have been made as a result:

- A reduction in the number of principal risks, an amalgamation of multiple risks based on similar topics and a reduction in risk scores;
- Alignment of five strategic risks to Committees of the Board;
- Clear alignment for every risk with the risk appetite and a clear rationale for scoring; and
- Clear action plans and articulation of future risks and opportunities.

Strategic risks are removed from the BAF and managed through the operational risk register once the target score falls below 15 and Board approval is given.

Whilst the initial selection and content of the strategic risks was developed following a number of Board workshops cumulating in detailed feedback from members of the Board to Executive Directors, ongoing responsibility for reviewing and updating the risk and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director.

The BAF has also been presented in full to the Audit Committee at each meeting since approval by the Board. The Audit Committee has gained assurance over the processes for identifying, understanding, monitoring and addressing current and future risks and agreed to escalate as an example of good practice to the Board.

During 2020-21, in support of the newly identified strategic risk register records, the Risk Maturity Project and development of the new Trust Risk Appetite Statement, all operational risks were categorised in line with the Trust Ambition that they predominantly impacted upon. As operational risks were aligned to the strategic ambitions rather than strategic aims, any operational risks associated with the strategic aims were realigned to a strategic ambition as appropriate. As such, operational risks aligned to the strategic aim of 'Providing a Range of the Highest Standard of Specialised Services to patients in Lancashire and South Cumbria' and 'Delivering world class Education, Training and Research' have been aligned to 'Fit for the Future' in the BAF to the Board. Any higher scoring operational 15+ risks are also presented to Committees of the Board strategic ambitions are aligned to.

Over the last 12 months, work has continued to review and cleanse the operational risk register and strengthen the Accountability Framework with renewed focus on monitoring of risks since April 2020. This focus on risk maturity, despite the pressures of Covid-19 has seen a reduction in high risks overall from 140 in April 2020 to 85 in March 2021. This has been achieved through embedding risk management within the Trust by various means, including:

- The Risk Management Strategy, which is available to all staff through our internet and intranet sites.
- Effective use of the strategic risk registers and operational risk registers at both divisional and corporate level and the BAF.
- Integrating the use of the risk appetite and defining the components and nomenclature of the BAF throughout the organisation i.e. Strategic Risk Register + Operational Risk Register = BAF and improve staff understanding of this.
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to the Board via the BAF.
- Redesigning and relaunching the Datix Risk Register module to support improvement programmes.
- Redesigning the BAF and Strategic Risk Templates.
- Extending the use of dashboards to include themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Implementation of governance dashboards for each division, monitored as part of the accountability framework in divisional improvement forums with specific risk key.
- Strengthening of divisional accountability and holding to account processes through Divisional Boards and the Accountability Framework through challenging performance of risk at Clinical Business Unit and Speciality Business Unit level.

- Enhancing training and support at all levels of the organisation
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- Enhancing lessons learned from risk management integrated into the learning to improve bulletins.
- Creation of a newly formed Executive Management Group as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive Team. This is achieved through presentation of a high risks report which contains key performance indicators each month alongside divisional and corporate risk registers on a cyclical basis.
- Actively monitoring all serious incidents at the Safety and Quality Committee on a quarterly basis and the Board annually.
- Using outcomes from complaints, incidents, claims, STAR visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Connecting performance across the Trust at Board, Committee, Divisional and Speciality level using Integrated Performance Reports which provides Ward to Board reporting that includes a range of metrics encompassing each of the elements of Our Big Plan by strategic ambition and includes quality, operations, finance and workforce.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Report cover sheets linked to the Trust strategic aims and ambitions.
- Information within specific reports are categorised by and presented by strategic ambitions – for example, Chief Executive’s Report and Integrated Performance Report.
- Risks within Committee papers are also connected to strategic risks within the BAF.
- ‘Freedom to Speak Up’ team in place and ‘Valuing Your Voice’ designated inbox for staff to raise concerns, both of which are promoted within the Trust and triangulated with other processes for management, improvement and shared learning.
- Use of a quality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes with a quarterly report presented to the Safety and Quality Committee.
- Quality impact assessment policy outlines requirements of Board members in describing service.

## Principal risks

The most significant risks that threaten the achievement of the Trust’s aims and ambitions are identified within the BAF, alongside controls and assurances which describe how the Trust manages and mitigates these risks. These are robustly monitored by the Board and Committees of the Board to ensure achievement of the Trust’s strategic objectives.

During 2020-21, the principal risks related to:

- **The inability to consistently deliver excellent care**, provide a positive patient experience and demonstrate sufficient responsiveness in the organisation’s recovery and restoration plans due to a shortage of suitably trained staff and high occupancy levels further impacted by Covid-19 and the requirement to configure services differently to accommodate infection status. To mitigate this, the Trust continues to execute novel and targeted recruitment and



retention campaigns, expand and develop relationships with community leaders and partners with increased focus on reducing health inequalities, reduce inefficiencies in internal processes and strengthen system wide partnerships to enhance the flow of patients in and out of the hospital. During 2021-22, the Trust aims to continue its organisational reset and ensure safe delivery of recovery and restoration plans by using the established control structure and by continuing to incorporate lessons learned and innovative solutions from the pandemic response. The Trust will also ensure capacity is right, embrace the latest learning, arising from robust clinical audit, and use data to drive decision making and improve health outcomes.

- **The inability to deliver value for money** due to the sustainability of complex services within an ageing estate and with continued reliance on temporary workforce leading to continued financial pressures. System wide solutions are being sought to adopt optimum service configurations and improve operational efficiencies, including through the New Hospitals Programme. This will be supported effective financial management by delivery of planned efficiencies that enables provision of sustainable services by ensuring the Trust's estate, infrastructure and plans are all focused on the long term, supported by effective business and clinical systems.
- **The inability to be a great place to work** due to the potential burnout of staff and the increasing psychological impact of the Covid-19 pandemic on staff resilience, coupled with local and national workforce shortages and an ageing estate. To ensure effective and sustainable solutions are implemented, the Trust has increased the provision of psychological support for staff, identified innovative ways of engaging with staff and enhanced its focus on equality, diversity and inclusion. Over the next four years, the Trust will be embarking in the Magnet4Europe research study which has a specific aim to improve the mental health and wellbeing of staff and reduce staff burnout.
- **The inability to be fit for the future** including modernising system delivery due to evolving system working impacting on the ability to develop and implement key change programmes within required timescales. Despite this, we continue to successfully drive change through the Trust's Our Big Plan Strategy, Governance and Risk Maturity Programme, Continuous Improvement Strategy and a number of other key programmes of work, including research. Over the next 12 months, the Trust will continue to build on the new ways of working that have arisen during the Covid-19 pandemic and ensure that it maintains and enhances the new and stronger relationships it has developed with system partners.
- **The inability to drive innovation through world class education, training and research** due to the impact of the pandemic on social distancing, the need to utilise education facilities for the Covid-19 vaccination programme and the consequences of continuing international travel limitations subsequently impacting the ability to provide face-to-face education. This is currently being mitigated through virtual, original and hi-tech solutions. As part of the Trust's ambition to develop our reputation as a provider of choice, sustain our position in the market, support business growth and our status as a teaching hospital, the Trust is committed and driven during 2021-22 to further expand opportunities for the provision of high quality, appropriately funded education, training and research.

## **Internal and External Assurance**

The Board receives independent assurance that the Trust's Risk Management System is in a place that meets the requirements of Risk Management Standards through the process of internal and external audit, including the CQC inspections, Royal College Reviews, national audits and national staff surveys.

### ***Care Quality Commission***

Lancashire Teaching Hospitals NHS Foundation Trust was last inspected between 2 July and 8 August 2019. Services that were inspected were Urgent and Emergency Services and Medical Care at Royal Preston Hospital and Chorley and South Ribble Hospital and Surgery and Critical Care at Royal Preston Hospital only.

Overall, we retained a rating of 'Requires Improvement', with 'Good' for caring and a new 'Good' for well led. This is a combined rating based on the inspection in specific core services and also based on the number of improvements observed and built on since the last inspection. Specifically, a rating of Good for 'caring' means that people are supported and treated with dignity and respect and are involved as partners in their care and a rating of Good for 'well led' means leadership, governance and culture promote the delivery of high quality person-centred care.

In the absence of an onsite inspection, we continue to maintain established and trusted relationships with the CQC by fostering a transparent relationship, sharing risks and concerns in respect of patient safety and quality as they occur, together with the actions taken or proposed in order to provide assurance that the Board has appropriate oversight of its quality governance and patient safety risks.

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

### ***Safety Triangulation Accreditation System***

We also ensure assurance of delivery of CQC standards and recommendations through the Trust's Safety Triangulation Accreditation System (STAR) which provides evidence of the standard of care delivery, including what works well and where further improvements are required through:

- **STAR Monthly reviews** – 17 audit questions are undertaken by the Matron or Professional Lead for each area.
- **STAR Accreditation Visits** – an in-depth CQC style audit is undertaken by the Quality Assurance Team with support from staff, governors and volunteers from across the Trust.
- The Trust now has the opportunity to transform its ageing infrastructure through the Government's flagship New Hospitals Programme and has agreed to work collaboratively with University Hospitals of Morecambe Bay NHS Foundation Hospital Trust, to maximise seed funding and healthcare opportunities to develop infrastructure plans which will range in scale across the region and enable a business case to be created to access significant 'final funds' which will include a new build hospital upgrade. The transformation will also provide residents and other service users with access to up-to-date facilities.

## ***Well Led Review***

In 2019, as part of an inspection, the CQC rated the Trust as Good for Well Led.

The Trust as a whole reviews its own leadership and governance arrangements periodically, in line with the requirements of NHSI that providers carry out developmental reviews. The Trust commissioned a review which was completed by MIAA in 2020. The overall conclusion of the review was that Lancashire Teaching Hospitals NHS Foundation Trust is Well Led.

MIAA highlighted 19 recommendations for improvement which the Trust has incorporated into a Well Led Plan. In addition to periodic governance reviews, the Board reviews its formal Board development programme on a quarterly basis to track and monitor whether there are any development gaps.

## ***Effectiveness of Governance and Risk Maturity***

The effectiveness of the Trust's governance structures continued to be internally tested during 2020-21 via the Annual Internal Audit Programme.

In March 2021, MIAA concluded a review of the BAF in light of the impact of the Covid-19 pandemic on the risk landscape, and the challenge for organisations to balance. Whilst no overall opinion was provided, the review concluded that the organisation's BAF is structured to meet NHS requirements, is visibly used by the organisation and clearly reflects the risks discussed by the Board.

In addition and notwithstanding the pandemic, an informal review of divisional quality and governance was also completed by the Quality Governance Lead from the Nursing Directorate at NHSE/I. This review concluded in October 2020 and highlighted a number of outstanding practices within divisional and speciality arrangements. Following the review, NHSE/I asked that the Trust work with them as an exemplar organisation to create some national guidance. NHSE/I have also signposted a number of organisations to the Trust and we continue to share our good practice in improving divisional quality and governance.

## ***Clinical Audit***

With respect to clinical audit, the Trust has an annual clinical audit and effectiveness plan for the year 2020-21 which incorporates national audits, corporate audits, audits associated with Trust-wide priorities, audit of national guidelines as well as other audits commissioned specifically in response to areas of identified risk and concern. The Audit Committee receives audit and effectiveness reports to provide assurance that the Trust has effective control and is responsive to areas of concern, which may have been highlighted through the audit process, as well as audit outcomes which demonstrates best practice. Processes around Clinical Audit were assessed by the CQC as functioning well.

## ***Head of Internal Audit Opinion 2020-21***

The overall opinion for the period 1 April 2020 to 31 March 2021 provides Substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This is an improvement on the previous financial year in spite of the impact of the pandemic.

Due to the impact of the pandemic, there was limited coverage of the quality and workforce areas highlighted in risk assessments. These areas will be considered as part of the 2021-22 risk assessment and planning process.

## **Safety and Quality**

The Trust has in place a range of mechanisms for managing and monitoring risks in respect of safety and quality including:

- A Patient Experience and Involvement Strategy 2018-2021.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director.
- Publication of an Annual Quality Account.
- The Integrated Performance Report (IPR) includes a quality report, which highlights progress against the key quality objectives in year, submitted monthly to the Trust Board.
- Arrangements and monitoring processes to ensure ongoing compliance with NICE guidance and service accreditation standards.
- The Medical Director is the Trust lead for mortality and reports regularly to the Safety and Quality Committee in respect of mortality.
- STAR Quality Assurance Framework – across all clinical areas.
- A programme of Board visits is in place to all wards and departments – clinical and non-clinical – in order to ensure that there is Board to Ward oversight and ownership of quality and safety issues. These have been conducted virtually during the pandemic.
- A Safe Staffing dashboard is in place to monitor nurse staffing levels across all wards and departments and a monthly staffing report is presented to the Safety and Quality Committee through the mandated safe staffing report. This is triangulated with measures of harm (for example hospital acquired infections) and patient experience (friends and family test).
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, e.g. national patient surveys.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient and Public Involvement representatives, such as HealthWatch and Trust governors.
- Patient and staff stories are presented to the Trust Board and actions and lessons learned are widely shared.
- Any whistleblowing concerns raised to the CQC are presented to the Safety and Quality Committee for further consideration and challenge.
- A robust process for the management of all patient safety and medical device alerts, field safety notices, estates and facilities alerts, service disruption alerts and all alerts that arise as a result of actions identified by NHSI or other national bodies are acted upon.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- The CCG undertake Quality Assurance visits and the feedback and recommendations are incorporated into our assurance framework processes. This has been suspended this year due to Covid-19. In the meantime, the CCG systematically reviews Trust delivery of the contract and key risk issues are discussed through the contract process.
- Operational and quality breaches are discussed at the relevant operational and governance forums and CCG meetings with remedial action plans enacted.

## Capacity and Flow

The NHS faced unprecedented times in 2020-21 and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has been significantly challenged by the Covid-19 pandemic. As a result, performance across the board, both emergency and elective has been significantly impacted with operational pressures experienced through the year resulting in non-compliance in relation to a number of key standards.

A whole health economy system pressures in response to Covid-19 demand resulted in high bed occupancy throughout the year with the need to focus primarily on Covid-19 non-elective activity, resulting in the standing down of non-urgent elective activity as mandated nationally for significant periods across year. A health economy system wide action plan is in place to address the urgent care system and pressures; with identified primary and social care initiatives/schemes delivering a level of sustainability across the health economy.

Since the beginning of the Covid-19 pandemic the Trust has put in place a range of measures including:

- Additional medicine bed capacity to meet increases in demand
- Re-zoning of our estate to meet infection, prevention and control requirements
- Delivery of SDEC
- Secured winter monies from the CCG to support the development of an integrated frailty model and a dedicated rehabilitation ward
- Additional Critical Care Unit surge beds with additional staffing through redeployment
- Creation of the Avondale therapy-led facility to further improve flow and create more community capacity
- Implemented digital health to reduce inappropriate admissions to hospital
- Use of continuous improvement methodology to make improvements in discharge including delayed transfers of care and reducing length of stay

These actions have all helped to support the Trust during these unprecedented times and enabled the Trust to achieve compliance against a range of measures within the risk assessment framework. These include the Emergency Department standard measured against the current improvement trajectory, two of the nine cancer waiting time standards, and one of the infection prevention standards.

However, the Trust has failed to achieve its objectives in relation to the 18-week incomplete access target and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both Referral To Treatment and cancer pathways was directly impacted by the Covid-19 pandemic and the need to cease all elective activity during the pandemic peak periods and prioritise only urgent elective activity as part of the elective restoration plan.

Alongside internal work, the Trust continues to undertake collaborative work with other partners in the local health economy through:

- A health economy wide action plan to address the urgent care system and pressures; with identified primary and social care initiatives/schemes expected to deliver a level of sustainability across the health economy.

- A range of continuous improvement and transformational work streams of which patient flow has a significant work plan attached.
- The Flow Coaching Academy which applies team coaching skills and improvement science at care pathway level to improve patient flow and experience through the healthcare system. During 2020-21, the Trust launched Lancashire and South Cumbria to become a Local Flow Coaching Academy to build improvement capacity and capability, training coaches locally.

We recognise that the longevity of system resilience is dependent on all stakeholders across our local health economy and we anticipate that there will be continued operational and subsequent compliance issues against key access targets during 2021-22 with the development of the Trust's new Planning Framework expected to identify all areas of improvement and their level of contribution to safety, quality, patient and staff experience and financial improvements.

### **Impact of Covid-19**

On 31 January 2020, the World Health Organisation (WHO) declared the Covid-19 pandemic a public health emergency and following this the United Kingdom (UK) Government Health Protection (Coronavirus) Regulations 2020 came into force on 10 February 2020.

During March 2020, at a national level the Department of Health, NHS Emergency Planning Guidance 2005, and the NHS England Incident Response Plan (National) 21 July 2017 were both enacted and in line with the guidance a level 4 incident, requiring NHS England National Command and Control support, was declared.

As a consequence to the level 4 incident, we triggered our Corporate Emergency Response and EPRR Plan and have prepared and responded to the evolving threats of the Covid-19 pandemic within the community by:

- Establishing originally bi-weekly strategic planning group meetings, reduced in wave 2 to weekly meetings and daily tactical meetings.
- Engaging in the regional EPRR structure, supported by the national EPRR team.
- Making cohort arrangements on each site to minimise the spread of infection.
- Forming an EPRR plan for each key area and testing and presenting these to senior operational and clinical leads.
- Enhancing on-call clinical executive arrangements to support decision making.
- Developing a Covid-19, Pandemic and Flu policy.
- Providing seven day IPC guidance and 24-hour microbiology support.
- Tracking the number of screened and new cases on a daily basis.
- Introducing daily communications to all staff from the Chief Executive in wave 1, reducing to 3 times weekly thereon in to ensure staff receive up to date information.
- Continuing to monitor patient safety risks through recognised systems and processes.

Covid-19 led to the reconfiguration of some key services across the Trust's two sites. On 27 March 2020, a decision was announced under Emergency Provisions, linked to the overarching statutory requirement to commission safe and effective healthcare at all times – to enact a temporary reconfiguration of services between Chorley and South Ribble Hospital and Royal Preston Hospital. This was revisited in November 2020 and has seen the Emergency Department on the Chorley site reopened, albeit with reduced hours of operation. Staff sickness has been impacted throughout the Covid-19 pandemic with both staff off sick and also due to self-isolation or shielding.

In response to wave 1, the Trust's structure of governance required a prompt response to a significant change in circumstances with the Trust stepping down Committees of the Board, except the Safety and Quality Committee, Audit Committee and Board of Directors. In response to this, the Trust temporarily introduced an operational 'Business As Usual' Group to ensure any notable business continuity issues were addressed during a period of unprecedented challenge. A report on the Trust response to the NHSI publication 'Reducing burden and releasing capacity at NHS providers and commissioners to manage the Covid-19 pandemic' was provided to the Trust Board and included an assessment of each area referenced, a position statement and where indicated any actions necessary as a result of this publication. However, in early summer 2020, the Trust made the decision to reinstate all Committee meetings, albeit via Microsoft Teams in order to provide appropriate assurance across all areas of the organisation.

## **Financial Sustainability**

During 2020-21, the Trust's underlying financial deficit position has been temporarily addressed by the arrangements put in place by the Department of Health and Social Care to support the NHS to deal with the pandemic. This has resulted in the Trust delivering a small surplus of £2.1m (page 18) in the financial year. Ongoing changes to the financial regime for Trusts with the shift away from activity based payment to block income contracts have also helped give greater certainty over income levels.

However existing expenditure trends continue in that usage of agency staff at premium rates, and significant operational pressures remain in place. This means that the Trust expects to revert to a deficit position at some point in the future and is planning its budgets for 2021-22 and beyond to include the assumption that significant financial improvement is required to deliver breakeven.

The pandemic and associated operational pressures in 2020-21 have meant that minimal savings have been delivered, and the Trust has received significant additional income to support the pandemic response.

At the end of 2019-20 there remained two outstanding areas in relation to our existing enforcement undertakings to the regulator:

- i. *Liquidity*: Following the conversion of financial support loans from 2020-21 and previous years into Public Dividend Capital (PDC) during that financial year, the Trust will be able to afford all remaining loan repayments that fall due in 2021-22 and future financial years.
- ii. *Long term sustainability*: With respect to the Trust's long term sustainability, both clinically and financially, we recognise that sustainable financial balance needs to come through engagement with the wider health economy; this requires not only the Trust to achieve service efficiencies but to maximise the use of its sites and support the wider transformational change in service delivery in particular where the Trust is not fully funded for services commissioned or patient pathways are resulting in increased costs to the Trust. The Trust is an active participant in the ICP Delivery Boards which aim to implement robust pathways of care. The Trust also sits within an ICS that is financially challenged. One of the 2021-22 objectives for the ICS is to work together as providers to gain a greater understanding of the drivers of the provider deficit within the ICS and what are the opportunities to resolve these issues in the short, medium and long term. We along with our local and system partners are

together seeking sustainable solutions through the New Hospitals Programme and we are working towards producing a range of options for the future provision of services. We will then complete a pre-consultation business case containing evidence of the work undertaken through the solution design process, following which a formal public consultation will be required.

## **Review of economy, efficiency and effectiveness of the use of resources**

The Covid-19 pandemic led to changes to the NHS financial framework with the establishment of the control and command structures both regionally and within individual organisations and an ongoing focus on the emergency response. This has required NHS organisations to operate in a different way to previous business as usual practice. Guidance was clear that financial constraints must not stand in the way of taking immediate and necessary action but that there was no relaxation in fiduciary duties. This has meant that rapid actions and decisions needed to be and continue to be made in relation to key governance processes and internal control arrangements. The challenge for the Trust has been to strike a practical balance between documenting the basis for decisions and not slowing down the decision-making processes.

Whilst continuation of some efficiency programmes have been adversely affected, including the Cost Improvement Plan, we have continued to build on and maintain some existing systems and processes to help us deliver an improvement in the financial performance, including:

- Development of a Planning Framework that applies oversight controls commensurate to the significance of the programme of work from Divisional Improvement Forums to Board, each with an identified accountable officer.
- Trust-wide commitment to the adoption of a continuous improvement approach, which has involved undertaking extensive staff engagement to identify priorities for improvement and is informing the development of a system wide Continuous Improvement Strategy for the whole health economy;
- An update to the Trust's Continuous Improvement Strategy creating a greater linkage to quantifiable financial benefits;
- Approval of the annual budget by the Board;
- Monthly Finance and Performance Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;
- Monthly Divisional Improvement Forums attended by members of the Executive Team to ensure that divisions meet the required level of performance for key areas;
- Continued grip and control activities for both requisitions and filling of vacancies by the Vacancy Control Panel, by ensuring established vacancy prior to recruitment and review of budgets before approval to recruit.
- Improvements have been made to the business planning processes with a clearer separation of business cases with a return on investment and net funding which might be required for a development or safety and quality issues.
- Further strengthening of the budget setting processes to give greater visibility to not only agreeing a budget but also to agreeing a funded establishment. We have had our nursing controls and establishment reviewed by NHSE/I which gave a positive assurance on our approach.



- The Trust's Our Big Plan Strategy also includes targets for all selected service areas to hit their identified benchmarked performance against their peers – delivered progressively over the next three years.
- The divisions continue to play an active part in ongoing review of financial performance including cost improvement requirements;
- Monthly reporting to the Board of Directors on key performance indicators covering finance and activity; quality and safety; and workforce targets through the Integrated Performance Report; and
- The Trust has updated its 'Quality Impact Assessment' process to ensure robust governance systems that require clinical approval of all cost improvement programme schemes are in place. These are escalated to the Safety and Quality Committee for consideration when impacts exceed defined thresholds with Quality Impact Assessment performance periodically reported at an agreed frequency to the Finance and Performance Committee. An example of where the Trust has used the Quality Impact Assessment is in relation to the reopening of Chorley Emergency Department.

### **The ICS Governance and a Trust Clinical Strategy**

In support of the draft strategy 'Our Integrated Care System Strategy' published by the ICS, the Trust is working to deliver clear governance arrangements for the planning and delivery of a robust Trust Clinical Strategy, which has been delayed due to the impact of Covid-19. This in turn will enhance the requirements for the CQC's assessment on Use of Resources as it will act as an enabler for best use of public sector investment to be considered on a population health outcomes basis incorporating the wider determinants of health with the Trust recognised by the ICP and System Delivery Boards as an anchor institution. The Trust is committed to the ICS process as it seeks to deliver improved health and wellbeing of local communities, joined-up care closer to home and safe and sustainable, high quality services. However, the Trust is cognisant of the challenges associated with any proposed reconfiguration and the interdependences and risks which may impact on the Trust as a result of decisions outside the Trusts control being made at an ICS level.

### **Workforce**

To ensure that short, medium and long-term workforce strategies and staffing systems are in place, the Trust has an annual workforce plan in place aligned to the Operational Planning cycle and with a focus on resourcing strategies to fill our long term, or hard to fill, workforce gaps.

This is reviewed and approved by the Workforce Committee and noted at Board. The workforce plan has taken into account changes to services, investment and cost improvement plans, recruitment successes, turnover, and predictive workforce supply. It also considers external factors that may influence services including commissioning strategies, local demographics, service transformations, service sustainability, nursing acuity reviews and local workforce challenges such as gaps in establishment, retention issues, roles which are difficult to fill, new roles, training opportunities and apprenticeships.

To balance workforce supply and demand, workforce plans and regular skill gap analysis have taken place to inform localised or profession specific recruitment plans, these plans detail the programme of activity to reduce gaps through proactive campaigns. Impacts on budgets for new requirements are also reviewed with close links between the Workforce Committee and Finance and Performance Committee. Actions have also been identified to look at opportunities to work across

the ICS to support workforce supply. This year the plan also includes details of our recovery programme in relation to workforce including strategies to look after our people and help them recover, new ways of working and delivering care, growth for the future and Covid-19 Mass Vaccination resource planning.

Monthly recruitment trajectories are also produced to monitor and review process against the plan for hard to fill medical, international recruitment and health care support worker recruitment. These are also reported to the Trust's Workforce Committee.

Succession plans are in place at Trust and divisional level to ensure a continual supply of staff with the skills to be effective in business critical roles in the future. Achievement against the plans has been monitored through Divisional Boards, Divisional Improvement Forums and the Trust's Workforce Committee. In addition to this, developing workforce safeguards reports are presented to the Safety and Quality Committee.

Since the start of the pandemic, staffing levels have been closely monitored to ensure safe staffing levels could be maintained and this was overseen on a daily basis by the Strategic Operations Group and in addition a weekly Nurse Staffing Group oversees and addresses any issues with nurse staffing levels.

### **Patient and Public Involvement in managing risk**

The Trust works with a multitude of partners including NHSE, CCGs, local Councils (including social care and education), Police, Prisons and the voluntary sector, together with the Trust's regulators. The Executive Team and senior managers work closely with the partners, to provide a local integrated service to our public and stakeholders.

The key ways in which public stakeholders are involved in managing risks which impact on them include:

- the Council of Governors at quarterly meetings take the opportunity to hold the Board of Directors to account on its performance, including quality and risk;
- the Trust's commitment to the commissioners, Chief Officer and Chief Executive meetings and consultation as required with the Overview and Scrutiny Committees and HealthWatch;
- consultation for the Quality Account involves key stakeholders;
- consultation with key stakeholders regarding key change programmes, service development and capital schemes – including the OHOC programme; and
- Executive Team, senior management and clinician involvement in the ICS and associated meetings.

In addition the Trust is involved in a range of multi-agency arrangements which assist with the management of risks across wider health and social care systems. As a member of the Lancashire and South Cumbria ICS, the Trust works with representatives from NHS providers in Lancashire with local GPs, social care colleagues and representatives of the voluntary sector for the integration of health and social care.

## Data Quality and Information governance

It is recognised that good quality information is vital to enable individual staff and the organisation to evidence they are delivering high quality care.

Risks to data security are managed through dedicated information risk and information governance policies and the Trust's information governance assessment report through the Data Security and Protection Toolkit (DSPT) submission for 2019-20 met the required standards.

This demonstrated that the Trust remains consistent with information governance compliance during 2020-21. The submission for 2020-21, which the Trust is currently working towards, has been deferred to a later date by the NHS due to the Covid-19 pandemic; however during the same period of 2020-21 there were no data breaches which reached the external reporting threshold to the Information Commissioners Office (ICO).

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

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

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

## Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. NHSI has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Foundation Trust annual reporting manual.

The content of the quality report reflects both internal and external sources of information to ensure consistency and accuracy of data. These sources of information include:

- Board and Safety and Quality Committee minutes and papers for the period April 2020 to March 2021.
- Papers relating to quality reported to the Board over the period April 2020 to March 2021.
- The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
- The 2020 national inpatient survey (subject to publication).
- The staff survey.
- Friends and Family Test responses.
- Safety incidents, clinical audit and complaints data.

As stipulated in the NHS Foundation Trust annual reporting manual 2020-21, feedback has been sought from Commissioners, governors and other key stakeholders.

The following arrangements are in place within the Trust to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

### **Policies and plans to support delivery of the Annual Quality Account**

- Policies and procedures are in place in relation to the capture and recording of patient data and to monitor and assess safety and quality.
- We synthesise patient feedback and performance information from a range of sources including local and national audit, clinical benchmarking and feedback from patients via surveys, friends and family test results, complaints, compliments and online feedback.
- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.
- Systematic internal inspection of all ward areas and departments utilising the STAR Quality Assurance Framework are carried out weekly by a team which may include a CCG representative, a governor and a specialist advisor from within the Trust. Where concerns are identified, a well-established process of rapid response is initiated, which includes a requirement to identify and implement corrective action and to monitor the effectiveness of this. Senior divisional and corporate teams oversee this process.
- We have participated in peer review exercises such as IPC and cancer services.

### **Systems and processes to support delivery of the Annual Quality Account**

- Systems and processes are in place for the audit and validation of performance data both centrally (through the data quality team) and at operational level. Weekly meetings are held to review performance, alongside a monthly performance improvement forum meeting. The latter brings together in one place all aspects of Trust performance with escalation to the Executive Team and Trust Board as required. There are plans to further strengthen these arrangements during 2021-22 with the introduction of Statistical Process Charts in all Committees of the Board and the Trust Board.

### **People and skills to support delivery of the Annual Quality Account**

- All staff involved in collecting and reporting on quality metrics are suitably trained and experienced.

- Clinical Coding is regularly audited both internally and externally and audits also take place with individual clinicians.

### **Data quality and governance**

- The Trust has in place robust policies and procedures governing the collection, collation and reporting of compliance in relation to performance standards including elective waiting times. Our elective access policy agreed with Commissioner colleagues governs the management of all patients awaiting elective treatment. The policy defines key roles and responsibilities and establishes good practice guidelines to assist staff with the effective management of the 18-week pathway experience, incorporating the outpatient, inpatient and diagnostic waiting lists.
- Monthly quality reports included within the Integrated Performance Report, which outline the Trust's performance against key quality objectives including benchmarking and comparative data, and are the subject of discussion and challenge at the Safety and Quality Committee and Trust Board meeting, inform the annual Quality Account. This information provides trend data as well as cumulative performance. In addition, more detailed qualitative and quantitative information is provided in specific reports to the Board on a regular basis.
- The Trust also considers and acts upon information received via CQC alerts, Dr Foster Intelligence alerts and clinical benchmarking tools, which inform the relevant Trust action plan e.g. mortality.
- Both the data quality assurance and operational performance teams quality assure the waiting time information utilised on a daily basis to manage patients on an elective pathway through the established comprehensive validation and rolling audit programme. The programme ensures that risks in terms of incorrect documentation or collation of data are identified with appropriate controls implemented.

The Trust's internal auditors review the processes and mechanisms through which data is extracted and reported in the quality account report to provide further assurance.

### **Review of effectiveness**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, I have detailed some examples of the work undertaken and the role of the Board, the Audit Committee, the BAF, internal audit and external audit in this process:

- The Head of Internal Audit, which provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 2020-21 is that Substantial Assurance can be given that there is an adequate system of internal control. Despite Substantial Assurance that there is an adequate system of internal control, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.
- The Assurance Framework and the monthly performance reports, which provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.
- The internal audit plan, which is risk-based, and reported to the Audit Committee at the beginning of every year. Progress reports are then presented to the Audit Committee on a regular basis, with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, raise any areas of concern at the Board, plus the minutes of the Audit Committee and a Committee Chair's report are considered at Board meetings;
- Internal audit's review on the Assurance Framework and the effectiveness of the system of internal control as part of the annual internal audit plan to assist in the review of effectiveness, which concluded the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board;
- The Board undertakes bi-monthly reviews of the Assurance Framework and the Committees of the Board undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular Committee on a monthly basis;
- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives;
- The Executive Directors and senior managers meet on a weekly basis and have a process whereby key issues such as performance management, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need;
- All relevant Committees have a clear timetable of meetings, cycles of business and a clear reporting structure to allow issues to be raised; and
- The findings of the MIAA Well Led review noted governance structures were working effectively.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of internal control.

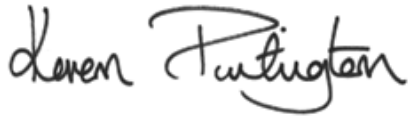
## Conclusion

In conclusion, my review confirms that Lancashire Teaching Hospitals NHS Foundation Trust has an adequate system of internal control and that there have been no significant control issues in the Trust in 2020-21. Where control issues have been identified, action has been taken or action/improvement plans are in place to address such issues.

The Trust Board recognises the challenges that the Trust faces to make the necessary service improvements and achieve financial sustainability, which will require solutions across the health system. The Trust will work collaboratively towards making these improvements during 2021-22,

whilst responding to the consequences and additional pressures arising from Covid-19. Where appropriate these action/improvement plans will be tested via relevant external scrutiny and review processes. The challenges the Board has focused on to deliver the Trust's aims and ambitions are robustly articulated in the strategic risk register that underpins the BAF in line with the Risk Management Strategy.

This Annual Governance Statement is signed on behalf of the Board of Directors by:

A handwritten signature in black ink, appearing to read 'Karen Partington'. The signature is written in a cursive, flowing style.

**Karen Partington**  
**Chief Executive**  
10 June 2021

## COUNCIL OF GOVERNORS' REPORT

**Our Council of Governors comprises elected and appointed governors who represent the interests of the members and the wider public. They also have an important role in holding the Board to account through the Non-Executive Directors.**

The Council of Governors has an essential function in influencing how we develop our services to meet the needs of patients, members and the wider community in the best way possible.

At the end of 2020-21, the Council consisted of 31 governor seats, of which: 18 are elected governors who represent the public constituency; four are elected governors who represent the staff constituencies; five are appointed by our partnership organisations (our five partner organisations being Older Adults (third sector), Preston and Western Lancashire Racial Equality and Diversity Council, the Trust's Volunteers, the Universities including University of Central Lancashire, Lancaster University and University of Manchester, and the Trust's Youth Forum); and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Council and South Ribble Borough Council).

The Chairman also chairs the Council of Governors and the Chief Executive usually attends formal meetings. Other Directors and senior managers attend some meetings, depending on the issues under discussion. Many governors also commit a significant amount of time outside of formal meetings to be involved in subgroups and in other ways to fulfil their role of representing the views of their constituents.

### Elections

The governors election process takes place between January and March each year, and governors generally serve a three-year term of office, beginning in April. At the end of March 2021, the terms of office of three public governors and two staff governors (representing doctors and dentists, and non-clinical staff) came to an end. 1,199 votes were cast in the public election: this represents a turnout of 11.8%. The staff governors representing doctors and dentists and non-clinical staff constituencies were elected uncontested.

Ahead of this year's election process, we carried out various governor recruitment activities to promote the role of the governor, such as: issuing dedicated pre-election mailing to all members; advertising governor vacancies within our latest edition of Trust Matters; held two pre-election workshops to encourage members to stand for election; and used social media to highlight the election opportunities.

### Committees and working groups

The Council of Governors has one formal Committee, the Nominations Committee, and more detail on the work of the Committee is provided within the remuneration report on page 59. For a number of years there have been three core governor working groups in place to consider specific issues in more detail than is possible at formal Council meetings. The groups focused on: our buildings and environment; our membership; and our patients' experiences.



Towards the end of 2019-20, the Council of Governors agreed that a task and finish group should be convened to understand whether the subgroup structure was fit for purpose and provide recommendations to the Council on any proposed changes. It was determined that the membership group and its terms of reference continued to be successful and relevant. However, the task and finish group considered there was significant overlap and duplication of discussion in the other two groups, therefore a recommendation was proposed, and endorsed by the Council, to amalgamate the buildings and environment and patient experience subgroups into a 'care and safety subgroup' which held its inaugural meeting on 8 June 2020. Both the groups have clear terms of reference and report their activities to formal Council of Governors' meetings.

### **Board and Council engagement**

As the Chairman chairs both the Board of Directors and the Council of Governors, he is an important link between the two bodies. To strengthen communication and engagement further there is Non-Executive Director representation on each of the core governor subgroups. This is particularly helpful in understanding relevant issues and promoting ways in which services and facilities can be developed to meet the needs of patients, staff and the wider community, which is integral to the forward planning process. There are a range of other ways in which the two bodies work together, including joint Board and Council development sessions and written communications.

To help governors fulfil their important role of holding the Board to account, governors receive updates on progress against Our Big Plan at their quarterly Council of Governors' meetings. We have also encouraged governors' attendance at Board meetings as a way in which Governors can view Non-Executive Directors providing challenge and scrutiny to the Executive Team. Non-Executive Directors also routinely attend Council of Governors' meetings which provides governors with the opportunity to report their activities to Non-Executive Directors and to raise questions. Regular briefings are also provided to governors on topical issues. In line with good practice, we also have a policy on engagement between the Board and Council, which was reviewed and refreshed during 2018-19. We have an established lead governor role and during 2020-21 this was held by public governor, Steve Heywood.

The importance of joint working between the Board and the Council is acknowledged by the members of both bodies, who are committed to building on the progress that they have made in this area. The benefits of sharing good practice across NHS organisations is recognised and governors benefit from networks with colleagues in other Foundation Trusts in the North West as well as involvement in events arranged by organisations such as NHS Providers and MIAA. This interaction has been impacted by the Covid-19 pandemic although opportunities have been provided for engagement using digital technology.

### **Declaration of interests**

All governors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Company Secretary and are subsequently reported to the Council and entered into a register. The register is published on our website or is available on request from the Company Secretary.

## Attendance summary

There were four formal Council meetings during 2020-21, which were quarterly meetings originally scheduled for April, July and October 2020 and January 2021. The April 2020 Council meeting was stood down due to the onset of the Covid-19 pandemic and in line with national guidance. However, a Council meeting was subsequently convened at the beginning of May 2020 as the programme of normal business was re-established.

The table below shows governors' attendance at Council meetings:

Name of governor	Term of office	Type of governor	A	B	Percentage of meetings attended (%)
Keith Ackers	01/04/20 – 31/03/23	Public	4	3	75%
Pav Akhtar	01/04/18 – 31/03/24	Public	4	4	100%
Takhsin Akhtar	01/04/19 – 31/03/22	Public	4	3	75%
Rebecca Allcock	01/04/17 – 31/03/23	Staff: other healthcare professionals and healthcare scientists	4	4	100%
Peter Askew	01/04/19 – 31/03/22	Public	4	4	100%
Alistair Bradley	18/05/19 – 31/05/22	Appointed	4	3	75%
Paul Brooks	01/04/20 – 31/03/23	Public	4	4	100%
Anneen Carlisle	01/04/20 – 31/03/23	Staff: nurses and midwives	4	4	100%
David Cook	01/04/20 – 31/03/23	Public	4	4	100%
Margaret France	01/04/17 – 31/03/23	Public	4	4	100%
Hazel Hammond	01/04/19 – 31/03/22	Public	4	3	75%
Steve Heywood	01/04/16 – 31/03/24	Public	4	4	100%
Javed Iqbal	01/12/17 – 31/05/21	Appointed	4	3	75%
Sue Jones	23/05/19 – 31/05/21	Appointed	4	1	25%
Trudi Kay	01/04/19 – 31/03/22	Public	4	4	100%
Karen Leckie *	01/04/18 – 31/03/21	Public	2	1	50%
Lynne Lynch	31/03/18 – 31/03/24	Public	4	4	100%
Janet Millet	01/04/17 – 31/03/23	Public	4	4	100%
Shirley Murray	08/04/19 – 31/03/22	Appointed: representing Volunteers	4	4	100%
Jacinta Nwachukwu	01/07/20 – 30/11/22	Appointed: Universities	3	1	33%
Janet Oats	01/04/19 – 31/03/22	Public	4	3	75%
Eddie Pope	15/06/18 – 31/07/21	Appointed	4	3	75%
Frank Robinson	01/04/20 – 31/03/23	Public	4	4	100%
Gurvinder Sahota *	10/11/18 – 09/11/21	Appointed	3	1	33%
Anne Simpson	01/04/20 – 31/03/23	Public	4	4	100%
Michael Simpson	01/04/19 – 31/03/22	Public	4	3	75%
Alison Slater	01/04/19 – 31/03/22	Staff	4	4	100%
Huw Twamley	01/04/18 – 31/03/21	Staff: doctors and dentists	4	4	100%
David Watson	01/04/20 – 31/03/23	Public	4	4	100%
<i>No governor currently represented for the Youth Forum</i>					
<i>No governor currently represented for the Older Adults (third sector)</i>					

A = maximum number of meetings the governor could have attended during 2020-21

B = number of meetings the governor actually attended during 2020-21

\*Stood down as a governor during 2020-21

## Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2020-21:

- Ebrahim Adia, Chairman
- Faith Button, Chief Operating Officer
- Sarah Cullen, Nursing, Midwifery and AHP Director
- Paul O'Neill, Non-Executive Director
- Karen Partington, Chief Executive
- Ann Pennell, Non-Executive Director
- Geoff Rossington, Non-Executive Director
- Gerry Skailes, Medical Director
- Kate Smyth, Non-Executive Director
- Karen Swindley, Strategy, Workforce and Education Director
- Tim Watkinson, Non-Executive Director
- Jim Whitaker, Non-Executive Director
- Tricia Whiteside, Non-Executive Director
- Jonathan Wood, Finance Director/Deputy Chief Executive

### Governor training and development

The importance of providing effective training and development opportunities for our governors is understood and is achieved in a number of ways.

On appointment, governors receive formal induction training to enable them to understand the context in which they are carrying out their role, including information on their statutory duties, as well as practical information such as the various subgroups available to them. The induction covers areas such as the local and national context, the role of regulatory bodies, the Foundation Trust provider licence, as well as practical details such as the calendar of meetings and the ways in which they will be expected to contribute in formal and subgroup meetings. Emphasis is placed on the respective roles of the Board and the Council of Governors. We recognise that induction should not be a 'one-off' session but should be a continuous process, with skills and knowledge being identified and developed at an early stage. On appointment, governors are also required to attend the Trust-wide corporate induction session.

We have a structured Governor Development Programme for governors to enable them to fulfil their statutory role as effectively as possible. Six governor workshop sessions are held each year that form a key part of the governor development process, the topics of which are largely governor-led. The opportunity is also taken at workshops for updates on operational performance, communications with the regulator and topical issues affecting the Trust.

During 2020-21, our governors have participated in a number of workshops which included the following topics:

- Being Well Led and Risk Mature: a workshop delivered by our Director of Governance.
- Risk Management: this was a follow-on session designed to discuss the role of governors in relation to risk management with a specific focus on assurance. The output of the session led to the development of a section on the role of the Council of Governors which was added to the Risk Management Strategy.
- Joint Council and Board Workshop: the Board undertakes a review of its strategy (Our Big Plan) on an annual basis and is required to have due regard to the views of governors in ensuring that the strategy is relevant, meaningful and reflective of the views of our patients.

The workshop was held to gather views of governors and their constituents as part of updating and refreshing Our Big Plan.

- **Well Led Review:** this session allowed governors to be included in the Well Led Review undertaken by MIAA between October and December 2020. A member of MIAA attended the Council of Governors' meeting on 22 October 2020 to explain that MIAA was supporting the Trust with undertaking an assessment against the Well Led requirements of the CQC inspection regime. The work to be carried out would include observations at meetings and interviews with key stakeholders. The views of the governors are considered extremely important and all governors were encouraged to attend.
- **Continuous Improvement:** the Director of Continuous Improvement sought governors' help with identifying key priorities for the continuous improvement programme for next year. The workshop was a great example of how our governors contribute their knowledge, skills and expertise to co-design our continuous improvement priorities, ensuring a real focus on patient engagement, involvement with our local communities and communication to disseminate the results. Governors raised issues that would benefit from an improvement approach and volunteered to engage in follow-up conversations around topics such as Always Safety First, further raising our level of ambition for the Trust's improvement programmes.
- **New Hospitals Programme (formerly HIP2)** – a joint Board and Council development session was held where two presentations were delivered covering the Case for Change and the Communications and Engagement Strategy.

Governors are encouraged to attend external education and training events. NHS Providers and MIAA run education and training events for governors throughout the year and our governors send delegates to these events, feeding back the topics discussed and sharing any learning with governor colleagues. In addition, there is a well-established network run by Company Secretaries, which hosts conferences known as North West Governors' Forums. These are well attended and popular with governors as they give an opportunity to share experiences with and learn from governor colleagues. The aim is to convey information on topical issues, which can help governors on an individual basis to develop and also enable them to work better collectively.

### Expenses claimed by Governors

Whilst governors do not receive payment for their work with us, we have a policy of reimbursing any necessary expenditure. During 2019-20 and 2020-21 the following expenses were claimed by our governors:

	2019-20	2020-21
Total number of governors in office (as at 31 March)	25	27
Total number claiming expenses:	11	3
Aggregate sum of expenses (£00s):	£45	£1

### Contacting your Governors

Governors are in attendance at regular members' events and the Annual Members' Meeting, and we provide facilities for governor surgeries where you can discuss your views with governors. If you wish to contact a governor outside of these events, please email: [governor@lthtr.nhs.uk](mailto:governor@lthtr.nhs.uk) or alternatively contact the Company Secretary email: [company.secretary@lthtr.nhs.uk](mailto:company.secretary@lthtr.nhs.uk).

## MEMBERSHIP REPORT

**Membership is free and aims to give local people and staff a greater influence on the provision and development of our services.**

Public membership is open to members of the public aged 16 or over who live in our membership area which comprises all of the component electoral wards in the following Local Authority areas:

- Blackburn with Darwen
- Bury
- Cumbria
- Liverpool
- Oldham
- Sefton
- Tameside
- Wigan
- Blackpool
- Cheshire East
- Halton
- Lancashire
- Rochdale
- St Helens
- Trafford
- Wirral
- Bolton
- Cheshire West
- Knowsley
- Manchester
- Salford
- Stockport
- Warrington
- 

Eligible staff members automatically become Foundation Trust members unless they choose to opt out. Staff eligible for Foundation Trust membership are those who either:

- hold a permanent contract of employment with us;
- are contracted to work for a period of 12 months or longer or have held a series of temporary contracts adding up to more than 12 months; or
- are employed by the private sector or other partners (for example local Government or other NHS Trusts) and work at the Trust on a permanent basis or fixed-term contract of 12 months or more.

### Our membership

Lancashire Teaching Hospitals NHS Foundation Trust has one of the largest membership populations in the North West although this was largely established when Foundation Trust status was gained in 2005. Since then there has been limited recruitment and consequently a slow overall reduction in total membership. The table below shows member numbers by constituency including the year-on-year percentage change:

Constituency	31 March 2021	31 March 2020	Difference	% Difference
Public	10,233	10,873	- 640	- 5.88%
Staff	8,357	8,282	75	+ 0.90%
<b>Total Membership</b>	<b>18,590</b>	<b>19,155</b>	<b>- 565</b>	<b>- 2.94%</b>

During 2020-21 regular data cleansing was carried out to ensure that records continue to be as accurate as possible. This has resulted in a number of members being removed from the database for reasons such as people moving out of the catchment area and also ensuring that deceased members have been removed, minimising potential distress to relatives caused by sending out communications addressed to them. This has caused a 5.8% reduction in the number of public members during 2020-21 compared with membership figures for 2019-20.

Recruitment activity has been focused on targeting underrepresented groups and those members that want to be actively involved.

There has been a pro-active campaign on the importance of members updating communication preferences and levels of desired involvement, with many members updating their details and requesting information via email. This helps us to engage with members more effectively and efficiently, as well as reducing expenditure on printing and postage costs.

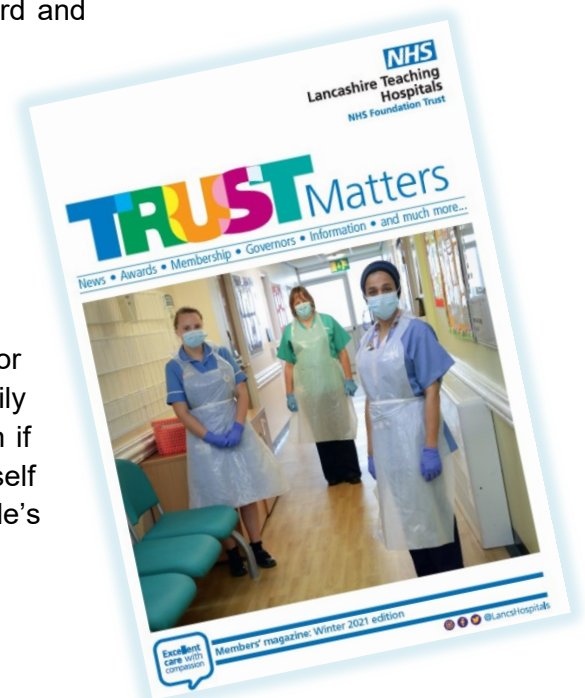
## Our strategy

Our Membership Management and Engagement Strategy 2019-2022 received approval of the Council of Governors and sets out how our membership community will remain involved and also develop; this is reinforced in the annual membership plan. For each year an annual plan will be produced which allows progress to be made against one or more of the strategic objectives. Each annual plan will take into account agreed priorities, resource and cost constraints and any external factors which may enhance or limit the chances of success. It is important that each annual plan is achievable and that high level success criteria are agreed as part of the planning process. Our vision for the membership is to have an informed, engaged and involved membership which is able to fully represent the needs and experiences of its community by actively participating in influencing and shaping how services are provided. The strategy outlines five objectives that are incorporated into the membership engagement plans; the objectives of the strategy are to:

- Ensure that the membership of the Trust is representative of the diversity of the population it serves.
- Raise awareness amongst Foundation Trust members of their role and opportunities as members.
- Ensure that there is regular and effective engagement between members and governors so that members' views can be represented.
- Ensure members are kept informed of future plans for the services provided by the Trust and have opportunity to shape those services.
- Ensure that governors have support and are equipped with the skills to represent the members effectively when working with the Trust Board and Non-Executive Directors.

## Review of 2020-21

Many of our traditional opportunities to meet with members and the public face-to-face have been put on hold by Covid-19, for example Health Melas, NHS Health Careers, individual event days on site at Chorley or Preston, public events such as Preston Pride, listening events and governor presentations to community organisations; this could easily continue throughout this year and even into next year. Even if the opportunity to hold such events in public presents itself sooner, it is possible attendance will be limited by people's concerns about group events.



Trust Matters, our members' magazine, is produced twice a year providing up-to-date information to members regarding the Trust's service developments and delivery against strategic priorities. The magazine also includes a dedicated section in which governors are able to inform members of the various ways in which they represent them and report back to members on how they have helped influence decision-making and service development from their views and feedback.

Through the magazine, we would normally take the opportunity to ask members if they would like governors to visit them in the community. As a consequence of the Covid-19 pandemic, governors have not been permitted to engage with members face-to-face due to national social distancing requirements which has impacted on them being able to listen to people's views; provide feedback to the Trust's senior management, recruit new members or raise the governor profile and that of the membership.



The Trust hosted its first virtual Annual Members' Meeting on 18 November 2020. The event provided an opportunity for patients, staff members and the public to find out about what had been happening at Royal Preston Hospital and Chorley and South Ribble Hospital and gave a detailed update on the progress and innovations the Trust had made during the last year.

At the meeting, the Trust's Directors shared a review of the organisation's 2019-20 annual report and accounts and an outline of the plans for 2020-21 and beyond. This was followed by two inspirational presentations from Consultant Chest Physician/Interventional Pulmonologist, Dr Mohammed Munavvar, on *Clinical Management and Research Trials in Covid-19*, and Consultant in Respiratory Medicine, Dr Aashish Vyas, on *Treatment of Respiratory Failure in the High Care Unit*.

The online meeting was run via Microsoft Teams Live; a link to join the meeting was available to anybody who wanted to join the meeting with a summary of the Trust's performance plans for the year ahead. Bringing the event online allowed the Trust to retain the interactive element during the question and answer session with the Trust's Executive Team which is always a dynamic and informative part of the evening. The virtual Annual Members' Meeting attracted a higher attendance when compared to previous years as it allowed people to join from their own homes or places of work. Following the live meeting, a link to watch a recording of the event was published on the Trust's website which benefitted those unable to join the live presentation as they were able to watch it at their convenience and from their own home or work place.

In partnership with the Communications and Engagement team, social media has continued to prove a useful tool throughout the year to promote Trust events, elections to the Council of Governors and to provide information to the public and members.

Historically, the Trust has offered wide ranging opportunities to enable members to become involved in its work and directly affect the planning and development of its services. There are many events organised by the Trust's departments that take place throughout the year; the Membership Office takes advantage of such events and notifies members of the details as and when appropriate.

