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Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2019–20

Excellent care with compassion

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Lancashire Teaching Hospitals NHS Foundation Trust
Annual Report and Accounts 2019-20

Presented to Parliament pursuant to schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

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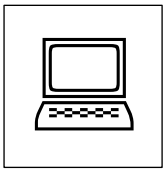


This symbol indicates that more information is available on our website:

www.lancsteachinghospitals.nhs.uk

Cover photograph:
Caroline Watson, Health Care Assistant and Dr Rajesh Kumar, Associate Consultant in Anasethetics

CHAIRMAN'S AND CHIEF EXECUTIVE'S WELCOME

Welcome to our annual report for the financial year 2019-20, which sets out our achievements, activity and performance. The annual report is also an opportunity to share our vision and priorities at a time of significant pressure and change within the NHS.

Well what a year 2020 has been so far! Clearly we are all living in very strange and uncertain times at the moment due to the Coronavirus (Covid-19) pandemic. The commitment and dedication of our staff has always been exceptional, but it is felt now more than ever. Many tell us that they are just doing their jobs but these are uncertain times for everyone, no matter how professional or experienced they are. The kindness and support shown by our local community is going a long way in boosting morale and keeping us positive; seeing so many people join in the Clap for Carers at 8pm every Thursday evening was very much appreciated and puts a smile on our faces.

We also want to say a huge thank you for all the kind and generous donations we have received. We have recently set up a new Charity team and they have been inundated with things to help our staff. To find out more about the Lancashire Teaching Hospitals' Charity you can access the charity website here. You can use the website to make a donation, there is also information about the staff wellbeing appeal and news about all the donations we have received so far and how it makes a real difference.

Providing the best care possible for our patients remains our top priority but we also recognise the importance of looking after the health and wellbeing of our staff too. Over the last few years we have introuduced a range of staff health and wellbeing initiatives; from opening health and wellbeing centres, bringing in our own Psychologists and we have even tried laughter yoga! The health and wellbeing of our staff has always been a priority for us but now it is more important than ever. We are doing everything we can to support our teams who are working so incredibly hard and in such difficult circumstances. 'Wobble rooms' have been set up in some areas to provide a space for our staff to take a moment out, have a wobble and gather themselves if they need to, we have delivered care packages to them and set up a helpline for our staff who are affected by Covid-19.

We want to assure our communities that we are still here for you, if you require urgent treatment, even if it is not Coronavirus-related, you should still seek medical help. Please do not take risks and leave it too late, you should still come to hospital if you need to. Many appointments and procedures are continuing as normal so if you still require treatment and your appointment is still going ahead, please make sure you attend. We have taken precautions to keep you as safe as possible and we have divided our hospitals into zones so that Covid-19 and non-Covid-19 patients are treated separately. We have temporarily reconfigured our services to ensure that we can manage the increasing patient numbers whilst dealing with the pandemic. As part of this reconfiguration we have moved all of our acute respiratory medicine from Chorley and South Ribble Hospital to Royal Preston Hospital; we have temporarily closed the Emergency Department and Critical Care unit at Chorley so that the teams can work on one site. This move allows 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 better care for our patients. In addition, it reduces the risks associated with transporting infectious patients between locations. Meanwhile, our Chorley

site continues to run a 24/7 Urgent Care and Minor Injury service so that patients who fall into this category are treated in a safer environment for them.

We want to thank you for staying at home to save lives and protect the NHS and we want to thank you for your patience and your support, we know how hard it is not being able to visit your loved ones who are in our hospitals. Our staff continue to do everything we can to keep loved ones in touch and provide updates for families during this difficult time.

Clearly during the coronavirus outbreak all of our teams have been under extreme pressure but one area that has been put in the spotlight is our Critical Care department. Before the pandemic we had already started work on expanding our Critical Care unit at Preston, that work is continuing and we are really excited to open the new multi-million pound, state-of-the-art facility very soon.

Aside from Covid-19 we have made some excellent progress in many areas over the past twelve months. Firstly, we welcomed our new Chairman, Dr Ebrahim Adia in December 2019. We are delighted to welcome Ebrahim to our organisation; he joins us at a challenging yet exciting time and brings with him a wealth of knowledge and experience from his leadership roles in higher education, the health economy and local government.

The Care Quality Commission (CQC) carried out a planned inspection of our hospitals last summer. Whilst our overall rating remains as 'Requires Improvement' we have now achieved a rating of 'Good' for being well-led and caring across both Royal Preston and Chorley and South Ribble Hospitals. Four of the six services that were inspected this year are rated as 'Good' which is an improvement on the previous inspection. We recognise that we are still not where we want to be and we still have a lot of work to do but these improvements show that we are moving in the right direction.