Our governors gain the opinion of Foundation Trust members and the wider public at events hosted by our hospitals and other external community organisations. Governors play a key role in seeking the views of members and the public on our services, and this information is in turn used to inform governors' views in relation to our objectives, priorities and strategy. Governors can ensure that these views are shared with the Board of Directors as part of joint planning work which is carried out each year.

### Assessment of the membership and ensuring representativeness

In accordance with our Membership Management and Engagement Strategy, the age, gender, ethnic origin and socio-economic grouping of members is monitored. Membership figures are also analysed against the profile of our patients and the census data for our membership area. Our externally sourced comprehensive membership database shows that membership is representative of the composition of the local community we serve and generally representative of our wider membership footprint. Steps are continuing to recruit members from those areas that are underrepresented. Following the decision in November 2015 to expand the area of our Trust membership catchment area to include all of the component electoral wards in the North West (as listed at the beginning of the Membership Report) further recruitment activity will take place during 2021-22 to ensure there is representation from across the North West area of Lancashire.

There are sections of the membership where there continues to be under-representation in young people and ethnic minority groups. During 2021-22, we plan to focus on these areas in order to promote the benefits of membership.

We produce an annual Membership Engagement Plan (MEP) that is approved by both the Council of Governors and the Board of Directors. The MEP sets out our approach to engaging with our membership and includes a detailed plan of activity for the coming year. The MEP focuses on increasing engagement opportunities with our membership and involves targeted recruitment to ensure our membership is representative of the local community.

Members can contact the Membership Office via:

Website: <https://www.lancsteachinghospitals.nhs.uk/get-involved>

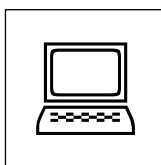
Email: [foundation.trust@lthtr.nhs.uk](mailto:foundation.trust@lthtr.nhs.uk)

Telephone: 01772 524412

Members can contact governors direct via:

Email: [governor@lthtr.nhs.uk](mailto:governor@lthtr.nhs.uk)

Telephone: Freephone 0800 073 0663



*Also available on our website:*

Further information on our membership scheme  
Information on our annual members' meetings



# AUDIT COMMITTEE REPORT

**I am pleased to present the Audit Committee report for 2020-21. The Committee's role is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.**

## Introduction

In essence the Audit Committee's remit is to ensure the systems and processes that the Trust relies upon that inform its financial statements, its operational decision making and its compliance with healthcare and governance standards are accurate, robust and can be relied upon. I am very clear as Chairman that the Committee's work is focused on providing the Trust Board with these assurances, which allow the Board to discharge its own responsibilities with regard to the outputs of our systems and processes with confidence.

Our Committee is made up of four independent Non-Executive Directors. The four members currently are: Ann Pennell, Jim Whitaker, Tricia Whiteside and myself (Tim Watkinson) with each member selected on the basis of their individual skills and attributes. Tricia is an experienced consultant in the financial services sector, with a range of relevant project management and financial knowledge and experience and is also the Chair of the Trust's Finance and Performance Committee. Jim is a Chartered IT Professional with the British Computer Society and his areas of particular expertise are strategic planning, managing change, governance and risk management and he is also the Chair of the Trust's Workforce Committee. Ann has had a long Executive career in local Government including senior roles in children's services, corporate improvement and housing, and has particular expertise in governance, strategic planning and quality and service improvement and she is also the Chair of the Trust's Safety and Quality Committee. My background is as a qualified accountant with over 25 years' experience in senior audit positions in the public sector, including the roles as Group Chief Internal Auditor for the Ministry of Justice and District Auditor for the Audit Commission. I was previously a Chief Internal Auditor in the NHS.

The Audit Committee has met four times between 1 April 2020 and 31 March 2021 and is assisted in its work through the routine attendance at meetings of our internal and external auditors and our counter-fraud specialist. If required, the Committee can also access independent legal or other professional advice to help in its work.

It is the responsibility of the Chief Executive, as the Accountable Officer of the Trust, to establish and maintain processes for governance and she is supported in this by a number of Executive Directors. The regular attendance of the Finance Director, Nursing, Midwifery and AHP Director and the Director of Governance, as a result of their lead roles in matters to be addressed by the Committee, is of further assistance to us.

During the year the Trust's overriding issue has been responding to the impact of Covid-19, with the Trust clearly having a key role in providing hospital care to patients with the virus. The Trust has also latterly played a key role in the vaccination programme. The way in which the Trust has delivered its services and its governance arrangements, including the NHS financial control frameworks, have all been significantly affected by the pandemic. The Trust has also been focussed on delivering ongoing healthcare during the pandemic, albeit the capacity to deliver such services has clearly been affected by the pandemic.

The Trust has sought to maintain strong oversight and governance during the year with all Board and Council of Governors meetings, and almost all Committee meetings continuing to take place through the medium of Microsoft Teams. The Audit Committee has met (virtually) in accordance with the agreed schedule throughout the year.

## Financial Reporting

The Audit Committee has reviewed the 2020-21 annual financial statements and has delegated responsibility from the Board for the approval of these statements.

In discharging its responsibilities the Committee has particular focus on:

- compliance with financial reporting standards;
- areas requiring significant judgements in applying accounting policies;
- the accounting policies; and
- whether the accounts and annual report are a fair reflection of the Trust's performance.

The Committee considered the financial statements audit risks including the areas where the Trust has applied judgement in the treatment of revenues and costs to ensure that annual accounts represented a true position of the Trust's finances.

The external audit plan for 2020-21 highlighted as significant audit opinion risks:

- (i) the valuation of land and buildings,
- (ii) Fraud risk from expenditure recognition,
- (iii) management override of controls,
- (iv) fraud risk from revenue recognition, and
- (v) going concern.

The Committee was assured that these identified risks are common across NHS bodies of our size and nature and are included as 'rebuttable presumptions' or in recognition of the inherent risk to an organisation of our size and complexity within the NHS.

The year-end production and audit of the financial statements has again been complicated this year through the impact of Covid-19, which has impacted on the finance department's resources, the need for the external auditors to undertake their role remotely, some changes to the year-end reporting requirements and some impacts on the sources of evidence.

During the year the Audit Committee received reports from internal audit on the Trust's financial systems and capital expenditure processes, the discussion about which has given the Committee further assurances on these systems. The overall objective of the internal auditors' work was to provide an opinion on the key controls within the systems for financial reporting, budgetary control, general ledger, treasury management, accounts receivable and accounts payable. For all these reviews the internal auditors have provided either high or substantial assurance.

The Committee routinely reviews management reports on losses and special payments, single tender waivers and off payroll arrangements to consider their appropriateness and correct implementation of management controls. We have continued to express some concern at the value of transactions processed following the application of single tender waivers and recognise that some

work is being done to ensure that the use of this process is minimized. Internal audit are due to review this area as part of the current year's programme.

The Committee has considered the appropriateness of the accounts being prepared on a going concern basis and drawn on the views of management and the external auditors to support the conclusion that it is appropriate for the accounts to be prepared on this basis. The Committee has also considered and agreed with the proposal to consolidate the accounts of the Lancashire Hospitals Services (Pharmacy) Limited subsidiary but not to consolidate the accounts for the Trust's Charities.

### **Overall assurances on integrated governance, risk management and internal control**

Operating risks considered by the Committee during the year have been around the Trust's systems and processes for activity and quality management and data collection.

The Committee has reviewed and discussed the work carried out by the internal auditors including work in relation to:

- (i) Financial systems (financial reporting, general ledger, accounts payable, accounts receivable and treasury management)
- (ii) Payroll
- (iii) Single tender waivers
- (iv) Consultant job plans
- (v) Staff risk assessments
- (vi) Hospital mortuary process
- (vii) Agency staffing

As mentioned in my report last year, some of the 2020-21 audit work was impacted by Covid-19 as elements of the audits required management input on a personal level or access to clinical areas which was not possible during the pandemic. It is commendable that during the year MIAA managed to complete the agreed programme of work for the year and have been able to provide the Trust with a Head of Audit Opinion supported by sufficient audit work.

The Committee receives all internal audit reports and pays particular attention to any 'Limited Assurance' or 'No Assurance' internal audit reports. Any significant issues arising out of such reports are escalated by the Committee to the Board. With respect to the internal audit reports issued this year, four have provided High Assurance, five have provided Substantial Assurance, one has provided Moderate Assurance and one has provided Limited Assurance. There were no reports which provided No Assurance.

The internal auditors also completed reviews on the data security and protection toolkit; Medical Assessment Unit culture survey; risk maturity follow-up; safeguarding workforce standards; third party clinical contracts Mental Health Capacity Assessment and Deprivation of Liberty safeguards; consent; and IT asset management lifecycle, but provided no overall opinion.

The Director of Internal Audit has provided an overall opinion of Substantial Assurance based on the work of internal audit during 2020-21.

The Committee draws heavily on the conclusions from the work of internal audit but also on the Committee members' own knowledge of the Trust, as members of the Trust Board. It has been a challenging year for the Trust managing the Covid-19 pandemic and it is reassuring to receive reports that confirm the general level of basic controls over the financial systems remain robust and that for the majority of the systems and processes reviewed by internal audit the Trust has received at least 'Moderate Assurance' or some other positive assurance. However, the Trust has continued to experience some difficulty in meeting its operational targets and the Trust's underlying financial position is unsustainable. The Committee will continue to seek assurance on the steps being taken to ensure improvements can be made in 2021-22 and beyond, whilst recognising the exceptional year we have had and the potential impact on the Trust's recovery plans as a consequence of Covid-19.

## Compliance

With respect to regulatory compliance, in 2014/15 NHSI (formally Monitor) opened an investigation into the Trust's financial resilience. On 18 June 2015 NHSI formally accepted enforcement undertakings given by the Trust pursuant to powers under section 106 of the Health and Social Care Act 2012 and imposed an additional licence condition (relating to additional governance requirements) on the Trust pursuant to powers under section 111 of the Health and Social Care Act 2012. On 17 May 2018 the Trust was issued a new set of enforcement undertakings, which were formally accepted by the Trust on 29 May 2018.

## Our external auditors

As reported last year, the external auditor's contract was extended for a further year to enable audit of the 2020-21 accounts due to the introduction of a new Code of Audit Practice that came into force on 1 April 2020, as the requirements within this new Code were not known at the time a re-tendering process would have taken place.

A tendering exercise was commissioned for the external auditor contract under the SBS Framework issued via the procurement department's EU Supply E-tendering system in August 2020. Applications from companies expressing an interest in the contract were evaluated by an internal panel in September 2020 including the service proposal and an assessment of value for money. This was followed by a meeting later the same month to receive presentations and further clarification from bidders on how the contract would be delivered including details of how the external auditors would work with the Trust and embrace its culture and values.

KPMG LLP was re-appointed as the Trust's external auditor with effect from 1 April 2020 for a three-year term, with the option to extend for a further two-year term. The terms of engagement and the remuneration of the external auditor are subject to approval by the Committee in accordance with the NHS Foundation Trust Code of Governance. The re-appointment was formally ratified by the Council of Governors at its October 2020 meeting.

One of the Committee's roles is to provide oversight of the performance of our external auditors. We judge KPMG through the quality of their audit findings, management's response and stakeholder feedback. This qualitative assessment, in conjunction with the use of key performance indicators within the contract for services, allows the Committee to be confident that the Trust is receiving high quality services. No decisions are taken by KPMG over the design of internal controls and they do not perform the role of management as part of any work they undertake. In

addition after each formal meeting, the Committee holds a private discussion with the internal and external auditors on an alternating basis. This is recognised best practice and allows for a frank exchange of views, without any management presence.

In addition to attending the Audit Committee, KPMG attend and report to the Council of Governors their findings for the year and make themselves available for governor workshops and briefings although during 2020-21 those sessions were impacted by the Covid-19 pandemic. Our auditors have also provided valuable support to the Trust by sharing their thoughts and guidance from across the sector and from the wider financial regulatory frameworks.

### **Our internal auditors**

The appointment of internal auditors is the responsibility of the Committee and the contract for provision of internal audit and counter-fraud services expired on 31 March 2021. The Committee considered the various procurement options bearing in mind discussions amongst Trusts within the Lancashire and South Cumbria ICS region regarding the possibility of creating a region-wide internal audit service, however, at year end no firm plans had materialised. In order to provide the Trust with continuity of services whilst discussions conclude and allow flexibility to participate in any regional arrangements that may emerge, it was decided to examine the options to put in place a short term contract arrangement with MIAA and the Committee agreed to appoint MIAA as its internal auditors for 12 months with effect from 1 April 2021, with an option to extend the contract for a further 12 months.

It is the role of the Committee to provide oversight of MIAA's performance. Our team at MIAA is led by an Engagement Lead along with a dedicated Audit Manager. The internal audit programme is risk-based and is aligned to our strategic risk assessment. The internal audit plans are developed in compliance with national standards and guidance. In addition MIAA have made themselves available to the Council of Governors for workshops and briefings although, similar to external audit, those sessions have been impacted during the year by the Covid-19 pandemic. MIAA have supported the Committee and the Trust by sharing best practice from across the sector and delivering valuable sector-wide training to members of the Committee along with other audit Committee members across the North West.

### **Counter fraud**

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by MIAA and they deliver the service in line with NHS Counter Fraud Authority's standards. In 2020-21 the anti-fraud specialist has completed the work programme in accordance with the agreed plan.

### **Audit Committee attendance summary from 1 April 2020 to 31 March 2021**

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chair)	4	4	100%
Ann Pennell	4	4	100%
Jim Whitaker	4	3	75%
Tricia Whiteside	4	3	75%

*A = maximum number of meetings the member could have attended during 2020-21*

*B = actual meetings attended during 2020-21*

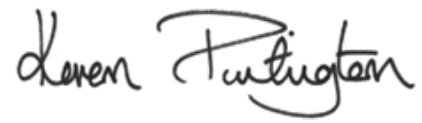
### **Audit Committee effectiveness**

The Committee undertakes a self-assessment on an annual basis although this was delayed for 2020-21 through re-prioritising work within the Trust as a consequence of Covid-19. In January 2021 the Committee undertook a review of its terms of reference and cycle of business and Committee members participated in a survey of its effectiveness, the results of which are expected to be considered by the Committee at its next meeting in quarter one of 2021-22 prior to submission to the Board. Notwithstanding the absence of a formal evaluation I am confident that the Committee has discharged its functions and responsibilities in accordance with its terms of reference, recognising the important role of this Committee to provide assurance to the Board.



**Tim Watkinson**  
 Audit Committee Chair  
 10 June 2021

This Accountability Report is signed on behalf of the Board of Directors by:

A handwritten signature in black ink that reads "Karen Partington". The signature is written in a cursive, flowing style.

**Karen Partington**

**Chief Executive**

10 June 2021

Lancashire Teaching Hospitals NHS Foundation Trust

**QUALITY REPORT**  
2020-21



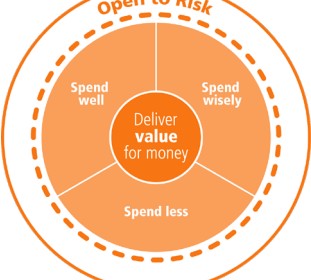



## Key - Our Ambitions

Our *Big Plan* is our Strategy which aligns to our mission “To provide excellent care with compassion” and is founded on our four ambitions which are:

- To ‘Consistently deliver excellent care’
- To ‘Deliver value for money’
- Be ‘Fit for the future’
- Be ‘A great place to work’

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

Consistently deliver excellent care	Fit for the future
 <ul style="list-style-type: none"> <li>• Improve outcomes &amp; reduce harm</li> <li>• Get it right first time</li> <li>• Positive patient experience delivered in partnership</li> <li>• Ensure a safe, caring environment</li> </ul>	 <ul style="list-style-type: none"> <li>• Transform services</li> <li>• System leadership</li> <li>• Develop of infrastructure</li> <li>• Drive innovation</li> <li>• Support healthy living</li> </ul>
Deliver value for money	A great place to work
 <ul style="list-style-type: none"> <li>• Spend well</li> <li>• Spend wisely</li> <li>• Spend less</li> </ul>	 <ul style="list-style-type: none"> <li>• Promote Health &amp; Wellbeing</li> <li>• Inform, listen &amp; involve</li> <li>• Develop people</li> <li>• Value each other</li> </ul>

# PART 1

## Chief Executive's Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period April 2020 to March 2021.

Over the last twelve months the NHS has faced unprecedented challenges in dealing with the onset of the Covid-19 pandemic which has claimed so many lives across the world and within the communities served by our Trust.

As a centre for many specialist services across our region, Lancashire Teaching Hospitals has treated many of those critically ill with Covid-19 alongside patients suffering from a range of other conditions requiring life-saving intervention. We have also put in place vaccination and testing hubs, numerous research studies and trials, and developed Covid-19 recovery and rehabilitation resources as part of the national strategy to help mitigate the effects of the virus.

Despite the pandemic we have continued to focus on our mission and our ambitions as set out in our organisational strategy *Our Big Plan* which has a very specific focus on quality. 2019-20 was year one of this during which the strategic, planning, performance and risk processes were integrated into every area of the organisation to drive leadership and quality to achieve a well-led and safe organisation delivering excellent care with compassion. Our year two metrics were revised during this year as much was put on hold during the pandemic. A new set of metrics, which have been co-developed with our divisional teams, will be relaunched across the organisation next month.

Our second Continuous Improvement Strategy was rolled out in December 2020 to reflect new priorities and incorporate a digital approach to the design and delivery of improvement programmes during the Covid-19 pandemic.

The pandemic has strengthened the partnership working with local partners, Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, third sector partners including our local hospices; Derian House and St. Catherine's Hospice with the Clinical Commissioning Group through a Central Lancashire Integrated Care Partnership and regionally with the Lancashire and South Cumbria Integrated Care System, to change the way we work and provide care and treatment more effectively and efficiently, leading to better outcomes for patients and their families, closer to home. The last 12 months has seen more mutual aid between organisations and a more collaborative approach to things like waiting lists to ensure that patients across the patch are treated equitably. The successful roll out of the vaccination programme in our region has also been a testament to partnership working in primary, secondary and community care.

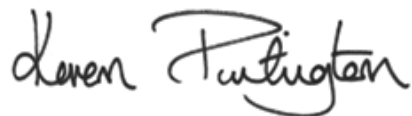
Although our financial deficit has increased due to continued growth in demand, rising costs, workforce shortages and the need to make our hospitals Covid-19 secure we have continued to make incremental improvements to our operational efficiency.

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

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

I would therefore like to record my thanks to all our staff, as well as our local partners and local communities for their unwavering dedication and support throughout a year which has been unlike any other I have experienced in my 43 years with the NHS.

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

A handwritten signature in black ink, reading "Karen Partington". The signature is written in a cursive style with a large, prominent initial 'K'.

**Karen Partington**

**Chief Executive**

10 June 2021

# PART 2

## 2.1 Priorities for Improvement

Our *Big Plan* was developed in partnership with our divisions and aligns the organisation’s mission “To provide excellent care with compassion” with our ambitions.

Our values underpin everything we do and support the delivery of our ambitions for the three years 2019-22.

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

**Our values**

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

**Figure 1 Our Ambitions**

Consistently deliver excellent care		Fit for the future	
	<ul style="list-style-type: none"> <li>• Improve outcomes &amp; reduce harm</li> <li>• Get it right first time</li> <li>• Positive patient experience delivered in partnership</li> <li>• Ensure a safe, caring environment</li> </ul>		<ul style="list-style-type: none"> <li>• Transform services</li> <li>• System leadership</li> <li>• Develop of infrastructure</li> <li>• Drive innovation</li> <li>• Support healthy living</li> </ul>
Deliver value for money		A great place to work	
	<ul style="list-style-type: none"> <li>• Spend well</li> <li>• Spend wisely</li> <li>• Spend less</li> </ul>		<ul style="list-style-type: none"> <li>• Promote Health &amp; Wellbeing</li> <li>• Inform, listen &amp; involve</li> <li>• Develop people</li> <li>• Value each other</li> </ul>

Our *Big Plan* is enabled through the commitments in the *Nursing, Midwifery, Allied Health Professional (AHP) and Care Givers Strategy* as well as those in the *Patient Experience and Involvement Strategy* using the methodology and approach outlined in the *Continuous Improvement Strategy*.

**Nursing, Midwifery, AHP and Care Givers strategy commitments**

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

### The Patient Experience and Involvement Strategy commitments

- Deliver a positive experience
- Improve outcomes and reduce harm
- Create a good care environment
- Improve capacity and patient flow



Patient Experience


Our *Big Plan* and the strategies can be found on our Hospital Internet site.

## Priorities for Improvement

Our *Big Plan* has committed to delivering a wide range of improvements over a 3 Year period (2019-22). The following key priorities were identified and reported in 2019-20 and continued into Year 2 (2020-21). Our performance in these priorities for 2020-21 is presented below.

### Our *Big Plan* 3 Key Priorities:

- A STAR status of 50% of wards and departments rated as silver in Year 1 with 25% of those rated as gold standard in Year 2, 2020-21.
  - Due to the impact of the COVID-19 pandemic it was recognised that the STAR accreditation visits would be significantly affected so the target was adjusted to '50% of areas achieving silver or above by the end of March 2021'.
- A yearly 5% reduction in patient falls causing major or above harm.
- A 5% reduction in the number of grade 2 hospital acquired pressure ulcers in Year 1 & a further 5% in Year 2.

-  **A STAR status of 50% of wards and departments rated as silver in Year 1 (2019-20) with 25% of those rated as gold in Year 2 (2020-21)**

23% of wards and departments have achieved having a silver STAR rating in the 2018-19 reporting period which increased to 43% in 2019-20. We temporarily stopped the STAR visits for short periods during the COVID-19 to enable resources to be re-directed to support clinical teams in caring for patients. Our target was adjusted in recognition of the impact of the pandemic.

- 50% of areas achieving silver or above by the end of March 2021' which was exceeded with 61% of wards having a silver or above star rating.

-  **A yearly 5% reduction in patient falls causing major or above harm over 3 years 2019-2022.**

The number of all falls has not reduced as planned in this reporting period:

- The total number of falls **with major and above harm** (severe, death) reduced from 14 inpatient falls in 2018-19 to 12 in 2019-20 which was a reduction of 21.43%, however the number has increased to 15 cases in 2020-21, therefore this target has not been met.

- Our All falls incident rate decreased from 1150 falls in 2018-19 to 1143 falls in 2019-20. There has also been a slight reduction from 1143 in 2019-20 to 1142 in 2020-21.

-  **A 5% annual reduction of hospital acquired grade 2 pressure ulcers**

This was not achieved in 2018-19, 2019-20 and 2020-21 which continues to be as a result of factors including the complexity and frailty of patients, increases in the number of patients admitted to hospital and in 2020-21 the impact of high levels of critically sick patients with COVID-19.

Our pressure ulcer prevention breakthrough series collaborative was established in June 2020 which has taken action to reduce incidence and to continually improve the interventions in pressure ulcer identification and management. Further information is presented on page 200.

## Priorities for Improvement 2021-22

Our priorities for improvement for 2021-22 are as follows:

- Further 5% reduction in the number of grade 2 pressure ulcers.
- Improvement in Mortality Structured Judgement Reviews ensuring a minimum 20% per month are undertaken by each speciality.
- Improvement in the Maternal *Clinical Negligence Scheme for Trusts* (CNST) Incentive Scheme.

These priorities will be monitored through our governance and reporting processes, managed through the arrangements described in the relevant strategies and supported by the Continuous Improvement team.

## Continuous Improvement and *Always Safety First*

We launched our second Continuous Improvement Strategy in December 2020 to reflect new priorities and incorporate a digital approach to the design and delivery of improvement programmes during the COVID-19 pandemic. The Continuous Improvement (CI) team also led the development of our first Integrated Care Partnership (ICP) Continuous Improvement Strategy which was approved by the ICP Board in October 2020, ensuring a consistent approach to collaborative improvement programmes. In line with national and regional guidance a number of the Trust's improvement programmes were temporarily halted to enable resources to be prioritised for front line care. The full Continuous Improvement programme has now recommenced as we have started to return to business as usual.

We continue to deliver our improvement programmes at three levels; system; pathway and local level. In 2020 we launched the Lancashire and South Cumbria Flow Coaching Academy with 30 coaches being trained to deliver improvements in 15 pathways (at Trust, ICP or Integrated Care System (ICS) level), including a team from University Hospitals Morecambe Bay NHS Foundation Trust (UHMB). Our local Microsystem Coaching Academy (MCA) also launched in 2020 training over 20 coaches to coach local ward and department level improvement.

Our strategy has a deliberate approach to undertake improvement at macro (system level), meso (pathway level) and micro (local) system levels presented below.

**Figure 2 Continuous Improvement Strategy Levels**




Source: LTHTR

### System Level Improvement

An organisational wide patient safety improvement programme *Always Safety First* was delivered in 2020, which aimed to reduce avoidable harm through a patient safety collaborative approach, focused on improving the areas outlined in Table 1 below. The safety programme provides our response to the National NHS Patient Safety Strategy and continues to be developed with a new Safety Strategy due to be launched in quarter 1 of 2021. The Quality Account priorities for improvement in 2020-21 are in *Our Big Plan* and both of the pressure ulcers and falls collaboratives are part of the *Always Safety First* agenda.

**Table 1 Always Safety First Improvement Programme Areas**

 #AlwaysSafetyFirst	
Pressure Ulcers	Deteriorating Patient
Falls	Children's Safety
Venous Thromboembolism (VTE)	Transfers of Care & Discharge
Health Care Associated Infections, Clostridium <i>Difficile</i>	Safeguarding Deprivation of Liberty Standards (DoLs), learning disabilities & mental health
Medicines Management	Invasive Procedure Safety Checks

Source: LTHTR

Throughout 2020-21 we have delivered and continue to work on the following key programmes as part of *Always Safety First*:

- Set up of a trust wide *Always Safety First* Breakthrough Series Collaborative.
- A review of patient risk assessments and care plans to improve process reliability and timely completion.
- Set up and delivered a virtual *Always Safety First* Pressure Ulcer improvement collaborative to reduce pressure ulcers and improve pressure ulcer prevention.

- Set up and delivered a virtual *Always Safety First* Falls improvement collaborative to reduce inpatient fall and improve falls prevention.
- Scoped and developed a Trust wide Safety Surveillance System based on the Health Foundations, 'Measuring and Monitoring Safety framework' to develop a sophisticated multi layered Safety Surveillance system, which will allow us to begin to predict and mitigate potential future harms.
- VTE improvement programme set up to increase risk assessment compliance and reduce the incidents of VTE.
- Transition of data and measurement from RAG rating to SPC charts in Trust Board and Committee report. Developing capability to interpret data for improvement.

In 2020-21 we have also led a system level virtual Breakthrough Series Collaborative to develop an Integrated Stoke and Neurorehabilitation Delivery Network (ISNDN). The objectives required all providers to work towards the achievement of an 'A' rating in the Sentinel Stroke National Audit programme (SSNAP) data, to develop and test a standardised ambulatory care pathway for stroke patients and to work towards the establishment of hyper-acute stroke units." This was achieved in September 2020, with the ISNDN fully functioning as per national guidance.

### **Pathway Level Improvement**

Our first wave of coaches completed their training and graduated from the Flow Coaching Academy Programme on 13th February 2020. This has now led to four big rooms focussing on the following clinical pathways: Colorectal cancer, Frailty, Inflammatory Bowel Disease and Sepsis which are now fully established and focused on the delivery of improvements.

The quality improvement measures we are using to improve patient care and experience in these pathways are outlined below:

- **Colorectal** - Initiating the straight to test pathway which will reduce waiting times for cancer testing. The Colorectal team will continue to improve this process through early pathway testing via the rapid diagnostic centre.
- **Frailty** - Primary focus includes reducing length of stay and admission avoidance. The Frailty team tests of change include collaborative community working and a designated acute frailty zone within the Medical Assessment Unit.
- **Inflammatory Bowel Disease** - The key outcome identified within this pathway improvement is to reduce the time it takes for a patient to contact the service. Testing also includes the development of a virtual biologic clinic which will lead to a regular review of patients; ensuring patient medications are up to date.
- **Sepsis** - The focus of improvement is to reduce the time it takes to administer antibiotics to a patient who presents with signs of sepsis.

To understand the impact of these improvement programmes, we have developed a robust evaluation plan which uses formative evaluation, using a Rapid Cycle approach. We have 30 new Flow Coaches who are currently being trained in our newly established Lancashire and South Cumbria FCA to increase capability of the workforce and 15 new pathways will commence later in 2021, these are presented in the Table 2 below:



**Table 2 Pathway Improvement Programmes 2021-22**

Pathway Improvement Programmes	
Brain Cancer	Gynaecology
Lung Cancer	Respiratory
Chemotherapy	Neurosurgery
Deteriorating Patients	Vascular
Enhanced Care	Ear, Nose & Throat (ENT)
End of Life Care	Endoscopy
Nutrition	Colorectal (UHMB-led)
Discharge	

Source: *LTHTR*

Through the process of redesigning pathways; staff and patients co-design tests of change, focussing on what matters the most to our patients to enhance the quality and experience of care. This process forms the basis for agreed quality improvement outcomes which will be monitored and report upon throughout the programme

### Local Level Improvement

Our CI team are currently leading a Microsystem Coaching Academy programme, which was launched in October 2019. Six coaches completed their training and graduated from the Microsystem Coaching Academy programme in the summer of 2020.

Six areas selected were the Medical Assessment Units (MAU) at Preston and Chorley, the Emergency Theatre, Ward 8 and the Paediatric Assessment Unit (PAU), Critical Care and Ward 15. These areas are aiming to improve patient care and experience outlined below:

- **Preston MAU** – To reduce the time to transfer patients from MAU to in-patient wards.
- **Chorley MAU** – To reduce time patients spend in the General Practice (GP) Escalation area of MAU.
- **Ward 8** – To improve the efficiency of observations leading to reducing risk.
- **Emergency Theatres** – To improve the efficiency of stock control, leading to overall cost reduction.
- **Critical Care** – To develop utilising Healthcare Assistants to aid patient recovery.
- **Ward 15** – To reduce pressure ulcers.
- **Preston PAU** – To review clinic capacity and utilisation (an addition to the programme)

In 2020-21, we commenced our own local Microsystem Coaching Academy; all improvements are co-designed, with staff and patients leading the way. This will facilitate opportunities for change at a microsystem level, ensuring that improvements are made and have impact where it most matters. Our CI team will continue to support meetings and coach teams, increasing improvement capability within the wider workforce and will continue to develop plans for the local programme running in 2020-21.

### Divisional Level Improvement

Our Divisions are supported by the CI team in bespoke improvement work streams, in addition to a capability building programme, which commenced in November 2019 and provides delegates with a foundation in improvement methodologies. This offer will be expanded through 2020-21.

This year we have seen a specific focus on ‘System Flow and Discharge’ and as a result of this, significant work has been put into redesigning pathways and processes through working collaboratively with our system partners, which we believe will provide significant benefit for our patients and improve experiences of the services which we provide. By using continuous improvement methodology and strengthening our workforce capability we plan to continually develop our improvement programmes to support our organisational priorities.

## Risk Maturity

Our organisation has adopted a strategic approach to the management of risk by integrating risk into ‘Our Ambitions’ so that they link to the strategic objectives of *Our Big Plan* and supports the “well-led” aspect of the CQC requirements. It has also addressed the feedback received from the Mersey Internal Audit Agency (MIAA) in 2018 and the CQC in 2019 which highlighted that we could further develop the way risks are managed and support the continued improvement of safety, effectiveness and the experience of patients through the way that services are delivered.

Our Board has defined the level of risk appetite for each ambition and a description of what the appetite means is presented below.

### Risk Appetite Statement

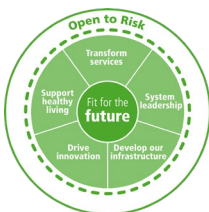
“The Trust has a low appetite for risk in relation to its strategic aim to **Consistently Provide Excellent Care**, only being prepared to adopt safe delivery options. However, the Trust has an open appetite for risk in relation to its strategic aims to be **Fit for The Future** and to **Deliver Value for Money**, so that the Trust embraces change and employs innovative approaches to the way services are provided. The Trust has a moderate appetite for risk in its strategic aim to create a **Great Place to Work**, recognising the need for a strong and committed workforce might involve accepting some, but not significant risk.” The Risk Appetite Statement was initially approved by the Trust Board on the 5<sup>th</sup> December 2019; it has been monitored regularly and reconfirmed by the Board on 3<sup>rd</sup> December 2020.

**The Consistently deliver excellent care ambition is cautious to risk.**



This means our Board is willing to accept some low risk, whilst maintaining an overall commitment to safe delivery options.

**The Fit for the future ambition is open to risk.**



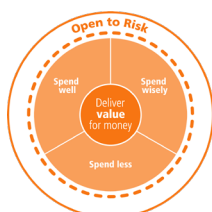
This means our Board is prepared to consider all delivery options, so that we embrace change and employ innovative approaches to the way our services are provided, selecting those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

## The Great place to work ambition is **moderate risk**,



This means our Board is tending always towards exposure to only modest levels of risk in order to achieve acceptable but possibly unambitious outcomes, recognising the need for a strong and committed workforce might involve accepting some, but not significant risk.

## The Deliver value for money ambition is **open to risk**.



This means our Board is prepared to consider all delivery options, so that we embrace change and employ innovative approaches to the way services are provided, selecting those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

To address the MIAA and CQC feedback, the Trust has taken a number of additional steps to meet the recommendations. These include:

- Integrating the use of the risk appetite and defining the components and nomenclature of the Board Assurance Framework (BAF) throughout the organisation i.e. Strategic Risk Register + Operational Risk Register = BAF and improve staff understanding of this.
- Refinement and strengthening of the use of the BAF in the Committees of the Board meetings to ensure that there is clarity on actions being undertaken to mitigate risks and that any changes to risks or assurance levels is updated in a timely manner.
- Review of the processes for recording, reporting and mitigating risk to ensure that risk registers and the BAF are up-to-date, in line with the trust's policy and reflective of the risks and their impact on the trust. The Key Performance Indicators associated with this are reflected in the new governance dashboard.
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to the Board via the BAF. This is reflected in the updated Risk Management Strategy.
- Re-designing and relaunching the Datix Risk Register module to support improvement programmes.
- Re-designing of the BAF and Strategic Risk Templates.
- Extending the use of dashboards to include themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Implementation of governance dashboards for each division, monitored as part of the accountability framework in divisional improvement forums with specific risk key performance indicators including risk, audit, incident and safeguarding management.

- Enhancing training and support at all levels of the organisation, including a series of Board Workshops throughout the year.
- Enhancing lessons learned from risk management integrated into the learning to improve bulletins.
- Creation of a newly formed Executive Management Group as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive Team.
- Review of the Risk Management Strategy and approval sought at Board of Directors in August 2020.

During 2020-21, an informal review of divisional quality and governance was undertaken by the Quality Governance Lead from the Nursing Directorate at NHS England/Improvement (NHSE/I). This review highlighted a number of outstanding practices within divisional and speciality arrangements and following the review, NHSE/I asked that the Trust work with them as an exemplar organisation to create some national guidance. In addition NHSE/I have signposted a number of organisations to our Trust and we continue to share our good practice in improving divisional quality and governance.

## 2.2 Statements of Assurance from the Board

This section of the quality account is presented with the numerical referencing required by NHS Improvement; therefore the numerical referencing in some parts is non-consecutive. It is also presented in places with the narrative which is mandated in the quality account regulations which refers to Lancashire Teaching Hospitals NHS Foundation Trust or the Trust.

- 1.0 During 2020-21 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted forty six relevant health services.
- 1.1 The Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in forty six relevant health services.
- 1.2 The income generated by the relevant health services reviewed in 2020-21 represents 100 % of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2020-21.

### Participation in Clinical Audits



- 2.0 During 2020-21 forty five national clinical audits<sup>1</sup> and two national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.
- 2.1 During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 98%<sup>2</sup> national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
- 2.2 The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2020-21 are as follows:

**Table 3 Audit and Confidential Enquiries - Eligible for Participation**

National Clinical Audit	
Project Name	Provider Organisation
Antenatal and Newborn National Audit Protocol 2019 to 2022	Public Health England
BAUS Urology Audit - Cystectomy	British Association of Urological Surgeons (BAUS)
BAUS Urology Audit - Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)
BAUS Urology Audit - Nephrectomy	British Association of Urological Surgeons (BAUS)
BAUS Urology Audit - Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)

<sup>1</sup> List of national clinical audits as per specification provided by the DH cited on the HQIP website <https://www.hqip.org.uk/national-programmes/quality-accounts/> <sup>2</sup> The Trust did not participate in the Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit due to pressures in the Gastroenterology service.

BAUS Urology Audit - Radical Prostatectomy	British Association of Urological Surgeons (BAUS)
British Spine Registry	Amplitude Clinical Services Ltd
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Elective Surgery - National PROMs Programme	NHS Digital
Emergency Medicine QIPs Pain in Children / Fractured neck of Femur / Infection Control	Royal College of Emergency Medicine (RCEM)
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians (RCP)
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD Registry Ltd
Learning Disabilities Mortality Review Programme (LeDeR)	University of Bristol / Norah Fry Centre for Disability Studies
Mandatory Surveillance of Health Care Associated Infections (HCAI)	Public Health England (PHE)
Maternal, Newborn and Infant Clinical Outcome Review Programme	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Royal College of Physicians (RCP)
National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons (RCS)
National Audit of Cardiac Rehabilitation (NACR)	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia Care (In general hospitals)	Royal College of Psychiatrists (RCPsych)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
National Cardiac Audit Programme (NCAP) - Heart Failure and MINAP	Barts. Health NHS Trust
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	NHS Blood and Transplant
National Diabetes Audit – Adults	NHS Digital
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)
National Gastro-intestinal Cancer Programme	NHS Digital
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists (RCOG)

National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)
National Prostate Cancer Audit	Royal College of Surgeons (RCS)
National Vascular Registry	Royal College of Surgeons (RCS)
Neurosurgical National Audit Programme	Society of British Neurological Surgeons
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections	Public Health England
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists
Sentinel Stroke National Audit programme (SSNAP)	King's College London
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine (SAM)
Surgical Site Infection Surveillance Service	Public Health England (PHE)
The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust
UK Registry of Endocrine and Thyroid Surgery	British Association of Endocrine and Thyroid Surgery (BAETS)
UK Renal Registry National Acute Kidney Injury programme	UK Renal Registry

#### National Confidential Enquiries

##### Clinical outcome review programmes / National Confidential Enquiries

Maternal, Infant and New-born Clinical Outcome Review Programme MBRRACE-UK

Child Health Clinical Outcome Review Programme

No studies collecting data during 2020-21

Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD:

Studies collecting data during 2020-21

- Physical health in mental health hospitals (includes acute Emergency Departments)
- Dysphagia in Parkinsons

2.3 The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2020-21 are as follows:

**Table 4 Audit and Confidential Enquiries - Participated**

National Clinical Audit	
Project Name	Participated
Antenatal and Newborn National Audit Protocol 2019 to 2022	Yes
BAUS Urology Audit - Cystectomy	Yes but no studies running 2020-21
BAUS Urology Audit - Female Stress Urinary	Yes

Incontinence	
BAUS Urology Audit - Nephrectomy	Yes but no studies running 2020-21
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes but no studies running 2020-21
BAUS Urology Audit - Radical Prostatectomy	Yes but no studies running 2020-21
British Spine Registry	Yes
Case Mix Programme (CMP)	Yes
Child Health Clinical Outcome Review Programme	Yes
Elective Surgery - National PROMs Programme	Yes
Emergency Medicine QIPs Pain in Children / Fractured neck of Femur / Infection Control	Yes
Falls and Fragility Fractures Audit programme (FFFAP)	Yes
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	No
Learning Disabilities Mortality Review Programme (LeDeR)	Yes
Mandatory Surveillance of Health Care Associated Infections HCAI	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (NCEPOD)	Yes but no studies running 2020-21
Medical and Surgical Clinical Outcome Review Programme (NECPOD)	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Yes
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Care at the End of Life (NACEL)	Yes
National Audit of Dementia Care (In general hospitals)	Yes but no studies running 2020-21
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Cardiac Audit Programme (NCAP) - Heart Failure and MINAP	Yes
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	Yes but no studies running 2020-21
National Diabetes Audit – Adults	Yes
National Emergency Laparotomy Audit (NELA)	Yes
National Gastro-intestinal Cancer Programme	Yes
National Joint Registry (NJR)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes
National Prostate Cancer Audit	Yes
National Vascular Registry	Yes
Neurosurgical National Audit Programme	Yes
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections	Yes



Perioperative Quality Improvement Programme (PQIP)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes
Surgical Site Infection Surveillance Service	Yes
The Trauma Audit & Research Network (TARN)	Yes
UK Cystic Fibrosis Registry	Yes
UK Registry of Endocrine and Thyroid Surgery	Yes
UK Renal Registry National Acute Kidney Injury programme	Yes

2.4 The national clinical audits and national confidential enquires that Lancashire Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2020-21, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

**Table 5 Audit and Confidential Enquiry - Case Submission**

<b>National Clinical Audit</b>		
<b>Project Name</b>	<b>Clinical Cases Required</b>	<b>Actual Number submitted</b>
Antenatal and Newborn National Audit Protocol 2019 to 2022	No set number, as met criteria	There are 8 component parts to this audit. Some do not collect patient level data but of those that do (5 audits in total) data on 179 patients was submitted
BAUS Urology Audit: Cystectomy Female Stress Urinary Incontinence Nephrectomy Percutaneous Nephrolithotomy - (PCNL) Radical Prostatectomy	No set number, as met criteria	Hospital Episode Statistics (HES) for 2017, 2018 and 2019 combined (published in 2020) RPH  <u>Cystectomy</u> 99% of cases of the total 89 cases  <u>Nephrectomy</u> 100% of the total 277 cases  <u>PCNL</u> 52 cases (total number of procedures performed)  <u>Radical Prostatectomy</u> 84 % of the total of 293 cases

British Spine Registry	No set number, as met criteria	427
Case Mix Programme (CMP)	No set number, as met criteria	<u>Critical Care Unit at RPH:</u> 1613
Child Health Clinical Outcome Review Programme	No studies collecting data during 2020-21	Data collection for this audit did not take place this year
Elective Surgery - National Patient Reported Outcome Measures (PROMs) Programme	No set number of questionnaires for completion, as patients met criteria	Data for Hip replacement 1st Apr 2019 – 31st Mar 2020 (final). Published Feb 2021  Hip replacement 131 Hip replacement primary 114 Revision 17  Knee replacement 123 replacement primary 115 Knee revision 8
Royal College Emergency Medicine (RCEM) Quality Improvement Programmes Pain in Children / Fractured neck of Femur / Infection Control	No set number, as met criteria	<u>RCEM Pain in children</u> 4  <u>RCEM Infection Control</u> 95  <u>RCEM Fractured neck of femur</u> 34  The audits are still ongoing though. We have therefore not yet submitted all the cases.
Falls and Fragility Fractures Audit programme (FFFAP)	No set number, as met criteria	7/17 submitted (41%)
Learning Disabilities Mortality Review Programme (LeDeR)	No set number, as met criteria	31 LeDeR notifications
Mandatory Surveillance of Health Care Associated Infections (HCAI)  Included: Clostridioides <i>Difficile</i> ( <i>C. Difficile</i> ) COCA = Community Onset Community Associated  COIA = Community Onset Indeterminate Associated  COHA = Community Onset	No set number, as met criteria	<u>C. Difficile Toxin</u> COCA – 37 cases COIA – 19 cases COHA – 22 cases HOHA – 78 cases  <u>Total Hospital associated cases</u> 100 Total Community associated cases - 56 Total number of cases – 156  <u>MRSA</u>

<p>Healthcare Associated</p> <p>HOHA = Healthcare Onset Healthcare Associated</p> <p>Escherichia Coli = E.coli</p> <p>MRSA = Methicillin-resistant Staphylococcus Aureus</p> <p>MSSA = Methicillin-susceptible Staphylococcus Aureus</p> <p>Klebsiella</p> <p>Pseudomonas</p>		<p>Community – 0 cases Hospital – 0 cases Total – 0 cases</p> <p><u>E.coli</u> Community – 205 cases Hospital – 41 cases Total – 246 cases</p> <p><u>MSSA</u> Community – 57 cases Hospital – 27 cases Total – 84 cases</p> <p><u>Klebsiella</u> Community – 45 cases Hospital – 12 cases Total – 57 cases</p> <p><u>Pseudomonas</u> Community – 21 cases Hospital – 11 cases Total – 32 cases</p>
Maternal, Newborn and Infant Clinical Outcome Review Programme (NCEPOD)	No studies collecting data during 2020-21	Data collection for this audit did not take place this year
Medical and Surgical Clinical Outcome Review Programme (NECPOD)	No set number, as met criteria	<p><u>Physical health in mental health hospitals:</u> 5 eligible patients</p> <p><u>Dysphagia in Parkinsons</u> 2 organisational surveys completed. 6 consultants were sent clinician questionnaires to complete, 1 returned</p>
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	No set number, as met criteria	<p><u>COPD:</u> 374</p> <p><u>Asthma (Adult):</u> 88</p> <p><u>Asthma (Paediatrics):</u> 50</p>
National Audit of Breast Cancer in Older People (NABCOP)	No set number, as met criteria	Patients > 50 yrs. in 2018 , 157 cases
National Audit of Cardiac Rehabilitation (NACR)	No set number, as met criteria	771
National Audit of Care at the End of Life (NACEL)	No studies collecting data during 2020-21	Data collection for this audit did not take place this year
National Audit of Dementia Care (In general hospitals)	No studies collecting data during 2020-21	Data collection for this audit did not take place this year
National Cardiac Arrest Audit (NCAA)	No set number, as met criteria	80

National Cardiac Audit Programme (NCAP) - Heart Failure/ and Myocardial Ischaemia National Audit Project (MINAP)	No set number, as met criteria	<u>Heart Failure</u> 400  <u>MINAP</u> 239
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	No studies collecting data during 2020-21	Data collection for this audit did not take place this year
National Diabetes Audit – Adults	No set number, as met criteria	136
National Emergency Laparotomy Audit (NELA)	No set number, as met criteria	121
National Gastro-intestinal Cancer Programme	No set number, as met criteria	<u>National Bowel Cancer Audit</u> – 178 (2020 Annual Report - patients diagnosed with bowel cancer between 01 April 2018 and 31 March 2019)  <u>National Oesophago-Gastric Cancer Audit</u> – 178 (2020 Annual Report - patients diagnosed with OG cancer between 1st April 2017 and 31st March 2019)
National Joint Registry (NJR)	No set number, as met criteria	244
National Lung Cancer Audit (NLCA)	No set number, as met criteria	291
National Maternity and Perinatal Audit (NMPA)	No set number, as met criteria	Early Neonatal deaths 7 Late Neonatal Deaths 2 Post Neonatal deaths 2
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	No set number, as met criteria	483 new admissions – (+14 re-admissions) Total 497
National Paediatric Diabetes Audit (NPDA)	No set number, as met criteria	221
National Prostate Cancer Audit	No set number, as met criteria	Latest figures 1st April 2018 – 31st Mar 2019 2020 report 318 cases
National Vascular Registry	No set number, as met criteria	Abdominal aortic aneurysm 84 Angioplasty 1183 Bypass 337 Amputation 169 Carotid endarterectomy 101
Neurosurgical National Audit Programme	No set number, as met criteria	April 2018 – Mar 2019 <u>Adults:</u>

		409 <u>Paediatrics:</u> <5
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections	No set number, as met criteria	13
Sentinel Stroke National Audit programme (SSNAP)	No set number, as met criteria	639
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	No set number, as met criteria	2019 16
Society for Acute Medicine's Benchmarking Audit (SAMBA)	No studies collecting patient data during 2020-21. Only the organisational audit	Patient data collection for this audit did not take place this year
Surgical Site Infection Surveillance Service	No set number, as met criteria	<u>Total Hip Replacements:</u> April-June = 0 July-September = 31 October-December = 56 Jan-March = 8  <u>Total Knee Replacements:</u> April-June = 0 July-September = 21 October-December = 36 Jan-March = 13
The Trauma Audit & Research Network (TARN)	No set number, as met criteria. Data completeness is the percentage of cases submitted to TARN compared to the expected number derived from the HES dataset	Up to December 2020: 665.100% case ascertainment
UK Cystic Fibrosis Registry	No set number, as met criteria	Data completeness not being reported due to COVID-19
UK Registry of Endocrine and Thyroid Surgery	No set number, as met criteria	6 <sup>th</sup> report not published yet. Surgeon Specific Outcome Report available on the BAETS website. Total number submitted: 25
UK Renal Registry National Acute Kidney Injury programme	No set number, as met criteria	Latest figures July 2020-September 2020 912

2.5/6 The reports of 20 published national clinical audits were reviewed by the provider in 2020-21 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

**Table 6 Audit and Confidential Enquiry – Intended Actions**

All Actions are monitored in our *Audit Management and Tracking* system (AMaT)

Title of Audit	Intended Actions
ANNB Women who miscarry or terminate the pregnancy after screening has taken place	<ul style="list-style-type: none"> <li>• Pathway to be clarified and fully implemented before re-audit               <ul style="list-style-type: none"> <li>- 80% of women who had screening bloods samples taken prior having a miscarriage or termination of pregnancy received the results of the blood test by letter</li> </ul> </li> <li>• To include the criteria 'infection disease leaflet given' in the audit 'infection disease in pregnancy screening audit'               <ul style="list-style-type: none"> <li>- Fully completed. To be audited annually</li> </ul> </li> </ul>
Mouth Care Matters - 6 Month Audit (12 month follow up audit)	<ul style="list-style-type: none"> <li>• Improve recording of mouth care in the patient's notes               <ul style="list-style-type: none"> <li>- Recording of mouth care is now documented on the Patient Safety &amp; Repositioning Chart</li> </ul> </li> <li>• Implement a mouth care assessment tool in the patient records               <ul style="list-style-type: none"> <li>- The Mouth Assessment tool has been developed and is now live on Quadramed (April 2020)</li> </ul> </li> </ul>
National Emergency Laparotomy Audit (NELA) - 2019 Report. Published November 2020	<ul style="list-style-type: none"> <li>• To introduce an Emergency Laparotomy Pathway to standardise approach               <ul style="list-style-type: none"> <li>- The Pathway to include NELA severity scoring for all patients to guide appropriate level of consultant input and postoperative care – work is still ongoing on this</li> </ul> </li> <li>• Data input of all emergency laparotomy cases into NELA database by surgeons and anaesthetists               <ul style="list-style-type: none"> <li>- Clinical Audit team involved to improve adherence to data inputting and to send reminders to clinicians involved in their care</li> </ul> </li> <li>• To revise the emergency laparotomy boarding card               <ul style="list-style-type: none"> <li>- The boarding card has been revised</li> </ul> </li> <li>• To appoint Surgical NELA lead               <ul style="list-style-type: none"> <li>- New surgical NELA lead appointed in Feb 2021</li> </ul> </li> </ul>
National Maternity Perinatal Audit (NMPA) April 2016 to March 2017 data. Published 2019	<ul style="list-style-type: none"> <li>• Improve rate of 3rd/4th degree tears               <ul style="list-style-type: none"> <li>- Perineal trauma guideline reviewed &amp; updated</li> </ul> </li> <li>• Devise a Lancashire Teaching Hospitals perineal care bundle using available evidence.               <ul style="list-style-type: none"> <li>- Still in progress (delayed due to COVID-19)</li> </ul> </li> <li>• Increase rate of vaginal birth after primary caesarean section</li> <li>• Recommence midwife led VBAC clinic for primary Caesarean Section.               <ul style="list-style-type: none"> <li>- Midwifery led clinic now established. Referral process agreed and clinic to be led by two Delivery Suite Coordinators</li> </ul> </li> </ul>
National Maternity Perinatal Audit (NMPA) April 2017 to March 2018 data.	<p>No further NMPA report as yet.</p> <p>Local perineal tear audits carried out OBS/CA/2020-21/20: Perineal Trauma - 3rd/4th Degree. Actions from local audit:</p> <ul style="list-style-type: none"> <li>• Update Perineal Trauma guideline to highlight the use of manual perineal protection (MPP)               <ul style="list-style-type: none"> <li>- In progress awaiting approval</li> </ul> </li> <li>• Teaching Midwives mandatory study days &amp; delivery suite</li> </ul>

	<p>champions.</p> <ul style="list-style-type: none"> <li>- Nominate "champions" of the obstetric anal sphincter injury (OASI) bundle on Delivery Suite</li> <li>• Teaching and informing about the OASI bundle, the use of episiotomy scissors and hands-on technique</li> </ul>
<p>NNAP National Neonatal Audit Programme 2019 (Published Nov 2020)</p>	<ul style="list-style-type: none"> <li>• Improve intrapartum and early care of preterm babies <ul style="list-style-type: none"> <li>- MatNeo Preterm optimisation Toolkit currently being developed</li> </ul> </li> <li>• Increase early colostrum rates</li> <li>• British Association of Perinatal Medicine (BAPM) Breastmilk Optimisation. <ul style="list-style-type: none"> <li>- In progress - Golden drops info board &amp; steering group</li> </ul> </li> <li>• Improve breastmilk at discharge <ul style="list-style-type: none"> <li>- Baby Friendly initiative (BFI) training and Nutrition rounds</li> <li>- In progress - Nutrition rounds have commenced</li> </ul> </li> </ul>
<p>National Audit of Cardiac Rehabilitation (2019 report)</p>	<ul style="list-style-type: none"> <li>• National recommendation: Ensure patient co-morbidity is taken into account as part of cardiac rehab recruitment, assessment and tailoring of all interventions <ul style="list-style-type: none"> <li>- Trust guidelines updated on the referral of appropriate patients to cardiac rehab, and on the management of patients on cardiac rehab so that patient co-morbidity is taken into account when offering and providing cardiac rehabilitation</li> </ul> </li> </ul>
<p>Sentinel Stroke National Audit programme –</p>	<ul style="list-style-type: none"> <li>• National recommendation 1: All hospitals providing hyper acute stroke care should ensure that they are providing sufficient nursing staff on their hyper acute stroke unit <ul style="list-style-type: none"> <li>- 3 x band 6 specialist nurses recruited as part of the establishment on HASU. Also, 1 x band 7 specialist nurse team leader</li> <li>- Training action plan created of HASU nurses in swallowing assessment. New nurses on ward 21 are allocated a stroke specialist nurse mentor as part of their induction to the ward to ensure all stroke specific training (including nurse dysphagia screening) is completed within 6 months</li> </ul> </li> <li>• National recommendation 5: All comprehensive stroke services should include specialist stroke rehabilitation at home, including an early supported discharge team with full coverage of the population <ul style="list-style-type: none"> <li>- All patients admitted to Acute Stroke Unit are assessed by the Community stroke team to decide pathway once discharged from acute trust. Community stroke team assess and discuss all stroke patients ready for discharge from rehab ward on a weekly basis</li> </ul> </li> <li>• National recommendation 7: All services for people with suspected transient ischaemic attack (TIA) and minor (non-hospitalised) stroke should provide a diagnostic service that includes same-day access to specialist assessment and Magnetic resonance imaging (MRI) scanning including diffusion-weighted and blood-sensitive sequences</li> </ul>

	<ul style="list-style-type: none"> <li>- 7 day service TIA clinic with specific diagnostic slots for MRI and Carotid Doppler is now in place. The referral forms have been updated to streamline referrals into the service from both General Practitioners (GP's) and Emergency Department (ED)</li> </ul>
NPDA National Paediatric Diabetes Audit 2017-2018. Published 2019	<ul style="list-style-type: none"> <li>• Participate in the national wave of the Quality Improvement collaborative programme. Application submitted for participation in the 2018/19 national wave of the Quality Improvement collaborative programme for diabetes units. <ul style="list-style-type: none"> <li>- Action now complete</li> </ul> </li> <li>• Smoother transition to pump therapy needed. Negotiating contract with Clinical Commissioning Group (CCG) for smoother transition to pump therapy. <ul style="list-style-type: none"> <li>- Action now complete</li> </ul> </li> <li>• Prepare Business Case for more multi-disciplinary staff (Dietitian and Team leader). Recruited. <ul style="list-style-type: none"> <li>- Action now complete</li> </ul> </li> </ul>
NPDA National Paediatric Diabetes Audit 2018-2019 (Published 2020)	<ul style="list-style-type: none"> <li>• Advertise and recruit a Clinical Psychologist <ul style="list-style-type: none"> <li>- Action now complete Psychologist in post</li> </ul> </li> <li>• Recruitment of a Nurse Team Leader Has been advertised <ul style="list-style-type: none"> <li>- Unsuccessful will be amending and re-advertising</li> </ul> </li> <li>• Consultant job plan review</li> </ul>
National Adult Asthma and COPD Organisational Audit 2019 (Report published March 2020)	<ul style="list-style-type: none"> <li>• National recommendation: Providers should resource and organise respiratory services to the national quality standards and guidelines highlighted in the report <ul style="list-style-type: none"> <li>- There are now consultant ward rounds seven days a week on the MAU.</li> </ul> </li> <li>• National recommendation: Providers should resource and organise respiratory services to the national quality standards and guidelines highlighted in the report <ul style="list-style-type: none"> <li>- SOPs created for patients requiring NIV.</li> </ul> </li> <li>• National recommendation: Providers should resource and organise respiratory services to the national quality standards and guidelines highlighted in the report <ul style="list-style-type: none"> <li>- Trust Oxygen Guideline in place that is regularly reviewed and updated</li> </ul> </li> </ul>
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme (2019 results)	<ul style="list-style-type: none"> <li>• Continue to report ,monitor incidents and review for trends, put CAPA in place where appropriate <ul style="list-style-type: none"> <li>- Possible trends for 2019 identified and addressed</li> </ul> </li> <li>• Laboratory staff reminded to check details on LIMS carefully when entering/verifying information <ul style="list-style-type: none"> <li>- Laboratory staff reminded to check expiry dates/antigen requirements etc. before sending out units</li> </ul> </li> </ul>
National Vascular Registry 2019 (Report published in December 2019) Most recent report (2020 report) published in Nov	<ul style="list-style-type: none"> <li>• To make sure that all data is entered appropriately into National Vascular Registry (NVR) <ul style="list-style-type: none"> <li>- NVR co-ordinator has been appointed.</li> </ul> </li> <li>• To change the pathway for local aneurysms to follow the same pathway as screen-detected aneurysms</li> </ul>



<p>2020 but action plan not yet received</p>	<ul style="list-style-type: none"> <li>- This problem has been discussed in the clinical reference group, network MDT and directorate meetings.</li> <li>• It has been agreed that all local aneurysms should follow the same pathway as screen-detected aneurysms. It was also agreed that if a consultant is not available to see a patient during any part of the pathway, other consultants in the same zone will take responsibility. This will avoid unnecessary delay in managing the patient during the aneurysm pathway</li> <li>• To introduce hot clinics in order to meet the Quality Improvement Framework (QIF) target of treating patients within 14 days of assessment in clinic <ul style="list-style-type: none"> <li>- The hot clinic has now been introduced and runs on Tuesdays and Thursdays (initially it was just on Thursdays). It is hoped that the introduction of the 2nd hot clinic on Tuesdays will enable us to meet the QIF of treating patients within 14 days of assessment in clinic. There are also mini hot clinics being introduced in Morecambe Bay and Blackpool to expediently treat these patients and help in the QIF</li> </ul> </li> </ul>
<p>2019 UK Parkinson's Audit (Report published February 2020)</p>	<ul style="list-style-type: none"> <li>• Patients on dopaminergic therapy should be warned about the possible side-effects of visual hallucinations, impulse control disorder, postural instability and daytime somnolence <ul style="list-style-type: none"> <li>- Clinic letters to patients on dopaminergic drugs now include a paragraph warning of possible impulse control disorders</li> </ul> </li> <li>• Ensure that staff are aware of the importance of giving Parkinson's Disease medications at the correct time <ul style="list-style-type: none"> <li>- Local guideline is being developed on the administration of levodopa within 30 minutes of the prescribed time. There is also a E-Learning training package available on the Blended Learning site on "Parkinson's Medication - Get It On Time"</li> </ul> </li> </ul>
<p>National Audit of Care at the End of Life (NACEL): Round 2. (Report published July 2020)</p>	<ul style="list-style-type: none"> <li>• There needs to be an improvement in addressing needs of families and others involving family and others in decisions, keep them well informed, and provide enough opportunity to discuss the person's condition and treatment with staff <ul style="list-style-type: none"> <li>- A Quality Improvement Group has been set up to support with action planning to improve patient and family experience for patients who die an expected death in hospital Bereavement surveys, DATIX (Datix is the Trust's electronic incident reporting system) reports, Patient Advice and Liaison Service (PALS) reports and NACEL Quality Survey will be discussed and actioned through this group. This will include the agreement of escalation processes to be followed if patient and family's needs are not being met, to enable a timely response to improve patient and family experience</li> </ul> </li> <li>• A Ward Charter for staff providing care in the last hours to days of life has been developed and is now in place and</li> </ul>

	<p>was disseminated across the trust as part of Dying Matters Week</p> <ul style="list-style-type: none"> <li>- Trust wide communication skills strategy now includes end of life care components</li> <li>- Charitable funds purchased Z beds, (Z Beds are a versatile mattress which, when not in use can be sorted away neatly) candles and diffusers to improve the ward environment have been approved and the items are currently being disseminated</li> <li>• Improve management of symptoms <ul style="list-style-type: none"> <li>- Electronic Prescribing and Medicines Administration (EPMA) order sets to support with anticipatory prescribing are now in use in the trust</li> <li>- Electronic care plan created on Quadramed for assessment and care for patients in the Last Days of Life</li> <li>- The Safety Triangulation and Accreditation Review (STAR) monthly ward audit pro-forma has been updated to include a question on the use of individualised end of life care plans, so that we can monitor the usage</li> <li>- The Trust mouth care guideline now includes reference to mouth care at end of life</li> </ul> </li> </ul>
NCEPOD Acute Bowel Obstruction 2018 (Report published Jan 2020)	<ul style="list-style-type: none"> <li>• Develop a management pathway for acute bowel obstruction <ul style="list-style-type: none"> <li>- The management pathway is in development and a guideline has been written in draft</li> </ul> </li> </ul>
<i>National Asthma and COPD Audit Programme</i>	<ul style="list-style-type: none"> <li>• <i>The Trust was awarded with being amongst the Trusts with the highest case ascertainment rates</i></li> </ul>
<i>National Joint Registry</i>	<ul style="list-style-type: none"> <li>• <i>The Trust received an award for Data Quality. Submitted all the relevant cases based on our hospital data</i></li> </ul>

2.7/8 The reports of 468 local clinical audits were reviewed by the provider in 2020-21 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

**Table 7 Audit and Confidential Enquiry – Resulting Actions**

<b>Audit title</b>	<b>Actions intended/completed</b>
Audit	Subsequent management of patients treated surgically for cord compression
Action - Complete	<ul style="list-style-type: none"> <li>• To change the pathway for radiotherapy patients who have had surgery for Metastatic spinal cord compression (MSCC)</li> <li>• Improve education of cord compression management</li> </ul>
Audit	Implementation of the Colorectal Ward Round Proforma
	<ul style="list-style-type: none"> <li>• Re-audit to be initiated to assess appropriate medications being prescribed for patients aged &gt;60 admitted with femur fractures in accordance with National Institute for Health and Care Excellence (NICE) guidelines</li> </ul>
Actions - Complete	<ul style="list-style-type: none"> <li>• Trust guidelines and specialist opinions from the anaesthetic lead for pain management in femur fracture patients have been sought, this has revealed a discrepancy between the</li> </ul>

	<p>medication order set we have devised to the guidelines</p> <ul style="list-style-type: none"> <li>The above changes have been passed onto the Information Technology team, for changes to be made to the femur fracture medication order set. The orthopaedic doctors on call will subsequently be informed. There is an opportunity for this to be re-audited in a months' time after the changes are made</li> </ul>
Audit	Saving Babies Lives- Element 5- Antenatal Corticosteroids
Action - Complete	<ul style="list-style-type: none"> <li>Move to cumulative audit section and monitor data continuously with monthly updates</li> </ul>
Audit	Saving Babies Lives (SBLv2) Element 3 - Raising awareness of decreased foetal movements - Has appropriate care been given to women that attend with reduced foetal movements
Action - Complete	<ul style="list-style-type: none"> <li>Move to cumulative audit section and monitor data continuously with monthly updates</li> </ul>
Action - Complete	<ul style="list-style-type: none"> <li>Training &amp; communication</li> <li>Educate and support staff in management of decreased foetal movements</li> <li>Share findings</li> </ul>
Audit	Record Keeping: Ward Round Oral Patients
Action - Complete	<ul style="list-style-type: none"> <li>Create a template on what needs to be included in the notes for use by Dental Core Trainees (DCTs).</li> </ul>
Audit	Audit of acute skin reactions following the introduction of the 5# breast radiotherapy clinical protocol during the COVID-19 pandemic
Actions - Complete	<ul style="list-style-type: none"> <li>All treatment and review staff to complete mandatory 'Skin assessment and management' E-Learning</li> <li>Liaise with review team and radiotherapy bookings to arrange appointments</li> <li>Radiotherapy review team to assess patients during telephone review</li> </ul>
Audit	Ensuring Venous thromboembolism (VTE) adherence in Upper gastrointestinal patients on ward 11
Action - Complete	<ul style="list-style-type: none"> <li>To work with Information Technology to make changes to Venous thromboembolism (VTE) documentation on Quadramed</li> </ul>
Audit	Breast Skin Toxicity Assessment
Actions - Complete	<ul style="list-style-type: none"> <li>Design an electronic skin assessment that can be used in the Mosaik treatment software</li> <li>Create an E-Learning package to educate staff on the use of the Radiation Therapy Oncology Group (RTOG) grading system and its frequency of use</li> <li>Update policies and protocols</li> </ul>
Audit	Quality of handover amongst the Oral and Maxillofacial Surgery (OMFS) team
Action - Complete	<ul style="list-style-type: none"> <li>To make changes to the current handover proforma and inform the first on calls of the requirements of the handover</li> </ul>
Audit	Venous thromboembolism (VTE) Assessment Completion for Ear, Nose and Throat (ENT) Inpatients
Actions - Complete	<ul style="list-style-type: none"> <li>Create and display VTE assessment instructional poster</li> <li>Schedule VTE assessments into the Foundation Doctors timetable</li> </ul>

Audit	Are we routinely measuring Uric Acid levels in patients who are found to have urolithiasis?
Action - Complete	<ul style="list-style-type: none"> <li>To liaise with Information Technology to create the pathway</li> </ul>
Audit	Re-audit of Level Three Carbohydrate counting education and haemoglobin A1c or glycated haemoglobin test (HbA1c)
Actions – In progress	<ul style="list-style-type: none"> <li>Review of carbohydrate counting education at key points post diagnosis using appropriate tools</li> <li>Develop tools to promote diabetes self-management</li> <li>Identify families who are not downloading the tools, identify issues and help to resolve</li> </ul>
Audit	Temperature Management in traumatic brain injury (TBI)
Actions - Complete	<ul style="list-style-type: none"> <li>We have changed temperature treatment thresholds in our current TBI guideline</li> <li>We have also included temperature thresholds on Quadramed intracranial pressure (ICP) treatment package</li> </ul>
Audit	Local Anaesthetic Toxicity
Actions - Complete	<ul style="list-style-type: none"> <li>Protocol for the management and recognition of Local Anaesthetic Systemic Toxicity (LAST) for Critical Care Unit (CrCu) has been written</li> <li>Storage of intralipid in the department: There are currently two bags of intel iPod being stored in CrCu</li> <li>Educate the nursing staff on the recognition and early management of LAST <ul style="list-style-type: none"> <li>- Laminated notes have been made that everyone can use. These have been passed onto the nurse education lead for them to sort out the education of nurses</li> </ul> </li> </ul>
Audit	Time to theatre for distal radius fractures
Action - Complete	<ul style="list-style-type: none"> <li>British Orthopaedic Association introduced an Audit Standard for Trauma (BOAST) guideline displayed in the seminar room on ward 14. These are available in fracture clinic also</li> </ul>
Audit	Suspected Scaphoid Fractures-Outcome of COVID-19 Virtual Pathway
Action – Complete	<ul style="list-style-type: none"> <li>Scaphoid score to be reviewed by statistician for validity <ul style="list-style-type: none"> <li>- Reviewed with the statistician</li> </ul> </li> </ul>
Action – In progress	<ul style="list-style-type: none"> <li>To agree a VFC pathway with an orthopaedic Clinical Director and the MSK radiologists <ul style="list-style-type: none"> <li>- Work underway regarding this action</li> </ul> </li> </ul>
Audit	Re-audit: Improving Completion of Ensuring Venous thromboembolism (VTE) Risk Assessment and Prophylaxis, weight assessment and recording in Quadramed
Actions - Complete	<ul style="list-style-type: none"> <li>Continuing education and reminders are required for appropriate healthcare staff regarding VTE assessment <ul style="list-style-type: none"> <li>- Re-distributed the VTE assessment poster to ward staff, and arrange for copy to be sent to ward doctors</li> </ul> </li> <li>Make changes to the VTE assessment domain within the ward round assessment on Quadramed, so that it is mandatory rather than optional <ul style="list-style-type: none"> <li>- The feasibility of changing the VTE domain from optional to mandatory has been discussed with Information Technology</li> </ul> </li> <li>Investigate the barriers that ward staff have in meeting these targets</li> </ul>

	<ul style="list-style-type: none"> <li>- Meet with ward manager/charge nurse to discuss barriers</li> </ul>
Audit	Urinary catheter care and documentation of inpatients on a medical ward
Actions - Complete	<ul style="list-style-type: none"> <li>• Make urinary catheter assessment and monitoring form (UCAM) form more easily visible in patient notes <ul style="list-style-type: none"> <li>- Add file divider for UCAM forms to all patient folders to ensure the UCAM forms have a designated place in all patient notes</li> </ul> </li> <li>• Improve nurses knowledge about UCAM forms and the need for daily review <ul style="list-style-type: none"> <li>- UCAM forms discussed at the morning board round to ward manager, who passes information on to the nursing staff at their weekly meeting.</li> </ul> </li> <li>• Improve documentation on the handover on catheter status and plans <ul style="list-style-type: none"> <li>- Following the board round meeting both nursing staff and doctors are more informed about catheter status of patient and plans and both have access to change the handover if needed</li> </ul> </li> </ul>
Audit	Are Central Venous Catheter (CVCS) required as routine as induction for cardio-oesophagectomies?
Actions - Complete	<ul style="list-style-type: none"> <li>• Shift in clinical practice from routine insertion of CVC to a more targeted approach based on clinical impression <ul style="list-style-type: none"> <li>- Agreed on a shift in clinical practice from routine insertion of CVC at time of anaesthetic for all cardio-oesophagectomy patients, to a more targeted approach based on clinical impression (may include pre-op assessment, Cardio-pulmonary exercise testing (CPEX), need for vasopressors whilst under anaesthetic)</li> </ul> </li> </ul>
Audit	Plastics Soft Tissue Diagnostic Clinic Audit - 2 Cycles
Action – In progress	<ul style="list-style-type: none"> <li>• Further develop pathway and ongoing discussion with radiology regarding slots for same week Magnetic Resonance Imaging (MRI) <ul style="list-style-type: none"> <li>- Ongoing work with Radiology team</li> </ul> </li> </ul>
Audit	Oxygen prescription for patients in Medical Assessment Unit (MAU)
Actions - Complete	<ul style="list-style-type: none"> <li>• Target oxygen should be defined in initial clerking/admission notes in MAU <ul style="list-style-type: none"> <li>- Medical staff were made aware of the guidelines relating to oxygen prescription and reminded about the need to document target range at an MAU teaching session on 02/03/21. Nursing staff were also informed of this</li> </ul> </li> <li>• Oxygen target to be defined through EPMA, with check box <ul style="list-style-type: none"> <li>- Doctors have been reminded of the need to prescribe and define target range on Quadramed at an MAU teaching session, and by posters on wards</li> </ul> </li> </ul>
Audit	The Effectiveness of Anti-double-stranded Deoxyribonucleic acid (dsDNA Antibody Detection)
Action - Complete	<ul style="list-style-type: none"> <li>• Undertake a project looking at Tandem Mass Spectrometry. This will be performed as part of the Higher Specialist Scientist Training (HSST) programme under section C and will cover the wider scope of autoimmunity rather than just dsDNA antibodies</li> </ul>

	<ul style="list-style-type: none"> <li>- A project proposal has been developed along with the University of Manchester</li> </ul>
<b>Audit</b>	<b>Multifactorial analysis of variables in cohort of COVID19 admitted to intensive care unit</b>
Actions - Complete	<ul style="list-style-type: none"> <li>• Timely decision on Intubation <ul style="list-style-type: none"> <li>- Intubate if- increased work of breathing, clinical worsening, persistent fraction of inspired oxygen (FiO2) requirement &gt;65-70% despite continuous positive airway pressure (CPAP) hood for &gt; 2-4 hours</li> </ul> </li> <li>• Avoid over hydration- maintain positive balance of maximum 2 litres overall <ul style="list-style-type: none"> <li>- Daily weight measurements of patients in Critical Care Unit</li> </ul> </li> </ul>
<b>Audit</b>	<b>Bronchoscopy in the intensive care unit (ICU)</b>
Action Complete	<ul style="list-style-type: none"> <li>• Create a bronchoscopy specific entry form on Quadramed to aid appropriate documentation and ease of future audits <ul style="list-style-type: none"> <li>- Liaise with Quadramed through the ICU clinical director to set up this Bronchoscopy specific entry form on Quadramed</li> </ul> </li> <li>• Printout an Intensive Care Society (ICS) bronchoscopy checklist and place them near ambuscopes for use in preparation for bronchoscopy to ensure safe procedure <ul style="list-style-type: none"> <li>- Print and Laminate the ICS checklist and place them on the designated places</li> </ul> </li> </ul>
Action – In progress	
<b>Audit</b>	<b>COVID-19 End of Life Care Snapshot Audit</b>
Actions Complete	<ul style="list-style-type: none"> <li>• Continue to support ward teams to identify dying patients through HSPCT education and support/advice <ul style="list-style-type: none"> <li>- Created E-Learning modules in End of Life Care for COVID-19</li> </ul> </li> <li>• Support ward teams in planning the care of patients who die in our hospital <ul style="list-style-type: none"> <li>- Implemented electronic individualised Last Days of Life care plans. (Medical, nursing and nursing daily review tab)</li> </ul> </li> <li>• Continue to support ward teams to identify patients who are approaching the end of their life <ul style="list-style-type: none"> <li>- Developed Ward 23 Outreach Service to support early identification of patients and to support staff, patients and families in a pro-active way. St Helens and Knowsley Hospital Specialist Palliative Care Team (HSPCT) input was provided by daily Microsoft Teams meeting as part of Ward Boards Rounds</li> </ul> </li> </ul>

## Research

### Participation in Clinical Research

3.0 The number of patients receiving relevant health services provided or sub-contracted by Lancashire Teaching Hospitals NHS Foundation Trust in 2020-21, that were recruited during that period to participate in research approved by a research ethics committee was 3231.

## Research Recruitment

Lancashire Teaching Hospitals NHS Foundation Trust has recruited 2952 patients to National Institute for Health Research (NIHR) portfolio adopted studies in 2020-21. It granted local confirmation of capacity and capability (formally NHS permission) for 37 new portfolio studies to commence during that time. The Trust recruited a further 279 participants to non-portfolio studies. In total, there are currently 166 active research studies recruiting patients at the Trust. Due to the recent pandemic, and following guidance for the NIHR, we suspended a large number of studies to focus on COVID-19 research. Over the course of the year, we have gradually reopened studies and currently have 69% of all studies reopen to recruitment. This provides us with a balanced portfolio of COVID-19 and non COVID-19 studies.

## Research Governance

The Department of Health Benchmarks for the set up and delivery of clinical research in the NHS were changed in the previous reporting period to 62 days for non-commercial and 80 days for commercial studies. These figures are a measure from site selection to first participant recruited. For 2020-21, the metrics have been suspended; however Lancashire Teaching Hospitals NHS Foundation Trust has continued to perform well with 78% of non-commercial studies and 66% of commercial studies opening within the metrics.

## Examples of Our Achievements in Research

Of the 164 active research studies in 2020-21 we have many examples of excellent practice; two examples of which are presented below.

### UK Reach Study – Recruitment Triumph

We shared a big thank you to everyone who completed a survey as part of the REACH UK study. This was to assess the experience of the COVID-19 period for staff, focussing on ethnic minorities. We have since found out that despite a target of 100 we had a remarkable 150 responses from staff and this has resulted in us being in the top 5 of 70 Trusts in the country. In recognition of the success of this study our principal investigator research nurse has been invited to be involved in the study publication as a named author.

### Magnet4Europe

We will be opening the Magnet4Europe study in spring 2021. This study aims to improve mental health and wellbeing among health care professionals by redesigning clinical environments in more than sixty hospitals across six European countries. The study will last for 4 years and there will be several initiatives that we will be involved with over that time and our Nursing, Midwifery & AHP Director will be the principle investigator for this study.

## Commissioning for Quality & Innovation

Due to the COVID-19 pandemic the Commissioning for Quality & Innovation (CQUIN) programme was suspended consequently there is no information or data for the current reporting period.

## Registration with the Care Quality Commission

5.0 Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that the Care

Quality Commission has registered and licensed Lancashire Teaching Hospitals NHS Foundation Trust to provide the following services;

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

5.1 There are no conditions to this registration

- c) The Care Quality Commission has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2020-21.

Lancashire Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period. Due to the COVID-19 pandemic, CQC have not been routinely inspecting services during the pandemic period and recovery phases, although have been carrying out some focussed inspections based on the level of risk identified. In lieu of routine inspections, the CQC have maintained contact with us through usual engagement calls and a series of enhanced monitoring meetings.

Throughout 2020-21, we have had a number of engagement calls to discuss Infection, Prevention and Control arrangements. Through these meetings, the CQC were pleased to note improvements in Hospital Onset (nosocomial) infection rates and were assured that robust action plans were in place to ensure safety was maintained through the pandemic.

As part of the assessment of Emergency Departments during this time, CQC developed a structured framework called Patient First, a support tool designed by clinicians to support and maintain delivery of good, efficient and safe patient care. To identify those Emergency Departments that require additional support and a focussed inspection, CQC have been carrying out a series of Patient First meetings with Acute NHS Trusts. The meeting with Lancashire Teaching Hospitals took place on 29<sup>th</sup> October 2020. CQC have confirmed that a high level of assurance was provided and there were no serious issues highlighted. Where issues were identified for example delays to discharges due to system wide challenges, this has been mitigated by opening another clinical area for such patients to be cared for.







In March 2021, the CQC also conducted a monitoring meeting for the St John's Vaccination Centre that has been set up in conjunction with the Integrated Care System (ICS) in line with the National COVID-19 Vaccination Programme with Lancashire Teaching Hospitals being the lead provider and East Lancashire Hospitals being the lead employer. Through this meeting, the CQC confirmed the St John's Vaccination Centre was a low risk site.



Lancashire Teaching Hospitals NHS Foundation Trust was last inspected between 2<sup>nd</sup> July and 8<sup>th</sup> August 2019. Services that were inspected were Urgent and Emergency Services and Medical Care at Royal Preston Hospital and Chorley and South Ribble Hospital and Surgery and Critical Care at Royal Preston Hospital only.

Overall, we retained a rating of 'requires improvement', with 'good' for caring and a new 'good' for well led. This is a combined rating based on the inspection in specific core services and also based on the number of improvements observed and built on since the last inspection. Specifically, a rating of good for 'caring' means that people are supported and treated with dignity and respect and are involved as partners in their care and a rating of good for 'well led' means leadership, governance and culture promote the delivery of high quality person-centred care.

**Figure 3 Overall CQC Ratings for the Trust**

Overall rating for this trust		Requires improvement 
Are services safe?		Requires improvement 
Are services effective?		Requires improvement 
Are services caring?		Good 
Are services responsive?		Requires improvement 
Are services well-led?		Good 

*Data source: CQC Report*

Inspectors also observed an improved position at site level and core service level.

At site level, Chorley and South Ribble Hospital, improved its rating from 'requires improvement' to 'good' with caring maintaining a rating of 'good' and a change in safe, effective and well led moving to 'good'. At Royal Preston Hospital, the site retained a rating of 'requires improvement' with 'good for caring and a new 'good' for well led.

**Figure 4 Overall CQC Results for Hospital Sites**

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Preston Hospital	Requires improvement ↔ Nov 2019	Requires improvement ↔ Nov 2019	Good ↔ Nov 2019	Requires improvement ↔ Nov 2019	Good ↑ Nov 2019	Requires improvement ↔ Nov 2019
Chorley and South Ribble Hospital	Good ↑ Nov 2019	Good ↑ Nov 2019	Good ↔ Nov 2019	Good ↑ Nov 2019	Good ↑ Nov 2019	Good ↑ Nov 2019
<b>Overall trust</b>	Requires improvement ↔ Nov 2019	Requires improvement ↔ Nov 2019	Good ↔ Nov 2019	Requires improvement ↔ Nov 2019	Good ↑ Nov 2019	Requires improvement ↔ Nov 2019

*Data source: CQC Report*

At core service level, four of the six services that were inspected were rated as 'good' demonstrating a further improvement on last year. Services that were given a 'good' rating were Surgery and Critical Care at Royal Preston Hospital and Urgent and Emergency Services and Medical Care at Chorley and South Ribble Hospital. These good rated services stand alongside Maternity, End of Life and Outpatients on both sites and Children and

Young People at Royal Preston Hospital which were already rated as 'good' in previous inspections.

**Figure 5 Service Results for Royal Preston Hospital**

Ratings for Royal Preston Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Requires improvement → ← Nov 2019
Medical care (including older people's care)	Requires improvement → ← Nov 2019	Requires improvement → ← Nov 2019	Good → ← Nov 2019	Requires improvement → ← Nov 2019	Requires improvement → ← Nov 2019	Requires improvement → ← Nov 2019
Surgery	Good → ← Nov 2019	Requires improvement ↓ Nov 2019	Good → ← Oct 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Good → ← Nov 2019
Critical care	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Good ↑ Nov 2019
Maternity	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Services for children and young people	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
End of life care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
<b>Overall*</b>	Requires improvement → ← Nov 2019	Requires improvement → ← Nov 2019	Good → ← Nov 2019	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Requires improvement → ← Nov 2019

Data source: CQC Report

**Figure 6 Service Results for Chorley Hospital**

Ratings for Chorley and South Ribble Hospital						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Nov 2019	Good → ← Nov 2019	Good → ← Nov 2019	Good → ← Nov 2019	Good ↑ Nov 2019	Good ↑ Nov 2019
Medical care (including older people's care)	Good ↑ Nov 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Good ↑ Nov 2019
Surgery	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Critical care	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Maternity	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
End of life care	Good Nov 2014	Good Nov 2014	Good Nov 2014	Outstanding Nov 2014	Good Nov 2014	Good Nov 2014
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
<b>Overall*</b>	Good ↑ Nov 2019	Good ↑ Nov 2019	Good → ← Nov 2019	Requires improvement → ← Nov 2019	Good ↑ Nov 2019	Good ↑ Nov 2019

Data source: CQC Report

In summary, since 2016 we have improved the rating of 26 core domains, with 16 core domains improving in 2018 and 10 core domains improving in 2019. We have also improved 9 service lines, with 6 service lines improving in 2018 and 3 service lines improving in 2019.

During the inspection, the CQC noted a number of areas of good practice. These included:

- Our approach to *Our Big Plan* corporate strategy
- Commitment and action to build continuous improvement practice

- Reliable measurement of essential safety checks such as resuscitation and fridge temperatures
- Mandatory training and appraisal rates
- Clinical incident management
- Learning from incidents
- Understanding and control of infection
- Monitoring of the effectiveness of services
- Good mechanisms for engaging and listening to patients

Alongside good practice, the CQC also identified areas for improvement under the following regulations of the Health and Social Care Act 2008:

- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014. Good governance

In order to deliver the recommendations in the CQC report and to continue embedding good governance, we have built on the CQC Quality Improvement Plan in place following the 2019 inspection to address the issues raised by the CQC, alongside wider contextual challenges. The delivery of the recommendations is monitored through the Quality Improvement Plan which is reported to the Board and through our Safety and Quality Committee on a monthly basis. Throughout 2020-21, we have been able to demonstrate ongoing progress in meeting the recommendations from the last inspection through a number of programmes of work, including the *Always Safety First* Programme, a number of Continuous Improvement Programmes, the Governance and Risk Maturity Plan, the Safety Triangulation Accreditation Review Framework as well as our Organisational Development and Equality and Inclusion Strategies.

We continue to maintain established and trusted relationships with the CQC by fostering a transparent relationship, sharing risks and concerns in respect of patient safety and quality as they occur, together with the actions taken or proposed in order to provide assurance that the Board has appropriate oversight of its quality governance and patient safety risks.

## Quality of Data

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

8.0 Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 100% for admitted patient care
- 99.9% for outpatient care
- 99.4% for accident and emergency care

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

- 99.6% for admitted patient care
- 99.7% for outpatient care
- 99.5% for accident and emergency care

All data set types are either consistent with or show an improvement compared to 2019-20. Both indicators below are either at or above the national average for 2020-21.

9.0 Lancashire Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2019-20 was 100% complete and was graded Green. The overall score for 2020-21 is not yet available due to COVID-19 pandemic delays.

10.0 Lancashire Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit completed by the Audit Commission during 2020-21 and could not be externally audited by Coding Collaborative partners due to pandemic restrictions. The Trust was subject to an internal Information Governance clinical coding quality assurance audit during 2020-21. Results indicate a high level of coding quality and completeness as follows:

- Primary Diagnosis 94%
- Secondary Diagnosis 91.17%
- Primary Procedure 93.13%
- Secondary Procedure 89.07%

In addition external review of SUS data by the Trusts Clinical Coding Quality Assurance partner IQVIA indicates that the Trust consistently performs above peer and national average for both depth and quality of coded data.

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

- Submission of a bi-annual Data Quality Assurance Report to the Board providing a summary of Data Quality Team activities, an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.
- In terms of the NHS Digital Data Quality Maturity Index the Trust scored the following for the latest position available, above the national average in all datasets.

**Table 8 NHS Digital Data Quality**

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Outpatient Dataset
National Average	84.0	82.3	95.3	91.6
Lancashire Teaching Hospitals NHS Foundation Trust	92.1	85.4	99.3	99.0

*Data source: NHS Digital*

- Integrated Performance Report aligned to *Our Big Plan* ambitions reflecting the golden thread of reporting from Board to Division and Sub Committee to Specialty and Ward.
- Extended suite of validation reports to increase validation and assurance of the quality of data on the main Patient Administration System (PAS).
- Interactive workshops to ensure engagement with clinical and support staff regarding importance of good data quality and individual responsibility.
- Development of a draft Data Quality Kite mark providing assurance regarding the underlying quality of data used for performance and quality of service monitoring.

## Adult Mortality Reviews and Serious Investigation Data

We implemented the nationally recommended approach to Mortality Review (MR) during 2017-18 which was based on the Royal College of Physicians Structure Judgement Review (SJR) model. This has been embedded in practice for the past three years. The SJR mortality model was developed for the review of adult deaths, the outcomes of which are presented below. Neonatal and Child deaths are managed through different nationally defined review and reporting processes which are presented separately in the Mortality Surveillance and Learning from Neonatal, Child & Adult Deaths section in this account. The deaths in 27.1 include Inpatient and Emergency Department deaths which are reviewed using SJR methodology.

27.1 During 2020-21, 2087 of Lancashire Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 555 in the first quarter
- 330 in the second quarter
- 645 in the third quarter
- 557 in the fourth quarter

*Data source: Trust data warehouse*

27.2 By 31/03/2021 595 case record reviews and 16\* Strategic Executive Information System (StEIS) investigations have been carried out in relation to the 2087 of the deaths noted above.

*\*6 StEIS investigations have been concluded and awaiting coroner's inquest, 1 complete and 9 are ongoing*

In 4 cases a death was subjected to both a case record review and a StEIS investigation. The number of deaths in each quarter for which a case record review or StEIS investigation was carried out was:

- 191 in the first quarter (plus 2 StEIS investigations)
- 128 in the second quarter (plus 2 StEIS investigations)
- 149 in the third quarter (plus 8 StEIS investigations)
- 127 in the fourth quarter (plus 4 StEIS Investigations)

*Data source: Trust MR Database & Datix*

27.3 1 representing 0.05% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient in relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 1 representing 0.18% for fourth quarter

*Data source: Trust MR Database & Datix*

These numbers have been calculated using the Structured Judgement Review (SJR) Mortality Review process and the StEIS process. Of the 6\* completed StEIS investigations in 2020 -2021 it is not possible to determine if deaths were on balance likely due to problems in care as inquests have been delayed due to the COVID-19 pandemic. It is noted that the Patient Safety Incident Response Framework from NHS Improvement (NHSI), which is expected to be implemented in 2021 advises that avoidability of death should not form part of the terms of reference for StEIS investigations with that being the remit of the Coroner.

#### **27.4 Learning from the deaths identified in 27.3**

The learning from investigations subject to inquest will be shared through our learning to improve process when available. The learning from the 1 StEIS case which investigation has been completed is the need for ward staff to improve patient care plans regarding enhanced levels of care.

#### **27.5 Actions in relation to the learning in 27.4**

The learning and actions from investigations subject to inquest will be shared through our learning to improve process when available. The actions from the completed StEIS investigation in 27.4 are audit of documentation of bedside care provision and monitoring and review of training compliance with enhanced care e- learning.

#### **27.6 Assessment of the impact of actions described in 27.5**

The assessment of the impact of actions from investigations subject to inquest will be shared through our learning to improve process when available. The assessment of the impact of actions in 27.5 will be evident from the audit which is not available at this time.

27.7 4 case record reviews and 2 adult Serious Incident Investigations were completed after 1/04/2020 which related to deaths which took place before the start of the reporting period (in 2019-20). Of these 2 cases 1 is awaiting a delayed inquest and in the second case the death was deemed to have been unavoidable.

27.8 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the SJR case record review and Serious Investigation processes.

*Still awaiting outcomes of inquest*

27.9 It is not possible to provide a revised estimate for the 2019-20 % of cases which are judged to be more likely than not to have been due to problems in care provided to the patient because of delays with inquests as a result of the COVID-19 pandemic.

It has not been possible to provide the avoidability of deaths data due to delays in investigations and inquests as a result of the COVID-19 pandemic. Learning from deaths is presented in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section of this account on page 214.

## 2.3 Reporting Core Indicators

The NHS faced unprecedented times in 2020-21 and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has been significantly challenged by the COVID-19 pandemic. As a result, performance across the board, both emergency and elective has been significantly impacted with operational pressures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures; in response to COVID-19 demand, resulted in high bed occupancy at peak times throughout the year with the need to focus primarily on COVID-19 non-elective activity, resulting in the standing down of non-urgent elective activity as mandated nationally for significant periods across year.

A health economy system wide action plan is in place to address the urgent care system and pressures; with identified primary and social care initiatives/schemes delivering a level of sustainability across the health economy.

In addition, whilst the national planning guidance for 2021-22 is expected imminently, Integrated Care Systems have been tasked with drafting system level elective recovery plans which clearly set out:

- Dates for restoration of cancer and 'priority 2' work to within current standards.
- Dates to return to 100% of 2019-20 activity levels.
- Trajectory for the eradication of >52 week waits.

Since the beginning of the COVID-19 pandemic the Trust has put in place a range of measures including:

- Additional medicine bed capacity to meet increased in demand.
- Rezoning of our estate to meet Infection, Prevention and Control (IPC) requirements.
- Delivery of Same Day Emergency Care (SDECs).
- Secured winter monies from the CCG to support the development of an integrated frailty model and a dedicated nursing level rehabilitation ward.
- Additional Critical Care surge beds with additional staffing through redeployment.
- Implemented digital health model to reduce inappropriate admissions to hospital.

These actions have all helped to support our organisation during these unprecedented times and enabled us to achieve compliance against a range of measures within the risk assessment framework. These include the Emergency Department (ED) standard measured against the current improvement trajectory up to the end of February 2021, 2 of the nine cancer waiting times standards, and 1 of the infection prevention standards. However, the Trust has failed to achieve its objectives in relation to the ED 4 hour wait in March 2021, the 18-week incomplete access target, and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both Referral To Treatment and cancer pathways was directly impacted by the COVID-19 pandemic and the need to cease all elective activity during the pandemic peak periods and prioritise only urgent elective activity as part of the elective restoration plan. The summary position detailing performance against key targets 2020-21 is shown in the table on the next page:



**Table 9 Performance against Key Targets**

**Data April 2019 to end of March 2021**

Indicator	National Target %	Cumulative Performance	Current Period
A&E - 4 hour standard	86	85.56	% - Cumulative to end Mar 2021 Position includes both ED and UCC locations. Target based on agreed Trajectory to Mar 2020
Cancer - 2 week rule (All Referrals) - New method	93	88.0	% - Cumulative to end Mar 2021
Cancer - 2 week rule - Referrals with breast symptoms	93	52.8	% - Cumulative to end Mar 2021
Cancer - 31 day target	96	89.5	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	77.8	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment – Drug	98	97.9	% - Cumulative to end Mar 2021
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	97.7	% - Cumulative to end Mar 2021
Cancer - 62 day Target	85	64.0	% - Cumulative to end Mar 2021
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	57.3	% - Cumulative to end Mar 2021
28 day faster diagnosis standard – compliance	75	80.3	% - Cumulative to end Mar 2021
MRSA	0	0	% - Cumulative to end Mar 2021
C.difficile Infections	<84	100	Cumulative to end Mar 2021
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	79.2	54.2	% - sum of Apr-Mar 2020-21 Target based on agreed Trajectory to Mar 2020
% of patients waiting over 6 weeks for a diagnostic test	<1	43.12	% - Cumulative to end Mar 2021


Source: LTHTR data

*MRSA Indicator: there is no longer a national target associated with MRSA. However, we continue to report performance against this metric to the Board and show it as a compliant measure.*

**Table 10 Summary of Performance against Core Indicators**

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

<b>Table 10.1 Summary Hospital-Level Mortality Indicator (SMHI)</b>			
<b>12. Summary Hospital-Level Mortality Indicator (SMHI)</b>	<b>October 2017-September 2018</b>	<b>November 2018-October 2019</b>	<b>November 2019-October 2020</b>
<b>(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period</b>	<b>Trust = 0.9713</b>	<b>Trust = 0.9845</b>	<b>Trust = 0.9626</b>
	England average = 1.0	England average = 1.0	England average = 1.0
	Low = 0.69	Low = 0.68	Low = 0.67
	High = 1.26	High = 1.20	High = 1.17
	Banding = 2	Banding = 2	Banding = 2
<b>(b) the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period</b>	<b>Trust = 46.3%</b> England = 33.6% High = 59.5% Low = 14.2%	<b>Trust = 53.0%</b> England = 36.0% High = 59.0% Low = 11.0%	<b>Trust = 52%</b> England = 36% High = 59% Low = 8%

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

- NHS Digital categorises NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). We remain in band 2 which is within expected range. The SHMI for the most current data available (Nov 2019 – Oct 2020) is 0.96 which is slightly lower than the previous 12 month period reported. This may be due to the reduced numbers of non-COVID-19 admissions during the reporting period.
- The SHMI data does not include the COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.
- The Palliative Care coding remains higher than the average for England which continues to be due to the ongoing extensive work of the Palliative Care team. The slight reduction in percentage is likely due to the higher numbers of patients at end of life during the extenuating circumstances in 2020-21 with the team having the same team capacity during that time.

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

- Continuing to promote the national Structured Judgement Review (SJR) Mortality process which highlights learning from deaths. We are improving the sharing of the learning from medical examiner reviews, SJR reviews and investigations through reports into our governance meeting framework from speciality to divisional and Trust level.
- Continuing to monitor mortality rates using the SHMI and HSMR and to escalate if there are any areas of concern and provide monthly reports to the Mortality & End of Life Care and Safety & Quality Committees.
- If mortality alerts are raised we will continue to investigate this through the relevant speciality using SJR mortality review.

Further information for SHMI & HSMR on page 215.

**Table 10.2 Patient Reported Outcome Measures**

18. PROMS; The Trust's patient reported outcome measure scores for:		April 2017- March 2018		April 2018- March 2019		April 2019- March 2020	
		EQ5D (Health gain)	Oxford score	EQ5D (Health gain)	Oxford score	EQ5D (Health gain)	Oxford score
<b>Hip replacement surgery. (Primary)</b> Average case mix adjusted scores	*England	0.46	22.7	0.46	22.7	0.45	22.7
	High	0.56	26.2	0.53	25.4	0.51	25.5
	Low	0.40	18.8	0.35	18.8	0.35	17.0
	Trust	0.45	21.9	0.48	23.0	0.37	20.3
<b>Knee replacement surgery (Primary)</b> Average case mix adjusted scores	*England	0.33	17.3	0.34	17.3	0.33	17.5
	High	0.41	20.6	0.39	20.0	0.41	20.6
	Low	0.23	13.1	0.27	13.8	0.21	12.6
	Trust	0.33	16.9	0.36	17.8	0.30	17.7

\*England score described in guidance as "Adjusted average health gain (England)" (see <https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms#guidance>)



Patient Reported Outcome Measures (PROMS) is a survey through which patients are asked about their health and quality of life before and after they have an operation. The higher the score, the greater the benefit experienced by the patient. The PROMS programme uses the following measures:

- The EQ5D tool provides a generic measure of quality of life.
- The Oxford score measures the impact of replacement surgery on quality of life.

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

- EQ5D scores for both hip and knee replacements are lower than average although not the lowest in England as is the Oxford score for primary hip replacements. This is likely a result of the very low numbers of questionnaires in our sample which is due to standing down non urgent surgery during the COVID-19 pandemic.
- The Oxford score for knee replacements is however higher than average and compares well with the previous reporting period.

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

- Continuing to monitor the published monthly data and raising concerns with our Consultant PROMS lead where necessary.
- Investigating any outlying status and taking appropriate action.
- Further increasing uptake of the PROMS questionnaires.

**Table 10.3 Readmissions within 30 days of Discharge**

19. The percentage of patients aged: <ul style="list-style-type: none"> <li>• 0 to 15 and</li> <li>• 16 or over</li> </ul> Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period	April 2017- March 2018	April 2018- March 2019	April 2019- March 2020
<b>0-15 years</b>	<b>Trust = 15.2 (A1)</b> England = 11.9 High = 17.0 Low = 1.7	<b>Trust = 15.8 (A1)</b> England = 12.5 High = 19.3 Low = 2.0	<b>Trust = 13.5 (A5)</b> England = 12.5 High = 18.5 Low = 2.4
<b>16 years – 74 years</b>	<b>Trust = 10.9 (B1)</b> England = 12.4 High = 21.0 Low = 2.2	<b>Trust = 12.0 (B1)</b> England = 13.0 High = 21.8 Low = 1.2	<b>Trust = 11.8 (B1)</b> England = 13.1 High = 19.5 Low = 3.2
<b>75 years +</b>	<b>Trust = 16.9 (B1)</b> England = 18.4 High = 22.5 Low = 6.7	<b>Trust = 17.8 (W)</b> England = 18.7 High = 29.4 Low = 6.1	<b>Trust = 17.6 (B5)</b> England = 18.6 High = 31.9 Low = 8.6



**Banding key:**

- B1** = Significantly lower than the national average at the 99.8% level
- B5** = Significantly lower than the national average at the 95% level but not at the 99.8% level
- W** = National average lies within expected variation (95% confidence interval)
- A5** = Significantly higher than the national average at the 95% level but not at the 99.8% level
- A1** = Significantly higher than the national average at the 99.8% level.

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

- The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years and 75+ years. The banding has been presented to indicate the Trust performance.
- The 0-15 year’s readmissions are higher than the average for England however there is a wide variation from the highest to lowest scores which affects the average. The Trust remains lower than the highest rates.
- The Trust re-admissions rate for patients 16-74 & 75+ is either as expected or lower than the average which is likely to have been influenced by a focus on quality discharges and readmission audit work at specialty level.

Lancashire Teaching Hospitals NHS Foundation Trust will continue to review and monitor readmission rates and respond where improvements are required.

**Table 10.4 Responsiveness to Personal Needs**

	2017-2018	2018-2019	2019-2020
<b>20. The Trusts responsiveness to the personal needs of its patients during the reporting period</b>	<b>Trust = 65.9</b>	<b>Trust = 66.2</b>	<b>Trust = 66.8</b>
	England = 68.6 High = 85.0 Low = 60.5	England = 67.2 High = 85.0 Low = 58.9	England = 67.1 High = 84.2 Low = 59.5



This indicator value is based on the average score of five questions from the National Inpatient Survey, which measure the experiences of people admitted to NHS Hospitals.

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

- The Trust is continually aiming to improve being responsive to the personal needs of patients and although it is below the national average it remains above the lowest scoring trusts nationally.

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

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

**Table 10.5 Staff Recommendation as a Provider of Care**

	2018	2019	2020
<b>21. Percentage of staff employed by, or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends</b>	<b>Trust = 65.4</b>	<b>Trust = 62.6</b>	<b>Trust = 69.0</b>
	England = 71.0 High = 90.4 Low = 39.7	England = 70.5 High = 90.5 Low = 39.8	England = 74.3 High = 91.7 Low = 49.7



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

- The Trust continues to receive staff feedback through a range of channels including the Staff Survey, Valuing your Voice and through the Trust 'Big Conversations' which has been responded to and this has most likely influenced the 6% improvement between 2019 and 2020


Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this

score, and so the quality of its services, by

- Continuing with workforce and organisational development strategy as our people plan for the organisation implementing staff engagement and continuous improvement programmes. We involve clinical and non-clinical staff in our improvement journey which has been presented in the Continuous Improvement section in this Quality Account.

**Table 10.6 Venous Thromboembolism Risk Assessment**

23. Percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	Q4 2017 -2018	Q4 2018 -2019	Q3 2019 -2020
	Trust = 96.2%	Trust = 95.7%	Trust = 97.0%
	England = 95.2% High = 100% Low = 67%	England = 95.7% High = 100% Low = 74%	England = 95.3% High = 100% Low = 71%

 \*NHS Digital VTE data collection/collation was stood down from Q3 2019 due to the COVID-19 pandemic

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


- The Risk assessment is integral to the Electronic Patient Record which has improved performance to 97% for the period Q3 2019-2020.

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

- To improve compliance further the VTE Assessment on Quadramed has been enhanced and an 'app' has also been developed to enable department level monitoring. .
- Continuing with the Getting It Right First Time (GIRFT) and *Always Safety First* Venous Thromboembolism (VTE) prevention programmes.
- Update reports on VTE monitoring and management presented to Safety and Quality Committee.

**Table 10.7 Clostridioides Difficile Infection**

24. The rate per 100000 bed days of cases of <i>C. Difficile</i> infection reported within the Trust amongst patients aged 2 or over during the reporting period	2017-2018	2018-2019	2019-2020
	Trust = 20.0	Trust = 17.8	Trust = 33.5
	England = 14.0 High = 91.0 Low = 0	England = 12.2 High = 79.7 Low = 0	England = 13.6 High = 51.0 Low = 0

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

- Hospital onset *Clostridioides difficile* (*C. difficile*) was higher than the Trust annual objective during 2019-20 according to the NHS Digital data and related to 84 cases.
- 2019-20 was a challenging year for many Trusts around *C. difficile* with many hospitals seeing

significant increases. The trajectory set for Lancashire Teaching Hospitals was based on a year where a 15% decrease in *C. difficile* cases occurred. This has not been achieved in any other year.

- To mitigate the exceeded trajectory we have undertaken the interventions outlined below;

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

- Continuing Post Infection Reviews (PIRs) which is a multidisciplinary approach to investigate each hospital onset *C. difficile* case.
- Sharing lessons learned from PIRs and implement quality improvement actions.
- Continuing to focus on antimicrobial prescribing with community partners.
- Continuing to promote best practice around antimicrobial stewardship.
- Continuing to be responsive to the need for isolation.
- Promoting hand hygiene and environmental cleaning.
- Promoting infection prevention and control education Trust wide with the implementation of a robust E-Learning package.
- Promoting clinical revalidation audits and environmental audits

Further information on *Clostridioides Difficile* can be found on page 210.

**Table 10.8 Patient Safety Incidents**

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

	<b>Oct 2017-March 2018</b>	<b>Oct 2018-March 2019</b>	<b>Oct 2019-March 2020</b>
<b>(i) Rate of Patient Safety Incidents per 1000 Bed days</b>	<b>Trust Number = 6506</b> <b>Trust Rate = 43.6</b>	<b>Trust Number = 7250</b> <b>Trust Rate = 52.4</b>	<b>Trust Number = 7766</b> <b>Trust Rate = 51.8</b>
	England – Not available All * Trusts Rate High = 69.0 All * Trusts Rate Low = 23.1	England – Not available All *Trusts Rate High= 95.9 All *Trust Rate Low = 16.9	England – Not available All *Trusts Rate High = 110.2 All *Trusts Low = 15.7
	<b>Severe harm or death</b>	<b>Severe harm or death</b>	<b>Severe harm or death</b>
<b>(ii) % of Above Patient Safety Incidents = Severe/Death</b>	<b>Trust Number = 62</b> <b>Trust Rate = 0.42</b> <b>% of all incidents = 0.95%</b>	<b>Trust Number = 60</b> <b>Trust Rate = 0.43</b> <b>% of all incidents = 0.83%</b>	<b>Trust Number = 49</b> <b>Trust Rate = 0.33</b> <b>% of all incidents = 0.63%</b>
	England – Not available All *Trusts Highest % = 1.54% All *Trusts Lowest % = 0%	England – Not available All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0%	England – Not available All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0%
<b>Rate = per 1000 Bed Days</b>			



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

- We continue to improve education regarding the reporting of incidents and near misses, the importance of doing so and the outcome of the learning gleaned from incident reporting.
- Continued improvements to the reporting system to make it easier to report in a timely manner, whilst obtaining essential information.
- Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients.

- Incident dashboards and a Governance Dashboard are now in use across the Trust for embedded incident analysis.