One area which has received an 'Outstanding' CQC inspection is our Maternity services, which were rated in the top ten out of all the Trusts across the country who took part in a patient experience survey. We were one of only three Trusts where performance in the survey was significantly better than expected. These results are a reflection of the hard work of our Maternity teams to make the experience as positive as possible for women, babies and their families. The team has also recently launched our new Transitional Care service; a facility to enable babies who need close monitoring or additional support to be cared for alongside their mothers so that we can reduce babies being separated from their mothers.

Our Maternity team has recently starred in a television series featured on Channel 5Star called *Babies 24/7: The Maternity Ward,* which follows the birth journeys of local families and showcases the incredible work of our teams.

Nationally, 2020 is the global Year of the Nurse and Midwife. This year has been chosen as it is the 200th Anniversary of Florence Nightingale and we have joined in with the celebrations recognising our fantastic Nurses and Midwives.

We continue to work hard to improve the experiences of patients with learning disabilities. They are now able to use state-of-the-art, specialist toilet facilities thanks to £50,000 of Government funding for a 'Changing Places' facility. The toilets feature additional equipment for people who are not able to use the toilet independently, including adult-sized changing benches and hoists.

Other building work currently taking place is the re-build of the Birth Centre at Chorley. The Maternity services at Chorley were temporarily halted when asbestos was discovered in the

building, so we are delighted that work is now underway to reinstate our Birthing Services for people living within Chorley and South Ribble. We are also building a new Ophthalmology Centre at Chorley which will provide extra capacity and dedicated space and is due to open in October 2021.

Our commitment to drive innovation through world-class research continues to go from strength to strength with our Clinical Research team regularly winning and being shortlisted for prestigious awards. They are also working hard on a number of Covid-19 research studies to try to find out more about the virus.

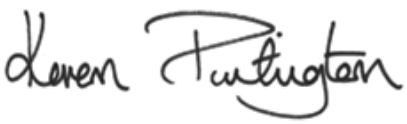
We are extremely proud to see that our staff continue to be recognised for their outstanding achievements as we continue to win awards across a range of areas. We were named as one of the CHKS top 40 Hospitals for 2019, a prestigious award given to acute sector organisations for their achievements in healthcare quality and improvement. And our Technology Services won a Health Tech Digital Award for their work in implementing a messaging service which allows electronic transfers of information between our hospitals and social care settings, which means patients can be discharged sooner and their information shared faster.

Every year demand for care increases and the past year was no different, even before the Coronavirus pandemic, which unfortunately means that, at times, we have not managed to achieve all the national performance standards. However, we continue to make some significant improvements and in April 2019 we launched Our Big Plan strategy for the next three years. 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 Our Big Plan strategy supports this. Our delivery promise is outcome driven, clearly outlining the expected outcomes in years one, two and three of the strategy and enables us to develop business plans annually to support delivery of Our Big Plan.

The continued growth in demand 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 as part of the Our Health Our Care (OHOC) programme. We also 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.

Clearly the unprecented challenges of the Covid-19 outbreak will continue for some time yet and that, combined with the challenges we were already facing as a health service, means it is a tough road ahead. However, the NHS is at the heart of the country now more than ever before, the support from our communities has blown us away and our staff continue to be extraordinary. Together we will get to where we want to be and we remain committed to providing excellent care with compassion.

Dr Ebrahim Adia
Chairman
18 June 2020



Karen Partington
Chief Executive
18 June 2020

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT
2019-20

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 82 to 86.

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 370,000 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 healthcare to our local communities
- To offer a range of high quality specialist services to patients in Lancashire and South Cumbria
- To drive 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:

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

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 National Institute of Health Research 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 business planning process, as well as our recruitment and appraisal processes:

Our strategic objectives, together with our four ambitions, provide the focus and drive on clinical quality and long-term sustainability, whilst informing local service planning and development priorities.

Our revised 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 will be refreshed annually to ensure they remain current in the context of both national and local changes.

Developing an Integrated Care Partnership (ICP) in Central Lancashire

Much focus during 2019-20 has been centred upon the undertaking of a governance review, which was wholly supported by the ICP Board. The purpose of undertaking this approach was to enable the evolution of the platforms to encompass the wider operational element of the ICP within its governance structure and to accelerate collaborative working across this delivery arm of the Partnership, in addition to maintaining the more strategic and transformational aspects of the ICP.

It was recognised that there was a need to encompass whole systems within the delivery arm of the Partnership focusing upon end to end pathways, from keeping our population well and preventing any health or social care issues to looking at the step down facilities available within our system. This 'whole system' approach will provide an improved level of accountability and oversight within the ICP and the more effective delivery of cross-cutting local, regional and national priorities.