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

- Continued Learning 2 Improve work through the Governance and Continuous Improvement Teams to address areas of concern from Incident trends (Pressure Ulcers, Never Events, and Safeguarding etc.).
- Develop an automatic Governance Dashboard which is more interactive and more widely accessible to staff for improved incident analysis.
- Develop and improve the scope and agenda for Safety & Learning Group to ensure systematic delivery on action plans and the embedded improvements for patient safety result in improved outcomes. This is being built into the Datix system.
- Continue to link incident analysis to the risk register and the Trust's Risk Maturity Programme of work.
- Linking incident and risk intelligence to *Our Big Plan*.

For Further information, 2020-21 Incident Reporting is presented on page 196.



## Clinical Standards for Seven Day Hospital Services

A Board Assurance Framework for seven day hospital clinical services was developed by NHSI in 2018, requiring all Trusts to provide Board level assurance every 6 months, through completion of a standardised template capturing performance against all 10 Clinical Standards. At the onset of the COVID-19 Pandemic this requirement was stood down by NHS England (NHSE)/NHSI. Despite the reporting requirement being stood down, a number of actions have been taken during 2020-21 to continuously improve performance as below:

- Adjustments to the Emergency Department attendance and admissions processes to safely manage COVID-19 positive and negative patients and ensure timely consultant reviews.
- Adjustments to the bed utilisation across both hospital sites to support cohorting enhanced high care, COVID-19 positive and negative patients.
- Adjustments to the medical, nursing and AHP staffing models across both hospital sites to ensure timely consultant reviews.
- Roll-out of electronic clinical notes across the Trust for in-patients.
- Development of the Clinical Documentation Business Intelligence ('ClinDoc') Application (App) to enable capturing current data relating to key clinical metrics.

Key performance data from the 'ClinDoc' App is now included in Divisional Performance information to facilitate discussions between the Divisional Leadership Teams and Executive Team, and inform decisions regarding improvement actions.

Additional functions have been added to 'ClinDoc' to expand the range of clinical standards captured which includes:

- Daily Consultant Review.
- Consultant Review within 14 hours of Admission.
- VTE Risk Assessment.
- Expected Day of Discharge.
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).
- Midday Discharges.

We have also undertaken some initial continuous improvement work focussed on VTE risk assessments, which has resulted in a 40% improvement in performance in 2020-21 through data refinement as well as process improvement. The learning from this work will be applied to the other clinical metrics during 2021-22.

## Freedom to Speak Up

Following publication of Sir Robert Francis' Freedom to Speak Up Review (2015) and in the shadows of the Gosport (2018) and East Kent (2019) enquiries and most recently the findings of the Ockenden review, we have reviewed our processes and systems for inviting, listening and responding to concerns raised by staff. The ability to raise concerns in a safe way is essential as a contribution to the delivery of safe, effective care. We recognise that this ability is also a key element towards a positive staff experience, impacting on our ability to retain our staff.

Our staff are encouraged to raise any concerns including those about patient safety and quality of care, bullying and harassment or financial impropriety, to immediate line managers or their line managers as they feel able. Where there are immediate safety concerns, staff are encouraged to report to their line manager and to record any incidents on our Datix incident reporting system. Where staff feel that their concern has not been addressed they can raise their concern with our Freedom to Speak Up (FTSU) guardian, a FTSU champion or their union representative.

Our FTSU guardian role exists to help and support staff who wish to raise a concern but who feel that they are not being listened to and concerns can be raised anonymously or in confidence. Where concerns are raised with the FTSU team, feedback is provided on actions taken and closure of a concern is agreed with the colleague raising it.

During 2020-21 we have built on the improvements reported in 2019-20, with 408 contacts made with the FTSU service, either directly via the Guardian, one of the FTSU Champions or via the Trusts Valuing your Voice intranet page. This compares to 119 in 2019-20 and represents a 242% increase in activity and is an even more significant improvement on 2018-19, during which only 26 concerns were raised.

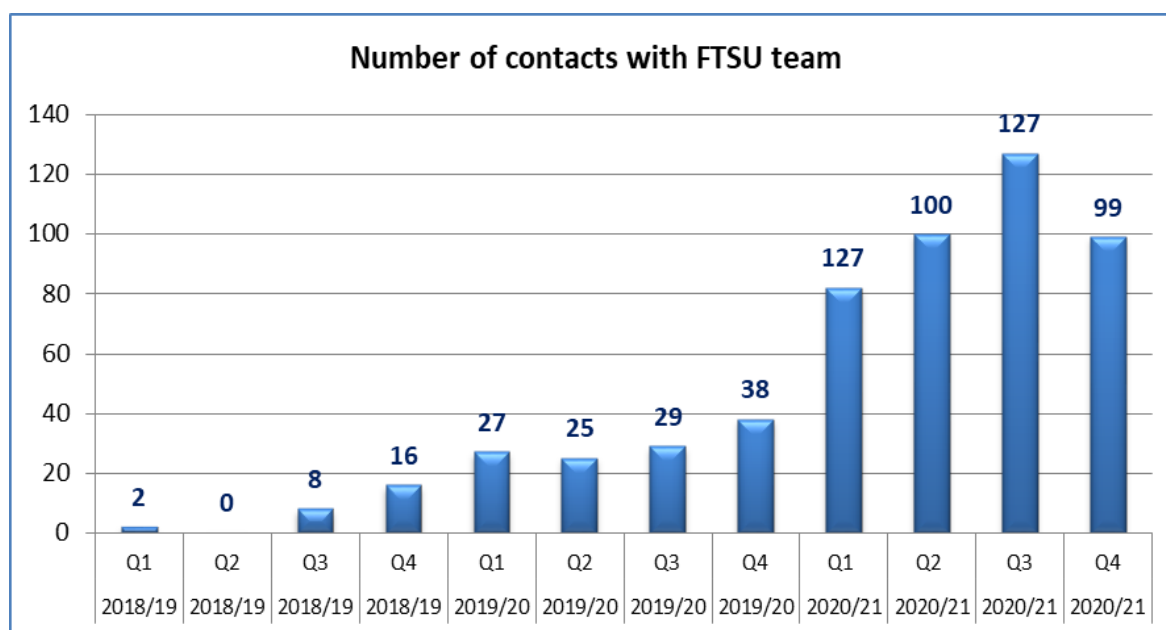
**Table 11 Freedom to Speak Up Cases**

Period	2018-19	2019-20	2020-21
Quarter 1	2	27	82
Quarter 2	0	25	100
Quarter 3	8	29	127
Quarter 4	16	38	99
<b>Annual total</b>	<b>26</b>	<b>119</b>	<b>408</b>

*Source: LTHTR data*

The increase is likely to be a result of ongoing publicity and promotion of speaking up arrangements. It is also likely colleagues that have experienced concerns being addressed through the service are supporting promoting its use.

**Figure 7 Freedom to Speak Up Concerns Raised**



Source: LTHTR data

Our FTSU Guardian will also offer support to any members of staff who suffer detriment as a direct result of raising concerns with the Freedom to Speak Up service, although during 2020-21 no one reported experiencing any detriment. Our FTSU Guardian provides assurance to the Board that we are responsive to concerns and meets regularly with our Chief Executive and Chair to share any concerns, emerging themes and trends.

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

Staff are able to access the 'Valuing your Voice' webpage on the intranet which allows them to comment, make suggestions or raise concerns. Staff can do this anonymously but are encouraged to provide contact details confidentially so that their concerns can be responded to in a more comprehensive manner.

Where staff have raised concerns through the Trust's electronic reporting tool (Datix) these are investigated and reported through the Safety and Learning Group meetings as well as being reviewed at the Raising Concerns Group. The group also review additional information including FTSU activity, staff surveys, whistleblowing events, exit interviews and disciplinary outcomes, with any trends and themes being acted on. Quarterly reports to the Workforce Committee and the Board of Directors provide an update on all concerns raised, any themes and trends and actions taken.

We also have an established grievance procedure through which staff are able to raise concerns. In 2020-21 we have been developing an early resolution policy designed to replace the grievance policy and encourage a less adversarial way of addressing some staff concerns.

## Medical and Dental Workforce Rota Gaps

Our Workforce Department monitor vacant posts and as part of the 'Guardian of safe working' requirements provide a quarterly vacancy gap analysis as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b. The medical vacancies are presented in Table 12 below.

**Table 12 Medical and Dental Vacancies**

*Data is for each post as a whole time equivalent. It does not reflect gaps as a result of long term sickness, COVID-19 shielding, maternity/adoption leave and working part time.*

Grade	Vacant	Filled	Total	Vacancy Rate
<b>Deanery</b>				
FY1	1	53	54	1.85%
FY2	6	55	61	9.84%
ST1-2	7	106	113	6.19%
ST3+	14	140	154	9.09%
<b>Trust</b>				
Junior Clinical Fellow	15	57	72	20.83%
Senior Clinical Fellow	24	71	95	25.26%
SAS	9	77	86	10.47%
Consultant	50	418	468	10.68%
<b>Grand Total</b>	<b>126</b>	<b>977</b>	<b>1,103</b>	<b>11.42%</b>

Source: LTHTR data

Our Medical Workforce team provide monthly reports to the Divisional Workforce Committees which includes the detailed status of each vacant post. Specialities and departments are also provided a monthly report to support services fully understanding the medical and dental staffing position. The team use this information to work closely with Clinical Directors and departmental managers to source vacancies and agree recruitment strategies for hard to fill posts. These strategies continue to include:-

- Reviewing job descriptions and creation of promotional activity, aligning job descriptions to the new employment brand and elements to make posts more attractive for example rotations and dedicated time for audit, research and teaching.
- Promoting vacancies through social media, relevant journals and websites, through the British Medical Journal (BMJ) website and has purchased a number of print credits and support from NHS creative to improve advertising.
- Continuing to source Doctors through international placement agencies. This includes more efficient shortlisting, skype interviews and supporting candidates to transition into the NHS. This has been especially successful during 2020-21 in recruitment to Emergency Department middle grade posts and Consultants in Respiratory and Oncology specialities.
- Continuing to source Doctors through the Medical Training Initiative in liaison with the Royal Colleges and the Trust has seen success particularly in the Critical Care Unit.

- Implementation of the recruitment and retention premia policy to be applied with hard to fill posts and financially support international candidates with visa costs.
- Implementation of an Associate Consultant posts to support retention of existing Middle Grade doctors by providing career progression. We have 6 Associate Consultants currently in post who were appointed between 2018 and 2020 and we have a further recruitment round in progress with 5 applications shortlisted for interview at the end March 2021.
- Continuing to develop quality job planning to ensure fully reflective of activity.
- Utilising our medical and dental in-house banks to reduce reliance on agency workers, reduce cost and improve quality of care. There are currently approximately 140 medical bank workers working regular shifts.
- Working with the lead employer to improve rotation information to ensure early identification of vacant posts where possible.
- Implementation of a medical intern program in partnership with the University of Manchester and the University of Mansoura in Egypt. A total of 9 Interns were appointed in August 2020 and a further 10 are under offer to commence in post in August 2021. These posts fill vacant junior clinical fellow gaps and where required vacant FY2/ST1 posts.
- Exploring a three way electronic systems interface with the lead employer and Health Education England to reduce manual data processing, improve quality and enable gap reporting to “Whole Time Equivalent” percentage reporting.

## PART 3

### Review of Quality Performance - Patient Safety

We consider the safety of patients to be our principle priority. To ensure the organisation is a safe place to receive care and treatment we monitor performance against certain factors and continually aim to reduce and eliminate patient harm where possible.

In 2019-20 we responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals *Always Safety First* programme. During 2020-21 this has continued to be led by the Nursing Midwifery & AHP Director and Medical Director and supported by the Governance, Nursing and Continuous Improvement Teams. The programme promotes staff to always consider safety across the organisation and has involved lay representatives from the community to support the programme to provide opportunities to share their ideas. This section of the Quality Account presents indicators related to patient safety, clinical effectiveness and patient experience as outlined below:

#### Patient Safety:

- The Trust Safety Triangulation Accreditation Review (STAR) programme
- Falls prevention
- Safeguarding Adults
- Safeguarding Children
- Maternity and Neonatal Safety
- Incidents & Never Events
- Duty of Candour

#### Clinical Effectiveness

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

#### Patient Experience

- Patient Surveys
- Friends & Family Feedback
- Concerns, Complaints & Compliments
- Patient, Family & Public Involvement
- Working Differently For Patients during COVID-19-19 Pandemic
- Patient Stories
- Staff Survey & Recommendation of Our Care

## Safety Triangulation Accreditation Review (STAR)

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

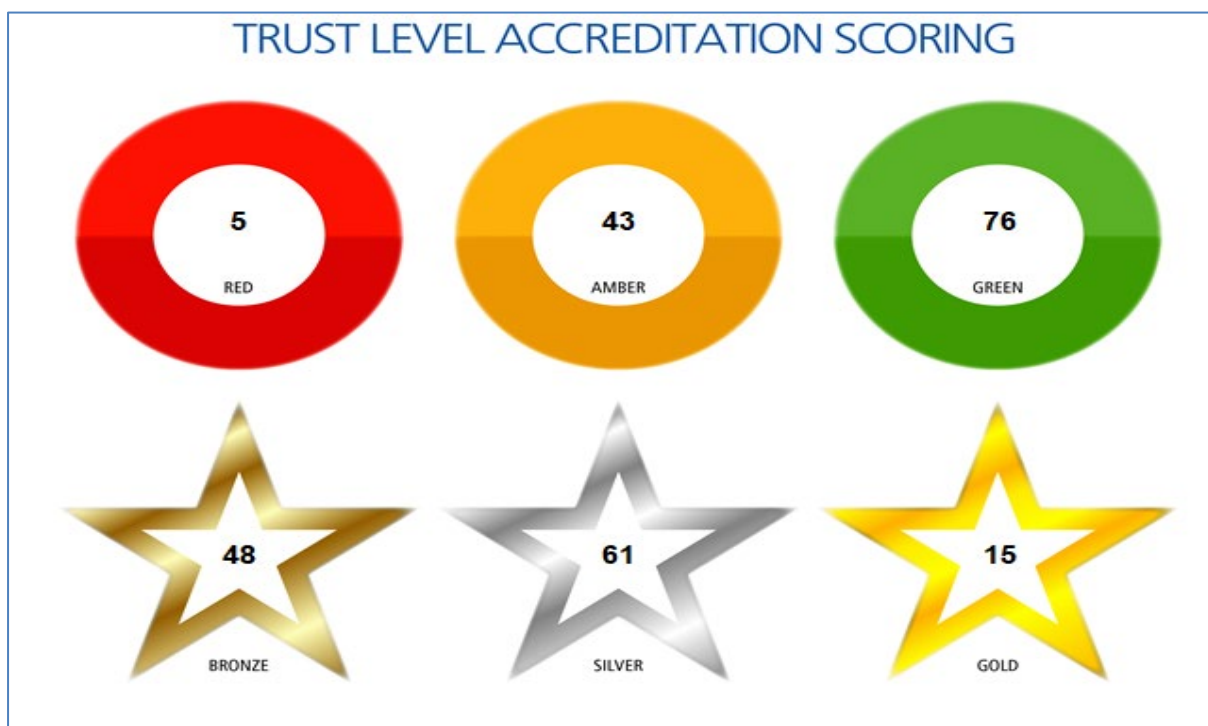
- STAR Monthly reviews – 17 audit questions are undertaken by the Matron or Professional Lead for each area.
- STAR Accreditation Visits – an in-depth CQC style audit is undertaken by the Quality Assurance Team with support from staff, Governors and volunteers from across the Trust.

In 2020-21 there are now 125 clinical areas registered for the STAR Quality Assurance Framework compared to 112 in 2019-20. Participants in this safety programme undertake monthly audits using the Trust audit system AMaT. The system hosts the actions required for improvement which are monitored by the ward Matron or Professional lead. A performance dashboard is also made available on the Trust Business Intelligence (BI) portal.

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

Up to the end of March, 2021 a total of 124 areas had STAR visits completed and there is only 1 new area awaiting their first STAR visit. These have resulted in the following scores:

**Figure 8 STAR Accreditation Scores**



Source: LTHTR data

We currently have 76 areas achieving a silver star or gold star status equating to 61% which achieves our target in *Our Big Plan* of 50% of areas achieving silver or above by the end of March 2021.

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

- Achieve 3 green rated STAR accreditation visits.
- Leaders have supported a peer ward or department to achieve an improvement in their rating.
- There is evidence that staff, learner and patient feedback is consistently responded to.
- Evidence of high standards of audit practice and environmental cleanliness.

Evidence that these criteria have been met is to be presented to a panel which would incorporate senior nurses, midwives and allied health professionals. We currently have 15 clinical areas which have successfully maintained three consecutive silver stars and have progressed onto a gold star.

Gold award celebrations were held in July and November 2020, supported by our Chief Executive, Chair, Governors, Nursing Midwifery & AHP Director and Deputy along with the Divisional Nurse, Midwifery and AHP Directors. The Gold teams presented virtually on their progression to achieving the Gold star, with many sharing very honest, inspirational stories. Key themes from the progression of the teams related to;

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

Our gold star teams all showed determination and commitment to act upon feedback and drive improvement to ensure the best possible care for our patients. There are currently 26 areas achieving 2 consecutive green scores, who currently have silver stars potentially progressing onto a third consecutive green on their next visit and therefore potentially a further 26 gold stars.

### **15 Step Challenge**

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

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

Areas are given a scoring based on the following:

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



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

**Table 13 15 Step Challenge Results**

	<b>A Very confident</b>	<b>B Confident</b>	<b>C Not very confident</b>	<b>D Not confident at all</b>
<b>Trust Overall</b>	78	45	1	0

Source: LTHTR data

In order to continuously improve the STAR Quality Assurance framework and to ensure the process is efficient and meets the priorities for the Trust, the Quality Assurance Team (QAT) undertake a regular review which incorporates feedback from clinical staff, Governors and the CQC key lines of enquiry.

Our Phase 4 review of the STAR accreditation visit and STAR monthly review standards was finalised and commenced in June 2020. Our STAR accreditation visits are now unannounced and conducted over a longer period of time to capture handovers and safety huddles. Feedback is now mainly delivered virtually to the divisional teams, ensuring the Trust is responsive and able to apply any immediate supportive measures and can cascade for a wider response if required. There is ongoing reflection and evaluation of the impact of these changes, with lots of positive feedback received to date.

Review of the scoring system has also been undertaken during 2020, with support from the Continuous Improvement Team. The parameters for achieving a green STAR visit rating have been reviewed and amended to 90% to be in line with Trust parameters for compliance which have been effective since 1<sup>st</sup> June, 2020. There is an exception to being awarded a green rating for those areas scoring 90% or over, if there are any immediate risks identified during the visit. In this instance, an amber rating with a maximum score of 89% would be awarded.

Merseyside Internal Audit Agency (MIAA) undertook a review of the STAR programme in December 2019 which made recommendations for improvement which were to develop a STAR page within our Learning Bank and features within the Learning Bulletin, the development of an improved electronic dashboard to improve capture of themes and trends. Both of which have been completed and have been accessible to all staff since December 2020.

## Falls Prevention



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

Falls and falls related injuries are a common and serious problem for people aged 65 and over with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. (NICE, 2013). Falls prevention is a complex challenge due to the large array of influencing factors requiring multifactorial patient assessments and implementation of

variable, individualised falls prevention measures. Older people in hospital are particularly vulnerable due to:

- Existing co-morbidities and presenting medical conditions including confusion, cardiac, neurological or muscular-skeletal conditions.
- Side effects from medication, or problems with their balance, strength or mobility.
- Poor eyesight or poor memory increasing the risk of falls when a patient is out of their normal environment because they are less able to recognise and avoid any hazards.
- Continence problems can mean patients may be vulnerable to falling whilst making urgent journeys to the toilet.

Risk is also increased when patients are acutely unwell, frail and in unfamiliar hospital environments. The challenge in patient safety has to be balanced against the patient's right to make their own decisions about the risks they are prepared to take, and their dignity and privacy. Rehabilitation always involves risks, and a patient who is not permitted to walk without staff may become a patient who is unable to walk without staff.

Over the past seven years we have implemented several falls prevention initiatives as part of the ongoing falls improvement project work, which has contributed to the reduction in the number of inpatient falls and falls with harm.

In this reporting period we have commenced a Falls Prevention Improvement Collaborative with a cohort of 10 wards, led by the Continuous Improvement team. Other falls prevention improvement actions have included:

- Continuation with the Royal College of Physicians (RCP) National audit of inpatient falls, an ongoing action plan which includes medications reviews, visual assessments and the provision of mobility aids.
- A Trust-wide falls prevention improvement plan cascaded to the Divisions and discussion of falls with severe harm at Divisional Governance and Harm Free care meetings and at the Safety and Learning Group.
- Improvements within the Quadramed electronic assessment system to be mandatory for all patients to have a lying and standing BP completed upon admission.
- Improvements within Electronic Prescribing Medications Administration (EPMA) system to be mandatory for medical staff prescribing to give a rationale when prescribing the hypnotics, anxiolytics and anti-psychotic medications.
- Falls risk assessments, moving and handling assessments, bedrails assessments and falls prevention care plans are being reviewed as part of risk assessment and care plan improvement work in collaboration with the Continuous Improvement team.
- Falls and falls with harm incidents being included in the monthly Nurse Staffing Report.
- Enhanced Levels of Care assessment and management plan being developed and cascaded trust-wide.
- Updating our 'Procedure for the Prevention of Slips, Trips and Falls' in June 2020.
- Updating our 'Procedure for the Safe and Effective use of Bed Rails and Side-rails on Trolleys' in November, 2020 in collaboration with the Safeguarding team, with improved consideration of least restrictive practices.

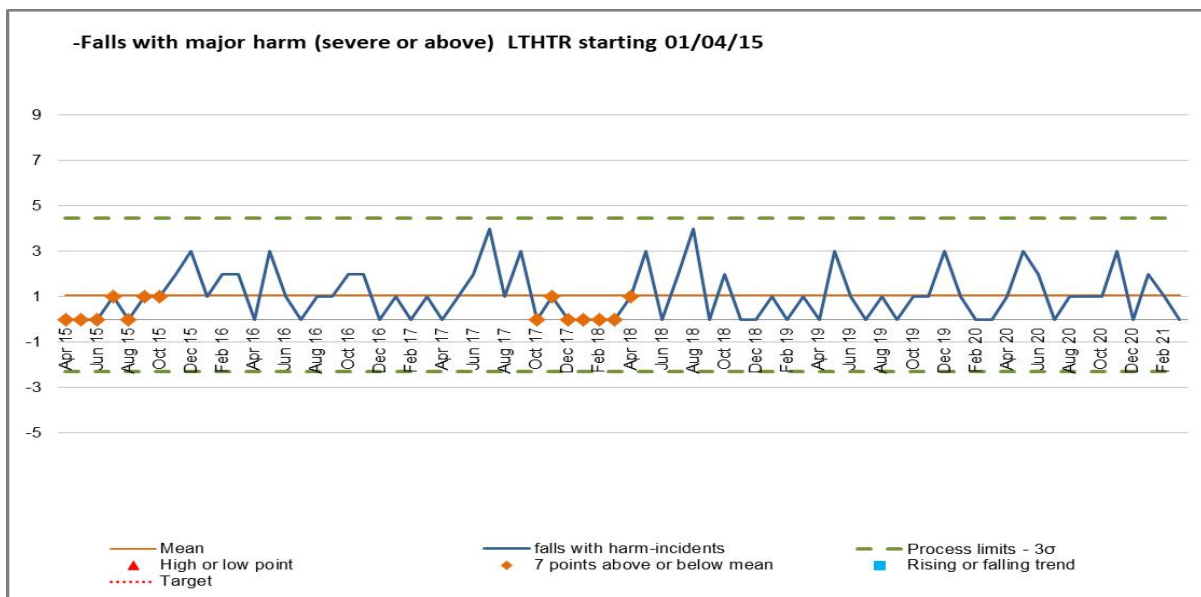
- Developing the Trust-wide Datix incident reporting system to include improved falls incident questions and data gathered regarding the 'swarm' post-fall rapid review questions.
- Reviewing of falls with severe or above harm at the Serious Incident (SI) panel at the Clinical Commissioning Group (CCG).

Future improvement plans include:

- Continuation of the Falls Prevention Collaborative as part of our Always Safety First Collaborative Programme.
- Development of a falls prevention champion role for teams to drive improvements in falls prevention within the Divisions.
- Improvement in patient information and evidencing discussions with patient about how to prevent falls.
- Updating the falls prevention E-Learning package.

Falls prevention remains one of our key priorities and the end of year falls statistics demonstrate some improvement in the overall number of falls but some variation with the number of falls resulting in harm. The total number of falls with major and above harm (severe, death) reduced from 14 in 2018-19 to 12 in 2019-20. However during 2020-21 there were 15 inpatient falls resulting in major or above harm.

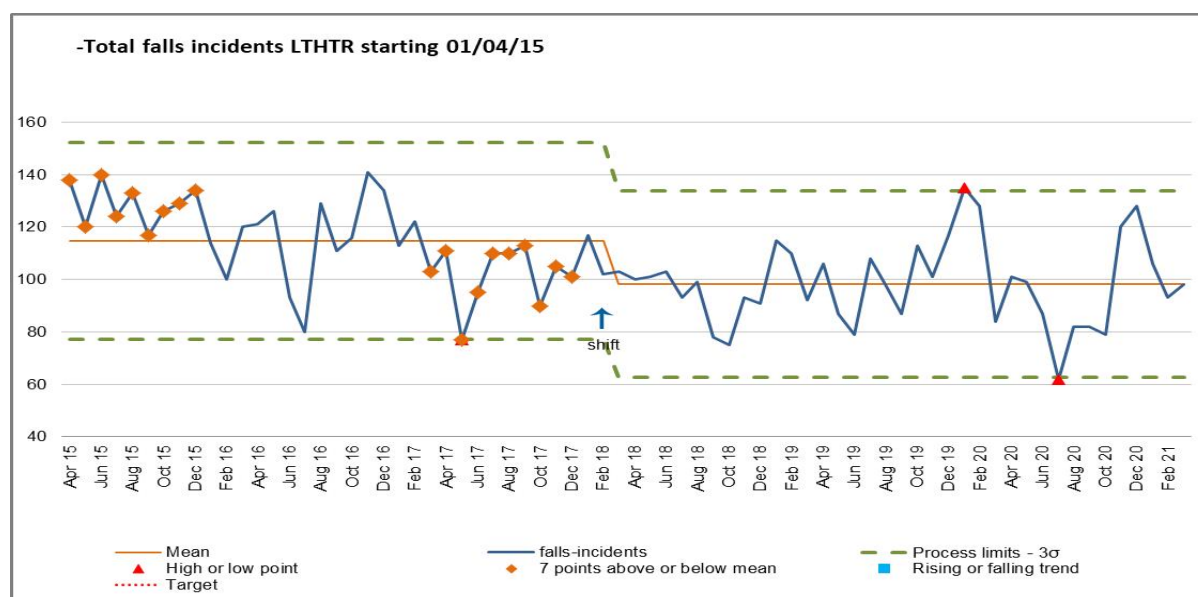
**Figure 9 Total Inpatient Falls with Major or Above Harm 2015 - March 2021**



Source: LTHTR data

We have reported all falls incidents since April 2015 and this is presented in Figure 10. Since 2018-19 the Trust has achieved a 0.7% reduction in total falls from 1150 falls in 2018-19 to 1042 falls in 2020-21.

**Figure 10 Total Inpatient Falls April 2015 – March 2021**



Source: LTHTR data

Although we did not achieve *Our Big Plan* target to achieve a 5% reduction in major and above harm caused by falls in 2020-21, we did maintain a slight reduction of all falls, from 1143 to 1142 between 2019-20 and 2020-21. We will continue to prioritise falls prevention as part of our continuous improvement programme.

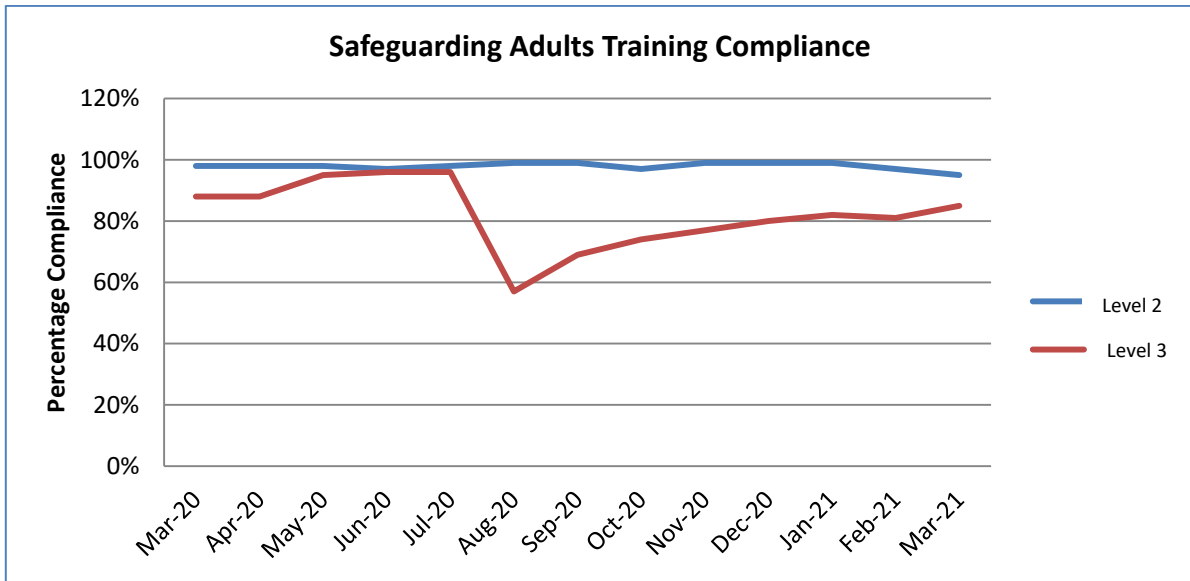
## Safeguarding Adults

Our Safeguarding Adult team continue to build upon risk and governance maturity and develop policy and practice and to optimise patient care where safeguarding concerns are realised externally to the organisation.

We operate a Safeguarding duty system and the Safeguarding team have a visible presence on wards and departments where required. Our team support staff with a wide range of safeguarding concerns including supporting multi-agency referrals and complex case management with wider system partners. Our Named Nurse for Safeguarding Adults is Chair of the Pan-Lancashire Acute Hospitals Task Force promoting the implementation of Liberty Protection Safeguards & Vice Chair of Lancashire Safeguarding Adults Board Safeguarding Adult Review group.

Safeguarding adult training has been fully revised in line with the Royal College of Nursing (RCN) competencies framework for health care staff and also the General Medical Council (GMC) adult safeguarding standards. The new Training Needs Analysis implemented in August 2020 has successfully achieved compliance of Adult Levels 1 and 2 training and significant progress has been made with workforce coverage of 84% of adult Level 3 competencies.

**Figure 11 Safeguarding Adults Training Compliance**

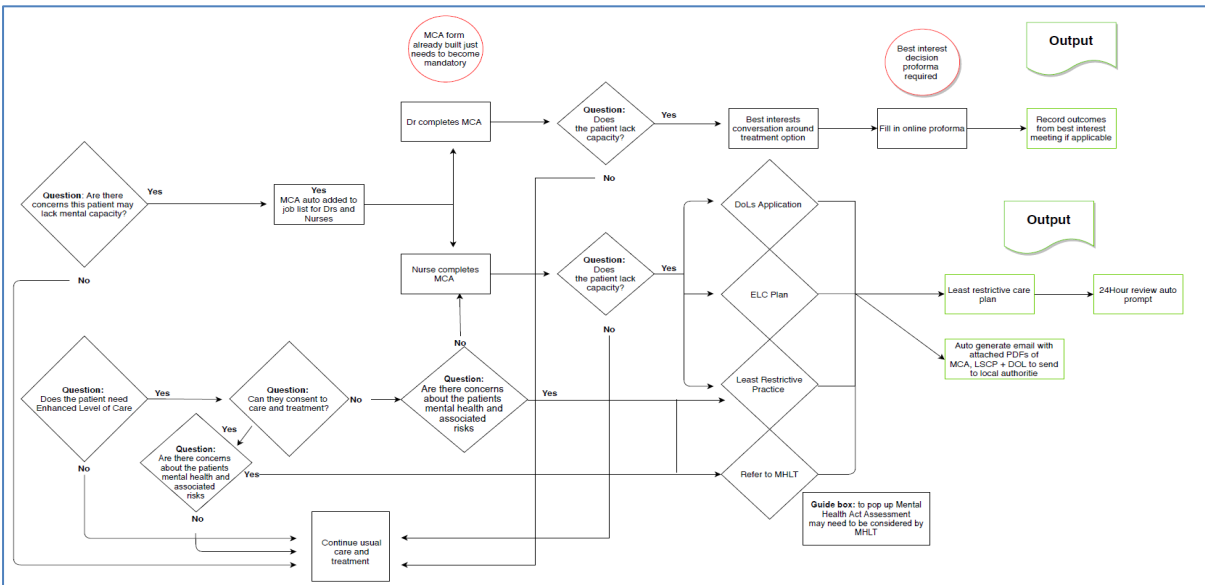


Source: LTHTR data

The Safeguarding leads contribute towards the weekly Safety & Learning Group. During the COVID-19 pandemic the team have supported the Divisions in releasing resource to support safeguarding management of Section 42 investigations, allowing nursing staff to remain free to deliver direct patient care.

We have undertaken a Mental Capacity and Deprivation of Liberty Safeguards project which has successfully produced an electronic patient journey process in Quadramed based on the Process Map below.

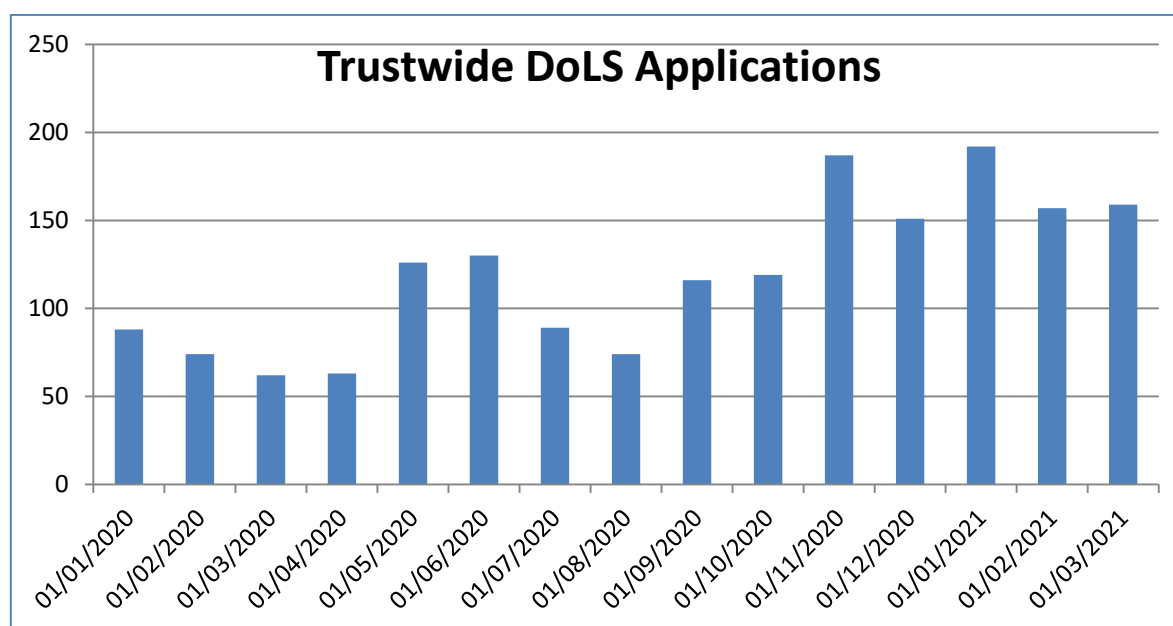
**Figure 12 Electronic Patient Journey Process Map**



Source: LTHTR data

The new electronic process has improved Deprivation of Liberty (DoLS) applications which are demonstrated through the DoLS application data shown in Figure 13.

**Figure 13 DoLS Applications**



Source: LTHTR data

During 2020-21 our Safeguarding team have contributed to 13 Safeguarding Adults reviews and 4 Domestic Homicide reviews, some of these have progressed to a full review, which are still in progress.

The team have contributed to wider organisational work streams in relation to Mental Capacity Act (MCA) and discharge processes, adverse discharge themes and pressure ulcer care. It is expected that these works streams will continue to develop in 2021-22 and that a positive culture of learning from safeguarding processes is embedded.

In order to support all the developments in Adult Safeguarding we have successfully recruitment a Named Safeguarding Adult Doctor. This will ensure multidisciplinary collaboration in the Safeguarding Adults agenda and enable us to prepare for the impending changes to Liberty Protection Safeguards legislation scheduled to be enacted April 2022.

## Safeguarding Children

Our Child Safeguarding Team operates a Safeguarding duty system whereby one of the safeguarding practitioners is available to support staff with a wide range of child safeguarding concerns. Our team are also visible on a daily basis within Paediatrics, Neonates, Maternity and the Emergency Department and we utilise our BI system to gain an oversight of all children age 16-17 who have been admitted to an adult ward. During 2020-21 we received approximately 120 - 230 child safeguarding enquires per month and we make between 15-35 referrals to Children's Social Care each month. The number of enquires and referrals has fluctuated greatly this year due to the COVID-19 pandemic with attendances for children in general reduced, as well as children being less visible to professionals with nurseries and schools being closed during lock down periods. Our team have close links with the local Multi-Agency Safeguarding Hub (MASH) and wider safeguarding system partners including the new local Child Safeguarding Assurance Partnership (CSAP).

In the last 12 months our team have created a separate Safeguarding Supervision policy which is being rolled out across the organisation and will ensure all staff have access to regular safeguarding supervision. We have also implemented our new child death arrangements with support of the newly appointed Named Doctor for Safeguarding Children. These new arrangements are in line with the Child Death Review Statutory and Operational Guidance and include Child Death Review Meetings in which the analysis form is drafted and submitted to the Lancashire Child Death Overview Panel.

Following lessons learnt from local and national Child Safeguarding Practice Reviews (CSPR) and child deaths, we have again this year been involved in promoting Safer Sleep and the ICON messages with parents including the creation of a video for Healthier Lancashire and South Cumbria's Better Births.



Remember – This phase will stop! Be an ICON for your baby and cope with their crying.

Babies Cry, You Can Cope!

- I** Infant crying is normal and it will stop
- C** Comfort methods can sometimes soothe the baby and the crying will stop
- O** It's OK to walk away if you have checked the baby is safe and the crying is getting to you
- N** Never ever shake or hurt a baby

This work will help to ensure that we embed lessons learnt following serious incidents by increasing staff knowledge and confidence in providing parents with Safer Sleep and how to cope with crying baby messages. This supports the aim to reduce the number of child deaths and traumatic head injuries in young babies.

Child safeguarding training compliance remains above 90% for level 1-3 training. This training is now available as E-Learning packages due to the restrictions in place regarding face-to-face training due to the COVID-19 pandemic. This has enabled staff to continue to access their essential child safeguarding training over the past 12 months.

We have a duty to ensure we keep children safe whilst they are in our care and we escalate concerns about care across the wider community by working collaboratively with other organisations, agencies and practitioners to protect children. Our team are currently involved in four on-going Child Safeguarding Practice Reviews within Central Lancashire.

## Maternity Safety and Quality

### Chorley Birth Centre

Our relocated freestanding Chorley Birth Centre within the Chorley and South Ribble Hospital site was opened on 14<sup>th</sup> December 2020. The centre is one of four birth options available to women booked within our care and offers an outstanding active birthing environment. Our centre offers 4 birthing rooms each with a birthing pool, active birthing equipment and ensuite facilities. Mood lighting is available in each birthing room and blue tooth technology in the pools is used to optimise the ambience of the rooms in preparation for birth.

Care for women booked at Chorley Birthing Centre is provided by a continuity of carer team; providing consistent care by a named midwife and team throughout the pregnancy, labour and postnatal period has been shown to impact positively upon physical and psychological outcomes as well as reported levels of satisfaction. The centre is also used as a community hub for the clinical assessment and education of families managed by the Chorley Birth Centre continuity of carer team.

**Figure 14** Our New Chorley Birth Centre



*Source: LTHTR*

**Figure 15** Birthing Room at Chorley Birth Centre



*Source: LTHTR*



## Maternity Safety Metrics

Maternity sensitive staffing metrics (Appendix 1) are displayed on our maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and therefore need investigation and prompt action. The metrics collated are triangulated with staffing levels when the maternity dashboard is reviewed at the Divisional Safety and Quality Committee on a monthly basis and a monthly safe staffing report is submitted to Trust Safety and Quality Committee detailing any areas of concern and actions to be undertaken.

The dashboard reflects a sustained attainment of 100% supernumerary status of Delivery Suite Coordinators (defined as having no caseload of their own during their shift). This indicator is a requirement of the Clinical Negligence Scheme for Trusts (CNST) to ensure there is an oversight of all birth activity within the service at all times.

We have seen a slight decrease in the trend for births taking place in midwifery led settings and this appears to correlate with the increased incidence in home birth following the introduction of the Ivy Continuity of Carer Homebirth Team. Our mean homebirth rate has improved significantly since the introduction of the team with a mean of 4.1% year to date (national mean 2.1%).

Our Maternity dashboard indicators reflect a stable service and provide evidence of sustained improvement in one to one care in labour rates over the past twelve months.

One to one care in labour compliance rates continue to be monitored and demonstrate a sustained improvement year to date. Unfortunately 100% compliance has not been attained each month as required. We have an action plan detailing how the maternity service intends to achieve 100% compliance with one to one care in active labour, which will enable us to declare compliance with this requirement.

## Incidents and Never Events

### Incidents

Our incident data has been presented in section 2 of this report with a rationale for the data and actions taken and planned. The levels of harm from incidents in 2020-21 are presented below.

**Table 14** Level of Harm Related to Incidents 2020-21

Level of Harm	Number of Incidents Reported
No Harm	15460
Low Harm	5081
Moderate Harm	1150
Severe Harm	50
Death	19
<b>Total</b>	<b>21,760</b>

Source: LTHTR Datix data

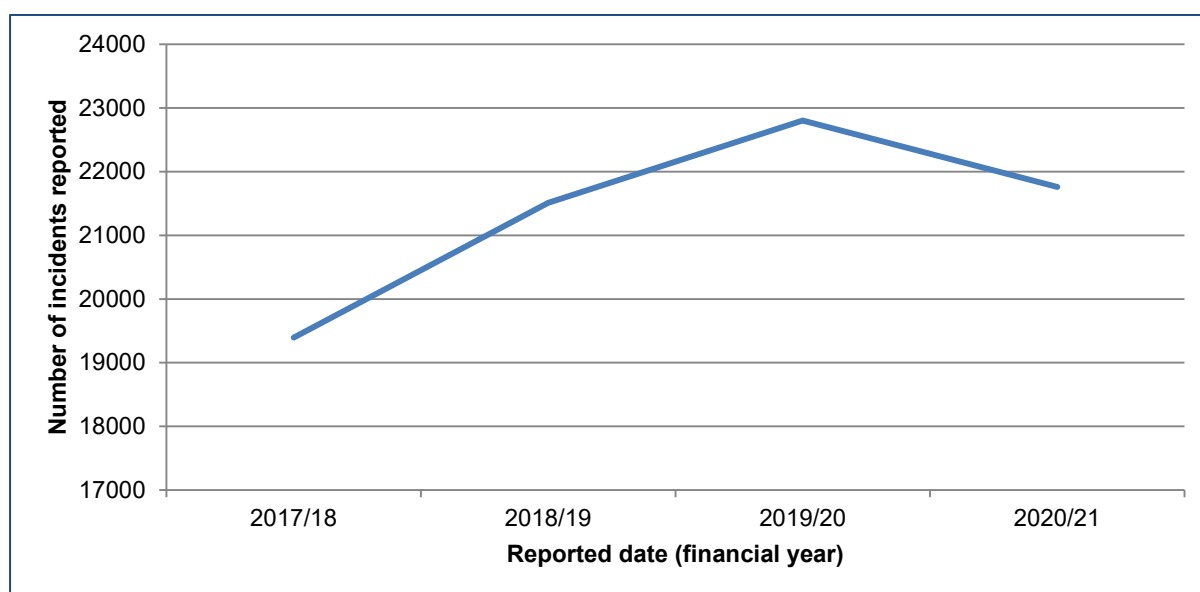
Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. In order to promote and develop our culture of incident reporting we continue to improve education regarding the reporting of incidents and near misses, the importance of reporting and the

learning we obtain from incident reporting. We have also made further improvements to our reporting system Datix, to make it easier to report in a timely manner.

During 2020-21 we have developed Governance and Incident Dashboards which are now in use across our organisation to embedded incident reporting and analysis. We have also linked our incident analysis to our risk register to promote our Risk Maturity programme of work in line with *Our Big Plan*.

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

**Figure 16 Incidents Reported 2017-2021**



Source: LTHTR Datix data

The predicted total of incidents reported for 2020-21 is a decrease of 1043 incidents, which has been influenced by the COVID-19 pandemic. For significant periods of time over the past 12 months there was a decrease in the volume of inpatients admitted to the Trust, which in turn has shown an expected decrease in the number of incidents reported.

### Never Events

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

During 2020-21 we reported 4 Never Events in the following categories:

- 3x misplaced naso-gastric tube
- 1x wrong site surgery (wrong site injection)

All Never Events are subject to a serious incident review and reported to the local Clinical Commissioning Groups as well as nationally to the Strategic Executive Information System (StEIS) and the National Reporting & Learning System (NRLS). Learning from both systems is shared nationally. Of the 4 never events in this reporting period 2020-21, 2 investigations have been completed and 2 remain ongoing

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

## Duty of Candour

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

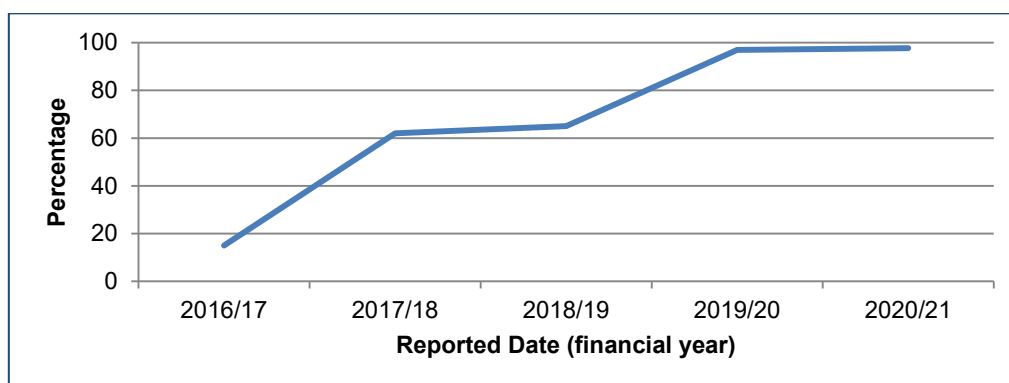
The investigation of incidents where actual or potential for harm has occurred, is carried out within a culture of openness and transparency with an absolute commitment to explaining and apologising to patients who have suffered harm. This is a key aspect of us delivering excellent care with compassion.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

In the year 2020-21 we identified 902 cases where Duty of Candour was applicable. This is a considerable increase in cases since the previous year, which is likely to be attributable to the challenges of the COVID-19 pandemic. Of the 902 cases where Duty of Candour was applicable, 516 of them were probable or definite hospital acquired COVID-19 cases. Of those 902 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 882 occasions (97.7%). The remaining 20 cases (2.3%) have documented validated reasons as to why Duty of Candour has not been carried out.

Reasons for Duty of Candour not being applied relate to:

- Due to the outcome of the incident, it is deemed inappropriate to have this discussion.
- No known address of the patient or appropriate person.
- Patient is too acutely unwell to receive the letter but will be delivered once the condition improves.
- Patient or appropriate person is untraceable.

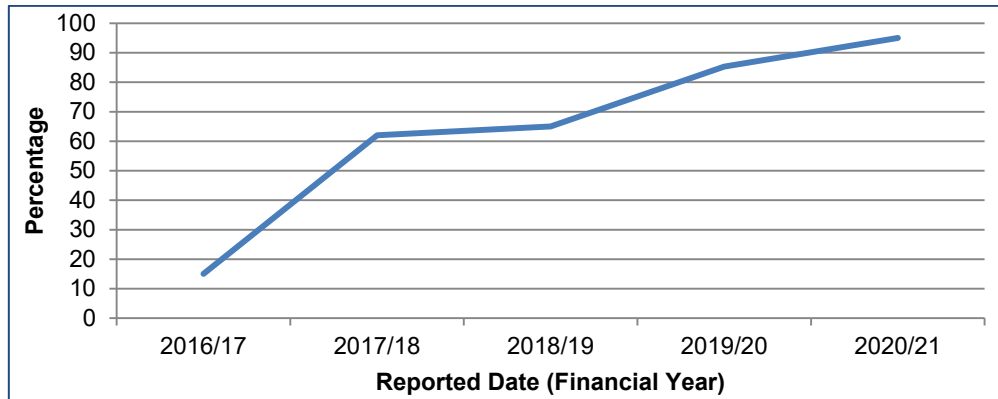
**Figure 17 Percentage of Cases with DOC Applied (Annual Comparison)**



Source: LTHTR Datix data

Of the 882 occasions where Duty of Candour has been undertaken, 838 cases (95%) were achieved either verbally or in writing within 10 working days of the incident being reported. This is a further improvement compared to 2019-20 where only 85.3% of cases had Duty of Candour carried out within 10 working days of the incident being reported and represents an improvement of 4.7%.

**Figure 18 Percentage of Cases with DOC Applied in 10 Working Days**



Source: LTHTR Datix data

Figure 18 demonstrates a strong trend of improvement over the last 4 years in regards to timely application of Duty of Candour and provides further assurance that the application of Duty of Candour is embedded in our culture and practice. However, we continue to focus on the 5% of cases where the 10 day response rate is not being delivered.

## Review of Quality Performance - Effective Care

We aim to continually provide effective care and treatment by ensuring clinical practice is evidence based against national standards and clinical research. Being involved with national quality and benchmarking programmes including 'Getting it Right First Time (GIRFT)' gives us opportunities to benchmark our services and improve our outcomes. Tissue viability and pressure ulcer prevention, nutritional support, management of medications and infection prevention and control are critical to the effective care and treatment of our patients.

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

This section provides information about all these areas in the narratives below.

### Getting it Right First Time

The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

We recognise the opportunities that the national GIRFT programme provides and the benefits it will bring to the services we provide. This quality improvement programme encompasses a wide range of clinical pathways and it enables us to benchmark with other similar hospital services and share the learning.

The GIRFT visits to the Trust commenced in 2014 with 25 specialties visited so far, 4 of which were revisits. A further 4 specialty visits were scheduled for 2020 however due to the COVID-19 pandemic these were cancelled. The GIRFT programme has been temporarily suspended externally and internally over the past year due to the pandemic and when normal services resume our GIRFT lead will be working with teams to rebook visits and update our implementation plans accordingly.

Our Trust lead for GIRFT also has a robust monitoring programme which is utilised Trust wide and it has the capability to link in with our Cost Improvement Plan and Quality Improvement work. All improvement actions identified are captured and linked into the relevant cost improvement and/or continuous improvement programme of work as GIRFT recommences.

### Tissue Viability – Pressure Ulcer Incidence and Prevention

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

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

We have an established programme of prevention and management of pressure ulceration, which includes training, education, clinical advice and support for clinical teams facilitated by the Tissue Viability Nurses (TVNs). This has been strengthened with the support of the Continuous Improvement Team through the commencement of a pressure ulcer prevention collaborative, which commenced in June 2020.

The continuous improvement pressure ulcer prevention collaborative started with the 10 wards with the highest incidence of new pressure ulcers and the collaborative has used reliable improvement methodology to reduce pressure ulcer incidence. The TVN's developed a 'change bundle' which includes the key actions for the wards to develop robust systems to ensure planned patient repositioning occurs and that skin assessment and continence management are consistently undertaken. Continuous improvements are supported at weekly collaborative meetings through the TVN team facilitating clinical discussions and providing follow up support to the teams involved in the collaborative. The ongoing pressure ulcer improvement work has been supported and strengthened by the increased training and support led by the TVN team. In February 2021 the pressure ulcer collaborative commenced a second cohort which involves an additional 11 wards.

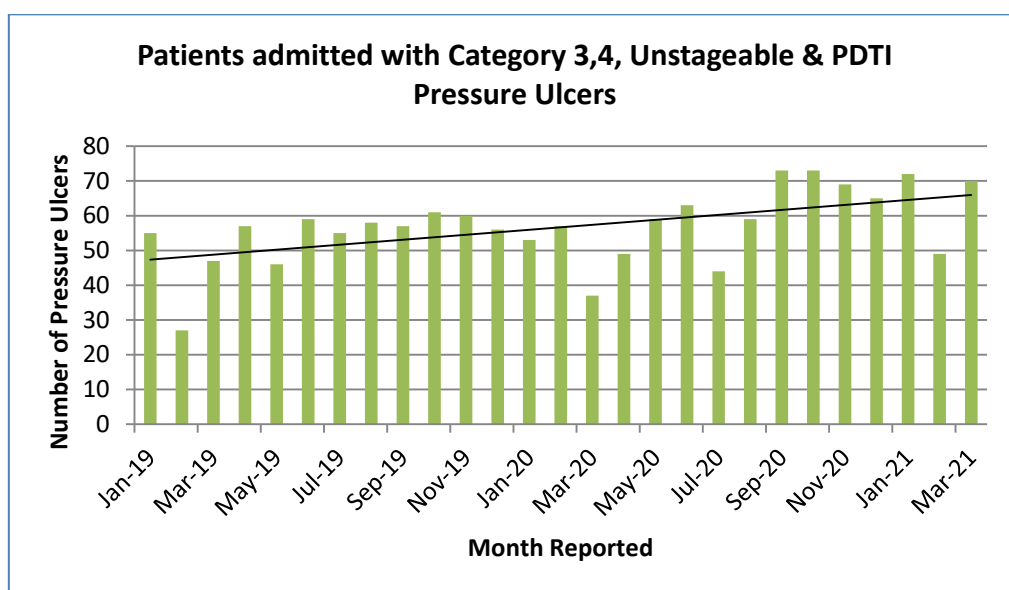
Education and audit of pressure relieving equipment is another key role of the TVNs, supported by the Medstrom clinical nurse advisor. Education has resulted in improved recognition of patients who need to be upgraded to a higher specification of mattress.

The effective utilisation, management and education of the pressure relieving surfaces is vital for both preventing and treating new hospital acquired pressure ulcers and also the effective care for the most vulnerable patients who are admitted with pressure ulcers.

### Admissions with High Category Pressure Ulcers

We recognise that there has been a year on year increase in the number of patients admitted with category 3, category 4, potential deep tissue injury (PDTI) and unstageable pressure ulcers (reported as moderate and severe harm) since 2018-19 which is highlighted in the graph below in Figure 19.

**Figure 19 Admitted with Category 3, 4 Unstageable and PDTI pressure Ulcers**



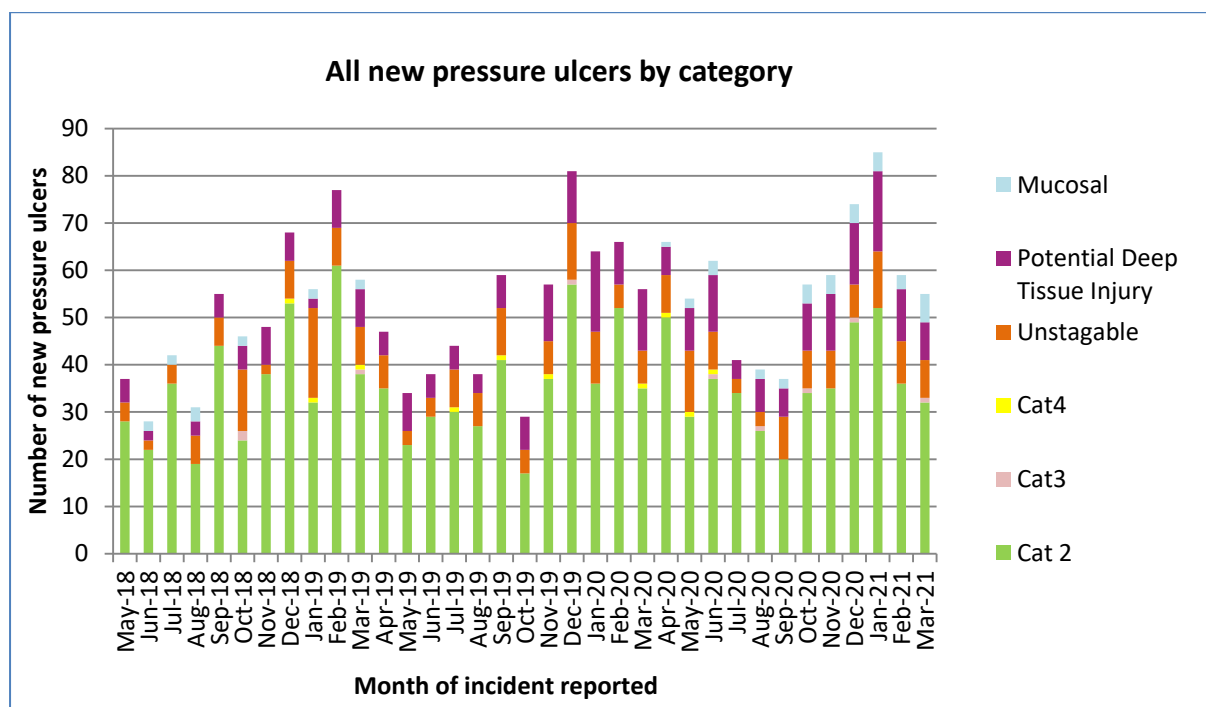
Source: LTHTR data

We are improving the identification and management of these categories of pressure ulcers by using photographs to promote prompt and timely validation of pressure ulcer categories and assist in the monitoring of pressure ulcer progress over time. Historically only Medical Illustration were able to take photographs in the Trust but our TVN team have trialled the use of electronic devices to take images of pressure ulcers and upload onto the Fotoweb system. This trial was successful and has assisted in facilitating remote reviews of patients. Our next stage is to roll this out across all ward areas which will enable wards to photograph any area of concern on a patient at the point of care. This will avoid the need for multiple unnecessary dressing changes which would otherwise be required for multiple person reviews. This will also facilitate multispecialty reviews of a concern remotely, potentially reducing the waiting time for a treatment plan.

### All New Pressure Ulcers

We acknowledge that there has been an increase in the overall number of patients with pressure ulcers since 2018. The reason for this is multifaceted which includes the complexity and frailty of patients, increase in the number of patients admitted to hospital and in 2020-21 increased pressures due to the COVID-19 pandemic. The bar chart below in Figure 20 highlights the numbers of individuals developing a new pressure ulcer and the category of harm from May 2018 to February 2021.

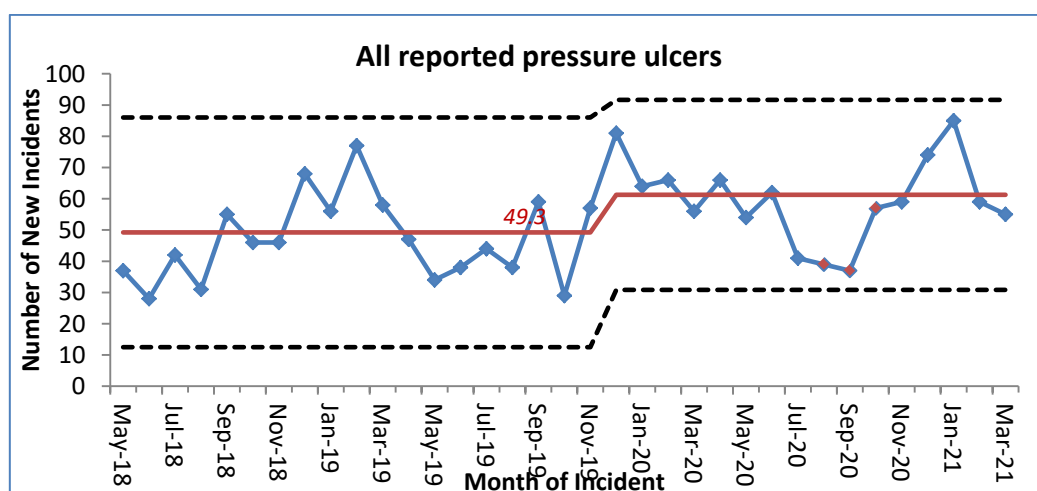
**Figure 20 New Pressure Ulcers by Category May 2018 – March 2021**



Source: LTHTR data

The Statistical Process Control (SPC) chart in Figure 21 below demonstrates a drop in rate after the start of the pressure ulcer collaborative in June 2020 but also another peak which correlates with the COVID-19 pandemic period.

**Figure 21 All Pressure Ulcers SPC Chart**



Source: LTHTR data

**Medical Device Related Pressure Ulcers**

Medical device related pressure ulcers are now clearly identified within our incident reporting as outlined in NHSI guidance. This promotes clearer visibility of these types of pressure ulcer and enables further targeted pressure ulcer prevention improvement actions. The key to preventing these pressure ulcers is careful skin assessment under and around any medical devices. Review and improvement of the medical device-related skin assessment processes and documentation is in progress, including development of a new ‘intentional rounding’ document facilitated via the pressure ulcer prevention collaborative. As part of the focus around device related pressure ulcers the TVNs developed a useful acronym DEVICE for the clinical areas to use which has been shared Trust wide and relates to:

- Do you need it
- Explore the options
- Valid application
- Inspection
- Change of position
- Evaluate

**Table 15 Device Related Pressure Ulcers**

Type of Pressure Ulcer	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Category 2 (d)	8	4	5	13	9	10	8	9	13	11	5	8
Category 3 (d)	0	0	1	0	0	0	0	0	0	0	0	0
Category 4 (d)	0	0	0	0	0	0	0	0	0	0	0	0
Unstagnable (d)	1	1	1	0	0	3	2	0	1	1	0	1
Potential Deep Tissue Injury (d)	3	1	3	3	1	1	1	1	1	1	0	2
Mucosal (d)	1	2	3	0	2	2	4	4	4	4	3	5
Total	13	8	13	16	12	16	15	14	19	17	8	16

Source: LTHTR data

Our TVN team regularly provide expert clinical input and support to the Divisional Governance Teams into pressure ulcer incident review at:



- Weekly in-depth divisional review.
- Monthly divisional harm free care meeting focusing on shared learning.
- Rapid incident reviews.
- Ensuring Trust-wide learning is included as part of the learning to improve bulletins.
- Quarterly TVN newsletters, sharing relevant update and sharing success.

Throughout the COVID-19 pandemic there has been a focus on learning and sharing of good practice. Our TVN team have been capturing the learning in relation to the effects COVID-19 has had on patients skin and pressure ulcer risk. During 2020-21 we have developed 2 COVID-19 learning packages shared with the ward teams. The most recent included a COVID-19 skin bundle to highlight the increased risk COVID-19 positive patients have of developing pressure ulcers. In 2020-21 we have increased our provision of pressure ulcer prevention equipment to ensure we have the availability of correct equipment for our patient's needs, which included an increase in dynamic mattress for the expansion and escalation of Critical Care.

**Table 16 COVID-19 Positive Patient with Pressure Ulcers Nov 20 – March 21**

Division	Total Number of New Pressure Ulcers					Number COVID-19 Positive Patients With Pressure Ulcers					% COVID-19 Positive Patients With Pressure Ulcers				
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Medicine	30	40	41	35	30	14	21	17	9	6	46%	53%	41%	26%	27%
Surgery	24	21	31	10	24	16	10	10	2	2	67%	48%	32%	20%	12%
Diagnostics & Clinical Support	10	14	12	14	10	8	9	7	7	6	80%	64%	58%	50%	43%
Women's & Children's	1	0	1	0	1	1	0	0	0	0	100%	-	0%	-	0%
<b>Trust Total</b>	<b>65</b>	<b>75</b>	<b>85</b>	<b>59</b>	<b>65</b>	<b>39</b>	<b>40</b>	<b>34</b>	<b>18</b>	<b>14</b>	<b>60%</b>	<b>53%</b>	<b>40%</b>	<b>35%</b>	<b>25%</b>

Source: LTHTR data

Our pressure ulcer prevention collaborative ongoing actions and interventions outlined in this section highlights the dedication of our teams in aiming to reduce the incidence of pressure ulcers in our organisation.

## Nutrition for Effective Patient Care



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

One of our aims continues to be to ensure that patients admitted to the Trust who remain for more than 48 hours (excluding maternity and day-case patients) have a nutritional screening assessment on admission. The assessment is carried out using the Malnutrition Universal Screening Tool 'MUST' developed by the British Association for Parenteral and Enteral

Nutrition. The screening tool highlights patients who are already malnourished or at risk of malnourishment and determines the need for referral for a more detailed nutrition assessment by a dietician or an alternative nutritional care plan.

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

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

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

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

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

During 2020 - 21 our services key achievements were:

- The development of weekly integrated secondary and primary care nutrition Multidisciplinary Team meetings.
- Due to COVID-19, there were some accelerated improvements to pathways including direct access to the Nasogastric Tube (NGT) pathway for community patients, a new gastrostomy referral and assessment process and transformation of out-patient services to include virtual platforms for tele-health.
- The International Dysphagia Diet Standardisation initiative embedded across the Trust for SLT and Dietetics.
- Reviewed dietetic interface with community colleagues and work closely with them through CI Big Room methodology to look at streamlining processes such as commencing Nasogastric Tube (NGT) feeding in the community.
- The Head of dietetics has been appointed as a Flow Coach and will be leading the work streams identified as their training progresses. This was paused during the pandemic but is due to re-start.
- Revised the policies and pathways around improving NGT safety.
- Worked with the *Learning to Improve* group to continue to refine opportunities for NGT safety.
- Worked with the Electronic Patient Record (Quadramed) team to refine the electronic documentation of NGT management.
- Been aiming to establish a difficult feeding service for over 2 years, and a business case to do this has been completed and is being progressed.
- Dietetics and SLT services now have electronic In-Patient referral systems.

- Appointed a Clinical Service manager to support governance, business intelligence and performance initiatives.
- Increased SLT services within critical care following a CQC should do.

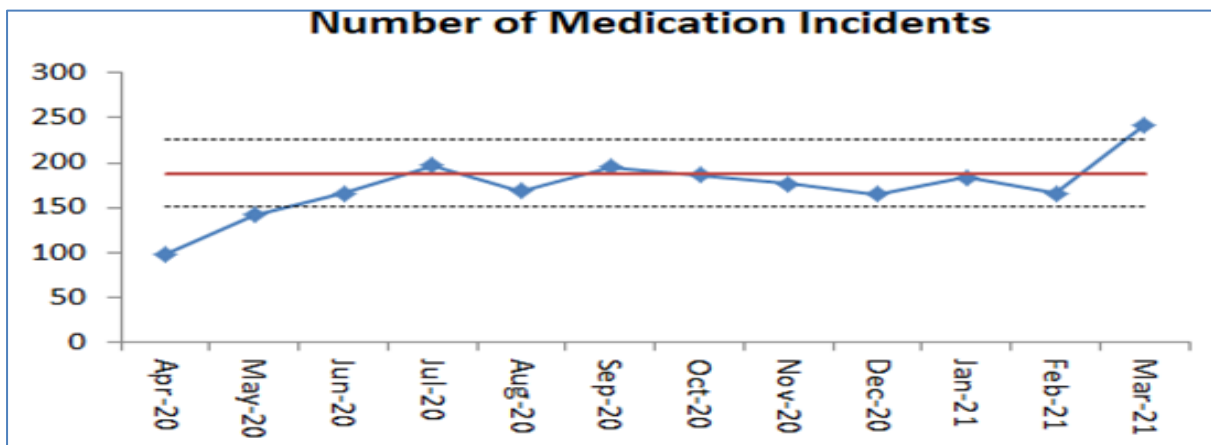
## Medication and Incident Monitoring

Medication errors have significant implications on patient safety. In 2018 The Secretary of State commissioned research into the 'Prevalence and Economic Burden of Medication Errors in the NHS in England' from the Policy Research Unit in Economic Evaluation of Health and Care Interventions (EEPRU). This research identified there are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant.

Our Medication Safety & Education Team review medication incidents on a monthly basis, monitoring types, trends and rates of errors. This review and analysis supports identification of immediate actions to be taken in response incidents, and also supports long term action plans to address on-going issues and trends. Our team has expanded during 2020-21 with the recruitment of a Medication Safety Pharmacist and a Governance and Safety Pharmacy Technician to support the Medicines Safety Officer, as well as 2 Medicines Governance Associates to develop and support the delivery of Medicines Safety and Controlled Drug audits and subsequent improvement agendas.

Our Pharmacy Medication Safety Team work hard to encourage a positive error reporting culture which is enabled by our active management and effective reporting system (Datix), which allows medication errors to be quickly reported and ensures thorough and timely investigation. Having a robust medication incident reporting culture is fundamental for the development and sustainability of a learning culture, which is essential for preventing future harm. Incidents reported are predominately incidents causing no harm or near misses and analysis of these help us develop strategies to prevent future harm events. The COVID-19 pandemic has had a significant impact on Medication Incident reporting. In the first quarter of 2020 the trust experienced a downturn in reporting. However, after significant campaigning through the Pharmacy Medicines Safety team the average reporting figures have increased back to our historical mean which demonstrates a positive culture of reporting.

**Figure 22 Medication Incidents Reported**



Source: LTHTR data

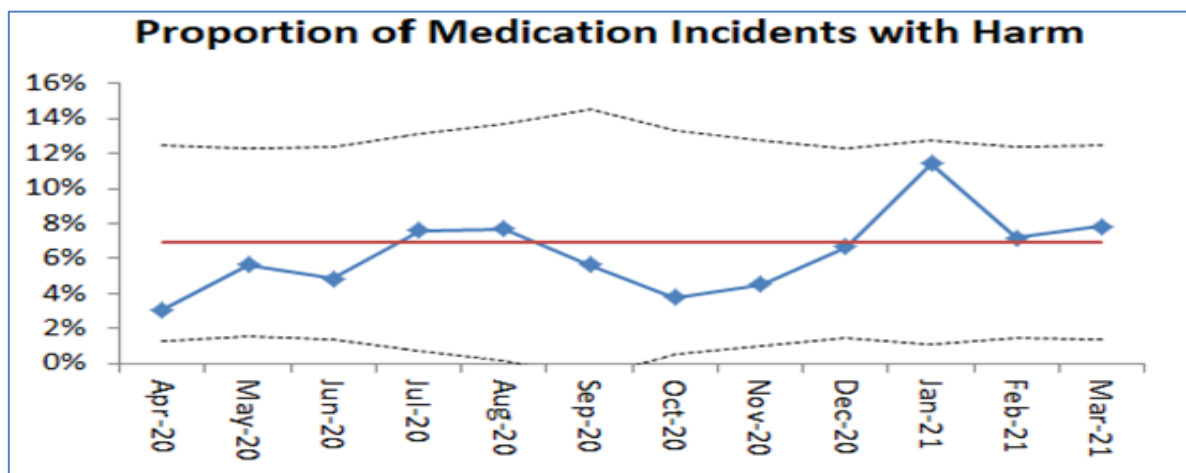
Between March 2020 and March 2021 there has been an average of 174 medication incidents reported each month. A study conducted by the University of Manchester in 2018 estimated that across the UK 25% of medication errors in hospital lead to harm, we are below this national average with an average of 10% of total medication incidents reported causing a degree of harm.

Every incident reported at moderate harm or above is subject to a rapid review meeting, led and facilitated by the Divisional Governance team and supported by the Medication Safety Officer. Early impact interventions are identified and disseminated prior to the outcome of formal investigations. Near Miss incidents have in 2020-21 become a focus for the Pharmacy Medication Safety Team who review and report on these monthly.

Medication incident themes are shared to the relevant divisional areas in Medication Safety reports presented at Always Safety First meetings along with any shared learnings from significant events in other divisions.

Our monthly performance is also reported to the Medicines Governance Committee which details harm and near miss themes and trends. The percentage of medication incidents resulting in harm is monitored by our Medicines Governance Committee on a monthly basis and is displayed in the graph below in Figure 23. The peak in harm events in January 2021 is attributable to the reporting of COVID-19 vaccine side effects and potential adverse effects as medication incidents. This was part of our initial vaccine surveillance and gave the Medicines Safety Officer the opportunity to investigate each and ensure all information was provided to the COVID-19 Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card system.

**Figure 23 Medication Incidents Leading to Harm**



Source: LTHTR data

We have a network of Medication Safety Champions, supported by the Medications Safety Education Pharmacist. Our champions are link nurses from each clinical area that meet monthly on both hospital sites to share learning from errors, implement change and act as an education forum. Medication Champions and their meetings will be a focus for the Pharmacy Medication Safety team in 2021, integrating allied roles such as cross departmental Oxygen & Medical Gas Champions and the Clinical Educators.

All our medication incidents continue to be reported on Datix and are linked the Risk Register on the same system. The Medicines Governance Committee have introduced a

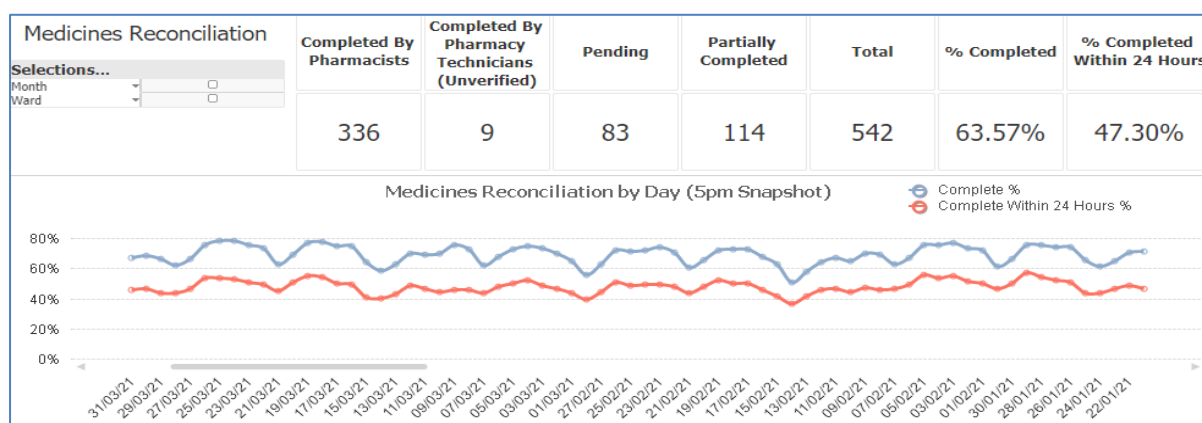
cycle of business for risk assurance reporting to monitor medication risks, which is in line with the trust’s risk maturity agenda.

### Medicines Reconciliation

Medicines reconciliation is the process by which information on a patient’s medication history is collected and verified following admission. Best practice determines that this should ideally take place within 24 hours of admission.

Our data for 2020-21 shows a variation from previous years however we are confident this is a positive step to improve patient care. Previously medicines reconciliation was measured by using a quarterly single day point prevalence audit that sampled a proportion of patients on each ward (a method developed by the NW Clinical pharmacy forum). Following the implementation of Electronic Prescribing and Medicines Administration (EPMA) system to wards across Royal Preston Hospital a pharmacy dashboard has been developed within the trust Business Intelligence application BI Portal. Using data taken from the live EPMA system that is refreshed every 15 minutes, medicines reconciliation can be tracked 24 hours a day. By using this application it is beginning to shape how we utilise our clinical pharmacy ward based resource. An example of the data for quarter 4 is presented in Figure 24 below.

**Figure 24 Daily Medication Reconciliation Quarter 4**



Source: LTHTR data

The average compliance in 2019-20 was 70%. For 2020-21 it is 46% within 24 hours. The total medicines reconciliation regardless of time from admission is on average 62% for 2020-21. Further investigation is required to determine the factors which are influencing the time gap between ‘Completed within 24hrs’ and ‘Total Completed’ one factor is likely to access to patients to verify medicines which has been a challenge in 2020-21 due to the impact of the COVID-19 pandemic. The other variance that can be clearly seen is how compliance varies across the week with a reduced pharmacy capacity having an impact at the weekend.

### Prescription Verification

Our Pharmacists review prescription charts in the clinical areas, assessing prescribing for dose, accuracy, legibility, interactions, appropriateness of therapy (including patient characteristics, disease state, laboratory results) formulary compliance and legal requirements. Our EPMA has also enabled this verification to be measured 24 hours a day via data in the pharmacy dashboard.

Average compliance for verification within 24 hours of prescription is 56%, the total percentage of prescriptions that have been verified each week peaks on a Friday at around 85%. On a daily basis the EPMA data can now be utilised to target resources at ward areas where there is a gap in compliance.

### Antimicrobial Stewardship

There are a range of metrics we use to demonstrate good antimicrobial stewardship to promote safety in the management of antibiotics which are:

- Compliance with documentation of the indication for antibiotics on the prescription
- Compliance with antimicrobial guidelines or recommended by Microbiology
- Compliance with LTHTR stop/review date guidance:
  - Stop/review date on the initial prescription – new in 2020
  - Stop/next review date on the prescription after 72 hours
  - Completion of the 48-72 hour Yellow Box (paper record) or electronic antimicrobial review on EPMA

We undertake quarterly antibiotic prescription and administration point prevalence audits and the results have remained >90% compliant with documented indication on the drug chart, antimicrobial choice compliant with guidelines or recommended by microbiology and the stop/review date on initial prescriptions. The results are presented in Table 17. Quarter 4 data will only quality assured and available in May.

**Table 17 Antimicrobial Stewardship Point Prevalence Audit Results**

	No. of patients on antibiotics	No. of antibiotic prescriptions Audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Stop/review date on initial prescription	% Compliance with stop/review date on Prescription at 72 hours	% Completion of the 48-72 hour Yellow Box or electronic antimicrobial review on EPMA
Trust wide Q1 2020-21	-	Stood down due to Covid-19 pandemic						
Trust wide Q2 2020-21	192	267	93%↓	92%↑	93%↑	96%	77%↑	20%↑
Trust wide Q3 2020-21	307	427	96%↑	93%↑	94%↑	95%↓	62%↓	15%↓

Source: LTHTR data

We are not yet achieving compliance with the stop/next review date after 72 hours and the completion of the 48-72 hours Yellow Box or electronic antimicrobial review on EPMA. The main contributing factor to this is because of the new EPMA system work queue that the antimicrobial review falls into for the doctors to complete, isn't easily accessible and where the doctors have several other tasks in the queue, signing the antibiotic check can be missed. To promote improved compliance our antimicrobial team have been working with our Information Technology department, to create a review that can be embedded into the doctors ward round documentation. The roll out for this change is planned for April 2021. Training is also being provided to the junior doctors and refresher sessions to ward teams to drive improvement.

In 2020-21 we were aiming to participate in the antifungal stewardship CQUIN, to improve diagnostics and guidelines for invasive fungal infections. A baseline assessment was undertaken of fungal diagnostics against the mycology society guidelines and we produced

guidelines for prophylaxis and treatment of fungal infections in haematology patients and treatment of invasive Candidaemia. Unfortunately all CQUINs were stood down to release resources for the COVID-19 pandemic. It is anticipated that this CQUIN will resume when conditions permit.

## Infection Prevention and Control

### MRSA Bacteraemia

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

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

- In 2018-19 there were zero incidents of hospital onset MRSA bacteraemia & 2 cases of community onset MRSA.
- In 2019-20 there was 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2020-21 there have been 0 incidents of hospital onset MRSA bacteraemia and 0 cases of community onset MRSA.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention.

### ***Clostridioides difficile* Infection**

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

The prevention of *C. difficile* infection remains a key priority for our organisation. During 2017-18 there were 60 cases and during 2018-19 there were 51 cases. This was an improving picture in relation to the overall objective of not exceeding 65 cases a year for the organisation during that reporting period. There was then an increase in 2019-20 as described above.

Due to the COVID-19 pandemic there was no national objective set by NHSI for 2020-21. We have therefore used the previous year's target to set a local objective. In 2020-21 we saw an improvement in the number of healthcare associated *C. difficile* cases as compared with 2019-20, although it remains higher than the target. There have been 100 cases in 2020-21 against the previous yearly objective of 84.

- Hospital Onset Healthcare Associated = 78.
- Community Onset Healthcare Associated = 22.

Of the 78 Hospital onset cases, 76 have already been reviewed to date and there were lapses in care identified for 49 cases; no lapses in care in 27 cases and 2 are still under review.

We acknowledge that we have exceeded the yearly objective of 84 cases for this reporting period. All our hospital cases are reviewed by an expert group including the Director of Infection Prevention and Control or Deputy Director of Infection Prevention and Control, Infection Prevention and Control Matron, Infection Prevention and Control Nurse, Antimicrobial Pharmacist, Specialist Antimicrobial Technician, Ward Manager, Ward Matron and Consultant in charge of the patients care.

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

- A lack of documentation of risk assessment around loose stools and need for isolation.
- A lack of documentation of escalation of isolation requirements to site/bed management.
- Sampling delays.
- IPC audits (environment and IPC practice) not reaching required standard.
- Less than optimum bay decontamination after *C. difficile* cases and carriage due to bed-pressures/constraints caused by the COVID-19 pandemic (inability to fog areas on occasion).

During the COVID-19 pandemic, isolation of patients with loose stools was more challenging due to access to side rooms associated with the isolation of COVID-19 patients. We also saw a significant increase in broad-spectrum antimicrobial consumption which mirrored the pandemic waves. Antimicrobials are a major risk factor for *C. difficile*.

For the coming year, as the COVID-19 pandemic reduces in intensity, there will be a renewed focus on *C. difficile* and the known actions to reduce incidence. We have an ongoing action plan relating to *C. difficile* which began in 2019-20 which continues to be updated and monitored, an update on which will be presented to Board as part of the annual Infection Prevention and Control report.

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

### **SARS coronavirus-2 (SARS-CoV-2) - COVID-19**

On 31 December 2019, WHO was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2



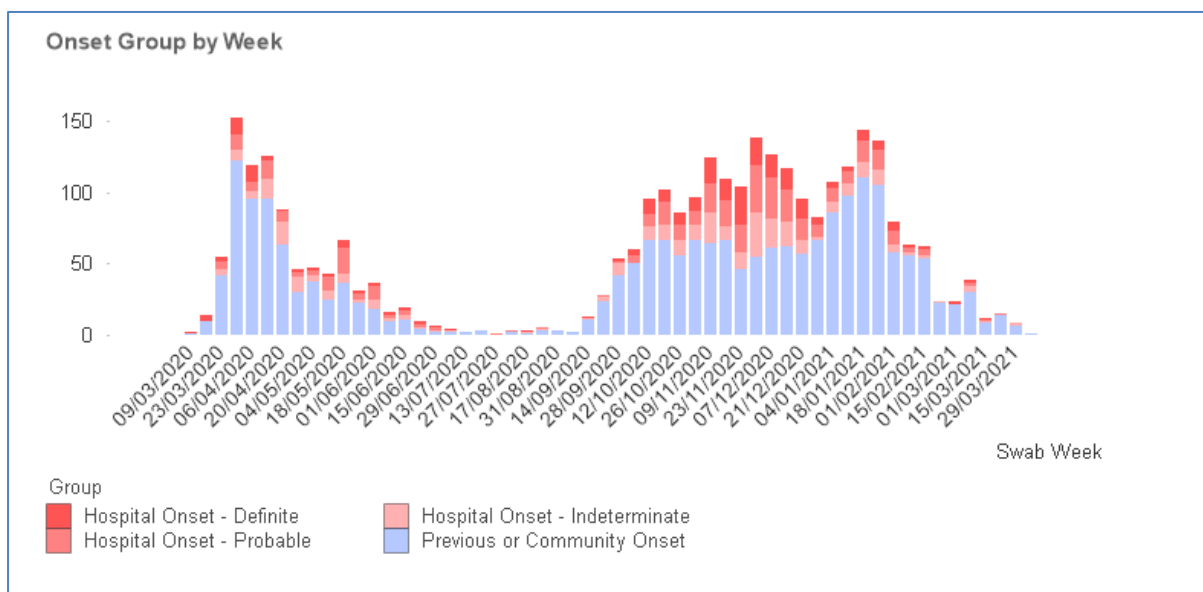
(SARS-CoV-2) was subsequently identified and symptoms were flu-like initially and also included a loss or change in the normal sense of taste or smell.

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

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

During the 2 waves of the pandemic we like all Trusts in the NHS unfortunately had some hospital acquired or nosocomial COVID-19 infections. Presented in Figure 25 is a breakdown in the number of hospital onset versus community onset cases by week. In the first wave, March 2020 to June 2020, most hospital services were suspended and all but the most urgent elective activity was postponed to release bed capacity. At this time patient flow issues were avoided and it was easier to prevent nosocomial infection. During this time period, 18% of cases had probable or definite hospital onset COVID-19.

**Figure 25 Hospital Onset versus Community Onset COVID-19 infections**



Source: LTHTR data

In the second wave, September 2020 to March 2021, we were required to manage the additional activity created by the pandemic and also re-establish many of its services. This was incredibly challenging for the organisation and in November 2020 we saw a spike in nosocomial cases.

We acted quickly, establishing an action plan to reduce nosocomial cases and the key actions included:

- The introduction of point of care testing in admission areas, resulting in better streaming of infected versus non-infected patients at the point of entry to the organisation.
- Reduction of turnaround time of confirmatory COVID-19 tests.
- Introduction and refinement of an IT driven contact tracing system to identify bay contacts of infected patients in the 48 hours before a positive result.
- Bed re-organisation with the introduction of designated COVID-19 wards.
- A program of regular testing of all inpatients increasing to 3 times per week.
- Asymptomatic staff testing by lateral flow tests.
- A communication strategy to improve awareness and compliance with infection control procedures.
- The introduction of transparent screens/curtains between patient spaces.
- Use of 'redi-rooms' to isolate patients where side-rooms not available.
- The introduction of High Efficiency Particulate Absorbing (HEPA) air-purifiers to areas with high risk of transmission

These measures led to a marked reduction in nosocomial cases. Between September-December 2020, 28% of the total COVID-19 cases were nosocomial which has fallen to 14% of cases reported to date in 2021.

**Table 18 Cases of COVID-19 by Month and Designation April 20 – March 21**

	HODHA	HOPHA	HOIHA	CO	Total
<b>Apr-20</b>	34	37	47	271	389
<b>May-20</b>	20	40	19	88	167
<b>Jun-20</b>	10	16	13	32	71
<b>Jul-20</b>	1	1	3	6	11
<b>Aug-20</b>	1	1	3	6	11
<b>Sep-20</b>	3	1	7	54	65
<b>Oct-20</b>	36	46	44	208	334
<b>Nov-20</b>	77	71	54	215	417
<b>Dec-20</b>	72	97	71	196	436
<b>Jan-21</b>	20	49	34	376	479
<b>Feb-21</b>	10	13	7	166	196
<b>Mar-21</b>	4	3	3	80	90
<b>Total</b>	<b>288</b>	<b>375</b>	<b>305</b>	<b>1698</b>	<b>2666</b>

Source: LTHTR data

**Key:** HODHA = Hospital onset definite healthcare associated  
HOPHA – Hospital onset probable healthcare associated  
HOIHA - Hospital onset indeterminate healthcare associated  
CO - Community onset



## Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths

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

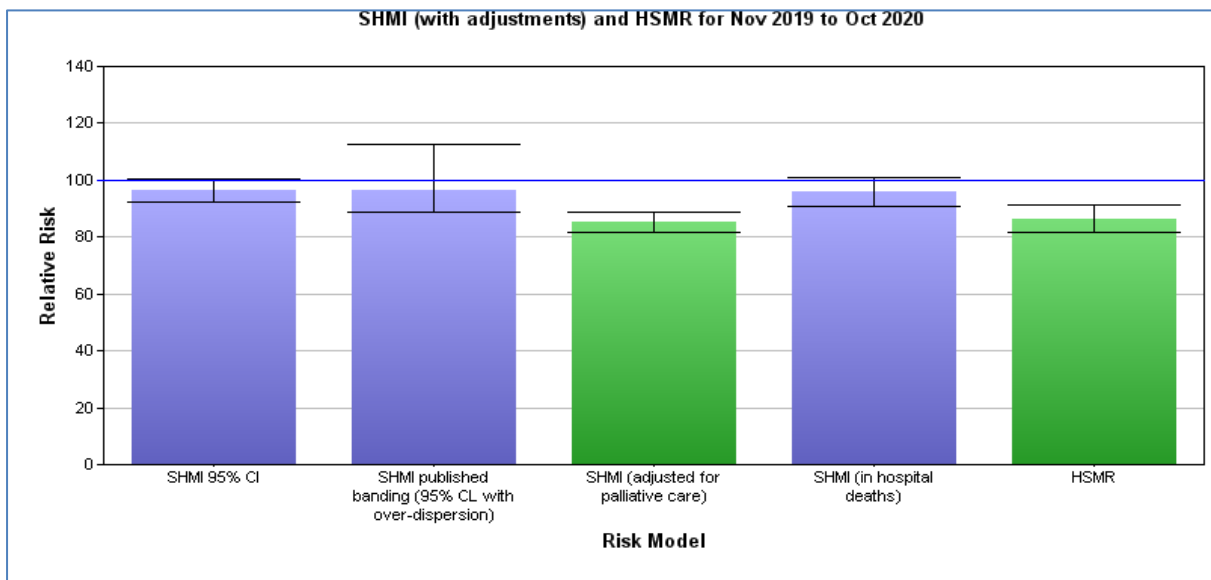
### Mortality Surveillance

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

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

The SHMI for the most current period available in March 2021 being the 12 months of November 2019 to October 2020 is 96.26 and remains within expected range as was the case during the previous reporting period 2019-20. When the SHMI is adjusted for palliative care it is 85.11 and remains lower than expected as in the reporting period 2019-20.

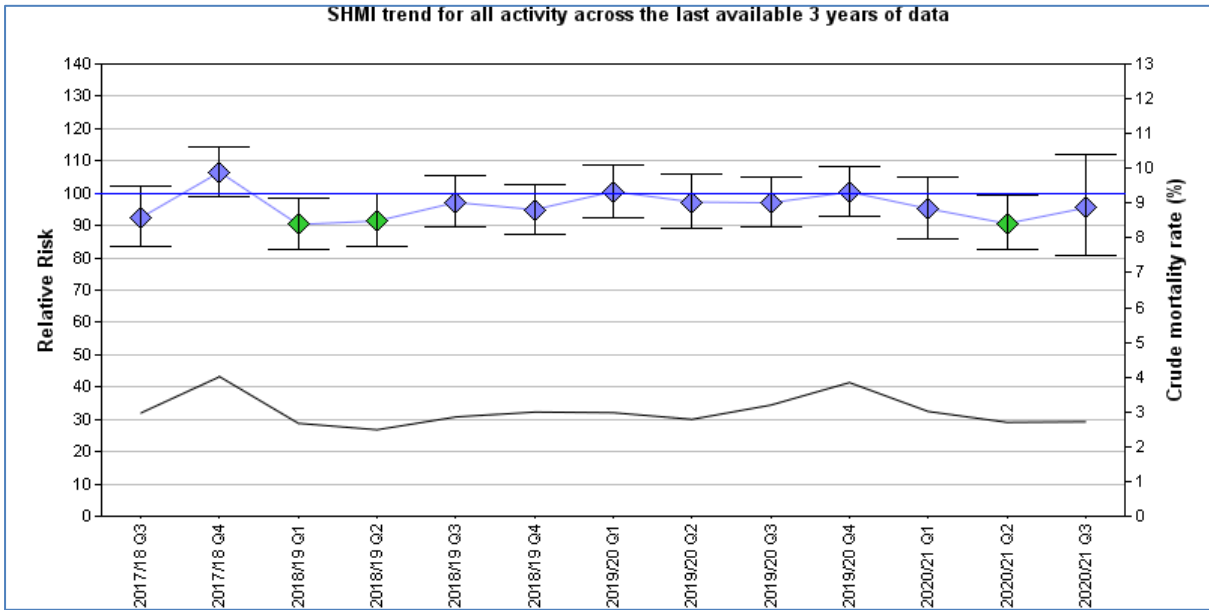
**Figure 26 Summary Hospital Mortality Indicator (SHMI) Nov 19 – Oct 20**



Source: Dr Foster Intelligence

The SHMI trend for the last 3 years is presented below which demonstrates the rate being continually within expected range.

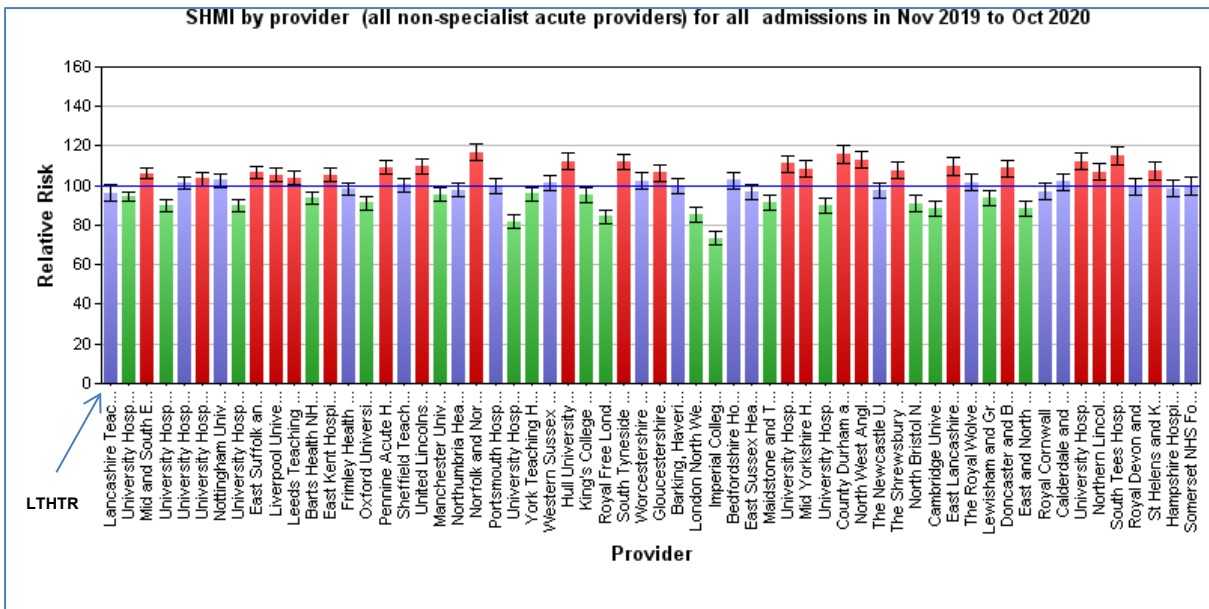
**Figure 27 Summary Hospital Mortality Indicator 3 Year Trend**



Source: Dr Foster Intelligence

We can compare our SHMI with national peers and this is presented in Figure 28 below with our organisation being the first organisation in the bar chart. Trusts in the blue bars are those within the expected range, green bars are lower than expected and those that are higher than expected are shown in red bars.

**Figure 28 Summary Hospital Mortality Indicator Peer Comparison**



Source: Dr Foster Intelligence

**Hospital Standardised Mortality Rate (HSMR)**

In addition to the SHMI we monitor mortality rates using the Hospital Standardised Mortality Rate (HSMR) which is derived from data based on 56 diagnostic groups that account for 80% of all hospital deaths.

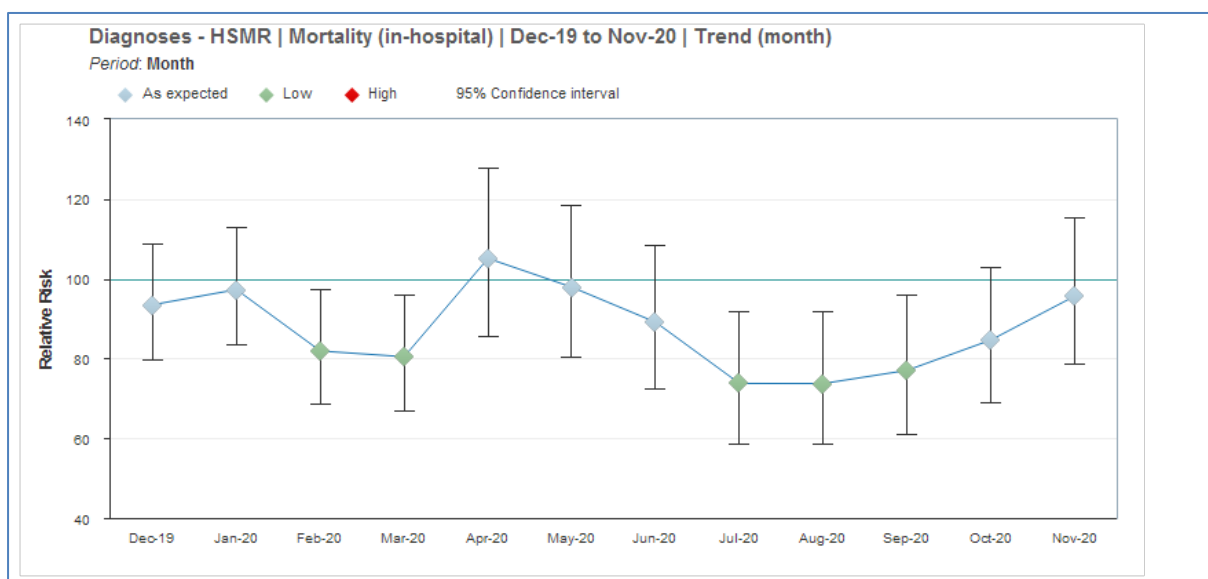
The data is adjusted to take into account a range of factors that can affect survival rates but that may be outside of our direct control such as age, gender, associated medical conditions and social deprivation. The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. A rate greater than 100 indicates a higher than expected mortality rate, whilst a rate less than 100 indicates either as expected or lower than expected.

The Hospital Standardised Mortality Ratio (HSMR) does not include patients who presented with a primary diagnosis of COVID-19; these are mapped to the viral infections group and included in the Standardised Mortality Ratio for all diagnoses. However, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop COVID-19, will be included in the HSMR. The Dr Foster statistical model, used to calculate the risk of mortality, has no historic data to accurately calculate patients expected risk of mortality for COVID-19 therefore, caution has to be taken when interpreting the current mortality data, and comparing the trusts figures with other providers.

The most current 12 month HSMR data in March 2021 relates to the period December 2019 – November 2020 and our HSMR is 87.7 which remains lower than expected as was the HSMR of 83.2 in the previous reporting period 2019-20.

Our HSMR trend over the past 3 years is presented in Figure 29 and demonstrates the continued HSMR trend of mortality being either ‘within expected’ or ‘lower than expected’ range.

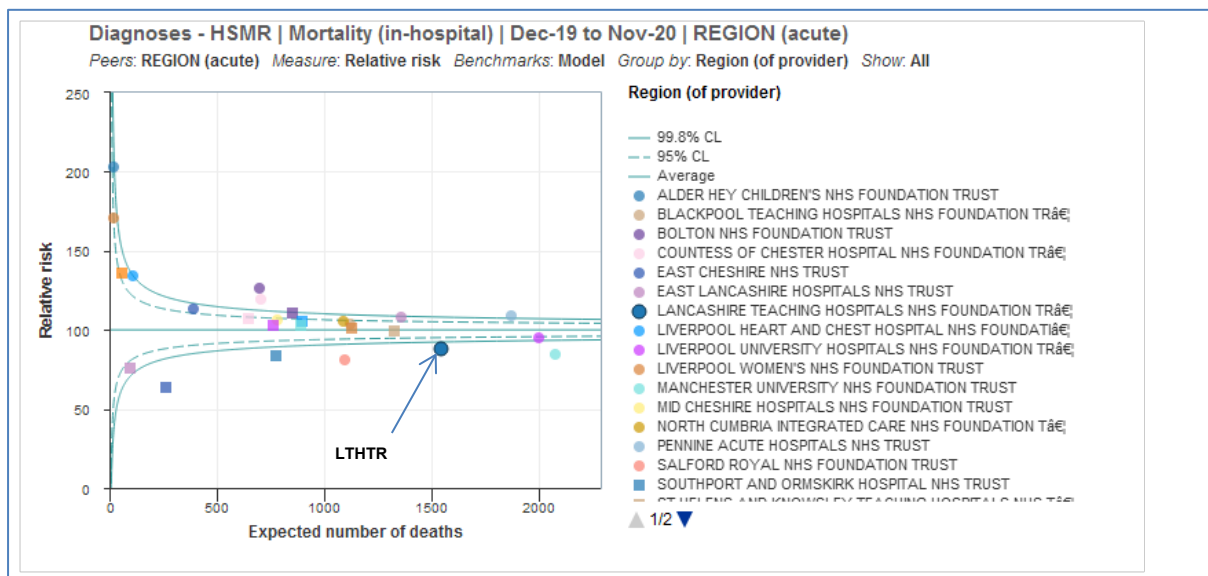
**Figure 29 Hospital Standardised Mortality Rate Dec 2019 – Nov 2020**



Source: Dr Foster Intelligence

A comparison with other regional acute peers is also presented in the funnel plot in Figure 30 below which shows we have one of the lowest HSMRs in relation to peers for the most recent data available.

**Figure 30 HSMR Regional Acute Peers Benchmark Dec 2019 – Nov 2020**

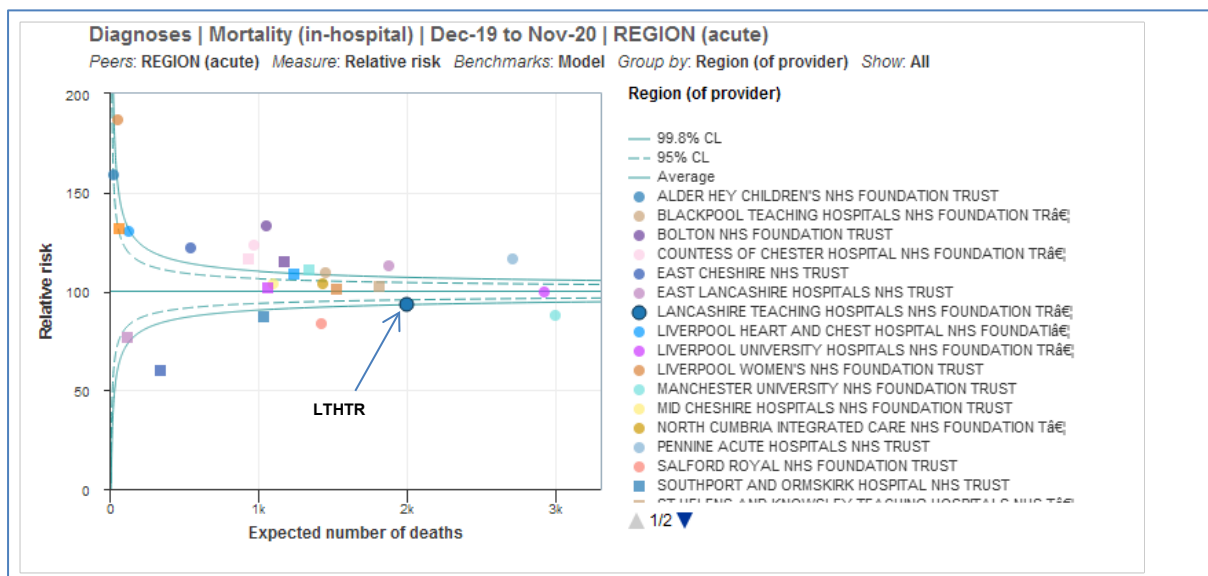


Source: Dr Foster Intelligence

**Standardised Mortality Ratio (SMR) - Relative Risk for All Diagnoses**

We also monitor our Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' and for the period December 2019 to November 2020 this was 93.1 which is lower than expected and as is demonstrated in the funnel plot below, again we have one of the lowest relative risks compared to regional acute peers.

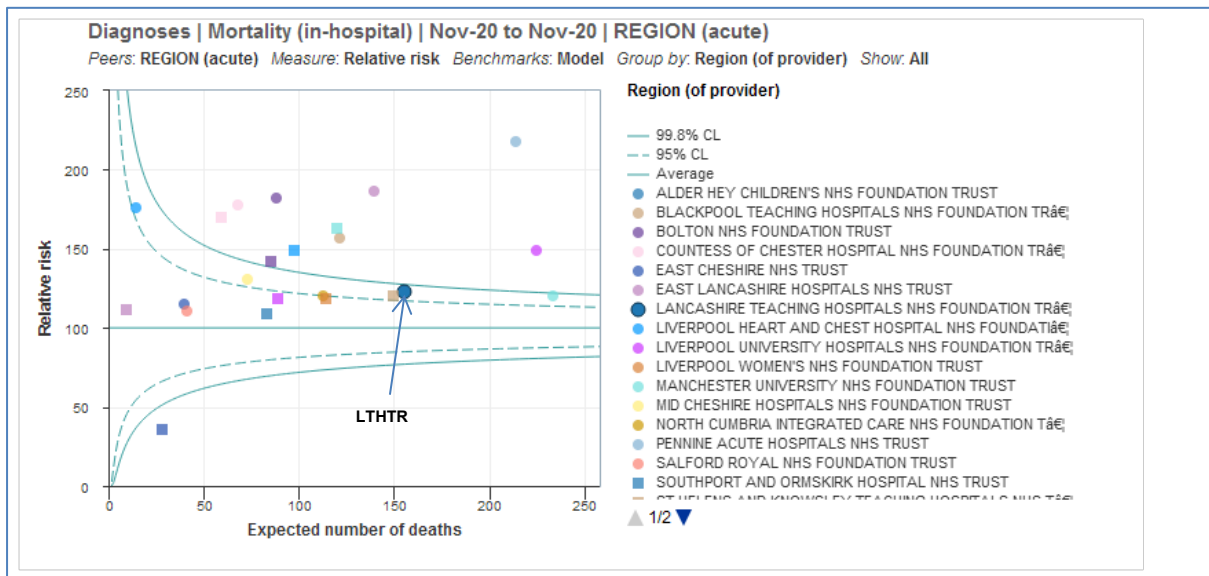
**Figure 31 SMR Regional Acute Trust Benchmark Dec 2019 – Nov 2020**



Source: Dr Foster Intelligence

Our HSMR for the month of November 2020 was 95.4 which is within expected range however the Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' in November 2020 was 122.9 which is higher than expected and due to the Viral Infection diagnostic group being high as a result of COVID-19 deaths. However other peers also have higher relative risks as is demonstrated in Figure 32 below.