Since the endorsement of the revised structure by the ICP Board, work has been ongoing, taking a step-change process to begin to align functions and forums into a more collaborative framework. To date, this has involved the drafting of terms of reference for some of the ICP Committees in Common whilst reviewing the existing Committees of Clinical Commissioning Groups (CCGs) and acute Foundation Trust Governing Bodies. It is intended that this approach will further be developed and subsequently tested and later expanded to include wider partners. A similar approach has been taken with Team Central Lancashire, which provides a joint Executive function evolving between the CCGs and Lancashire Teaching Hospitals, overseeing functions on behalf of the ICP. It is expected that as the maturity of the ICP develops other ICP partners will formalise their involvement in this group and adapt governance mechanisms to suit.

In addition, an underpinning framework is being developed to enable each of the organisations within the ICP to effectively work together on behalf of its local population. These include standardised working practices, a governance framework and a revised ICP Memorandum of Understanding which will form the basis of the agreement for how each of the partners engage with one another to deliver the vision and aims of the Central Lancashire Integrated Care Partnership.

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. We continue to work closely with ICS partners to develop our integrated care system strategy which states *"Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives."*

The strategy will be delivered by:

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

This strategy will be enabled by ICS plans to:

- Create a great place to work and develop
- Use technology and innovation to deliver great care
- Make the most of public sector investment
- Inform, involve and engage local people, staff, partners and stakeholders

Our principal issues and risks

Our Board assurance framework reflects the principal strategic risks associated with failure of the organisation to meet its corporate objectives and the actions being taken by the Trust to mitigate such risks. The board assurance framework is used to enable 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 most significant risks that threaten the achievement of the Trust's ambitions as identified within the board assurance framework for 2019-20 related to:

1. Availability of clinical and medical workforce
2. Availability and sustainability of operational and strategic capital
3. Operational capacity, demand and performance
4. Effectiveness of current system resilience and capacity

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.

Our performance

Overall during 2019-20 the Trust achieved compliance against a range of measures identified in the NHS Improvement compliance framework and the acute services contract such as two of the nine cancer waiting times standards, and one of the infection prevention standards. In addition, the Trust has maintained performance against a range of other measures identified in the acute services contract. However, the Trust has failed to achieve its objectives in relation to Accident and Emergency waiting times throughout the year, the 18-week incomplete access target and the 62-day cancer treatment standard. This was largely due to significant pressures within emergency services throughout 2019-20 which adversely impacted on access standards compliance and delivery of the Trust's elective care programme.

Going concern

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

The Trust has 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 are in place from 1 April to 31 July, 2020, 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 have been frozen as of 31 March 2020, and will be replaced by Public Dividend Capital (PDC) as at that date, in a transaction due to take place in September 2020. This means that the Trust no longer faces uncertainty regarding repayment of these previous temporary financing arrangements. The new arrangement will also provide for further PDC advances rather than loans to Trusts in financial distress, the permanent nature of 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. This work includes the acceptance of the Trust into the Hospital Improvement Programme (HIP2) capital schemes reviewing the hospital sites in the longer term although in the short term the Trust's expectation is that services will continue to be provided from the existing hospital sites.

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. However the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern, and therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

PERFORMANCE ANALYSIS

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

During 2019-20 the Trust continued to experience significant operational pressures resulting in non-compliance in relation to some key standards. This was primarily due to whole health economy system pressures and continued high bed occupancy throughout the year. A health economy 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 2019-20 the Trust has continued to expand the scope of the Continuous Improvement and transformational work streams. Patient flow has a significant work plan attached to this work stream. Work has been undertaken in redesigning pathways around Urgent and Emergency Care settings, including Ambulatory Care at both hospital sites and the Emergency Observation Unit at Royal Preston Hospital. This has involved Urgent and Emergency Care Value Stream Analysis.

Overall during 2019-20 the Trust achieved compliance against a range of measures within the risk assessment framework including two of the nine cancer waiting times standards, and one of the infection prevention standards. In addition, the Trust has maintained performance against a range of other measures identified in the acute services contract.

However, the Trust has failed to achieve its objectives in relation to Accident and Emergency waiting times throughout the year, the 18-week incomplete access target, and the 62-day cancer treatment standard. This was largely due to significant pressures within the emergency service throughout 2019-20 that adversely impacted on access standards compliance and delivery of the Trust's elective care programme.