**Figure 32 SMR Regional Acute Trust Benchmark Month Nov 2020**

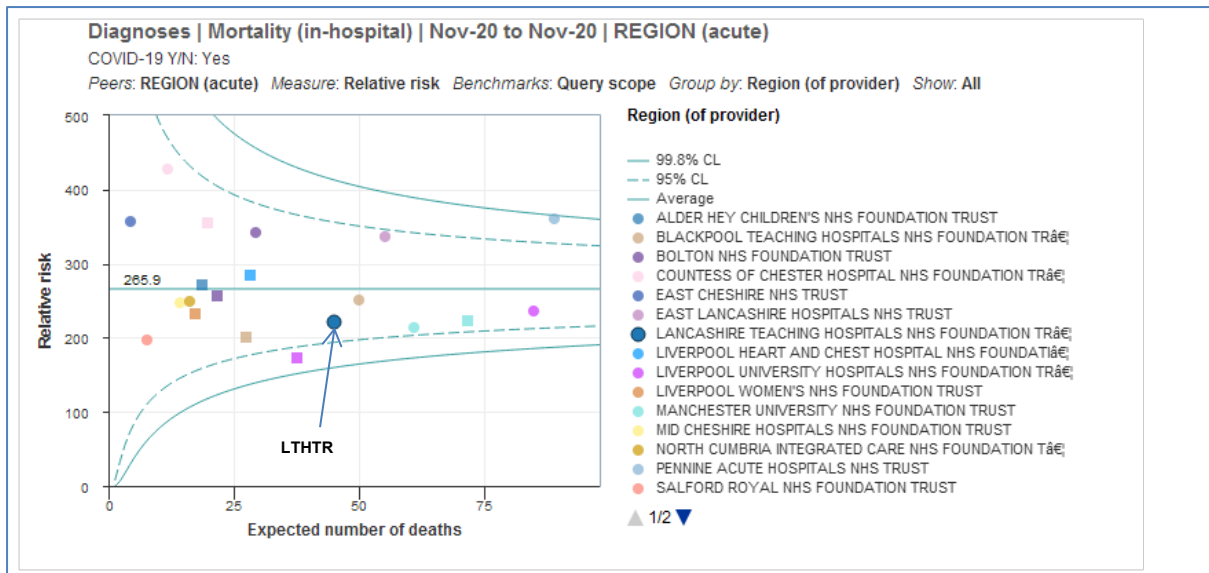


Source: Dr Foster Intelligence

**COVID-19 Mortality Data Analysis**

When only the COVID-19 data is analysed the relative risks are all higher than the 100 benchmark for all regional acute peers. When the scope is changed to account for the raised levels the benchmark becomes 265.9 and in the funnel plot below we are again within the lower group of peers.

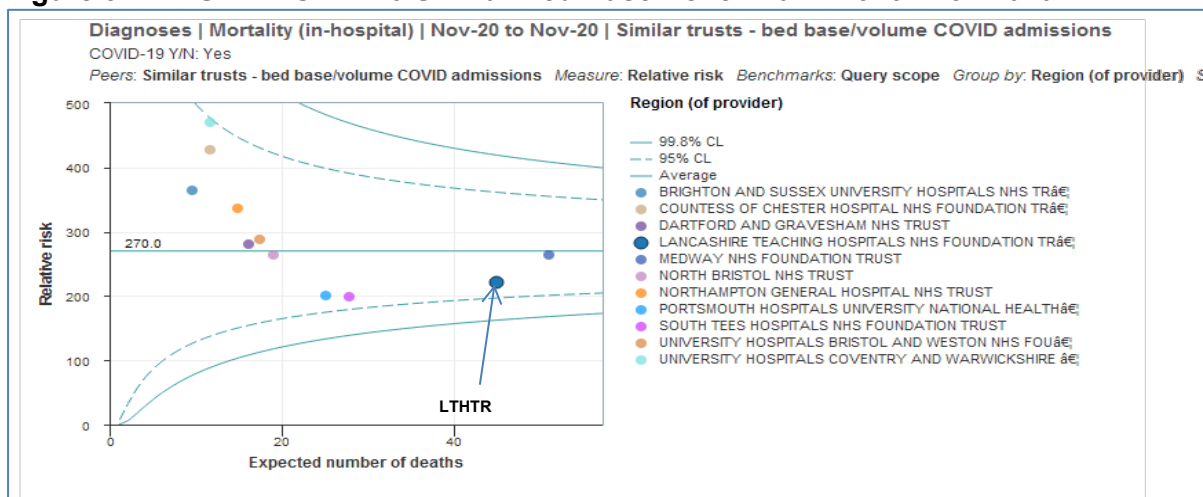
**Figure 33 SMR Regional COVID-19 Benchmark Month Nov 2020**



Source: Dr Foster Intelligence

The funnel plot below in Figure 34 compares the SMR with peers who have a similar number of beds and numbers of COVID-19 admissions. This suggests that we had one of the lowest SMRs for COVID-19 deaths; however it is necessary to note that the model, used to calculate the risk of mortality, has no historic data to accurately calculate patients expected risk of mortality for COVID-19 and caution has to be taken in interpreting and comparing the data.

**Figure 34 SMR COVID-19 Similar Bed Base Benchmark Month Nov 2020**



Source: Dr Foster Intelligence

**COVID-19 Patient Deaths**

Patients who get COVID-19 whilst in hospital are particularly at risk of death from the infection, because hospitalised patients are already unwell and often have significant co-morbidities. Since the start of the COVID-19 pandemic we have taken all the protective measures available to us to ensure our patients and staff have been as safe as possible while in our hospitals. We have sadly had 713 deaths attributed to COVID-19 between April 2020 and March 2021 which was 34.2% of our deaths during that period. All deaths and those attributed to COVID-19 from April 2020 to March 2021 are presented the table below. We are continually improving our safety and protection measures to minimise the impact of COVID-19 within our services.

**Table 19 Deaths and COVID-19 Deaths 2020-21**

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Year to Date
Number of Inpatient deaths (Total)	219	178	132	97	100	96	156	195	226	206	166	130	1901
Number of Inpatient deaths (attributed to Covid)	122	75	34	6	0	6	50	96	126	95	73	20	703
% of Inpatient deaths attributed to Covid	55.7%	42.1%	25.8%	6.2%	0.0%	6.3%	32.1%	49.2%	55.8%	46.1%	44.0%	15.4%	37.0%
Number of ED deaths (Total)	15	6	5	10	18	9	19	20	29	24	13	18	186
Number of ED deaths (attributed to Covid)	2	0	0	0	0	0	1	1	2	3	1	0	10
% of ED deaths attributed to Covid	13.3%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	5.0%	6.9%	12.5%	7.7%	0.0%	5.4%
All Deaths (Total)	234	184	137	107	118	105	175	215	255	230	179	148	2087
All Deaths (attributed to Covid)	124	75	34	6	0	6	51	97	128	98	74	20	713
% of All deaths attributed to Covid	53.0%	40.8%	24.8%	5.6%	0.0%	5.7%	29.1%	45.1%	50.2%	42.6%	41.3%	13.5%	34.2%

Source: LTHTR data

**Learning from Adult Deaths**

Although it has not been possible to provide any learning from the serious investigations in the ‘Mortality Reviews and Serious Investigation’ section on p. 46 because of delays in inquests, a summary of the learning from the Structured Judgement Mortality Reviews (SJR) is presented below:



These are the key themes that have been identified from primary and secondary SJRs undertaken in 2020-21 and are areas for continual improvement:

- Clarification of responsibilities where there is shared team care.
- Conservative management may be more appropriate rather than surgical interventions in some cases.
- More appropriate blood tests and timing.
- More effective medications management.
- Improved monitoring on ward required post discharge from critical care.
- Delays in decision making.
- Delays in escalation to senior staff.
- Recognising deterioration and management.
- All aspects of care and treatment pathways not always being followed.
- Delayed discharges potentially an influencing factor in death.

It is important to note that areas of good practice are also highlighted at primary and secondary review and key themes were:

- Co-morbidities influencing decisions to transition to conservative management and end of life care in a positive way.
- Good discussions with family keeping them up to date and explaining the limitations to treatment and risk of deterioration.
- Good pre-emptive planning and discussions around DNACPR.
- Good end of life care with the family supported and updated including Palliative care involvement.
- Timely review and prompt admission to Critical Care.
- Good liaison with multiple specialities and full Multidisciplinary Team involvement.
- Good nursing care.
- Communication and considerations well documented.
- Excellent end of life care.
- Care provided to the patients was of good medical practices and professional standards.
- All aspects of care and treatment pathways e.g. Stroke were followed.
- The deaths reviewed of patients with Learning Disabilities had good to excellent care

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

### **Neonatal and Child Deaths 2020-21**

Our process for reporting neonatal and child deaths have been managed in line with local and national guidance. We offer immediate support to parents and families and we have a bereavement midwife available to support the parents of newborn infants.

All neonatal and child deaths should be reported to the Coroner unless the death is expected and this has previously been agreed with the Coroner. The statutory requirements

for reporting child deaths to the Child Death Overview Panel (CDOP) have been followed, this panel provide an independent multi- disciplinary review with the purpose of identifying lessons and preventing future deaths.

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

In addition local reviews have been undertaken by the neonatal lead Consultant for neonatal death or the Named Doctor for Safeguarding Children. All reviews have been shared locally at departmental level and neonatal reviews have been shared at the Lancashire and South Cumbria Neonatal Operational Delivery Network Clinical Effectiveness Group. We have also presented a summary to the Trust Mortality and End of Life Committee on a quarterly basis. In addition to reviewing children who have died in the Trust a case review has been undertaken of any children known to the children’s services at the Trust for example those transferred to Paediatric Critical Care or children who have died unexpectedly at home.

In 2020-21 there were 4 child deaths in our hospital, 3 in ED and 1 on the children’s ward 8

**Table 20 Child Deaths by Quarter in 2020-21**

Quarter 1		Quarter 2		Quarter 3		Quarter 4	
<i>Expected</i>	<i>Unexpected</i>	<i>Expected</i>	<i>Unexpected</i>	<i>Expected</i>	<i>Unexpected</i>	<i>Expected</i>	<i>Unexpected</i>
1	1	0	2	0	0	0	0
<i>Location</i>	<i>Location</i>	<i>Location</i>	<i>Location</i>	<i>Location</i>	<i>Location</i>	<i>Location</i>	<i>Location</i>
ED	ED		ED Ward 8				

*Data source: LTHTR Data*

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

- Consider earlier decision to withdraw treatment and commence palliative care.
- Importance of antibiotic stewardship.
- Encourage early trophic feeds (even minimal).
- Explore use of probiotics.
- Continue to enhance support for breast milk expressing.
- Be aware of Hyper-osmolality of milk plus additives.
- Maintain situational awareness.
- Monitor and review growth trends better.

A summary of the learning from the neonatal deaths is presented below:

- Importance of following Sudden Death in Childhood (SUDIC) policy for all unexpected deaths even when explained.
- SUDIC nurses are available 7 days a week 9am-5pm (including bank holidays). It this learning or examples of what we have in place please?
- Police and Emergency Department have the SUDIC duty rota.
- COVID-19 swabs are required on all patients who die during the pandemic.
- Ophthalmology review is part of the protocol and should be obtained where possible.

- Ensure all clinicians are aware of the limited support available on the Chorley District Hospital (CDH) site for managing critically unwell children.
- Increase the availability of in situ simulation training in ED at CDH to increase familiarity of sick child scenarios.
- Ensure staff are aware of the ability to upgrade North West Ambulance Service (NWAS) calls from category 1 to category 2 via direct discussion with the control room clinical lead.
- Further discussion regarding the appropriate management of children at CDH.
- Improve communication between tertiary and secondary services.
- Consider consultant to consultant links to improve relationships.
- Consider end of life plan instead of escalation to critical care which would have allow consideration of home as a place for death (however not possible when child deteriorates quickly).
- Disseminate children's major trauma pathway so all clinicians are aware of trauma team leader at RMCH phone number.

In order to progress our ambition to consistently deliver excellent care, during 2021-22 we will be focusing on improving outcomes and reducing harm and also delivering a positive experience by:

- Commencing peer review of all neonatal deaths and further develop support for staff with the introduction of a pilot project for staff psychology support.
- Following a successful joint teaching session with the SUDIC team we are planning regular sessions every 6 months and this will include neonatal and paediatric colleagues.
- Developing the palliative care service for children and young people in collaboration with Commissioners and Derian House Children's Hospice with the intended outcome of increasing awareness of palliative pathways, supporting advanced communication, improving education and clinical caseload management.

### **Perinatal Mortality**

We use the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. Between April 2020 and March 2021 we have reported 38 deaths that have met the defined threshold for reporting using the Perinatal Mortality Tool (PMRT). The tool is used to review the care of all the relevant cases and draft reports are generated for use with families and staff groups to share wider learning. We also share a summary report of all cases at the Maternity Safety Champions meetings held bimonthly for review and discussion. Formal assurance is provided in a summary report to the Board following submission of a detailed report to the Trust Safety and Quality Committee containing details of the deaths reviewed and the consequent action plans.


We have a template to share key learning to promote wider learning within the maternity service an example of which is presented below.

Figure 35 MBRRACE-UK Learning Points Quarter 3

**We submitted 30 qualifying cases to PMRT from 1<sup>st</sup> January 2020-31<sup>st</sup> December 2020. This includes:**

- 18 Antenatal Stillbirths
- 1 Intrapartum Stillbirth <37 weeks
- 1 Intrapartum Stillbirth >37 weeks
- 10 Neonatal Deaths within 28 days of birth

### MBRRACE PMRT Learning Points December 2020



**What is PMRT?**

The Perinatal Mortality Review Tool (PMRT) is a national review tool supported by MBRRACE. It encourages a standardised approach to the investigation of:

- Any late fetal losses born between 22+0 and 23+6 weeks gestation, or babies born weighing >500g where gestation is unknown.
- All stillbirths occurring after 24 weeks, or a baby born weighing >500g where gestation is unknown.
- All neonatal deaths where the baby is born after 22+0 weeks and dies up to 28 days from birth, or a baby born weighing >500g where gestation is unknown.
- Post-neonatal deaths when a baby is born alive from 22+0 weeks but dies after 28 days following neonatal care.

**Over the last 12 months we have seen a significant improvement into routine enquiry into domestic abuse when completing PMRT reviews. Thank you.**


**In 3 of the cases reviewed in the last twelve months it was identified that the Aspirin in Pregnancy assessment was not completed or completed incorrectly.**

**Please remember to complete the Aspirin in pregnancy assessment sticker, taking into account a lady's medical and previous obstetric history.**


**CO monitoring at booking was missed in 3 of the PMRT cases reviewed in the last 12 months:**

**Please remember to complete a CO reading for all women at booking now that this testing has been re-commenced.**

**Please remember that placental histology should be performed in accordance with the 'Placental Investigations' guideline for all cases where family consent has been given.**



Women's and Children's Division – delivery suite

 @LancsHospitals

Data source: PMRT & LTHTR Data

## Stillbirths

The incidence of stillbirth remains an area of focus within the maternity service. The maternity dashboard reflects an overall increase in the reported incidence of stillbirth over the past twelve months. The Trust mean for 2020-21 in March was 5.1/1000 following an increase in cases during the waves of the COVID-19 pandemic.

Table 21 Incidence of Stillbirths

Metric	Red flag	Green flag	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Births			364	341	357	346	317	346	394	351	336	360	315	374
Stillbirth rate (per 1,000 births)	> 4.2	≤ 4.2	5.5	5.9	8.4	0.0	6.3	5.8	0.0	8.5	6.0	2.8	9.5	10.7

Data source: PMRT & LTHTR Data

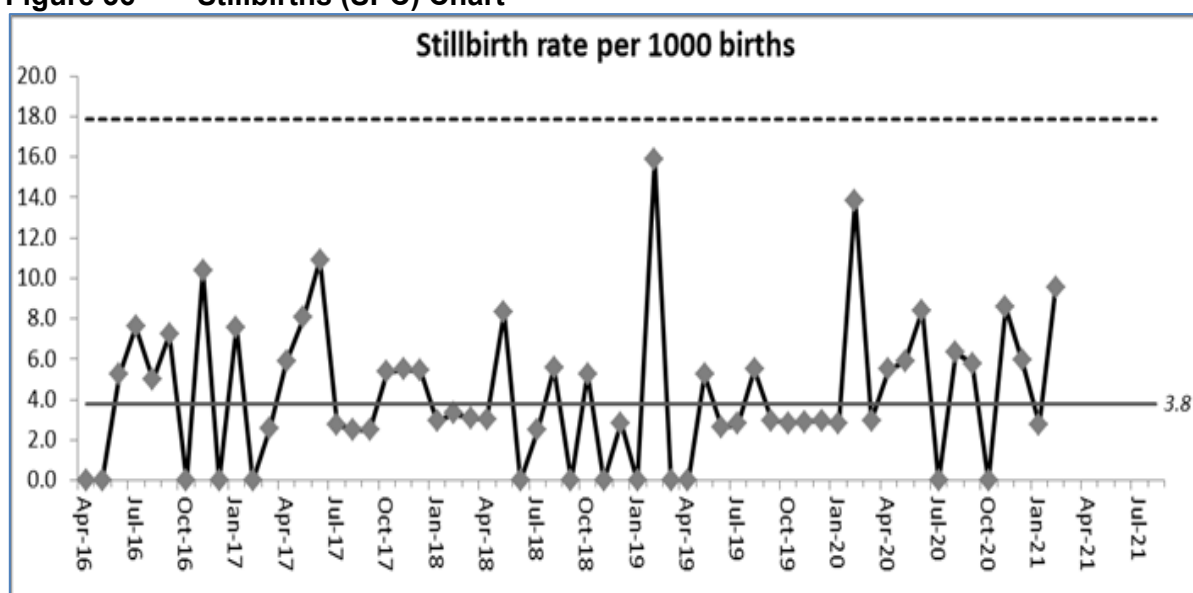
Data collected between 23/03/2020 and 19/04/2020 by the North West Coast Strategic Clinical Network (SCN) showed a statistically significant difference in the number of stillbirths recorded in Lancashire and South Cumbria compared with neighbouring Cheshire and Merseyside. The data also suggested some variation in the number of 'Born Before Arrival' (BBA) between the two Local Maternity System (LMS) areas however differences in the definition of BBA used by different trusts made direct comparison of the figures difficult and precluded statistical analysis.

As a result of these disparities, a multi-disciplinary review of 41 cases (13 stillbirths and 28 BBA) was conducted. Of the 13 stillbirths reviewed, 9 were in the Lancashire and South Cumbria LMS and 4 were in Cheshire and Merseyside LMS. Of the 28 BBA cases reviewed, 7 were in the Lancashire and South Cumbria LMS and 21 were in Cheshire and Merseyside LMS. The following key findings were identified:

- Trusts across the North West Coast SCN are using different definitions of BBA when recording this statistic.
- In about a fifth of the babies BBA, possible communication barriers were identified; two mothers had learning difficulties and three mothers spoke English as a second language.
- Concerns and restrictions due to the COVID-19 pandemic were identified as factors affecting maternal behaviour in one stillbirth and three BBA cases. In a further three stillbirths, there were delays in women with reduced foetal movements presenting to services however no information was available about the reasons for this.
- There was little reference in the clinical notes relating to the advice given to women about COVID-19. Communications approaches and messages about COVID-19 also varied between Trusts.
- Women with complex social issues, poor peri-natal mental health and late bookers were highly represented.
- A number of other specific concerns involving particular cases were highlighted by the review process. These included issues with; (i) record keeping, (ii) access to translation services and (iii) clinical practice.

A local review of the incidence using a statistical process chart was undertaken in January 2021. On average there are around 2 stillbirths a month, with a range of 0 and 4 a month within expected variation. The review confirmed that there were no signs of sustained change since 2017 and no recent patterns in the last 12 months up to January 2021 that indicated change could be occurring soon. A spike in incidence was highlighted in February 2019 that related to four complex cases of preterm birth.

**Figure 36 Stillbirths (SPC) Chart**



Source: LTHTR data

All stillbirth cases continue to be reviewed using the perinatal mortality review tool to elicit learning from the cases and areas of further investigation. The outcome of these cases is presented on a quarterly basis to our Safety and Quality Committee. Incidence is also compared on a quarterly basis within the North West Coast SCN.

Previous deep dives have not identified specific areas of concern or themes across the service. The introduction of the perinatal quality surveillance model in response to the publication of the recent Ockenden report with add further rigour to the local and regional oversight of cases and sharing of learning.

The regional maternity dashboard collated by the North West Coast SCN has recently identified the Trust as an outlier with regard to the incidence of stillbirth between April and December 2020 and cases occurring after 37 weeks gestation.

A further detailed review of the data will therefore be undertaken in response to the outlier status to elicit any thematic learning from the cases that occurred during this period.

## Medical Examiner Service

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

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

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

The Medical Examiners undertake the following:

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

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

**Table 22 Medical Examiner Service Performance**

	Number	Percentage
Inpatient & ED Deaths	2087	
ME Reviews of all Deaths	571	27%
MEO Reviews of all Deaths	1332	64%
ME/MEO Reviews of all Deaths	1903	91%
ME/MEO Conversations with Bereaved	1386	66%
Referrals to Coroner	270	13%

*Source: LTHTR data*

As a result of the COVID-19 pandemic, there has been an increased demand on the MEs to complete the MCCDs and the cremation forms which has impacted on the capacity to undertake the detailed scrutiny of deaths. The MEO has however been able under delegated authority to support the reviews.

The Coroner's Officers hold conversations with the bereaved when the death is referred to the Coroner and out of hours the families are supported by the General Office team and bereavement service.

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

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

A second MEO has been recruited which will allow for more support for the Lead Medical examiner and cover for annual leave. The increased capacity will also facilitate scrutiny of cases at Chorley Hospital. The national medical examiner database system will be introduced in April 2021 which will replace the current AMAT proformas. Resources have also been secured to start scoping the ME scrutiny of non-acute/community deaths, which it is hoped will result in the recruitment of two additional MEOs.

## Review of Quality Performance - Experience of Care

Improving patient experience is a key priority for us and is central to our aims and ambitions, underpinned by our mission to provide excellent care with compassion. Patient experience and feedback forms the bedrock of our service provision and provides opportunities for the organisation to reflect on practice to ensure developments are consistent and appropriate to meet the needs of our service users and carers. Our Patient Experience Involvement Strategy 2018-2021 is aligned to the Trust ambitions and values to enable staff to embed best practice in relation to patient experience, whilst ensuring that at every level of care and treatment this is taken into account. The four aims of the strategy are:

1. To Deliver a positive patient experience.
2. Improve outcomes and reduce harm.
3. Create a good care environment.
4. Improve capacity and patient flow.

The actions within the strategy are monitored through the Patient Experience and Involvement Group and assurance provided to the Safety and Quality Committee where complaints and feedback are presented on a monthly basis with an annual report of experience including thematic analysis presented to Board of Directors.

Our Patient Experience Involvement Group consists of over 40 people from the local community, Governors, patient representatives, carer organisations and staff. The Group provides an opportunity for input from a fully diverse representation of the communities across Chorley and Preston and is an open and honest reflection of the local community. It oversees the feedback that we receive in relation to several areas, including:

- National Patient Surveys.
- Friends and Family Test Feedback.
- Complaints, Concerns and Compliments.
- NHS Website Feedback (Formerly NHS Choices).

During 2020-21 the national surveys have been postponed due to the COVID-19 pandemic. As a result of this the survey information held by the organisation remains largely the same as for 2019-20. The organisation was however given the opportunity to participate in the new mothers' experience of care survey, and these results are contained within the following information. It should be noted that this survey was optional and therefore should be treated with some caution in terms of benchmarking across other organisations. Outcomes of the surveys are presented for the following:

- National Adult Inpatient Survey 2018.
- Urgent and Emergency Care Survey 2018.
- National Maternity Survey 2019.
- New Mothers' Experience of Care Survey 2020.
- Children and Young People's Survey 2018.
- Cancer Patient Experience Survey 2019.

### National Adult Inpatient Survey

The most recent survey we participated in was the National Inpatient Survey 2018 which provided analysis of the experiences of inpatients from July 2018. A total of 397 patients returned a completed questionnaire, giving a response rate of 33% which was a 1% increase



on the 2017 survey. These results were also presented in our Quality Account for 2019-20 and are included below for information. Patient comments from survey about our Trust demonstrated:

- Overall: rated experience as 7 out of 10 or more – 85%.
- Overall: treated with respect or dignity – 98%.
- Doctors: had confidence and trust – 97%.

When comparing the average results received across all other hospitals; we ranked best in the following areas:

- Hospital: food was very good or good – 65%.
- Discharge: staff discussed need for additional equipment or home adaptation – 84%.
- Hospital: got enough help from staff to wash or keep clean – 94%.
- Procedure: told how to expect to feel after operation or procedure – 91%.
- Care: staff helped within reasonable time when needed attention – 95%.

When considering the most improved areas from the previous 2017 survey; these were:

- Hospital: food was very good or good – 65%.
- Nurses: always or nearly always enough on duty – 58%.
- Discharge: told side-effects of medications – 58%.
- Discharge: was not delayed – 58%.
- Overall: rated experience as 7 out of 10 or more – 85%.

## **Urgent and Emergency Care Survey**

The last national Urgent and Emergency Care Survey we participated in was in 2018 which was published in October 2019. These results were presented in our Quality Account for 2019-2020 and are included for information below. The next Urgent and Emergency Care Survey is planned for publication in September 2021, with the fieldwork currently in progress.

The Urgent and Emergency Care Survey 2018 provided analysis of the experiences of care provided in Type 1 Emergency Department from September 2018. The purpose of the survey was to understand what patients think of the care they have received within a Type 1 department. It considered arrival, waiting, doctors and nurses, care and treatment, tests, pain, hospital environment and facilities, leaving A&E and overall experience. The survey was carried out every two years with the previous Urgent and Emergency Care Survey being undertaken in 2016.

A total of 950 of our patients were sent a questionnaire of which 252 were returned, giving a response rate of 27% an increase of 4% from the 2016 survey. The average response rate for the 69 'Picker' Trusts in 2018 was 30%.

A total of 35 questions were used in the 2018 survey, of these 28 compared historically to questions in 2016. Compared to the 2016 survey, we achieved a positive score change of 8 points and we were ranked 47<sup>th</sup> out of the 69 Trusts surveyed, compared to 57<sup>th</sup> out of 75 Trusts in 2016:

- 80% rated care as 7 out of 10 or more.
- 97% treated with respect and dignity.
- 97% doctors and nurses listened to patient.

When comparing the average results received across all other hospitals; we ranked best in the following areas:

- Told how would receive the results of tests – 64%.
- Family, friend or carer able to talk to a doctor – 95%.
- Told purpose of medications – 100%.
- Enough attention from medical or nursing staff – 95%.
- Understood results of tests – 95%.

When considering the most improved areas from the previous 2016 survey; these were:

- Waited under an hour in the ambulance – 89%.
- Waited under an hour in A&E to speak to a doctor/nurse – 82%.
- Able to get suitable food or drink – 60%.
- Told when could resume normal activities – 64%.
- Enough attention from medical or nursing staff – 95%.

We demonstrated some improvement within Urgent and Emergency Care, however we acknowledged that the experience of patients was significantly affected by the waiting time and the environment the care was delivered in. Several improvements were undertaken to positively influence patient experience in this area. These included; environmental improvements through significant capital improvements and expansion of the ED, increased nurse staffing and a priority focus on flow pathways throughout the hospital aiming to reduce the time patients spend in the ED.

## National Maternity Survey

The last national Maternity Survey was carried out in 2019 which was published in July 2020. The NHS national Maternity Survey was cancelled in 2020-21 due to the COVID-19 pandemic with the next planned for publication in January 2022. The results of the 2019 survey were presented in our Quality Account for 2019-2020 and are included below for information.

Our Maternity services received positive feedback in 2019 and demonstrated continuous improvements from the previous survey in 2018. We were one of 63 maternity providers who participated in the survey during 2019. A total of 298 mothers who used our services and were eligible for the survey were sent a questionnaire, of which 94 returned a completed questionnaire, giving us a response rate of 32%. The average response rate for the 63 'Picker' trusts was 36%.

Our results demonstrated an improved position for maternity services compared to the previous survey in 2018. We were ranked 10<sup>th</sup> out of 63 trusts nationally compared to 12<sup>th</sup> out of 68 Trusts surveyed in 2018.

Our maternity services ranked significantly better than the 2018 survey on the following 3 statements in particular:

- Treated with respect and dignity – 98%.
- Had confidence and trust in staff – 99%.
- Involved enough in decisions about their care – 100%.

When comparing the average results received across all other hospitals; we ranked best in the following areas:

- Found partner was able to stay with them as long as they wanted – 92%.
- Not left alone when worried – 91%.
- Received support or advice about feeding their baby during evening, nights or weekends – 85%.
- Able to ask questions afterwards about labour and birth – 90%.
- Had skin to skin contact with baby shortly after birth – 100%.

And when looking at the most improved areas from the previous 2018 survey; these were:

- Discharged without delay – 60%.
- Not left alone when worried – 91%.
- Felt concerns were taken seriously – 91%.
- Had skin to skin contact with baby shortly after birth – 100%.
- Had enough time to ask questions during antenatal check-ups – 100%.

We were very pleased to be ranked within the top 10 of the surveyed organisations. Our focus on working with partners through the Maternity Voices Partnership and increase in Midwives was translating into improved experiences for women.

## **New Mothers Experience of Care Survey**



The NHS Maternity Survey 2020 was cancelled as previously stated, due to the COVID-19 pandemic. Organisations were asked if they wanted to participate in the new mothers' experience of care survey 2020 as an alternative to the Maternity Survey. We welcomed the opportunity to participate in this survey and the results are presented below.

Picker administered the survey on behalf of only 12 acute Trusts who participated. The survey was based on a sample of mothers who gave birth in February 2020. A total of 345 new mothers from our Trust were eligible for the survey, of which 78 returned a completed questionnaire, giving a response rate of 23%.

The new mothers' experience of care survey overall ratings for the following 3 statements in particular are:

- Treated with respect and dignity – 99%.
- Had confidence and trust in staff (during labour and birth) – 99%.
- Involved enough in decisions about their care (during labour and birth) – 94%.

When comparing the average results received across the 12 areas surveyed we ranked best in the following areas:

- Felt concerns were taken seriously – 94%.
- Offered NHS antenatal classes or courses – 82%.
- Received support or advice about feeding their baby during evenings, nights or weekends – 83%.
- Found partner was able to stay with them as long as they wanted – 86%.
- Received help and advice from health professionals about their baby's health and progress – 94%.

This is a new survey and therefore there is no comparison data from any previous surveys, consequently this data will be the benchmark for any future New Mothers Experience of Care surveys we participate in.

## Children and Young People's Survey

The last national Children and Young People's Survey was undertaken in 2018 and it was published in November 2019. The results of the 2018 survey were presented in our Quality Account for 2019-2020 and are included below for information. The next planned Children and Young People's Survey is planned for publication in November 2021, with the fieldwork currently in progress.

The Children and Young People's Survey 2018 report provided analysis of experiences from July 2018. The previous Children and Young People's survey was undertaken in 2016. The survey was comprised of three age-appropriate versions:

- Parent Version A – for parents/carers of inpatients & day case patients aged 0-7 years.
- Child Version B – for young inpatients & day case patients aged 8-11 years and their parents/carers.
- Young Person Version C – for young inpatients & day case patients aged 12-15 years and their parents/carers.

A total of 255 questionnaires were completed which was a response rate of 21% an increase of 2% from the 2016 survey. The average response rate for the 66 'Picker' Trusts in 2018 was 26%. A total of 64 questions were used in the survey, of these 61 can be compared to questions in the 2016 survey.

We achieved a small positive score change and were ranked 58<sup>th</sup> out of the 66 Trusts surveyed, compared to 65<sup>th</sup> out of 71 Trusts in 2016:

- 92% Parent felt well looked after by staff.
- 86% Child felt well looked after in hospital.
- 89% Staff agreed a plan with parent for their child's care.

When comparing the average results received across all other hospitals; we ranked best in the following areas:

- Given choice of admission date – 50%.
- Child able to talk to doctor or nurse without parent or carer being there if they wanted to – 57%.
- Parent received written information about child's condition or treatment – 83%.
- Parent felt that they could tell hospital staff if they were unhappy with child's care and treatment – 93%.
- Hospital did not change admission date – 85%.

The most improved areas from the previous 2016 survey were:

- Given choice of admission date – 50%.
- Parent received written information about child's condition or treatment – 83%.
- Parents were able to prepare food in the hospital if they wanted to – 58%.
- Parent told what to do or who to contact if worried when home – 95%.
- Parent told what would happen next with their child's care – 95%.

The Trust has performed below expectation in this children's survey. It has been a significant area of focus. Significantly enhanced nurse staffing have since been introduced along with

enhanced leadership across the Multidisciplinary team, including the formation of a Womens and Children's division to ensure these service receive dedicated leadership. Experience training and enhanced feedback has been undertaken aiming for significant improvement in the next survey.

## **Cancer Patient Experience Survey**

The national Cancer Patient Experience Survey provides analysis of the experiences of all adult patients with a primary diagnosis of cancer, discharged from an inpatient stay or day case attendance in the months of April, May and June 2019.

A total of 1357 patients responded to the survey from our Trust giving a response rate of 65%, against a national response rate of 61%.

A total of 52 questions were used in the 2019 survey, which was comparable to the number of questions that were asked in 2018. Views from survey about our Trust demonstrated the overall rating of care was 8.9 compared to the national average of 8.8. Our results below are above the national average:

- 83% of respondents said they were definitely involved as much as they wanted to be in decisions about their care and treatment.
- 93% of respondents said they were given the name of a Clinical Nurse Specialist.
- 87% responded that it had been quite or very easy to contact their Clinical Nurse Specialist.
- 87% of respondents said that, overall, they were always treated with dignity and respect.
- 93% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

The trust continues to perform well compared to peers in Cancer patient experience

## **Friends and Family Test (FFT)**

The Friends and Family Test (FFT) is a key indicator of patient experience to gather information in relation to patient experience. This enables us to identify how services meet the needs of patients and how they may be improved in the future. A performance threshold of 90% of patients recommending the ward/department for inpatients and 85% for emergency department patients has been established.

From April 2020 the national Friends and Family Test data no longer requires NHS Trusts to gather information in relation to response rates at the point of discharge. Organisations are encouraged to gather feedback more widely on patient experiences. Information is obtained from key areas, Inpatients, Outpatients, Day Case treatment, our Emergency Department and Maternity services, as well as our Neonatal and Children and Young People's services.

FFT performance is monitored on a monthly basis and is reported through our Safety and Quality Committee. Our reports have been adapted to ensure a true reflection and analysis of the feedback that is recorded and reported. A more in-depth quarterly report is also provided to the Divisions. Work is currently in progress to combine FFT, Complaints, Concerns and Compliments so that all of the Patient Experience information is triangulated for the Divisions.

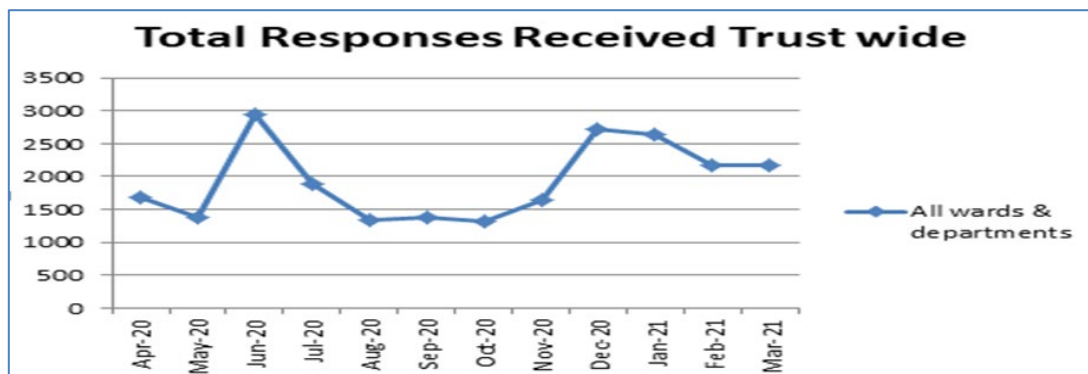
A new provider was introduced in April 2020 to facilitate gathering FFT data. This has provided an opportunity to cleanse the data provided and reconfigure the hierarchy information contained in the FFT IT system. This will allow information to be shared across the organisation in a consistent way.

We have standardised our promotion of FFT by using the national branding. We have also produced materials in British Sign Language as a way of further enabling the deaf community to provide feedback more effectively.

The COVID-19 pandemic has proved to be a challenge in relation to gathering FFT feedback. At the start of the pandemic we were required to remove the option of paper-based postcards due to infection, prevention and control measures and all departments were advised to remove these from circulation. The advice given by NHS England and NHS Improvement at the start of the pandemic was to 'pause' the process and they removed the requirement to report nationally until January 2021.

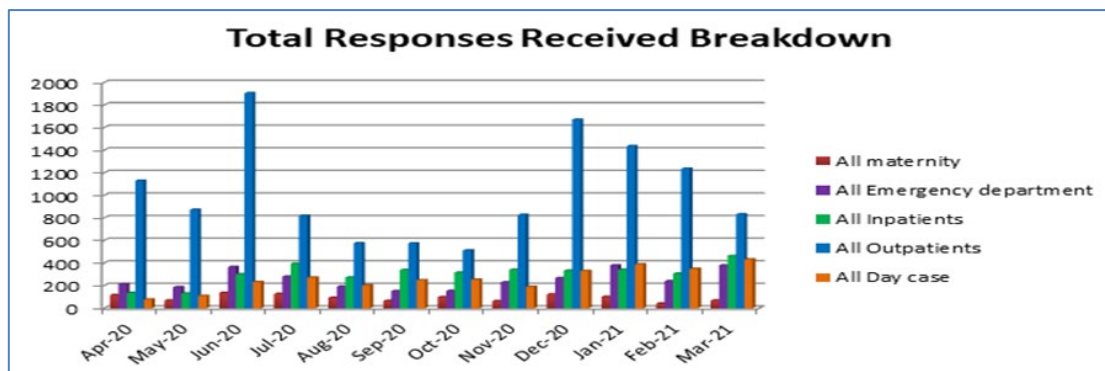
We however took the decision to continue to gather feedback on a monthly basis and considered alternative methods of collecting the information. We introduced QR codes on posters into over 200 clinics across the organisation and these linked specifically to the clinics where patients were attending for treatment. National reporting recommenced from January 2021. The responses received ranged from 1400 to 3000 approximately per month between April and December 2020 as shown in Figure 37 below.

**Figure 37 Total FFT Responses Received April 2020 – March 2021**



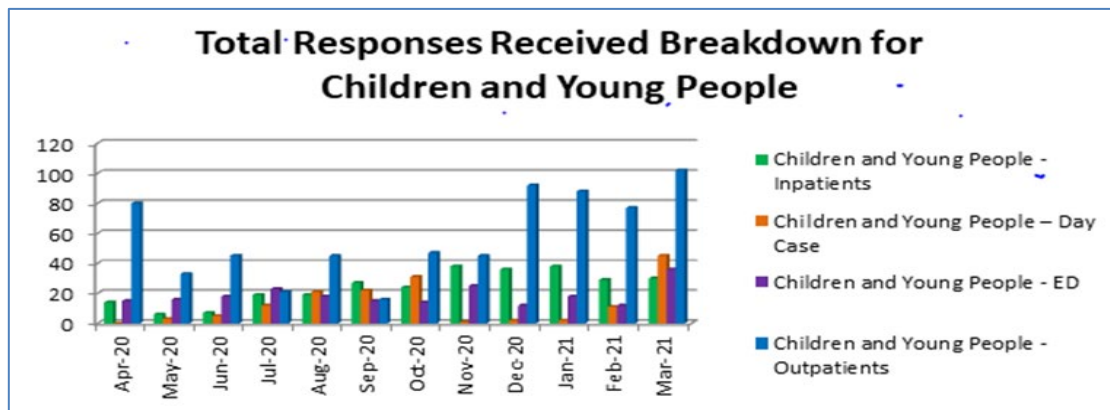
Source: FFT data

**Figure 38 FFT Responses by Areas April 2020 – March 2021**



Source: FFT data

**Figure 39 FFT Responses for CYP by Areas April 2020 – March 2021**



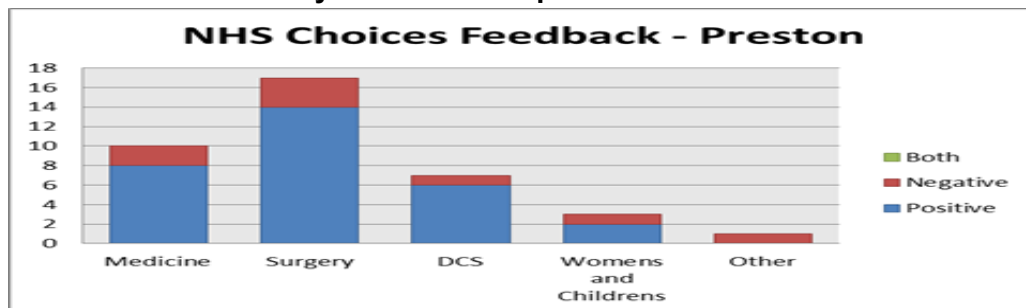
Source: FFT data

Whilst there has been an overall improvement from previous years in the data gathered, in the coming year we will focus on improving the number of responses received. As described above the COVID-19 pandemic has had a significant impact on facilitating the feedback. The Trust has an average 91% rating for satisfaction with the services provided.

### NHS Website Feedback

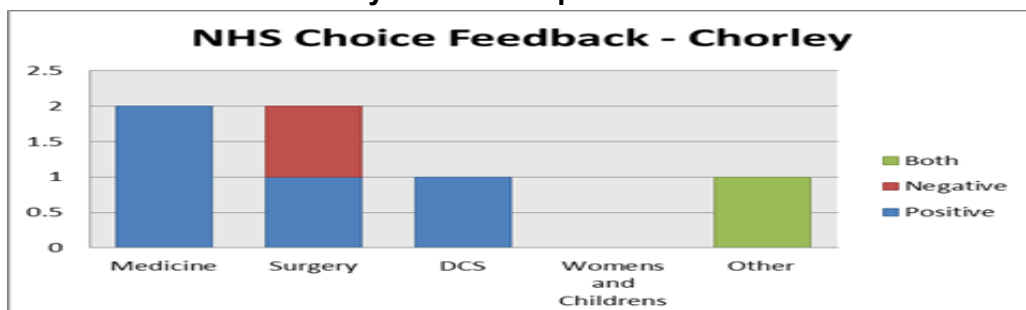
The NHS Website provides patients, relatives and carers the opportunity to leave feedback on their online platform in relation to attendance at the hospitals. In the period of April 2020 to March 2021 there were a total of 44 reviews left of the website, 34 positive messages, 9 negative messages and 1 both positive and negative for our Trust.

**Figure 40 Feedback - Royal Preston Hospital 2020-21**



Source: NHS Choices Data

**Figure 41 Feedback - Chorley District Hospital 2020-21**



Source: NHS Choices Data

## Complaints, Concerns and Compliments

For the year 2020-2021 we received 361 complaints, a decrease of 96 compared to 2019-2020.

**Table 23** Comparator data for Complaints 2015 - 2020

Year	Complaints received	Increase/reduction
2015-16	575	-4
2016-17	595	+20
2017-18	553	-42
2018-19	710	+157
2019-20	457	-253
2020-21	361	-96

Source: LTHTR Datix

This demonstrates a 21% decrease in complaints since 2019-20 for the same reporting period. When considered in terms of the ratio of complaints to patient contact, we received a complaint for every 1:1292 inpatient and outpatient episodes between April 2020 and March 2021. The trend in the ratio of complaints to patient contacts over the past four years is detailed below:

**Table 24** Trend of Ratio of Complaints per Patient Contact 2016 - 2020

Year	No of complaints	Total episodes (IP/OP)	Ratio of complaints to patient contacts
2016-17	595	790696	1:1329
2017-18	553	789643	1:1428
2018-19	710	815607	1:1148
2019-20	457	576447	1:1261
2020-21	361	821526	1:1292

Source: LTHTR Datix

Of the 361 complaints we received between April 2020 and March 2021, 292 (81%) related to care or services provided at the Royal Preston Hospital (RPH), 65 (18%) to care or services provided at Chorley and South Ribble District General Hospital (CDH) and 4 (1%) to care or services provided offsite by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre.

**Table 25** Number of Complaints by Division April 2020 – March 2021

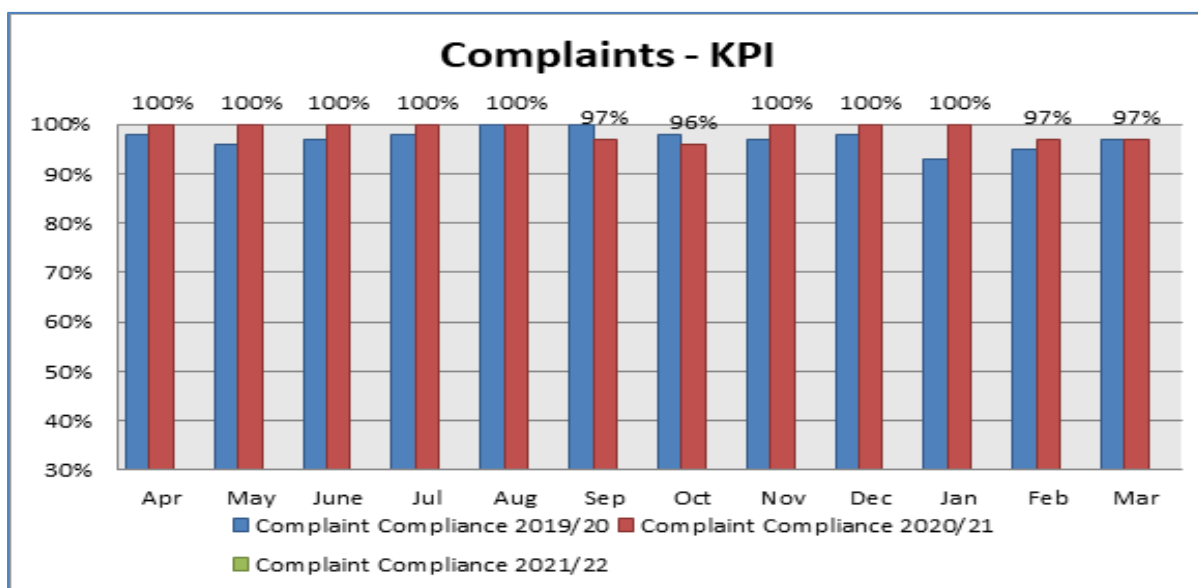
Division	Number (%)	Division	Number (%)
Medicine	166 (46%)	Women's & Children's	34 (9%)
Surgery	131 (36%)	Diagnostics & Clinical Support	19 (5%)
Estates & Facilities	5 (1.3%)	Corporate Services	4 (1.1%)

Source: LTHTR Datix

Of the 361 cases received between April and March 2021, 321 cases due for closure during this period were achieved.



**Figure 42 Complaints Answered within 35 days April 2020 - March 2021**



Source: LTHTR Datix

Investigations that were undertaken into the 321 closed complaints concluded that 38 (12%) of the complaints had been upheld, 188 (58%) were partly upheld and 93 (28%) had not been upheld. The 7 (2%) remaining records were cases that were withdrawn.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In current reporting period, 100% of complainants received into the Patient Experience and Patient Advice & Liaison Service (PALS) Team have had an acknowledgement within that timescale.

Second letters may be received as a result of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2020 and March 2021, we received 15 second letters.

Between April 2020 and March 2021 there were 0 cases where the Parliamentary & Health Service Ombudsman (PHSO) determined that the outcome would be upheld, 1 case would be partially upheld; 1 not upheld. A further 6 cases continue to be ongoing and no final decision has yet been reached.

At the start of the COVID-19 pandemic, NHS England and NHS Improvement permitted NHS organisations to 'pause' the complaints process, as long as complainants were informed of the reason. We however decided to continue with normal ways of working as far as possible.

We are always aiming to improve our services and in February 2021 all complaint response letters started to contain a link to a satisfaction survey for complainants to complete. The outcomes will enable our Patient Experience and PALS team analyse the feedback and make changes to improve the complaints process.

Work is also currently in progress to develop an E-Learning package which aims to promote complaints being supported initially though local resolution and how complaints should be responded to. This will be launched by August 2021 to support the ongoing achievements and quality of responding and learning from concerns and complaints.

## Concerns and Compliments

Our Patient Experience and PALS Team have dealt with over 1436 concerns which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients. This is a positive reflection of the move to locally resolve concerns, supporting the organisations *Big Plan* and ensuring a positive patient experience. We also receive formal and informal compliments from patients and their families in relation to their experience of care. Between April 2020 and March 2021 a total of 2311 compliments and thank you cards were received by wards, departments and through the Chief Executive's office.

## Patient, Family and Public Involvement



Our Patient Experience and Involvement strategy is centred on engaging with people who use our services and providing opportunities to share their views, identify areas for change and shape our services. Our overall ambition is to deliver excellent care through promoting positive patient experiences, improving outcomes and reducing harm. We have had to work very differently this year because of the COVID-19 pandemic to ensure we continued to involve all our service users. Information Technology (IT) has been vital during this time to facilitate engagement during the national restrictions which have impacted on face to face contact. Despite the challenges we have continued to include our patients and families in many forums and working groups and created some new ones in addition to the Patient Experience and Involvement Group. We have public representation on the following groups and meetings presented in the table below;

**Table 26 Patient, Family and Public Involvement Groups**

Patient, Family & Public Involvement Groups	
Upper Gastrointestinal (GI) Cancer Support Group	Upper GI Cancer Patient Documentation Group
Cancer Patient Information Group	Cancer Patient and Carers Forum
Preston Dystonia/Migraine Group	Maternity Voices Partnership
Dermatology –Psoriasis Support Group	Plastics Patient Forum
Patient Information Group	Men's Health Forum
Specialist Mobility Rehabilitation Centre (SMRC) Forum – Joint User Group	Lancashire Learning Disability and Autism Partnership
SMRC – Mobility Matters meeting	Women's Health Forum
SMRC - Complex Regional Pain Syndrome	Renal Dialysis Service Group
Lancashire & South Cumbria dialysis units roadshow	Diabetes Workshop (focusing on learning disabilities)
Renal Strategy Group	Patient Research Group
Oncology Patient Support Group	Youth Forum
Colorectal Risk Stratified Cancer Pathway	Critical Care Ex patients & Relatives Support Group

## Improvements from Patient, Family and Public Involvement

Patient and family involvement with redesigning our services has resulted in a wide range of improvements some examples of which are presented below:

- Working with the Deaf Community and Deafways Charity we have improved hearing loops, promoted deaf awareness with poster campaigns in all reception areas, used clear masks for lip readers, introduced on demand video British Sign Language

(BSL), provided up to date BSL COVID-19 information on our website and we have celebrated World Hearing Day.

- We improved patient referral to Vine House and their services supporting patients with gynaecology cancer.
- Changes were made to the Patient Contribution to Case Notes (PCCN). Document as suggested by the Oncology Patient Support Group.
- Patients have been involvement in the future design of new renal centres.
- Improvements are being made through our Visual Impairment Forum to develop better accessibility for visually impaired people. Activity boxes have been developed for ward areas and an alert system on our electronic patient record highlighting where reasonable adjustments for patients are indicated.

## Working Differently For Patients During COVID-19 Pandemic

To ensure improvement to our patient experiences we carried out many actions to help aid service users during the pandemic. Here is a summary of some of the actions taken:

- IPADS with mobile stands were made available for each inpatient area to enable patients to communicate with families and enable our clinicians meet with multiple family members for discussions.
- We participate in the Hidden Disability Sunflower Scheme with lanyards being made available for patients to highlight they have a hidden disability and need some additional support, help or understanding. Face mask exemption Identity cards were also made available.
- A supply of clear face masks were distributed to key areas where patients attend who lip read.
- We have adopted the #AndILookLikeThis where by staff can upload a smiley photo of themselves and wear on their uniforms to show the smile behind the mask.
- Multi-faith boxes were created from donations by the local faith community and distributed across every inpatient area for patient use.
- Newly appointed Imam's are supporting with an educational promotion video of vaccine uptake within the local BAME community.
- Our Chaplaincy team created a Christmas service leaflet with links to local virtual Christmas Services which patients could dial into and Christmas Carols were played over the Hospital Radio.
- Feedback from our Multi Faith Forum contributed to an updated Pastoral support guide book for staff to support the specific needs of each faith including end of life care and post death requirements.
- Supported patient and staff mental health wellbeing through creating a pastoral support service with helpline and email contact and a volunteer multi faith clergy to provide an on call service, visit wards and provide spiritual and end of life care as well as general companionship and being a listening ear.
- Provided on-demand language translation and interpretations for all areas via iPads, to ensure communication was inclusive.

## Patient Stories

We continue welcome feedback from many sources, and none more than those from real life experiences of the service. Patients, carers and relatives are invited to our Board meetings to discuss the care given and to share their experiences from a real and lived perspective.

Each of our Divisions deliver a patient story to the Board and the messages from the stories are cascaded through to various other meetings across the organisation to share experiences and discuss, where appropriate improvements that may be required. Our Continuous Improvement 'Big Rooms' continue to include patients stories at the start of every weekly session and the Divisions are using patient stories at Divisional level meetings.

In addition to this safety and Quality Committee now also include a patient story that is more sensitive on the cycle of business to allow patients with more intense, difficult or sensitive experiences to be heard by members of the Board.

### A highlight from Critical Care

Our Consultant Dr Tom Owen serenaded a patient who had spent 50 consecutive days in Critical Care battling against COVID-19.



This post was shared on our [Critical Therapy RPH Twitter](#) account and has since been viewed over 12,500 times. You can read the full story, and watch the video, on [LancsLive's](#) website.



## Staff Survey and Recommendation of Our Care

Improving staff experience continues to be a high priority for us, particularly given the operational challenges the organisation has experienced during the COVID-19 pandemic. The staff survey provides us with vital feedback about the experience of our workforce, enabling us to build on what is working well for them, and learn from and address the areas that are causing dissatisfaction.

The survey provides us with an overall staff engagement score which is calculated using the results for key questions around motivation, advocacy and involvement. In the 2019 survey our staff engagement score was 6.9 (on a scale of 0 to 10, with 0 being the lowest and 10 being the highest) and in 2020 we have seen a slight improvement to 7.0.

Two of the questions that contribute to our staff engagement score are those which are mirrored in the Staff Friends and Family Test – recommendation of the organisation as a place to work and recommendation of the organisation as a place to receive care. It is encouraging to see that both measures have improved as presented in Table 27 below and these results are now only slightly below national average, which is an improved benchmarking position compared to previous years.

**Table 27 NHS Staff Survey – Recommendation of the Trust**

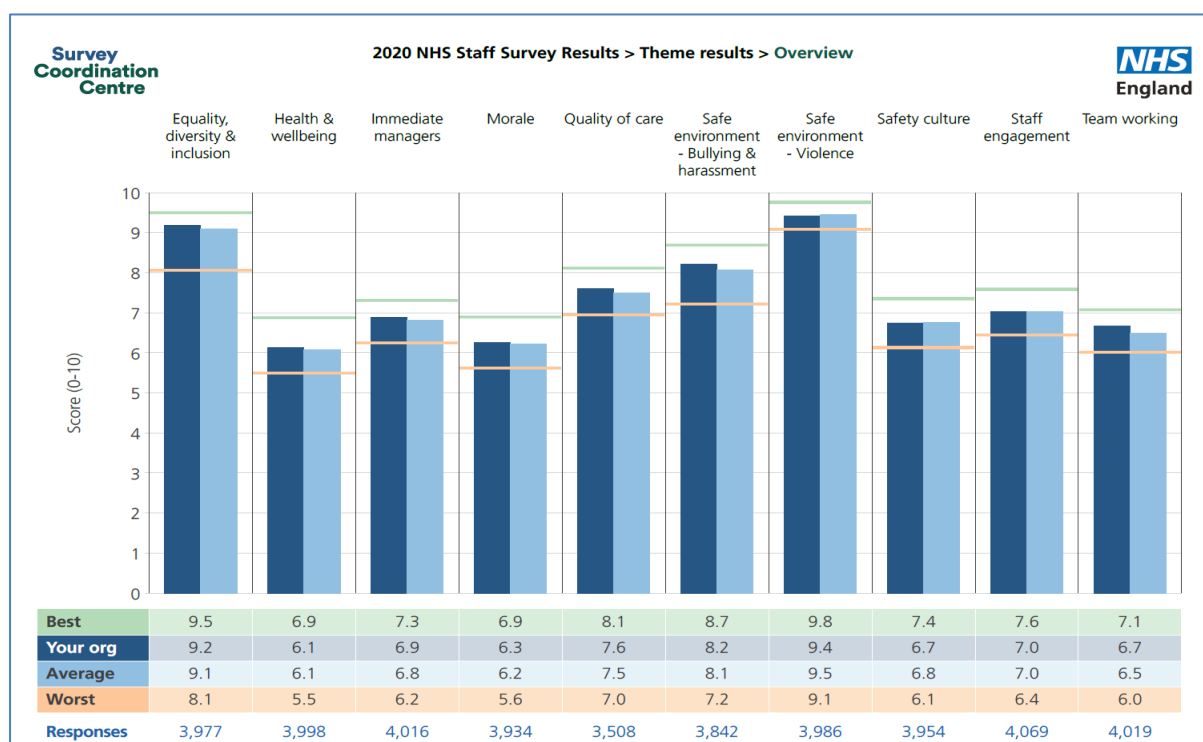
Theme		2018	2019	2020
Advocacy	If friend / relative needed treatment would be happy with the standard of care provided by organisation	66%	63%	69% 
	Would recommend organisation as a place to work	59%	58%	63% 

Source – National Staff Survey

We will explore these results further through Big Conversation focus groups during April 2020; and our Divisions, specialty areas and departments have also been provided with their specific results, enabling them to hold local conversations.

Figure 43 provides a high level overview of our organisation’s performance against the key themes from the staff survey. It provides benchmarking data for our organisation compared to the best, worst and average for acute Trusts. All scores are out of 10 with 0 being the lowest and 10 being the highest

**Figure 43 NHS Staff Survey Results Bar Graph**



Source – National Staff Survey

At an organisational level results have improved significantly in 6 out of 10 themes, with other areas remaining the same. No themes have deteriorated.

We perform slightly better than the national average in most areas and we perform worse in relation to: Safe Environment Violence and Safety Culture. Health and Wellbeing and Morale are our lowest scoring themes with 44% of staff saying they have experienced work related stress, although this reflects the national picture. Improving the Environment and

Facilities remains a key theme for us. Improvements are still required to improve the experience of BAME staff and staff with a disability. Experience is significantly worse for staff who prefer to self-describe their gender, those who describe their sexuality as bisexual, other or prefer not to say and lastly those staff who prefer not to disclose their religion.

These are all areas which will be addressed through our Workforce and Organisational Development Strategy and we have comprehensive action plans in place to improve staff experience in relation to Equality, Diversity and Inclusion and Health and Wellbeing.

## Quality Assurance

Our Quality Account has presented the data, information and assurance required by NHS Improvement (NHSI). We have provided information related to the statutory core performance indicators and assurance on our data quality. We have presented progress with our key priorities for 2020-21 which were stated in the 2019-20 account and highlighted new priorities for 2021-22 which align to *Our Big Plan*. We have presented a review of activity in relation to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

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

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

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

Our Governor involvement in the *Our Health Our Care* programme has been hugely valued and much appreciated by the Trust. Our Governors also continue to offer valuable challenge and assurance as well as contribute to significant environmental improvements for patients through use of their charitable fund.

Our Quality Account for 2020-21 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care and excellent experience.

## Annex 1:

### Statements from External Stakeholders

#### **Statement from the Lancashire County Council Health Scrutiny Committee re: Quality Accounts for 2020/21**

The Lancashire Health Scrutiny function welcomes the opportunity to comment on the Lancashire Teaching Hospitals NHS Foundation Trust's Quality Accounts for 2020/21.

It was felt the draft Quality Accounts provided a good and clear report of the Trust's performance over the last year and it was reassuring to see that, whilst the pandemic could have adversely affected the Trust's priorities and targets, overall, they had been unaffected.

The high level of participation in national clinical audits and national confidential enquiries was welcomed. The Trust should be commended for viewing these enquiries as an opportunity to review and improve and noted that many assessments and processes had been improved as a result. It was felt the draft Quality Accounts clearly outlined this process.

On the differences between the Care Quality Commission's overall results for the Trust's different hospital sites it was felt that further detail was required to explain the differences given that the hospitals are under the same leadership. Whilst Chorley and South Ribble Hospital received consistently 'good' ratings, the Royal Preston Hospital received mostly 'requires improvement,' which affected the Care Quality Commission's results for the Trust as a whole.

On the Trust's performance against key targets, it was acknowledged that many of the targets had not been achieved due to the direct impact of the COVID-19 pandemic on hospital services. It was noted that some targets were close to being met, whereas performance against some indicators fell below the national target. It was felt further explanation regarding the inconsistency in the results was required.

Members commended the Trust for including a comprehensive report on the Freedom to Speak Up service highlighting that staff were encouraged to raise concerns with the Trust's Freedom to Speak Up Guardians. More detail would have been beneficial to identify the nature of the concerns raised, but overall, it was good to see that Freedom to Speak Up cases were being reported on and that the Guardians were being approached.

The Trust should be commended for recruiting a Named Safeguarding Adult Doctor to support Adult Safeguarding generally and to involve clinicians in safeguarding practices.

Though there had been a reduction in the number of incidents reported since 2019/20, there appeared to be a significant number of incidents where the level of harm associated was no harm or low harm. Members felt that more detail was required, including a breakdown of the nature of these incidents and an explanation to ensure patient safety was not affected.

The Trust should be commended on its infection prevention and control recognising that there had been no infections of MRSA in 2020/21, given the high number of patients admitted to hospital over the year.



The Trust's reports on neonatal and child deaths and on perinatal mortality were reassuring, particularly regarding services to support bereaved parents. The level of progress reported within the maternity service was good, as were the actions and steps introduced by the service in response to the Ockenden report.

On the review of quality performance and experiences of care members commended the Trust on the outcomes of the National Adult Inpatient Survey and the national Maternity Survey. Noting that 100% of respondents to the Maternity Survey said that they had been involved enough in decisions about their care, and the positive responses about the Trust's maternity service from patients and their partners.

Members commended the Trust for the inclusion of patient stories and feedback and a comprehensive glossary at the end of the draft Quality Accounts.

The Lancashire Health Scrutiny function would welcome early involvement with the planning process to produce the Trust's 2021/22 Quality Account.

**Healthwatch Lancashire  
Response to Lancashire Teaching Hospitals NHS Foundation Trust  
Quality Accounts Report for  
2020-21**

**21<sup>st</sup> April 2021**

**Introduction:**

Healthwatch Lancashire is pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust 2020-21.

**Chief Executive's Statement:**

It was reassuring to read that despite the challenges the Trust faced due to the pandemic that it maintained focus on the organisation strategy 'Our Big Plan' which has a very specific focus on quality.

Partnership working is something we have seen a great deal of during the pandemic and it is gratifying to note that the Trust also strengthened partnership working with local partners, increased mutual aid between organisations and collaborated closely to ensure equitable treatment of patients.

**Part 2: Priorities for Improvement:**

We consider that the draft Quality Accounts provided a good and clear report of the Trust's performance over the last year and we are pleased to note that, whilst the pandemic could have adversely affected the Trust's priorities and targets, overall, they had been unaffected.

We welcome the high level of participation in national clinical audits and national confidential enquiries and would commend the Trust for viewing these enquiries as an opportunity to review and improve and noted that many assessments and processes had been improved as a result. It was felt the draft Quality Accounts clearly outlined this process.

We noted the differences between the Care Quality Commission's overall results for the Trust's different hospital sites and did wonder why this was so considering that the hospitals are under the same leadership.

Regarding the Trust's performance against key targets, it is understandable that many of the targets had not been achieved due to the direct impact of the COVID-19 pandemic on hospital services however we acknowledge that some targets were close to being met.

We very much welcomed the comprehensive report on the Freedom to Speak Up service and the fact that staff were encouraged to speak with the Freedom to Speak up Guardians. We would have liked to see more detail regarding the nature of the concerns raised, however it was good to see that staff are reporting instances to the Guardians.

### **Part 3 Review of Quality Performance:**

We note that the Trust has recruited a Named Safeguarding Adult Doctor to support Adult Safeguarding and to work with clinical staff to address safeguarding issues. We would commend the Trust for this action as it will ensure multidisciplinary collaboration and prepare for the Liberty Protection Safeguards legislation expected during 2022.

Regarding the Incidents and Never events we are pleased to see the reduction in the number of incidents reported since 2019/20 however it would have been useful to have had some degree of breakdown as to the nature of the significant number of incidents relating to No Harm and Low Harm.

It is commendable that despite the challenges of the pandemic and the high volume of patients admitted the level of MRSA infections during 2020-21 was nil.

We found the Mortality Surveillance section very clear and informative and would single out the Neonatal and Child Deaths section as a good example of how the Trust is enacting improvements brought about by the learning from reviews.

Patient experience of care is a key part of the role of Healthwatch and we were therefore particularly interested in the patient feedback obtained. We would commend the Trust on the high rate of patient satisfaction with their care, in particular the Maternity Survey in which 100% of respondents had felt involved enough in decisions relating to their care.

In a similar vein we very much welcome the Patient, Family and Public Involvement work and the improvements and redesign made as a result of this. We particularly like the fact that patients stories regarding their experience are presented to the Board.

Thank you for including an extremely comprehensive Glossary, very helpful,

### **Summary**

Overall, we consider this Quality Account an excellent document, very clear and well detailed. We look forward to seeing continuation of collaborative and partnership working and patient involvement contributing to the delivery of tangible improvements.

Yours sincerely,



**Sue Stevenson  
Chief Operating Officer  
Healthwatch Lancashire**

# Chorley and South Ribble and Greater Preston Clinical Commissioning Groups' Response to the Lancashire Teaching Hospitals Quality Account 2020-21



Contact: Mrs Helen Curtis  
E-mail: [helen.curtis15@nhs.net](mailto:helen.curtis15@nhs.net)

NHS Greater Preston CCG  
Chorley House  
Lancashire Business Park  
Centurion Way  
Leyland  
Lancashire  
PR26 6TT

12 May 2021

Christine Morris  
Interim Director of Governance  
Sent via email to: [Christine.morris@lthtr.nhs.uk](mailto:Christine.morris@lthtr.nhs.uk)

Dear Christine

## CCG response to the Lancashire Teaching Hospitals Quality Account 2020/21

Greater Preston CCG would like to take this opportunity to comment on the annual Quality Account from Lancashire Teaching Hospitals NHS Foundation Trust. As in previous years, the account has been shared with the CCG's Quality and Performance Committee and will be shared with associate commissioners.

The CCG acknowledges the extraordinary efforts the Trust has made in response to the unprecedented challenges brought on by the COVID-19 pandemic. The courage and selfless dedication demonstrated by all staff groups in both saving lives and maintaining critical services through the introduction of innovative practices to mitigate risks to patients and staff is unequivocally recognised.

The Trust's Care Quality Commission (CQC) overall rating has remained at 'requires improvement' since November 2019 (rating 'good' for 'caring' and 'well-led'; and at site level for Chorley & South Ribble Hospital). The CCG have remained sighted on the Trust's progress in delivering its 'must-do' and 'should-do' action plan. Despite unavoidable delays on some workstreams due to the pandemic, the CCG are pleased to note the progress to date across several programmes of work in relation to patient safety, improvement and governance. Although the CQC have not conducted any routine inspections this year, they have continued to engage with the Trust via a series of monitoring meetings. This has resulted in a positive outcome as they were assured over several areas: Infection Prevention and Control (IPC) arrangements, Emergency Departments and vaccination facilities. Notably, the CQC have recently announced they are planning to restart inspections, prioritising NHS Trusts with ratings of inadequate or require improvement.

The CCG recognise the improvements that continue to be made under the Trust's value-based three-year 'Big Plan' (2019-22). However, it is understood that this has been a difficult year resulting in some ambitions for improvement having to be pared back, including the STAR (Safety Triangulation Accreditation Review) accreditation target as the Trust's focus and priorities were reset. It is disappointing to note the Trust's continued challenges in meeting their five per cent annual reduction targets for grade two pressure ulcers and falls resulting in severe harm. However, the impact of both the changes in the complexity and acuity of patients due to COVID-19 is recognised. The CCG supports the continued focus on this but would like to see improvements in the coming year.

It is concerning that four Never Events were reported by the Trust in 2020-21 and that three of these incidents related to misplaced naso-gastric tubes. Although the investigations for two of these cases are still ongoing, it is acknowledged that the Trust continue to proactively engage with the CCG to learn from these events. It is positive to note the open and transparent investigation that was undertaken with the Trust Executive team as well as NHS England and Improvement



Dr Sumantra Mukerji – Chair  
Denis Gizzi – Chief Officer

which resulted in a robust action plan. The CCG will continue to seek assurance on how improvement actions are embedded moving forward.

The CCG note the developments made in relation to Safeguarding Adults, specifically the preparatory work in readiness for the Liberty Protection Safeguarding and safeguarding training compliance. Similarly, the CCG also recognises the successful completion of the Mental Capacity Act and Deprivation of Liberty Safeguards project which has produced an electronic patient journey in the Quadramed system. It is positive to see the appointment of a named doctor for Safeguarding Adults which will ultimately enhance multi-agency collaboration.

Performance in relation to NHS Constitutional targets has been severely impacted by the pausing of elective activity at peak points throughout the pandemic. This has resulted in the Trust failing to achieve 18-week referral to treatment, six-week diagnostic and key cancer targets (two-week-waits and 62 day treatment). Notably there has been a significant increase in the number of patients waiting 52 weeks or more to start treatment. In order to provide assurances around patients on the existing waiting list the Trust are following the mandated National Clinical Prioritisation Programme. Additionally, the CCG is a member of the Cancer Performance Improvement Group (CPIG) as part of the Cancer Alliance which continues to meet on a weekly basis to discuss system performance and management.

Whilst the recovery and restoration plans to address the backlog continues to be led by the Integrated Care System (ICS) and the hospital cell, the CCG continue to be a key partner in monitoring the safety of those patients awaiting treatment.

The CCG acknowledges the difficulties the Trust has encountered in regard to nosocomial (hospital acquired) COVID-19 infections. Due to a spike in infection rates during November 2020, the Trust faced additional regional scrutiny. The CCG notes the Trust's collaboration with the CCG, CQC and NHSE/I in implementing a 10-point improvement plan. This was critical in driving the infection rate down, primarily through improved testing and enhancing staff awareness as well as mitigating the estate insufficiencies through re-zoning and purchasing additional equipment.

The CCG welcomes the Trust's commitment to renewing the focus on reducing the number of *C. difficile* infections as the pandemic eases. It is recognised the COVID-19 related increase in the use of broad-spectrum antibiotics and reduced isolation opportunities are contributory factors in the continued relatively high incidence of hospital onset cases. The CCG values the Trust's IPC team's focus on learning and improvement and looks forward to further collaborative working to reduce the number of Healthcare Associated Infections (HAIs) in the coming year.

It is positive to note that the Summary Hospital Mortality Indicator (SHMI) remains lower than expected (the standardised statistical methodology excludes COVID-19 deaths) for the latest 12-month reporting period and favourably low when benchmarked regionally. However, despite continued extensive work with the Palliative Care team, the coding of patients with palliative care continues to be higher than the national average.

The CCG notes both the learning and good practice identified in Structured Judgement Mortality Reviews and of the further development of the Medical Examiner service during the last year which has had a positive effect on Coroner referrals.

The CCG recognises that with the exception of the optional New Mothers' Experience of Care Survey, national surveys relating to patient experience were postponed in 2020-21 due to the pandemic. It is encouraging that the Trust ranked 'best' in 5 of the 12 areas, with 99 per cent of new mother participants stating they had confidence and trust in staff during labour and birth and that they (99 per cent) were also treated with respect and dignity.



Dr Sumantra Mukerji – Chair  
Denis Glizzi – Chief Officer

The Friends and Family Test provides a valuable indicator and source of information for patient experience. The CCG commends the Trust's decision to continue to gather responses throughout the pandemic, despite the national requirement being paused; and notes the average 91 per cent satisfaction rating for Trust services from respondents.

The CCG acknowledges the reduction in the number of complaints and the improved ratio of complaints per patient contact episode this year. The ongoing improvement work around the new satisfaction survey and the development of an e-learning package to improve the handling of complaints is also recognised. The CCG look forward to the outcomes of this in driving further improvements.

The Trust's positive NHS Staff Survey results (improving in 6 of the 10 themes and scoring higher than the national average in 7 themes) is acknowledged. The CCG were also pleased to see the recommendation for the Trust as a 'place to work' and as a 'place to receive care' had both increased from last year, showing an improved position to marginally below the national average. However, the CCG note that the Trust scored slightly less than average for 'safe environment' and 'safety culture'. The CCG will monitor this through the associated action plan produced by the Trust as part of their Workforce and Organisational Development Strategy.

The CCG note there was no requirement for providers to submit their CQUIN returns in 2020-21 due to the COVID-19 pandemic.

To conclude, 2020-21 has been an exceptionally difficult year for the Trust in terms of the operational and workforce challenges it has experienced throughout the pandemic. It is clearly evident that the impact of COVID-19 over the last year will be felt throughout 2021/2022 and beyond. The CCG commends the innovate practice and new ways of working that have occurred with increased collaboration and partnership working across the Integrated Care Partnership (ICP) and the ICS. The year ahead will provide additional challenges in terms of restoring services, addressing the back- log of patients waiting, plus the new care demand. Additionally, the Trust will also need to carefully manage the transition to future ways of working under a single integrated care system. The CCG looks forward to continuing to work in a collaborative partnership with the Trust to further improve the quality of care to our patients.

Yours sincerely



**Denis Gizzi**  
Chief Accountable Officer



Dr Sumantra Mukerji – Chair  
Denis Gizzi – Chief Officer

## **Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust**

### **Quality Account: Feedback from Council of Governors Meeting 29<sup>th</sup> April 2021**

The draft Quality Account had been circulated with the agenda and a presentation provided to the Council of Governors. Feedback from the Council of Governors has been summarised and presented below:

- This report was extensive, comprehensive and would be time consuming to complete. Congratulations were to be passed to all of the staff involved in producing the Quality Account and it also highlighted the significant number of people who the Council did not see but who just get on with the job.
- The document was focused on the hospital but perhaps the Trust could have an area of focus on communications with patients outside the hospital.
- The Quality Account mentioned that the Governors attend the Patient Safety Collaborative although this may not have been the case in 2020-21 it has been the case in the previous year.
- The report highlighted high rates of readmission within 30 days of discharge for children 0-15 years in the years 2017/18, 2018/19 and 2019/20 however the Governors have been informed that audit will be undertaken to explore this issue.
- The Council noted the ambition for the Trust to achieve an 'Outstanding' CQC rating and would like to have further information as to what the Trust CQC key priorities are and the progress being made in a summary report.
- An increase in the use of the Freedom to Speak Up section was noted by the Council, concerned that this may reflect an increase in staff being unable to cope with the work however it was also recognised that the increase showed staff were comfortable raising issues. It was also positive that the Freedom to Speak Up Guardian was supported by a number of Champions.
- There were some inconsistencies with strategy titles and group names
  - *Addendum* – all these changes have been made in the final document.

## Annex 2:

### Statement of directors' responsibilities for the Quality Account

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2020-21 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2020 to March 2021.
  - Papers relating to quality reported to the board over the period April 2020 to March 2021.
  - Feedback from commissioners 00/00/0000.
  - Feedback from Healthwatch 23/04/2021.
  - Feedback from Overview and Scrutiny Committee 23/04/2021.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2019-20.
  - The 2018 national inpatient survey 1 June 2019.
  - The 2020 national staff survey 9 March 2021.
  - CQC Inspection report dated 7 November 2019.
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts



regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board



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Chairman

Date: 10 June 2021



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Chief Executive

Date: 10 June 2021

## Appendix 1

**Table 28 Maternity Sensitive Staffing Indicators**

Metric	Red flag	Green flag	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
CNST 10 Key safety actions											80%	80%	80%	90%
Births			364	341	357	346	317	346	394	351	336	360	315	374
Stillbirth rate (per 1,000 births)	> 4.2	≤ 4.2	5.5	5.9	8.4	0.0	6.3	5.8	0.0	8.5	6.0	2.8	9.5	10.7
Examination of the newborn completed within 72 hours	< 95%	≥ 95%	96%	96%	96%	96%	96%	98%	93%	95%	93%	95%	95%	96%
Breastfeeding initiation	< 70%	≥ 70%	73%	78%	72%	70%	70%	73%	73%	79%	72%	71%	70%	72%
Births per Funded clinical midwife WTE (Staff in post)	> 28	≤ 27	28	25	27	26	23	26	29	27	25	26	26	27
Women giving birth in a midwife-led setting	< 25%	≥ 30%	26%	28%	22%	24%	28%	25%	27%	25%	22%	23%	25%	26%
Home birth	< 1.7%	≥ 2.0%	3%	4%	4%	3%	4%	4%	7%	3%	4%	3%	5%	3%
One-to-one care in labour in DeliverySuite	< 95%	= 100%	99%	100%	99%	99%	99%	99%	99%	100%	99%	99%	99%	99%
One-to-one care in labour in Preston Birth Centre	< 95%	= 100%	100%	100%	100%	99%	98%	100%	98%	100%	100%	100%	100%	98%
One-to-one care in labour in Chorley Birth Centre	< 95%	= 100%	N/A	NA	NA	NA	N/A	N/A	N/A	NA	100%	100%	100%	100%
One-to-one care in labour overall	< 95%	= 100%	99%	100%	100%	99%	99%	100%	99%	100%	99%	99%	99%	99%
Supernumerary status of DS coordinator	< 100%	= 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
CTG update training	< 90%	≥ 90%	62%	29%	59%	57%	52%	45%	49%	69%	83%	86%	92%	93%
Annual competency (K2 Training Package)	< 90%	≥ 90%		53%	50%	68%	63%	74%	76%	81%	87%	87%	82%	86%
Antenatal CTG	< 90%	≥ 90%		60%	67%	83%	85%	84%	85%	93%	93%	92%	88%	91%
Intrapartum CTG	< 90%	≥ 90%		52%	57%	71%	75%	78%	78%	84%	87%	88%	86%	89%
Intrapartum IA	< 90%	≥ 90%		48%	61%	81%	80%	82%	84%	90%	92%	92%	89%	90%
GAP/GROW ( Growth Assessment Protocol Training)	< 90%	≥ 90%			37%	54%	56%	57%	69%	84%	83%	86%	90%	85%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	< 90%	≥ 90%	86%	83%	76%	71%	66%	54%	46%	68%	70%	71%	79%	92%
Incidents of moderate harm and above											0	0	2	2
HSIB referrals			1	0	1	1	0	0	0	2	2	0	0	0
Prevention of future deaths regulation 28			0	0	0	0	0	0	0	0	0	0	0	0
Number of Consultant hours on obstetric unit	<70 hours	=/> 96.5hours	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
Complaints			0	1	1	2	1	2	3	0	1	2	2	1
Maternal Death			0	0	0	0	0	0	0	0	0	0	0	0

## Glossary of Abbreviations

<b>A&amp;E</b>	Accident & Emergency
<b>AHP</b>	Allied Health Professionals
<b>AMaT</b>	Audit Management and Tracking System
<b>BAETs</b>	British Association of Endocrine and Thyroid Surgeons
<b>BAME</b>	Black, Asian and Minority Ethnic
<b>BAPM</b>	British Association of Perinatal Medicine
<b>BAUS</b>	British Association of Urological Surgeons
<b>BFI</b>	Baby Friendly Initiative
<b>BI</b>	Business Intelligence
<b>BSL</b>	British Sign Language
<b>BTS</b>	British Thoracic Society
<b>CCG</b>	Clinical Commissioning Group
<b>CCOT</b>	Critical Care Outreach team
<b>CDH</b>	Chorley District Hospital
<b>CDOP</b>	Child Death Overview Panel
<b>CI</b>	Continuous Improvement
<b>CMP</b>	Case Mix Programme
<b>CNST</b>	Clinical Negligence Scheme for Trusts
<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>CQC</b>	Care Quality Commission
<b>CQUIN</b>	Commissioning for Quality and Innovation
<b>CrCu</b>	Critical Care Unit
<b>CRF</b>	Clinical Research Facility
<b>CS</b>	Caesarean Section
<b>CSAP</b>	Child Safeguarding Assurance Partnership
<b>CSPR</b>	Child Safeguarding Practice Reviews
<b>CTG</b>	Cardiotocograph Traces
<b>CUR</b>	Clinical Utilisation Review
<b>CVC</b>	Central Venous Catheter
<b>DCT</b>	Dental Core Trainees
<b>DNACPR</b>	Do Not Attempt Cardiopulmonary Resuscitation
<b>DoLs</b>	Deprivation of Liberty Safeguards

<b>dsDNA</b>	Anti-double-stranded Deoxyribonucleic acid
<b>E.Coli</b>	Escherichia coli
<b>ED</b>	Emergency Department
<b>ELC</b>	End of Life Care
<b>EMB</b>	Ethambutol Endometrial Biopsy
<b>ENT</b>	Ear, Nose and Throat
<b>EPMA</b>	Electronic Prescribing and Medicines Administration
<b>EWS</b>	Early Warning Score
<b>FCA</b>	Flow Coaching Academy
<b>FFFAP</b>	Falls and Fragility Fractures Audit Programme
<b>FFT</b>	Friends and Family Test
<b>FTSU</b>	Freedom to Speak Up (FTSU) guardian
<b>GIRFT</b>	Getting It Right First Time
<b>GMC</b>	General Medical Council
<b>GP</b>	General Practitioners
<b>HASU</b>	Hyper Acute Stroke Unit
<b>HbA1c</b>	Haemoglobin A1c or Glycated Haemoglobin Test
<b>HDU</b>	High Dependency Unit
<b>HRA</b>	Health Research Authority
<b>HSMR</b>	Hospital Standardised Mortality Ratio
<b>HSPCT</b>	Hospital Specialist Palliative Care Team
<b>HSST</b>	Higher Specialist Scientist Training
<b>HQIP</b>	Healthcare Quality Improvement Partnership
<b>IA</b>	Intermittent auscultation
<b>IBD</b>	Inflammatory Bowel Disease (Programme)
<b>ICP</b>	Intracranial Pressure
<b>ICNARC</b>	Intensive Care National Audit & Research Centre
<b>ICU</b>	Intensive Care Unit
<b>ICS</b>	Intensive Care Society
<b>IG</b>	Information Governance
<b>INCS</b>	Integrated Nutrition and Communication Service
<b>IPC</b>	Infection Prevention Control
<b>LAST</b>	Local Anaesthetic Systemic Toxicity

<b>LeDeR</b>	Learning Disability Mortality Review Programme
<b>MPP</b>	Manual Perineal Protection
<b>LTHTR</b>	Lancashire Teaching Hospitals NHS Foundation Trust
<b>MASH</b>	Multi Agency Safeguarding Hubs
<b>MAU</b>	Medical Assessment Unit
<b>MBRRACE-UK</b>	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
<b>MCA</b>	Mental Capacity Act
<b>MCCDs</b>	Medical Certificate of Cause of Death
<b>MDT</b>	Multidisciplinary Team
<b>ME</b>	Medical Examiner
<b>MEO</b>	Medical Examiner Officer
<b>MINAP</b>	Myocardial Ischaemia National Audit Project
<b>MIAA</b>	Mersey Internal Audit Agency
<b>MRI</b>	Magnetic Resonance Imaging
<b>MRSA</b>	Methicillin Resistant Staphylococcus Aureus
<b>MSO</b>	Medications Safety Officer
<b>MSSA</b>	Methicillin-Susceptible Staphylococcus Aureus
<b>MSU</b>	Midstream Specimen of Urine
<b>MUST</b>	Malnutrition Universal Screening Tool
<b>NACAP</b>	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
<b>NACEL</b>	National Audit of Care at the End of Life
<b>NAOGC</b>	National Audit of Oesophago-gastric Cancer
<b>NASH</b>	National Audit of Seizure Management in Hospitals
<b>NBOCA</b>	National Bowel Cancer Audit
<b>NBOCAP</b>	National Bowel Cancer Audit Programme
<b>NCAA</b>	National Cardiac Arrest Audit
<b>NCASRI</b>	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury
<b>NCEPOD</b>	National Confidential Enquiry into Patient Outcome and Death
<b>NELA</b>	National Emergency Laparotomy Audit
<b>NHSI</b>	NHS Improvement
<b>NHSE</b>	NHS England

<b>NICE</b>	National Institute for Health and Care Excellence
<b>NJR</b>	National Joint Registry
<b>NRLS</b>	National Reporting and Learning System
<b>NLCA</b>	National Lung Cancer Audit
<b>NMPA</b>	National Maternity and Perinatal Audit
<b>NNAP</b>	National Neonatal Audit Programme
<b>NPDA</b>	National Paediatric Diabetes Audit
<b>NVR</b>	National Vascular Registry
<b>OASI</b>	Obstetric Anal Sphincter Injury
<b>OMFS</b>	Oral and Maxillofacial Surgery
<b>PALS</b>	Patient Advice and Liaison Service
<b>PAS</b>	Patient Administration Systems
<b>PEWS</b>	Paediatric Early Warning Score
<b>PICANET</b>	Paediatric Intensive Care Audit Network
<b>PCCN</b>	Patient Contribution to Case Notes
<b>PCNL</b>	Nephrolithotomy
<b>PDTI</b>	Pulsed Doppler Tissue Imaging
<b>PHSO</b>	Parliamentary and Health Service Ombudsman
<b>PMRT</b>	Perinatal Mortality Review Tool
<b>PQIP</b>	Perioperative Quality Improvement Programme
<b>PROMS</b>	Patient Reported Outcome Measures
<b>QAT</b>	Quality Assurance Team
<b>QIF</b>	Quality Improvement Framework
<b>RAG</b>	Red/Amber/Green
<b>PIR</b>	Provider Information Request
<b>PPH</b>	Postpartum Haemorrhage
<b>PREM</b>	Patient Reported Experience Measure
<b>PROMs</b>	National Patient Reported Outcome Measures programme
<b>RCEM</b>	Royal College of Emergency Medicine
<b>RCN</b>	Royal College of Nursing
<b>RCOA</b>	Royal College of Anaesthetists

<b>RCOG</b>	Royal College of Obstetricians and Gynaecologists
<b>RCOPHTH</b>	Royal College of Ophthalmologists
<b>RCP</b>	Royal College of Physicians
<b>RCPCH</b>	Royal College of Paediatrics and Child Health
<b>RCPSYCH</b>	Royal College of Psychiatrists
<b>RCS</b>	Royal College of Surgeons
<b>RPH</b>	Royal Preston Hospital
<b>RTOG</b>	Radiation Therapy Oncology Group
<b>SAM</b>	Society for Acute Medicine
<b>SAMBA</b>	Society for Acute Medicine Benchmarking Audit
<b>SDEC</b>	Same Day Emergency Care
<b>SHMI</b>	Summary Hospital-level Mortality Indicator
<b>SHOT</b>	Serious Hazards of Transfusions
<b>SI</b>	Serious Investigation
<b>SJR</b>	Structured Judgement Review
<b>SLT</b>	Speech and Language Therapy
<b>SOP</b>	Standard Operating Procedures
<b>SPC</b>	Statistical Process Control
<b>SSI</b>	Surgical Site Infection
<b>SSNAP</b>	Sentinel Stroke National Audit Programme
<b>STAR</b>	Safety Triangulation Accreditation Review
<b>StEIS</b>	Strategic Executive Information System
<b>SUS</b>	Secondary User Service
<b>TARN</b>	Trauma Audit and Research Network
<b>TIA</b>	Transient Ischaemic Attack
<b>TBI</b>	Traumatic Brain Injury
<b>UCAM</b>	Urinary Catheter Assessment and Monitoring Form
<b>VBAC</b>	Vaginal Birth After Previous Caesarean
<b>VTE</b>	Venous Thromboembolism

Lancashire Teaching Hospitals NHS Foundation Trust

**FINANCIAL REVIEW**  
2020-21



# **INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST**

## **REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS**

### **Opinion**

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Group and Trust Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2021 and of the Group's and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

### **Basis for opinion**

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### **Going concern**

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group and Trust will continue in operation.

## **Fraud and breaches of laws and regulations – ability to detect**

### ***Identifying and responding to risks of material misstatement due to fraud***

To identify risks of material misstatement due to fraud (“fraud risks”) we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group’s high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group’s channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to meet external expectations.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group’s accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet financial improvement trajectory targets, we perform procedures to address the risk of management override of controls, in particular the risk that Group management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as asset valuations and impairments. On this audit we do not believe there is a fraud risk related to revenue recognition due to the temporary NHS funding arrangements that have been in place throughout the financial year and, due to their non-variable nature, we don’t believe there to be an incentive to manipulate other operating income streams that are material.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of the Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the existence and accuracy of recorded expenditure throughout the financial year ended 31 March 2021 with specific focus on items recorded in period 12.

### ***Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations***

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

### ***Context of the ability of the audit to detect fraud or breaches of law or regulation***

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

### **Other information in the Annual Report**

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

### **Annual Governance Statement**

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

## **Remuneration and Staff Reports**

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

### **Accounting Officer's responsibilities**

As explained more fully in the statement set out on page 91, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

### **Auditor's responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities).

## **REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

### **Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

### **Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

### **Statutory reporting matters**

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

### **THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES**

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

### **CERTIFICATE OF COMPLETION OF THE AUDIT**

We certify that we have completed the audit of the accounts of Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



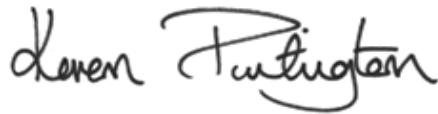
Timothy Cutler  
**for and on behalf of KPMG LLP**  
*Chartered Accountants*  
1 St Peter's Square,  
Manchester  
M2 3AE

28 June 2021

## Foreword to the accounts

### Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Lancashire Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



**Signed**

**Name** Karen Partington  
**Job title** Chief Executive  
**Date** 10 June 2021

## Consolidated Statement of Comprehensive Income

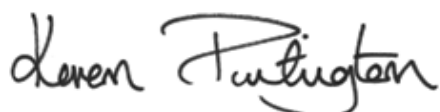
		Group	
	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2	560,542	484,994
Other operating income	2.5	122,864	60,678
Operating expenses	3	<u>(681,521)</u>	<u>(589,545)</u>
<b>Operating deficit from continuing operations</b>		<b><u>1,885</u></b>	<b><u>(43,873)</u></b>
Finance income	7.1	63	188
Finance expenses	7	(362)	(4,712)
PDC dividends payable		<u>(7,701)</u>	<u>(1,203)</u>
<b>Net finance costs</b>		<b><u>(8,000)</u></b>	<b><u>(5,727)</u></b>
Other gains	7.4	80	42
<b>Deficit for the year</b>		<b><u>(6,035)</u></b>	<b><u>(49,558)</u></b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Impairments	4	(4,178)	(1,596)
Revaluations		398	2,955
<b>Total comprehensive expense for the period</b>		<b><u>(9,815)</u></b>	<b><u>(48,199)</u></b>
<b>Deficit for the period attributable to:</b>			
Lancashire Teaching Hospitals NHS Foundation Trust		<u>(6,035)</u>	<u>(49,558)</u>
<b>TOTAL</b>		<b><u>(6,035)</u></b>	<b><u>(49,558)</u></b>
<b>Total comprehensive expense for the period attributable to:</b>			
Lancashire Teaching Hospitals NHS Foundation Trust		<u>(9,815)</u>	<u>(48,199)</u>
<b>TOTAL</b>		<b><u>(9,815)</u></b>	<b><u>(48,199)</u></b>

In accordance with Trust accounting policies the land and buildings of the Trust were revalued resulting in impairments and reversals of previous impairments charged to expenditure. In 2019/20 the Trust qualified for £11million of Support Funding (see note 2.5 for more information), this was replaced with Top-up and reimbursement funding in 2020/21. Without these elements the surplus of the Trust would have been £2.1million (2019/20 £58.4million) as shown in the table below.

## Statements of Financial Position

	Note	Group		Trust	
		31 March	31 March	31 March	31 March
		2021	2020	2021	2020
		£000	£000	£000	£000
<b>Non-current assets</b>					
Intangible assets	8	4,415	3,454	4,415	3,454
Property, plant and equipment	9	303,019	265,766	303,019	265,757
Receivables	11	8,024	8,501	9,024	8,501
Other assets		-	-	-	-
<b>Total non-current assets</b>		<b>315,458</b>	<b>277,721</b>	<b>316,458</b>	<b>277,712</b>
<b>Current assets</b>					
Inventories	10	15,088	15,786	14,275	14,163
Receivables	11	29,924	37,521	28,460	35,699
Cash and cash equivalents	12	58,832	7,108	58,409	6,855
<b>Total current assets</b>		<b>103,844</b>	<b>60,415</b>	<b>101,144</b>	<b>56,717</b>
<b>Current liabilities</b>					
Trade and other payables	13	(92,193)	(56,585)	(90,493)	(52,648)
Borrowings	15	(4,116)	(221,155)	(4,116)	(221,155)
Provisions	17	(703)	(526)	(703)	(526)
Other liabilities	14	(13,497)	(6,207)	(13,497)	(6,207)
<b>Total current liabilities</b>		<b>(110,509)</b>	<b>(284,473)</b>	<b>(108,809)</b>	<b>(280,536)</b>
<b>Total assets less current liabilities</b>		<b>308,793</b>	<b>53,663</b>	<b>308,793</b>	<b>53,893</b>
<b>Non-current liabilities</b>					
Trade and other payables	13	-	-	-	-
Borrowings	15	(7,391)	(10,775)	(7,391)	(10,775)
Other financial liabilities		-	-	-	-
Provisions	17	(3,069)	(3,287)	(3,069)	(3,287)
Other liabilities	14	-	-	-	-
<b>Total non-current liabilities</b>		<b>(10,460)</b>	<b>(14,062)</b>	<b>(10,460)</b>	<b>(14,062)</b>
<b>Total assets employed</b>		<b>298,333</b>	<b>39,601</b>	<b>298,333</b>	<b>39,831</b>
<b>Financed by</b>					
Public dividend capital		496,896	228,579	496,896	228,579
Revaluation reserve		41,783	46,713	41,783	46,713
Income and expenditure reserve		(240,346)	(235,691)	(240,346)	(235,461)
<b>Total taxpayers' equity</b>		<b>298,333</b>	<b>39,601</b>	<b>298,333</b>	<b>39,831</b>

The notes on pages 270 to 305 form part of these accounts.



Name: **Karen Partington**

Position: **Chief Executive**

Date: **10 June 2021**



**Consolidated Statement of Changes in Equity for the year ended 31 March 2021**

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2020</b>	<b>228,579</b>	<b>46,713</b>	<b>(235,461)</b>	<b>39,831</b>
Deficit for the year	-	-	(6,035)	(6,035)
Other transfers between reserves	-	(1,150)	1,150	-
Impairments	-	(4,178)	-	(4,178)
Revaluations	-	398	-	398
Other recognised gains and losses	-	-	-	-
Public dividend capital received	268,317	-	-	268,317
<b>Taxpayers' and others' equity at 31 March 2021</b>	<b>496,896</b>	<b>41,783</b>	<b>(240,346)</b>	<b>298,333</b>

**Consolidated Statement of Changes in Equity for the year ended 31 March 2020**

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2019</b>	<b>224,782</b>	<b>46,450</b>	<b>(186,999)</b>	<b>84,233</b>
Deficit for the year	-	-	(49,558)	(49,558)
Other transfers between reserves	-	(1,096)	1,096	-
Impairments	-	(1,596)	-	(1,596)
Revaluations	-	2,955	-	2,955
Other recognised gains and losses	-	-	-	-
Public dividend capital received	3,797	-	-	3,797
<b>Taxpayers' and others' equity at 31 March 2020</b>	<b>228,579</b>	<b>46,713</b>	<b>(235,461)</b>	<b>39,831</b>

**Consolidated Statement of Changes in Equity for the year ended 31 March 2021**

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
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Deficit for the year	-	-	(6,035)	(6,035)
Other transfers between reserves	-	(1,150)	1,150	-
Impairments	-	(4,178)	-	(4,178)
Revaluations	-	398	-	398
Other recognised gains and losses	-	-	-	-
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**Consolidated Statement of Changes in Equity for the year ended 31 March 2020**

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2019</b>	<b>224,782</b>	<b>46,450</b>	<b>(186,999)</b>	<b>84,233</b>
Deficit for the year	-	-	(49,558)	(49,558)
Other transfers between reserves	-	(1,096)	1,096	-
Impairments	-	(1,596)	-	(1,596)
Revaluations	-	2,955	-	2,955
Other recognised gains and losses	-	-	-	-
Public dividend capital received	3,797	-	-	3,797
<b>Taxpayers' and others' equity at 31 March 2020</b>	<b>228,579</b>	<b>46,713</b>	<b>(235,461)</b>	<b>39,831</b>

## Statements of Cash Flows

	Note	Group		Trust	
		2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
<b>Cash flows from operating activities</b>					
Operating Surplus/(Deficit)		1,885	(43,873)	1,885	(43,873)
<b>Non-cash income and expense:</b>					
Depreciation and amortisation	3	16,387	15,565	16,387	15,565
Net impairments	4	11,866	2,314	11,866	2,314
Income recognised in respect of capital donations	3	(1,724)	(475)	(1,724)	(475)
(Increase)/decrease in receivables and other assets		6,531	(7,528)	6,995	(5,706)
(Increase) in inventories		(925)	(2,677)	(112)	(1,002)
Increase in payables and other liabilities		32,700	3,629	31,000	484
Increase/(decrease) in provisions		(41)	1,500	(41)	1,500
<b>Net cash flows from / (used in) operating activities</b>		<b>66,679</b>	<b>(31,545)</b>	<b>66,256</b>	<b>(31,193)</b>
<b>Cash flows from investing activities</b>					
Interest received		63	188	63	188
Purchase of intangible assets		(1,984)	(670)	(1,984)	(670)
Purchase of PPE and investment property		(53,294)	(24,930)	(53,294)	(24,930)
Sales of PPE and investment property		80	53	80	53
Receipt of cash donations to purchase assets		881	475	881	475
<b>Net cash flows from / (used in) investing activities</b>		<b>(54,254)</b>	<b>(24,884)</b>	<b>(54,254)</b>	<b>(24,884)</b>
<b>Cash flows from financing activities</b>					
Public dividend capital received		268,317	3,797	268,317	3,797
Movement on loans from DHSC		(219,508)	63,552	(219,508)	63,552
Movement on other loans		304	111	304	111
Capital element of finance lease rental payments		(515)	(803)	(515)	(803)
Interest on loans		(1,010)	(4,382)	(1,010)	(4,382)
Other interest		(1)	(3)	(1)	(3)
Interest paid on finance lease liabilities		(55)	(110)	(55)	(110)
PDC dividend paid		(7,980)	(1,606)	(7,980)	(1,606)
<b>Net cash flows from financing activities</b>		<b>39,552</b>	<b>60,556</b>	<b>39,552</b>	<b>60,556</b>
<b>Increase / (decrease) in cash and cash equivalents</b>		<b>51,977</b>	<b>4,127</b>	<b>51,554</b>	<b>4,479</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>		<b>7,108</b>	<b>2,981</b>	<b>6,855</b>	<b>2,376</b>
<b>Cash and cash equivalents at 31 March</b>	12	<b>59,085</b>	<b>7,108</b>	<b>58,409</b>	<b>6,855</b>

## **1 Accounting policies and other information**

### **1.1 Basis of preparation**

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

### **1.2 Accounting convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### **1.3 Going concern**

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

New guidance from the Department of Health and Social care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.

The Trust recorded a significant deficit for 2019/20 and was expecting to enter 2020/21 with a plan for a further large deficit. However the Coronavirus pandemic has resulted in emergency funding arrangements being put into place by the Department of Health and Social Care. These have had the effect of ensuring that the Trust will receive sufficient funding for the duration of the pandemic, effectively to achieve breakeven for this period. Currently these arrangements continue to be in place from 1st April 2021 to 30th September 2021, and guidance will be published in due course about how the plan for the remainder of the 2020/21 financial year will be prepared and implemented.

The Trust's working capital loans were frozen as of 31st March 2020, and were replaced by Public Dividend Capital as at that date, in a transaction that took place in September 2020. This means that the Trust no longer faces uncertainty regarding repayment of these previous temporary financing arrangements. The new arrangement also provides for further PDC advances rather than loans to Trusts in financial distress which gives greater confidence for the Trust's funding arrangements in coming years.

It is clear that outside of the pandemic response the Trust remains in a deficit position and will need to work with its partners across the local healthcare system to achieve efficiencies, maximise the use of its assets and sustainable financial balance. The Trust will work with NHS Improvement (NHSI) and its stakeholders to achieve this objective.

In addition to the matters referred to above, the Trust has not been informed by NHSI that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

#### **1.4 Consolidation**

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The Trust is corporate trustee of the Lancashire Teaching Hospitals NHS Foundation Trust Charity and the Rosemere Cancer Foundation Charity. The Trust has assessed its relationship to the charitable funds and determined them to be subsidiaries because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and the ability to affect those returns and other benefits through its power over the funds. However the combined charitable funds are not material to the Trust and therefore consolidation is not required.

The Trust is sole owner of Lancashire Hospitals Services (Pharmacy) Limited, a company dispensing prescription drugs to Trust patients. The company has traded throughout the 2020/21 financial year. As sole owner the company therefore constitutes a subsidiary of the Trust and the financial results of the company through the financial year have been consolidated with the Trust to form the Group.

#### **1.5 Segmental reporting**

An operating segment is a component of the Trust that engages in activities from which it may earn revenues and incur expenses, including revenues and expenses that relate to transactions with any of the the Trust's other components.

The chief operating decision maker for the Trust is the Board of Directors. The Board receives the monthly financial reports for the whole Trust and subsidiary information relating to income and divisional expenses. The board makes decisions based on the effect on the monthly financial statements.

The single segment of Healthcare has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

#### **1.6 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods or services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods or services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

**Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services.

While accounting policies for revenue recognition and the application of IFRS 15 are consistently applied, the contracting arrangements in the NHS changed between 2019-20 and 2020-21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

In 2020-21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level.

The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

**Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

**NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations have been satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

**Grants and donations**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider the corresponding notional expense is also recognised at the point of recognition for the benefit.

### **1.8 Other Income**

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Other income includes income from car parking and catering which is recognised at the point of receipt of cash consideration.

### **1.9 Expenditure on employee benefits**

#### **Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

#### **Pension costs**

##### **NHS Pension Scheme**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

### **1.10 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### **1.11 Property, Plant and Equipment**

#### **Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

## **Measurement**

### *Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

As directed by HM Treasury, the Trust has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use.

The land and buildings of the Trust have been revalued as at 31st March 2021 by Cushman & Wakefield Ltd. The valuation is based on rules issued by RICS, interpreted in accordance with Trust accounting policies and DH guidance. There have been no changes in the estimation techniques used by the valuers since the last valuation, but see note 1.25 for more explanation of this.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

### *Subsequent expenditure*

Subsequent expenditure relating to an item or property, plant and equipment is recognised as an increase to the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### *Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

### *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

### *Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

### **De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales:
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed as a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

### **Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.



### Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	80
Plant & machinery	1	15
Transport equipment	6	7
Information technology	1	12
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

## 1.12 Intangible assets

### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

#### *Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

#### *Software*

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS40 or IFRS 5

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell

#### *Amortisation*

Intangible assets are amortised over their expected lives in a manner consistent with the consumption of economic or service delivery benefits

#### **Useful lives of intangible assets**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	<b>Min life Years</b>	<b>Max life Years</b>
Software licences	1	10

### **1.13 Inventories**

Inventories are valued at the lower of cost and net realisable value.

### **1.14 Financial assets and financial liabilities**

#### *Recognition*

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

#### *Classification and Measurement*

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

#### ***Financial assets and financial liabilities at amortised cost***

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

#### ***Impairment of financial assets***

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

#### ***Derecognition***

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### **1.15 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

#### **The Trust as lessee**

##### ***Finance Leases***

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

### *Operating Leases*

Operating lease payments are recognised as an expense on a straight line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight line basis over the lease term

### *Leases of land and buildings*

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

### **The trust as a lessor**

#### *Operating Leases*

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

## **1.16 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021.

### **Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 17 but is not recognised in the Trust's accounts.

### **Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

## **1.17 Contingencies**

Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, and are not recognised as assets but are disclosed in the notes to the financial statements where an inflow of economic benefit is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise they are not recognised, but are disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

### **1.18 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### **1.19 Value Added Tax**

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### **1.20 Corporation tax**

The Trust is a health service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (S519A(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare.

### **1.21 Foreign exchange**

The functional and presentational currency of the trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Any resulting exchange gains or losses are recognised in income or expense in the period in which they arise.

### **1.22 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FRoM.

### **1.23 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

#### **1.24 Critical judgements in applying accounting policies**

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

#### **1.25 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The revaluations of hospitals have been carried out by Cushman & Wakefield, who have applied the modern equivalent asset valuation. This approach assumes that the asset would have been replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may well be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assessment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financial year that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 9.

#### **1.26 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

#### **1.27 Standards, amendments and interpretations in issue but not yet effective or adopted**

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under old standards of whether existing contracts contain a lease

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

#### **IFRS 16 Leases**

The trust has not estimated the impact of applying IFRS 16 in 2021/22 given the difficulties of accurate forecasting that far in advance however, the impact is not expected to be material.

## 2 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.

2.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
<b>Acute services</b>		
Block contract/system envelope income	502,278	288,059
High cost drugs income from commissioners	40,116	29,709
Other NHS clinical income	209	148,960
<b>All trusts</b>		
Private patient and overseas income	653	599
Additional pension contribution central funding*	15,341	14,079
Other clinical income	1,945	3,588
<b>Total income from activities</b>	<b><u>560,542</u></b>	<b><u>484,994</u></b>

\* The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20 and 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

## 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21	2019/20
	£000	£000
NHS England	195,203	185,332
Clinical commissioning groups	362,531	295,005
Department of Health and Social Care	19	74
Other NHS providers	209	201
NHS other	-	141
Local authorities	-	-
Non-NHS: private patients	59	342
Non-NHS: overseas patients (chargeable to patient)	595	257
Injury cost recovery scheme	1,926	3,479
Non NHS: other	-	163
<b>Total income from activities</b>	<b><u>560,542</u></b>	<b><u>484,994</u></b>
<b>Of which:</b>		
Related to continuing operations	560,542	484,994
Related to discontinued operations	-	-

During the pandemic in 2020/21, the usual funding via commissioners ceased and an emergency funding arrangement was introduced. This was delivered in two stages; a format for Q1/Q2 which gave Trusts block allocations and then the ability to spend as needed and be retrospectively reimbursed to breakeven; and Q3/Q4 which gave Trusts block allocations and then provided secondary ICS growth and covid allocations for ICS to manage and determine across their economy. This has caused a significant increase in income, expenditure and capital compared to previous years.

## 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	£000
Income recognised this year	595	257
Cash payments received in-year	45	73
Amounts added to provision for impairment of receivables	477	-
Amounts written off in-year	605	51

The above note relates to the treatment of overseas visitors charges directly by the Trust in accordance with Guidance on implementing the overseas regulations 2015 issued by the Department of Health and Social Care.

Amounts written off in-year 2020/21: 215 customers (2019/20: 29 customers)



## 2.4 Commissioner and non-commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that the commissioners believe would need to be provided in the event of provider failure. This information is

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Income from services designated as commissioner requested services	557,734	480,337

## 2.5 Other operating income (Group)

	<b>2020/21</b>	<b>2019/20</b>
	<b>Contract</b>	<b>Contract</b>
	<b>£000</b>	<b>£000</b>
<b>Other operating income from contracts with customers</b>		
Research and development	2,004	2,591
Education and training	20,906	22,100
Non-patient care services to other bodies	5,248	6,763
Support funding including PSF, FRF and MRET	-	11,048
Reimbursement and top up funding	72,333	-
Income in respect of employee benefits accounted on a gross basis	-	-
Other income**	9,841	17,701
<b>Other non-contract operating income</b>		
Receipt of capital donations	1,724	475
Contributions to expenditure - equipment and consumables donated for the Covid Response	10,808	-
<b>Total other operating income</b>	<b>122,864</b>	<b>60,678</b>
<b>Of which:</b>		
Related to continuing operations	<b>122,864</b>	60,678
Related to discontinued operations	-	-

\* In 2019/20 the Trust received income from each of the Provider Sustainability Fund (PSF), the Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff (MRET) funding, together known as support funding. Emergency funds distributed to support the trust during the pandemic have replaced these sources and are shown as reimbursement and top up funding above.

The £72.3m of income relates to the £66.7m of top up allocation received by the Trust via the new funding regime and £5.6m of income reimbursement for covid vaccination related costs.

\*\* Items within other income that exceed £1m include:

	<b>£000</b>	<b>£000</b>
Pharmaceutical sales	1,945	2,529
Car Parking	381	4,339
Catering Income	747	1,322

### 3 Operating expenses (Group)

	2020/21	2019/20
	£000	£000
Staff and executive directors costs (see note 5.1)	433,139	381,875
Supplies and services - clinical (excluding drugs costs)	55,163	49,857
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	52,152	55,877
Premises	42,367	29,639
Clinical negligence	21,127	18,525
Depreciation on property, plant and equipment	15,364	14,400
Purchase of healthcare from non-NHS and non-DHSC bodies	14,054	14,971
Net impairments	11,866	2,314
Supplies and services - general	10,832	8,532
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	6,799	-
Establishment	5,782	3,384
Transport (including patient travel)	2,299	2,149
Other	2,108	1,010
Inventories written down	1,707	513
Amortisation on intangible assets	1,023	1,165
Legal fees	918	689
Inventories written down (consumables donated from DHSC group bodies for COVID response)	907	-
Education and training	886	1,465
Insurance	779	611
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	760	-
Rentals under operating leases	434	491
Movement in credit loss allowance: contract receivables / contract assets	280	286
Remuneration of non-executive directors	177	164
Increase in other provisions	156	381
Change in provisions discount rates	122	100
Internal audit costs	118	113
Audit fees payable to the external auditor		
audit services - statutory audit	95	79
other auditor remuneration (external auditor only)	-	-
Research and development	87	152
Consultancy costs	19	661
Redundancy	1	142
Purchase of healthcare from NHS and DHSC bodies	-	-
<b>Total</b>	<b>681,521</b>	<b>589,545</b>
<b>Of which:</b>		
Related to continuing operations	681,521	589,545
Related to discontinued operations	-	-

During the pandemic in 2020/21, the usual funding via commissioners ceased and an emergency funding arrangement was introduced. This was delivered in two stages; a format for Q1/Q2 which gave Trusts block allocations and then the ability to spend as needed and be retrospectively reimbursed to breakeven; and Q3/Q4 which gave Trusts block allocations and then provided secondary ICS growth and covid allocations for ICS to manage and determine across their economy. This has caused a significant increase in income, expenditure and capital compared to previous years.

### 3 Operating expenses (Trust)

	2020/21 £000	2019/20 £000
Staff and executive directors costs (see note 5.1)	432,351	381,875
Supplies and services - clinical (excluding drugs costs)	55,163	49,857
Drug costs (drugs inventory consumed and purchase of non-inventory)	53,061	55,877
Premises	42,310	29,639
Clinical negligence	21,127	18,525
Depreciation on property, plant and equipment	15,364	14,400
Purchase of healthcare from non-NHS and non-DHSC bodies	14,054	14,971
Net impairments	11,866	2,314
Supplies and services - general	10,822	8,532
Supplies and services – clinical: utilisation of consumables donated from Establishment	6,799	-
Internal audit costs	5,782	3,384
Internal audit costs	118	113
Transport (including patient travel)	2,299	2,149
Other	2,106	1,010
Inventories written down	1,707	513
Amortisation on intangible assets	1,023	1,165
Legal fees	911	689
Inventories written down (consumables donated from DHSC group bodies)	907	-
Education and training	886	1,465
Insurance	747	611
Supplies and services - general: notional cost of equipment donated from	760	-
Rentals under operating leases	434	491
Movement in credit loss allowance: contract receivables / contract assets	280	286
Remuneration of non-executive directors	177	164
Increase in other provisions	156	381
Change in provisions discount rates	122	100
Audit fees payable to the external auditor		
audit services - statutory audit	82	79
other auditor remuneration (external auditor only)	-	-
Research and development	87	152
Consultancy costs	19	661
Redundancy	1	142
Purchase of healthcare from NHS and DHSC bodies	-	-
<b>Total</b>	<b>681,521</b>	<b>589,545</b>
<b>Of which:</b>		
Related to continuing operations	681,521	589,545
Related to discontinued operations	-	-

### 3.1 Other auditor remuneration (Group)

	2020/21	2019/20
	£000	£000
<b>Other auditor remuneration paid to the external auditor:</b>		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
<b>Total</b>	<u>-</u>	<u>-</u>

### 3.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2019/20: £2m).

### 4 Impairment of assets (Group)

	2020/21	2019/20
	£000	£000
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Changes in market price	11,487	2,314
Impairments of charitable fund assets	-	-
Loss as a result of a catastrophe	379	-
Other	-	-
<b>Total net impairments charged to operating surplus / deficit</b>	<u>11,866</u>	<u>2,314</u>
Impairments charged to the revaluation reserve	<u>4,178</u>	<u>1,596</u>
<b>Total net impairments</b>	<u>16,044</u>	<u>3,910</u>

The impairment was significantly higher due to the large capital programme in 20/21.

### 5.1 Employee benefits (Group)

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	302,880	268,633
Social security costs	31,273	28,247
Apprenticeship levy	1,586	1,454
Employer's contributions to NHS pensions	50,463	46,261
Pension cost - other	176	161
Temporary staff (including agency)	46,761	37,119
<b>Total gross staff costs</b>	<u>433,139</u>	<u>381,875</u>
Recoveries in respect of seconded staff	-	-
<b>Total staff costs</b>	<u>433,139</u>	<u>381,875</u>
<b>Of which</b>		
Costs capitalised as part of assets	-	-

Employer's contributions to NHS Pensions includes the costs of the increased contribution rate referred to in note 2.1

### 5.2 Retirements due to ill-health (Group)

During 2020/21 there were 10 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £548k (£8k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension

### 5.3 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows.

#### **a) Accounting Valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous reporting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### **b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

## 6 Operating leases (Group)

	2020/21 £000	2019/20 £000
<b>Operating lease expense</b>		
Minimum lease payments	434	491
<b>Total</b>	<b>434</b>	<b>491</b>
	<b>31 March</b>	<b>31 March</b>
	<b>£000</b>	<b>£000</b>
<b>Future minimum lease payments due:</b>		
- not later than one year;	434	491
- later than one year and not later than five years;	-	-
- later than five years		
<b>Total</b>	<b>434</b>	<b>491</b>
Future minimum sublease payments to be received	-	-

## 7.1 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2020/21 £000	2019/20 £000
Interest on bank accounts	-	130
Other finance income	63	58
<b>Total finance income</b>	<b>63</b>	<b>188</b>

## 7.2 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2020/21 £000	2019/20 £000
<b>Interest expense:</b>		
Interim loans from the Department of Health and Social Care	217	4,278
Normal course of business loans from DHSC		273
Other loans	73	58
Finance leases	55	110
Interest on late payment of commercial debt	1	3
<b>Total interest expense</b>	<b>346</b>	<b>4,722</b>
Unwinding of discount on provisions	-	(10)
<b>Total finance costs</b>	<b>346</b>	<b>4,712</b>

## 7.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21 £000	2019/20 £000
Amounts included within interest payable arising from claims made under	1	3

## 7.4 Other gains (Group)

	2020/21 £000	2019/20 £000
Gains on disposal of assets	80	42
<b>Total gains on disposal of assets</b>	<b>80</b>	<b>42</b>
<b>Total other gains</b>	<b>80</b>	<b>42</b>

## 7.5 Trust income statement and statement of comprehensive expense

In accordance with section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for period was £6 million (2019/20 £49.6million). The Trust's total comprehensive expense for the period was £9.8million (2019/20 £48.2million).

## 8 Intangible assets 2020/21

Group & Trust	Software licences	Licences & trademarks	IT (internally generated and 3rd party)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
<b>Gross cost at 1 April 2020 - brought forward</b>	<b>16,214</b>	-	-	<b>272</b>	<b>16,486</b>
Additions	1,586	13	214	171	<b>1,984</b>
Transfers	203	-	-	(203)	-
<b>Gross cost at 31 March 2021</b>	<b>18,003</b>	<b>13</b>	<b>214</b>	<b>240</b>	<b>18,470</b>
<b>Amortisation at 1 April 2020 - brought forward</b>	<b>13,032</b>	-	-	-	<b>13,032</b>
Provided during the year	1,023	-	-	-	<b>1,023</b>
<b>Amortisation at 31 March 2021</b>	<b>14,055</b>	-	-	-	<b>14,055</b>
<b>Net book value at 31 March 2021</b>	<b>3,948</b>	<b>13</b>	<b>214</b>	<b>240</b>	<b>4,415</b>
<b>Net book value at 1 April 2020</b>	<b>3,182</b>	-	-	<b>272</b>	<b>3,454</b>

## Intangible assets 2019/20

Group & Trust	Software licences	Licences & trademarks	IT (internally generated and 3rd party)	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
<b>Gross cost at 1 April 2019 - brought forward</b>	<b>15,569</b>	-	-	-	<b>15,569</b>
Additions	645	-	-	272	<b>917</b>
<b>Gross cost at 31 March 2020</b>	<b>16,214</b>	-	-	<b>272</b>	<b>16,486</b>
<b>Amortisation at 1 April 2019 - brought forward</b>	<b>11,867</b>	-	-	-	<b>11,867</b>
Provided during the year	1,165	-	-	-	<b>1,165</b>
<b>Amortisation at 31 March 2020</b>	<b>13,032</b>	-	-	-	<b>13,032</b>
<b>Net book value at 31 March 2020</b>	<b>3,182</b>	-	-	<b>272</b>	<b>3,454</b>
<b>Net book value at 1 April 2019</b>	<b>3,702</b>	-	-	-	<b>3,702</b>

## 9 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Valuation/gross cost at 1 April 2020 -</b>	<b>20,395</b>	<b>192,989</b>	<b>7,888</b>	<b>115,239</b>	<b>205</b>	<b>43,573</b>	<b>1,656</b>	<b>381,945</b>
Additions	-	29,355	14,731	13,477	9	10,613	87	68,272
Impairments	-	(4,216)	-	-	-	-	-	(4,216)
Reversals of impairments	-	38	-	-	-	-	-	38
Revaluations	-	(16,366)	-	(583)	-	-	-	(16,949)
Disposals / derecognition	-	-	-	(63)	-	-	-	(63)
<b>Valuation/gross cost at 31 March 2021</b>	<b>20,395</b>	<b>201,800</b>	<b>22,619</b>	<b>128,070</b>	<b>214</b>	<b>54,186</b>	<b>1,743</b>	<b>429,027</b>
<b>Accumulated depreciation at 1 April 2020 -</b>	<b>-</b>	<b>2,276</b>	<b>-</b>	<b>79,027</b>	<b>163</b>	<b>33,156</b>	<b>1,557</b>	<b>116,179</b>
Provided during the year	-	5,571	-	6,547	12	3,222	21	15,364
Impairments	-	11,487	-	379	-	-	-	11,866
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	-	(16,764)	-	(583)	-	-	-	(17,347)
Disposals / derecognition	-	-	-	(63)	-	-	-	(63)
<b>Accumulated depreciation at 31 March</b>	<b>-</b>	<b>2,570</b>	<b>-</b>	<b>85,307</b>	<b>175</b>	<b>36,378</b>	<b>1,578</b>	<b>125,999</b>
<b>Net book value at 31 March 2021</b>	<b>20,395</b>	<b>199,230</b>	<b>22,619</b>	<b>42,763</b>	<b>39</b>	<b>17,808</b>	<b>165</b>	<b>303,019</b>
<b>Net book value at 1 April 2020</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>99</b>	<b>265,766</b>
<b>Net book value at 31 March 2021</b>								
Owned - purchased	20,395	197,534	22,598	40,086	36	17,455	165	298,269
Finance leased	-	292	-	-	-	-	-	292
Owned - donated	-	1,404	21	2,677	3	353	-	4,458
<b>NBV total at 31 March 2021</b>	<b>20,395</b>	<b>199,230</b>	<b>22,619</b>	<b>42,763</b>	<b>39</b>	<b>17,808</b>	<b>165</b>	<b>303,019</b>



## 9 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Trust</b>								
<b>Valuation/gross cost at 1 April 2020 -</b>	<b>20,395</b>	<b>192,989</b>	<b>7,888</b>	<b>115,239</b>	<b>205</b>	<b>43,573</b>	<b>1,647</b>	<b>381,936</b>
Additions	-	29,355	14,731	13,477	9	10,613	87	68,272
Impairments	-	(4,216)	-	-	-	-	-	(4,216)
Reversals of impairments	-	38	-	-	-	-	-	38
Revaluations	-	(16,366)	-	(583)	-	-	-	(16,949)
Disposals / derecognition	-	-	-	(63)	-	-	-	(63)
<b>Valuation/gross cost at 31 March 2021</b>	<b>20,395</b>	<b>201,800</b>	<b>22,619</b>	<b>128,070</b>	<b>214</b>	<b>54,186</b>	<b>1,734</b>	<b>429,018</b>
<b>Accumulated depreciation at 1 April 2020 -</b>	-	<b>2,276</b>	-	<b>79,027</b>	<b>163</b>	<b>33,156</b>	<b>1,557</b>	<b>116,179</b>
Provided during the year	-	5,571	-	6,547	12	3,222	12	15,364
Impairments	-	11,487	-	379	-	-	-	11,866
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	-	(16,764)	-	(583)	-	-	-	(17,347)
Disposals / derecognition	-	-	-	(63)	-	-	-	(63)
<b>Accumulated depreciation at 31 March</b>	-	<b>2,570</b>	-	<b>85,307</b>	<b>175</b>	<b>36,378</b>	<b>1,569</b>	<b>125,999</b>
<b>Net book value at 31 March 2021</b>	<b>20,395</b>	<b>199,230</b>	<b>22,619</b>	<b>42,763</b>	<b>39</b>	<b>17,808</b>	<b>165</b>	<b>303,019</b>
<b>Net book value at 1 April 2020</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>90</b>	<b>265,757</b>
<b>Net book value at 31 March 2021</b>								
Owned - purchased	20,395	197,534	22,598	40,086	36	17,455	165	298,269
Finance leased	-	292	-	-	-	-	-	292
Owned - donated	-	1,404	21	2,677	3	353	-	4,458
<b>NBV total at 31 March 2021</b>	<b>20,395</b>	<b>199,230</b>	<b>22,619</b>	<b>42,763</b>	<b>39</b>	<b>17,808</b>	<b>165</b>	<b>303,019</b>

## 9 Property, plant & equipment - 2019/20

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Valuation / gross cost at 1 April 2019 - as</b>	<b>21,830</b>	<b>189,126</b>	<b>1,986</b>	<b>107,527</b>	<b>205</b>	<b>40,062</b>	<b>1,584</b>	<b>362,311</b>
Additions	-	8,342	5,902	8,498	-	3,511	72	26,325
Impairments	(1,950)	(738)	-	-	-	-	-	(2,688)
Reversals of impairments	332	1,092	-	-	-	-	-	1,424
Revaluations	183	(4,833)	-	-	-	-	-	(4,650)
Disposals / derecognition	-	-	-	(786)	-	-	-	(786)
<b>Valuation/gross cost at 31 March 2020</b>	<b>20,395</b>	<b>192,989</b>	<b>7,888</b>	<b>115,239</b>	<b>205</b>	<b>43,573</b>	<b>1,656</b>	<b>381,936</b>
<b>Accumulated depreciation at 1 April 2019 -</b>	<b>-</b>	<b>2,042</b>	<b>-</b>	<b>73,157</b>	<b>147</b>	<b>30,617</b>	<b>1,550</b>	<b>107,513</b>
Provided during the year	-	5,193	-	6,645	16	2,539	7	14,400
Impairments	-	4,074	-	-	-	-	-	4,074
Reversals of impairments	-	(1,428)	-	-	-	-	-	(1,428)
Revaluations	-	(7,605)	-	-	-	-	-	(7,605)
Disposals / derecognition	-	-	-	(775)	-	-	-	(775)
<b>Accumulated depreciation at 31 March</b>	<b>-</b>	<b>2,276</b>	<b>-</b>	<b>79,027</b>	<b>163</b>	<b>33,156</b>	<b>1,557</b>	<b>116,179</b>
<b>Net book value at 31 March 2020</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>99</b>	<b>265,757</b>
<b>Net book value at 1 April 2019</b>	<b>21,830</b>	<b>187,084</b>	<b>1,986</b>	<b>34,370</b>	<b>58</b>	<b>9,445</b>	<b>34</b>	<b>254,798</b>
<b>Net book value at 31 March 2020</b>								
Owned - purchased	20,395	189,047	7,866	34,231	37	10,417	99	262,083
Finance leased	-	525	-	-	-	-	-	525
Owned - donated	-	1,141	22	1,981	5	-	-	3,149
<b>NBV total at 31 March 2020</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>99</b>	<b>265,757</b>

## 9 Property, plant & equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
<b>Trust</b>								
<b>Valuation / gross cost at 1 April 2019 - as</b>	<b>21,830</b>	<b>189,126</b>	<b>1,986</b>	<b>107,527</b>	<b>205</b>	<b>40,062</b>	<b>1,575</b>	<b>362,311</b>
Additions	-	8,342	5,902	8,498	-	3,511	72	26,325
Impairments	(1,950)	(738)	-	-	-	-	-	(2,688)
Reversals of impairments	332	1,092	-	-	-	-	-	1,424
Revaluations	183	(4,833)	-	-	-	-	-	(4,650)
Disposals / derecognition	-	-	-	(786)	-	-	-	(786)
<b>Valuation/gross cost at 31 March 2020</b>	<b>20,395</b>	<b>192,989</b>	<b>7,888</b>	<b>115,239</b>	<b>205</b>	<b>43,573</b>	<b>1,647</b>	<b>381,936</b>
<b>Accumulated depreciation at 1 April 2019 -</b>	<b>-</b>	<b>2,042</b>	<b>-</b>	<b>73,157</b>	<b>147</b>	<b>30,617</b>	<b>1,550</b>	<b>107,513</b>
Provided during the year	-	5,193	-	6,645	16	2,539	7	14,400
Impairments	-	4,074	-	-	-	-	-	4,074
Reversals of impairments	-	(1,428)	-	-	-	-	-	(1,428)
Revaluations	-	(7,605)	-	-	-	-	-	(7,605)
Disposals / derecognition	-	-	-	(775)	-	-	-	(775)
<b>Accumulated depreciation at 31 March</b>	<b>-</b>	<b>2,276</b>	<b>-</b>	<b>79,027</b>	<b>163</b>	<b>33,156</b>	<b>1,557</b>	<b>116,179</b>
<b>Net book value at 31 March 2020</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>90</b>	<b>265,757</b>
<b>Net book value at 1 April 2019</b>	<b>21,830</b>	<b>187,084</b>	<b>1,986</b>	<b>34,370</b>	<b>58</b>	<b>9,445</b>	<b>25</b>	<b>254,798</b>
<b>Net book value at 31 March 2019</b>								
Owned - purchased	20,395	189,047	7,866	34,231	37	10,417	90	262,083
Finance leased	-	525	-	-	-	-	-	525
Owned - donated	-	1,141	22	1,981	5	-	-	3,149
<b>NBV total at 31 March 2019</b>	<b>20,395</b>	<b>190,713</b>	<b>7,888</b>	<b>36,212</b>	<b>42</b>	<b>10,417</b>	<b>90</b>	<b>265,757</b>

## 10 Inventories

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Drugs	2,562	4,332	1,749	2,709
Work In progress	-	-	-	-
Consumables	10,069	11,328	10,069	11,328
Energy	115	126	115	126
Consumables donated from DHSC group bodies	2,342	-	2,342	-
<b>Total inventories</b>	<b>15,088</b>	<b>15,786</b>	<b>14,275</b>	<b>14,163</b>
<b>of which:</b>				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £62,717k (2019/20: £68,041k). Write-down of inventories recognised as expenses for the year were £2,614k (2019/20: £513k).

## 11 Receivables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
<b>Current</b>				
Contract receivables	24,598	29,878	24,598	29,878
Contract assets	35	2,279	35	2,279
Allowance for impaired contract receivables/assets	(2,565)	(2,993)	(2,565)	(2,993)
Prepayments	2,736	2,493	2,699	2,479
PDC dividend receivable	671	392	671	392
VAT receivable	1,677	2,810	250	1,002
Other receivables	2,772	2,662	2,772	2,662
<b>Total current receivables</b>	<b>29,924</b>	<b>37,521</b>	<b>28,460</b>	<b>35,699</b>
<b>Non-current</b>				
Contract assets	7,096	7,929	7,096	7,929
Allowance for other impaired receivables	(1,592)	(1,728)	(1,592)	(1,728)
Other receivables	2,520	2,300	3,520	2,300
<b>Total non-current receivables</b>	<b>8,024</b>	<b>8,501</b>	<b>9,024</b>	<b>8,501</b>
<b>Of which receivable from NHS and DHSC group bodies:</b>				
Current	18,675	24,395	18,675	24,395
Non-current	1,520	1,300	1,520	1,300

## 11.1 Allowances for credit losses

2020/21	<b>Group</b>	<b>All other receivables</b>	<b>Trust</b>	<b>All other receivables</b>
	<b>Contract receivables and contract assets</b>		<b>Contract receivables and contract assets</b>	
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Allowances as at 1 Apr 2020 - restated</b>	<b>4,721</b>	-	<b>4,721</b>	-
New allowances arising	1,778	-	1,778	-
Changes in existing allowances	(97)	-	(97)	-
Reversals of allowances	(1,401)	-	(1,401)	-
Utilisation of allowances (write offs)	(844)	-	(844)	-
<b>Allowances as at 31 Mar 2020</b>	<b>4,157</b>	-	<b>4,157</b>	-
<b>2019/20</b>	<b>Group</b>	<b>All other receivables</b>	<b>Trust</b>	<b>All other receivables</b>
	<b>Contract receivables and contract assets</b>		<b>Contract receivables and contract assets</b>	
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Allowances as at 1 Apr 2019 - brought forward</b>	<b>4,192</b>	-	<b>4,192</b>	-
New allowances arising	301	-	301	-
Changes in existing allowances	(11)	-	(11)	-
Reversals of allowances	(4)	-	(4)	-
Utilisation of allowances (write offs)	243	-	243	-
<b>Allowances as at 31 Mar 2021</b>	<b>4,721</b>	-	<b>4,721</b>	-

## 12 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
<b>At 1 April</b>	<b>6,855</b>	<b>2,981</b>	<b>6,855</b>	<b>2,376</b>
Net change in year	51,977	4,127	51,554	4,479
<b>At 31 March</b>	<b>58,832</b>	<b>7,108</b>	<b>58,409</b>	<b>6,855</b>
<b>Broken down into:</b>				
Cash at commercial banks and in hand	16	18	16	18
Cash with the Government Banking Service	58,816	7,090	58,393	6,837
<b>Total cash and cash equivalents as in SoFP</b>	<b>58,832</b>	<b>7,108</b>	<b>58,409</b>	<b>6,855</b>
<b>Total cash and cash equivalents as in SoCF</b>	<b>58,832</b>	<b>7,108</b>	<b>58,409</b>	<b>6,855</b>

## 13 Trade and other payables

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
	<b>Current</b>			
Trade payables	15,076	13,185	15,076	9,283
Capital payables	26,841	12,706	26,841	12,706
Accruals	28,260	16,813	27,795	16,778
Annual leave accrual	8,119	1,327	8,119	1,327
Social security costs	4,327	3,923	4,327	3,923
Other taxes payable	4,001	3,532	4,001	3,532
PDC dividend payable	-	-	-	-
Other payables	5,569	5,099	4,334	5,099
<b>Total current trade and other payables</b>	<b>92,193</b>	<b>56,585</b>	<b>90,493</b>	<b>52,648</b>
<b>Of which payables from NHS and DHSC group bodies:</b>				
Current	8,600	6,698		
Non-current	-	-		

Included in Accruals in 2020/21 are costs relating to the Flowers ruling, international nursing recruitment and associated visa costs.

## 14 Other liabilities

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
<b>Current</b>				
Deferred income: contract liabilities	13,497	6,207	13,497	6,207
<b>Total other current liabilities</b>	<b>13,497</b>	<b>6,207</b>	<b>13,497</b>	<b>6,207</b>

## 15 Borrowings

	Group & Trust	
	31 March	31 March
	£000	£000
<b>Current</b>		
Loans from DHSC	3,394	220,249
Other loans	342	390
Obligations under finance leases	380	516
<b>Total current borrowings</b>	<b>4,116</b>	<b>221,155</b>
<b>Non-current</b>		
Loans from DHSC	6,611	9,987
Other loans	680	308
Obligations under finance leases	100	480
<b>Total non-current borrowings</b>	<b>7,391</b>	<b>10,775</b>

All interim loans outstanding at 31st March 2020 were repaid by means of an advance of PDC during 2020/21. The transaction was dated as at 31st March 2020 so that interest on loans and PDC dividend were calculated on the basis that the PDC was in place for the full year, and loans were not.

### Reconciliation of liabilities arising from financing activities (Group & Trust)

2020/21	Loans from		Finance	Total
	DHSC	Other loans	leases	
	£000	£000	£000	£000
<b>Carrying value at 1 April 2020</b>	<b>230,236</b>	<b>698</b>	<b>996</b>	<b>231,930</b>
<b>Cash movements:</b>				
Financing cash flows - payments and receipts of principal	(219,508)	304	(515)	(219,719)
Financing cash flows - payments of interest	(940)	(70)	(55)	(1,065)
<b>Non-cash movements:</b>				
Application of effective interest rate	217	73	55	345
Other changes	-	17	(1)	16
<b>Carrying value at 31 March 2021</b>	<b>10,005</b>	<b>1,022</b>	<b>480</b>	<b>11,507</b>
<b>2019/20</b>				
	<b>DHSC</b>	<b>Other loans</b>	<b>Finance</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
<b>Carrying value at 1 April 2019</b>	<b>166,454</b>	<b>587</b>	<b>1,799</b>	<b>168,840</b>
<b>Cash movements:</b>				
Financing cash flows - payments and receipts of principal	63,552	111	(803)	62,860
Financing cash flows - payments of interest	(4,321)	(61)	(110)	(4,492)
<b>Non-cash movements:</b>				
Application of effective interest rate	4,551	58	110	4,719
Other changes	-	3	-	3
<b>Carrying value at 31 March 2020</b>	<b>230,236</b>	<b>698</b>	<b>996</b>	<b>231,930</b>

## 16 Finance Leases

### Lancashire Teaching Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group & Trust	
	31 March	31 March
	2021	2020
	£000	£000
<b>Gross lease liabilities</b>	<b>506</b>	<b>1,077</b>
of which liabilities are due:		
- not later than one year;	406	570
- later than one year and not later than five years;	100	507
Finance charges allocated to future periods	(26)	(81)
<b>Net lease liabilities</b>	<b>480</b>	<b>996</b>
of which payable:		
- not later than one year;	380	516
- later than one year and not later than five years;	100	480

## 17 Provisions for liabilities and charges analysis - Group & Trust

	Other	Total
	£000	£000
<b>At 1 April 2020</b>	<b>3,813</b>	<b>3,813</b>
Change in the discount rate	122	122
Arising during the year	376	376
Utilised during the year	(250)	(250)
Reversed unused	(289)	(289)
Unwinding of discount	-	-
<b>At 31 March 2021</b>	<b>3,772</b>	<b>3,772</b>
<b>Expected timing of cash flows:</b>		
- not later than one year;	703	703
- later than one year and not later than five years;	3,069	3,069
- later than five years.	-	-
<b>Total</b>	<b>3,772</b>	<b>3,772</b>

### Clinical Negligence Liabilities

At 31 March 2021, £350,094k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2020: £345,889k).

### Permanent Injury Benefit

Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

### Clinicians Pension Tax

Clinicians who were members of the NHS Pensions Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of growth of their NHS pension benefits above their pensions savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.

The Trust has been required to make a contractually binding commitment to pay them a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement.

The Trust has created a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This is offset by a receivables balance from NHS England as there has been a commitment by the Government to fund the payments to clinicians as and when they arise.



## 18 Contingent assets and liabilities

	Group & Trust	
	31 March 2021 £000	31 March 2020 £000
<b>Value of contingent liabilities</b>		
NHS Resolution legal claims	(125)	(166)
<b>Gross value of contingent liabilities</b>	<b>(125)</b>	<b>(166)</b>
Amounts recoverable against liabilities	-	-
<b>Net value of contingent liabilities</b>	<b>(125)</b>	<b>(166)</b>
<b>Net value of contingent assets</b>	<b>-</b>	<b>-</b>

## 19 Post Balance Sheet Events

There are no post balance sheet events

## 20 Contractual capital commitments

	Group & Trust	
	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	5,721	27,337
<b>Total</b>	<b>5,721</b>	<b>27,337</b>

The contractual commitments represent the outstanding Ophthalmology and Critical Care schemes.

## 21 Related Party Transactions

Lancashire Teaching Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the Board members or members of key management staff or parties related to them has undertaken any material transactions with Lancashire Teaching Hospitals NHS Foundation Trust.

### **Council of Governors**

The roles and responsibilities of the Council of Governors of the Foundation Trust are carried out in accordance with the Trust's Provider Licence:

The Council has specific powers including:

- appointment and, if appropriate, removal of the Chair and other non-executive Directors
- approval of the appointment of the Chief Executive
- to decide the remuneration and allowances and the other terms and conditions of office of the Chair and other non-executive Directors
- to appoint and, if appropriate, remove the Trust's external auditors
- to appoint or remove any other external auditor
- to receive the annual accounts, annual report and any report on them by the auditor
- to provide their views to the board of directors when the board of directors is preparing the Trust's forward plan
- to hold the non-executive directors individually and collectively to account for the performance of the board of directors
- to represent the interests of the members of the Trust as a whole and of the public
- to approve 'significant transactions' as defined within the constitution
- to approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- to decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose
- to approve any proposed increase in private patient income of 5% of total income or more in any financial year
- to approve, along with the Board of Directors, any changes to the Trust's constitution
- to require the attendance of one or more directors at a Council of Governors meeting, for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or directors' performance).

The Foundation Trust maintains a register of interests for the Board and for members of the Council of Governors.

Of the total of 30 members of the Council of Governors, 6 represent the interests of other organisations who the Trust has identified as key partners in the delivery of healthcare to the population of Preston Chorley and South Ribble.

## 21 Related party transactions (continued)

The Trust had a significant number of transactions with other NHS or Government departments which are all classed as 'related parties' to the Trust. Material

	<b>Income</b>	<b>Expenditure</b>	<b>Receivable</b>	<b>Payable</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Health Education England	22,735	-	255	534
NHS Blackburn with Darwen CCG	5,874	-	-	-
NHS Blackpool CCG	65,128	-	75	18
NHS Chorley and South Ribble CCG	111,337	-	419	1,026
NHS East Lancashire CCG	10,053	-	-	2
NHS England	252,074	-	7,241	3,707
NHS Fylde and Wyre CCG	21,252	-	131	-
NHS Greater Preston CCG	130,104	-	2,451	308
NHS Morecambe Bay CCG	13,081	-	-	-
NHS Resolution	-	21,496	-	601
NHS Pension Scheme	-	50,463	-	4,852
HM Revenue and Customs	-	32,859	-	8,328

Members of the Council of Governors, Executive Directors and Non-Executive Directors, or close family members of the same, who have interests in or hold positions with organisations with which the trust has had transactions during the year, are listed below:

	<b>Income</b>	<b>Expenditure</b>	<b>Receivable</b>	<b>Payable</b>	<b>Relationship</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	
Chorley Borough Council	-	-	-	620	Member of Council of Governors
Lancashire County Council	82	42	4	158	Member of Council of Governors
Preston Council	-	-	-	766	Member of Council of Governors
South Ribble Borough Council	5	-	1	42	Member of Council of Governors
UCLAN	39	-	-	-	Member of Council of Governors
NWAS	26	242	-	46	Executive Director
East Lancashire Hospitals NHS Trust	1,281	4,787	848	1,494	Non-Executive Director

## 21 Related party transactions (continued)

The Trust is Corporate Trustee of two charities which means that the Trust has control over the charities. Both Charities are registered with the Charity Commission and produce a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) These documents will be available in September 2021, on request from the Finance Department of the Trust. Details of the charities and of material transactions between them and the Trust are detailed below.

Charity	Registered Number	Donations		
		received £000	Receivable £000	Payable £000
Lancashire Teaching Hospitals NHS	1051194	871	751	1
The Rosemere Cancer Foundation Charity	1131583	10	259	0

## 22 Financial Instruments

International Financial Reporting Standard 9 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. The Trust's treasury activities are also subject to review by Internal Audit.

### Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. While the Trust is in deficit it is accessing working capital support by means of PDC through DHSC. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the DHSC. Additional funding by way of loans has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework.

### Currency Risk

The Trust is a domestic organisation with the overwhelming majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations, and therefore has low exposure to currency rate fluctuations.

### Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

### Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2018 is within Receivables from customers, as disclosed in the Trade and Other Receivables note to these Accounts

## 22.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	32,863	<b>32,863</b>	32,863	<b>32,863</b>
Cash and cash equivalents	58,832	<b>58,832</b>	58,832	<b>58,832</b>
<b>Total at 31 March 2021</b>	<b>91,695</b>	<b>91,695</b>	<b>91,695</b>	<b>91,695</b>

Carrying values of financial assets as at 31 March 2020	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	40,327	<b>40,327</b>	40,327	<b>40,327</b>
Cash and cash equivalents	6,855	<b>6,855</b>	6,855	<b>6,855</b>
<b>Total at 31 March 2020</b>	<b>47,182</b>	<b>47,182</b>	<b>47,182</b>	<b>47,182</b>

## 22.2 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2021	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	10,005	<b>10,005</b>	10,005	<b>10,005</b>
Obligations under finance leases	480	<b>480</b>	480	<b>480</b>
Other borrowings	1,022	<b>1,022</b>	1,022	<b>1,022</b>
Trade and other payables excluding non financial liabilities	83,865	<b>83,865</b>	83,865	<b>83,865</b>
Provisions under contract	-	-	-	-
<b>Total at 31 March 2021</b>	<b>95,372</b>	<b>95,372</b>	<b>95,372</b>	<b>95,372</b>

Carrying values of financial liabilities as at 31 March 2020	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	230,236	<b>230,236</b>	230,236	<b>230,236</b>
Obligations under finance leases	996	<b>996</b>	996	<b>996</b>
Other borrowings	698	<b>698</b>	698	<b>698</b>
Trade and other payables excluding non financial liabilities	45,193	<b>45,193</b>	45,193	<b>45,193</b>
Provisions under contract	-	-	-	-
<b>Total at 31 March 2020</b>	<b>277,123</b>	<b>277,123</b>	<b>277,123</b>	<b>277,123</b>

## 22.3 Maturity of financial liabilities

	Group		Trust	
	31 March	31 March	31 March	31 March
	2021	2020	2021	2020
	£000	£000	£000	£000
In one year or less	88,522	267,117	88,522	267,117
In more than one year but not more than two	6,350	9,898	6,350	9,898
In more than five years	1,608	2,003	1,608	2,003
<b>Total</b>	<b>96,480</b>	<b>279,018</b>	<b>96,480</b>	<b>279,018</b>

## 23 Losses and special payments

Group and trust	2020/21		2019/20	
	Total Number	Total value £000	Total Number	Total value £000
<b>Losses</b>				
Losses of cash	-	-	5	2
Bad debts and claims abandoned	1,225	755	1,148	466
Damage to buildings, property etc. including	2	420	3	513
<b>Total losses</b>	<b>1,227</b>	<b>1,175</b>	<b>1,156</b>	<b>981</b>
<b>Special payments</b>				
Ex-gratia payments	49	96	87	108
<b>Total special payments</b>	<b>49</b>	<b>96</b>	<b>87</b>	<b>108</b>
<b>Total losses and special payments</b>	<b>1,276</b>	<b>1,271</b>	<b>1,243</b>	<b>1,089</b>

## 24 Third party assets held by the Trust

Lancashire Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March	31 March
	£000	£000
Bank balances	5	6
Monies on deposit	-	-
<b>Total third party assets</b>	<b>5</b>	<b>6</b>

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

Company Secretary  
Lancashire Teaching Hospitals NHS Foundation Trust  
Royal Preston Hospital, Sharoe Green Lane,  
Fulwood, Preston,  
PR2 9HT

T: 01772 522010

E: [Company.Secretary@lthtr.nhs.uk](mailto:Company.Secretary@lthtr.nhs.uk)

For more information about Lancashire Teaching Hospitals NHS Foundation Trust see:

[www.lancsteachinghospitals.nhs.uk](http://www.lancsteachinghospitals.nhs.uk)

 [@LancsHospitals](https://twitter.com/LancsHospitals)

 [Facebook Page](#)



# Auditor's Annual Report 2020/21

Lancashire Teaching Hospitals NHS  
Foundation Trust

28 June 2021



## Key contacts

Your key contacts in connection with this report are:

### Tim Cutler

Partner

Tel: +44 161 246 4774

[tim.cutler@kpmg.co.uk](mailto:tim.cutler@kpmg.co.uk)

### Richard Lee

Senior Manager

Tel: +44 161 246 4661

[richard.lee@kpmg.co.uk](mailto:richard.lee@kpmg.co.uk)

### Laura Helme

In-charge auditor

Tel: +44 7733 307 803

[Laura.Helme@kpmg.co.uk](mailto:Laura.Helme@kpmg.co.uk)

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This report is addressed to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

# Summary

## Introduction

This Auditor’s Annual Report provides a summary of the findings and key issues arising from our 2020-21 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the ‘Trust’). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

## Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

- **Accounts** - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).
- **Annual report** - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.
- **Value for money** - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust’s use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.
- **Other reporting** - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

## Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities:

<b>Accounts</b>	<p>We issued an unqualified opinion on the Trust’s accounts on 28 June 2021. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust.</p> <p>We have provided further details of the key risks we identified and our response on page 4.</p>
<b>Annual report</b>	<p>We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust.</p> <p>We confirmed that the Governance Statement had been prepared in line with the DHSC requirements.</p>
<b>Value for money</b>	<p>We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money.</p> <p>We have nothing to report in this regard.</p>
<b>Other reporting</b>	<p>We did not consider it necessary to issue any other reports in the public interest.</p>

# Accounts audit

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Findings
<p><b>Valuation of land and buildings</b></p> <p>Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. There is a risk the assumptions used to determine the valuation are not accurate.</p>	<p>We did not identify any misstatements from our work on this significant risk.</p> <p>We identified two recommendations relating to the absence of management's formalised and documented assessment of impairment and challenge of the external valuation methodology, inputs and assumptions used.</p> <p>We determined that the judgements made by the external valuers and adopted by the Trust were neutral.</p>
<p><b>Fraudulent expenditure recognition</b></p> <p>As the Trust has agreed an outturn total with local NHS partners for its expected financial performance there is a risk that non-pay expenditure may be manipulated in order to report that the control total has been met.</p> <p>We considered there to be a risk over existence and accuracy of non-pay expenditure at the year-end, as there is greater incentive for management to overstate expenditure in 2020-21 by bringing forward expenditure from 2021-22, to mitigate financial pressures in that period.</p>	<p>We identified two items of expenditure relating to international nurse recruitment fees that had been incorrectly accrued. In both instances, the conditions had not been met to recognise the expenditure within the 2020-21 accounts. The total value of these errors was £2.367m. No adjustment was made to the accounts in respect of these errors.</p> <p>We identified one recommendation relating to management's review and challenge of accruals that are made at the year end.</p>
<p><b>Management override of controls</b></p> <p>We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.</p>	<p>We did not identify any indication of management override of controls.</p> <p>We identified two control recommendations relating to the posting off journals. These related to segregation of duties and journals being posted on behalf of other users.</p>

# Value for money

## Introduction

We consider whether there are sufficient arrangements in place for the Trust for each of the elements that make up value for money. Value for money relates to ensuring that resources are used efficiently in order to maximise the outcomes that can be achieved.

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

Further details of our value for money responsibilities can be found in the Audit Code of Practice at [Code of Audit Practice \(nao.org.uk\)](https://www.nao.org.uk)

## Matters that informed our risk assessment

The table below provides a summary of the external sources of evidence that were utilised in forming our risk assessment as to whether there were significant risks that value for money was not being achieved:

<b>Care Quality Commission rating</b>	Requires Improvement
<b>Single Oversight Framework rating</b>	Segment three - Mandated and targeted support: Support needs identified in quality of care, finance and use of resources and operational performance
<b>Governance statement</b>	There were no significant control deficiencies identified in the governance statement.
<b>Head of Internal Audit opinion</b>	Substantial assurance (unqualified opinion)

## Commentary on arrangements

We have set out on the following pages commentary on how the arrangements in place at the Trust compared to the expected systems that would be in place in the sector.

## Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
<b>Financial sustainability</b>	One significant risk identified	No significant weaknesses identified
<b>Governance</b>	No significant weaknesses identified	No significant weaknesses identified
<b>Improving economy, efficiency and effectiveness</b>	No significant weaknesses identified	No significant weaknesses identified

Financial sustainability	
Description	Commentary on arrangements
<p>This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it.</p> <p>We considered the following areas as part of assessing whether sufficient arrangements were in place:</p> <ul style="list-style-type: none"> <li>▪ How the Trust sets its financial plans to ensure services can continue to be delivered;</li> <li>▪ How financial performance is monitored and actions identified where it is behind plan; and</li> <li>▪ How financial risks are identified and actions to manage risks implemented.</li> </ul>	<p>Financial plans are formulated in conjunction with NHS planning guidance and are reviewed by the Senior Management Team and the Board of Directors.</p> <p>In 2020/21 financial planning process was suspended due to the pandemic and has since been delayed for the 2021/22 financial year. Block contracts, set up in the temporary financial regime established for the first half of 2020/21, were retained during the second six months, and will now continue into the first six months of 2021/22.</p> <p>Through our review of relevant Board and Finance and Performance Committee meeting minutes we saw evidence of appropriate financial reporting and monitoring of financial performance. We are also satisfied that the original M7-12 financial plan and subsequent resubmitted forecasts were considered, discussed and approved in an appropriate, sufficient and timely manner as part of the Trust's governance processes.</p> <p>Following the onset of the COVID-19 pandemic, NHSE/I requested all NHS entities halt the development and formal reporting of cost improvement plans (CIPs) as part of the wider financial planning suspension for 2020/21. We have seen evidence at other trusts that CIPs continued to be monitored throughout the year, albeit at a reduced value and largely ignoring clinical operational areas as they coped with COVID-19 pressures.</p> <p>Whilst the Trust has demonstrated its ability to manage its resources within the confines of the funding regime, the Trust did not formally monitor or report on in year CIPs. Progress with implementing CIP savings were not included as part of the Trust's Board or Finance and Performance Committee reporting.</p> <p>The Trust has however provided evidence that cost improvement activity has taken place by providing evidence of reporting on Continuous Improvement and details of one of the Trust's ongoing CIP schemes relating to radiology. The Drivers for Deficit paper, prepared during 2020-21 also highlights that corporate benchmarking indicates limited opportunities for clinical CIP savings to be delivered, particularly in light of the COVID-19 pandemic.</p> <p>For the 2021/22 financial year, NHSE/I has continued the arrangements from the second half of 2020/21 in recognition of the continued pressure felt by NHS organisations from the COVID-19 pandemic. The Trust is in the process of developing a financial plan alongside partners in the wider Lancashire and South Cumbria Integrated Care System (ICS) which achieves financial balance at the system level.</p> <p><i>(continued on next page).</i></p>

Financial sustainability	
Description	Commentary on arrangements
	<p><i>(Continued from previous page)</i></p> <p>In the period to 31 March 2021 we have seen evidence of the budget setting process that has been undertaken by the Trust. In general, the budget is based on a rollover of 2020-21 budgets adjusted for non-recurring and known new activities. Budget setting papers presented to the Board and Finance and Performance Committee identify revenue risks and quantify the potential impact.</p> <p>During 2020-21, the Trust has identified a formal CIP target for 2021-22 of £9.9m which represented 2% of annual influenceable expenditure budgets. Of this, £3m had been allocated to procurement savings, £2.5m to outpatients and £2m to nursing related activities. Since the year end this target has been increased to 3% as part of the ICS system balancing process. The Trust has a CIP dashboard that identifies CIP targets against specific divisions and activities. This is risk rated and will be used as a mechanism for monitoring and tracking savings through 2021-22 and future periods.</p> <p><b>Conclusion</b></p> <p>As a result of our risk assessment work we identified a significant risk around the continued financial sustainability of the Trust and specifically, the Trust's approach to identification and monitoring of cost improvement savings.</p> <p>Following the work that we have done subsequently over financial planning, we observed that there has been less visibility over cost improvement and associated governance processes in 2020-21 than in normal years. However, we are satisfied that there are understandable reasons why this is the case. When considering this in the context of operating the organisation in a pandemic, we consider it reasonable that no significant cost improvement planning or monitoring was carried out.</p> <p>This is supported by guidance from the regulator, local consideration of corporate service savings through effective procurement and the emergency funding arrangements in place which ensured that the absence of formal CIP monitoring did not create a risk of significant financial loss.</p> <p>We have raised recommendations to management to improve financial governance around CIP and financial risk monitoring but do not believe this constitutes a significant weakness in the period of audit.</p>

# Value for money

Governance	
Description	Commentary on arrangements
<p>This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions.</p> <p>We considered the following areas as part of assessing whether sufficient arrangements were in place:</p> <ul style="list-style-type: none"> <li>▪ Processes for the identification and management of strategic risks;</li> <li>▪ Decision making framework for assessing strategic decisions;</li> <li>▪ Processes for ensuring compliance with laws and regulations;</li> <li>▪ How controls in key areas are monitored to ensure they are working effectively.</li> </ul>	<p>The Trust has a robust risk management framework and processes are in place to identify and manage specific risks. The Trust operates a risk monitoring and reporting system to ensure that there is clear ownership of risk at the appropriate hierarchical levels and robust scrutiny and oversight of how risks are managed.</p> <p>Reporting on the Board Assurance Framework (BAF) and Risk Register has happened throughout 2020-21, with issues being escalated as necessary. Appropriate levels of detail are included in respect of each risks along with the potential impact and mitigating actions required and agreed to manage each risk. The Trust has included COVID-19 specific risks within the BAF which are overseen by appropriate executive risk leads.</p> <p>Each department also has an individual risk register which forms part of the action log in meeting agendas. Strategic risks are recorded in the departmental risk registers and consolidated into the BAF for reporting in to the Trust Board.</p> <p>The Trust has adequate controls in place to prevent and detect fraud. Counter fraud services are provided by the Trust's Internal Audit provider, MIAA. A Local Counter Fraud Service Plan is reviewed and approved by the Audit Committee annually which sets out key activities within the Trust's anti-fraud plan. Anti-fraud progress reports are also presented to the Audit Committee, providing details of referrals, ongoing investigation activities and outcomes of investigations that have concluded.</p> <p>The Board and Finance and Performance Committee have been kept informed of the funding arrangements in place for 2020-21 and the monthly finance reports provide commentary on financial performance and the associated risks and uncertainties that exist. These meetings also allow for appropriate challenge and response to adverse variances. We also found robust processes to have been in place to ensure accurate recording and monitoring of the additional costs associated with the COVID-19 pandemic. We have however made recommendations to management around the visibility of cost improvement savings during 2020-21 and the processes followed to inform the identification of efficiency savings throughout the year. We do not consider these recommendations to constitute significant weaknesses.</p> <p>There is an overarching committee structure in place which is part of the internal governance arrangements, in which policies and procedures are continually validated and ratified. All relevant policies and procedures, including those for gifts and hospitality and the recording of interests, are communicated and made available to staff via the intranet.</p> <p><i>(continued on next page).</i></p>

# Value for money

Governance	
Description	Commentary on arrangements
	<p><i>(Continued from previous page)</i></p> <p>Compliance with regulations and standards is reported in the Annual Report and Annual Governance Statement (presented to Board and Audit committee). The Audit Committee is responsible for monitoring the effectiveness of internal control. The Trust's internal auditors (MIAA) develop and agree an annual work plan which is approved and monitored at the Audit Committee. Through our review of the Audit Committee papers, we have seen evidence of audit reports identifying recommendations for improvements for any weaknesses in internal control.</p> <p>The Trust is currently rated as 'Requires Improvement' by the CQC, however has received a 'Good' grading in respect of Well Led activity.</p> <p><b>Risk assessment conclusion</b></p> <p>Based on the risk assessment procedures performed we have not identified a significant risk associated with Governance.</p>



**Improving economy, efficiency and effectiveness**

**Description**

**Commentary on arrangements**

This relates to how the Trust seeks to improve its systems so that it can deliver more for the resources that are available to it.

We considered the following areas as part of assessing whether sufficient arrangements were in place:

- The planning and delivery of efficiency plans to achieve savings in how services are delivered;
- The use of benchmarking information to identify areas where services could be delivered more effectively;
- Monitoring of non-financial performance to assess whether objectives are being achieved; and
- Management of partners and subcontractors.

We note that from the 17 March 2020, as part of the revised financial planning regime launched in response to the COVID-19 pandemic, CIP programmes were paused in accordance with national guidelines to allow CCGs and providers to respond to the pandemic. For months 7 - 12 any service redesign, service extension and/or transformation are to be based on provider capacity, IPC guidelines and estates.

The Trust produce an integrated performance report which incorporates, financial, performance, quality and workforce metrics into a single report. The integrated performance report incorporates a score card risk assessment matrix, performance indicators across the different themes and monthly performance data for each area included.

Reporting themes included within the integrated performance report are consistent with those discussed at sub-committees and included in departmental reports, ensuring that decision making and local performance monitoring contributes to the achievement of the Trust's overall 'Big Plan'.

The Trust is an active member of the ICS and ICP and has representation at the ICS Board, Executive and other ICS groups. Updates on activities and performance of these partnerships is provided to the Board and the Finance and Performance Committee which has a standing agenda item report on and receive ICS updates.

During 2019-20, the Trust participated in NHS National Costing Exercises that compared the cost of services and identified areas where costs were considered high (high Reference Cost Indexes). In addition, the Trust obtained corporate benchmarking information, from sources such as Model Hospital, in order to identify higher cost areas of service provision. These findings and reports were presented and considered by the Board and Finance and Performance Committee during 2020-21, however it is unclear what resulting actions were taken during 2020-21 that could contribute to the potential identification of further savings or how these were monitored and reported on to the Board. As a result, we raised a recommendation with management around the processes followed to inform the identification of efficiency savings throughout the year. We do not consider this recommendations to constitute significant weaknesses.

**Conclusion**

We have observed that the extent to which the Trust utilises corporate benchmarking to identify savings opportunities has reduced during 2020-21, primarily due to the COVID-19 pandemic. We are however satisfied that there is not a significant risk that the Trust does not have sufficient arrangements in place for improving economy, efficiency and effectiveness to secure its value for money achievement.



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