The summary position detailing performance against key targets 2019-20 is shown in the table on the next page:

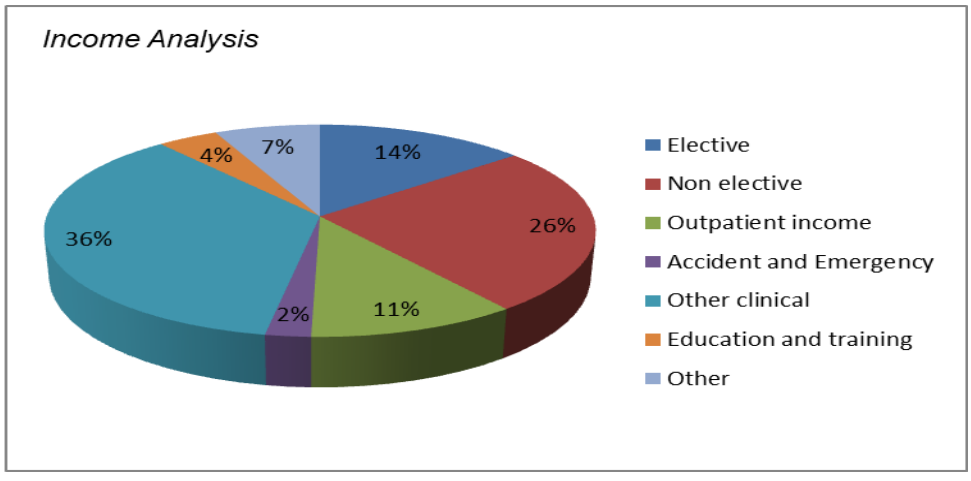
Indicator	National Target %	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	86	81.46	Not Achieved	% - Cumulative to end Mar 2020 Position includes both ED and UCC locations. Target based on agreed Trajectory to Mar 2020
Cancer - 2 week rule (All Referrals) - New method	93	92.5	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 2 week rule - Referrals with breast symptoms	93	83.3	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 day target	96	93.4	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	86.6	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.3	Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	97.0	Achieved	% - Cumulative to end Mar 2020
Cancer - 62 day target - total	85	70.3	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 62 day target - Day 38 reallocations	85	72.1	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	78.7	Not Achieved	% - Cumulative to end Mar 2020
MRSA	0	0	NA	% - Cumulative to end Mar 2020
C.difficile Infections	<84	108	Not Achieved	Cumulative to end Mar 2020
C.difficile infection avoidable (Lapses in care)	<84	50	Achieved	Cumulative to end Mar 2020
18 weeks - Referral to Treatment - Incomplete Pathways	79.2	77.95	Not Achieved	% - sum of Apr-Mar in 2019-20 Target based on agreed Trajectory to Mar 2020
% of patients waiting over 6 weeks for a diagnostic test	<1	5.0	Not Achieved	% - Cumulative to end Mar 2020

**MRSA Indicator: performance is stated as 'N/A' because 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.*

Our finances

Income Generation

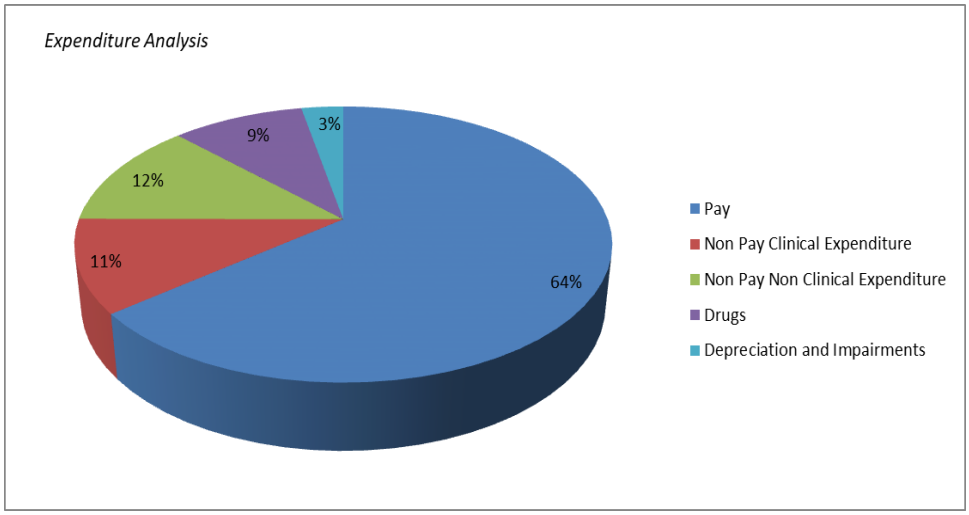
During 2019-20 the Trust generated income of £485m from patient care, an increase of 10% from 2018-19. A further £61m was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations. In the management of these other income sources, the Trust has complied with the cost allocation and charging guidance issued by HM Treasury. The Trust has met the requirement that income from the provision of goods and services to the health service in England is greater than income from other activities.



Expenditure

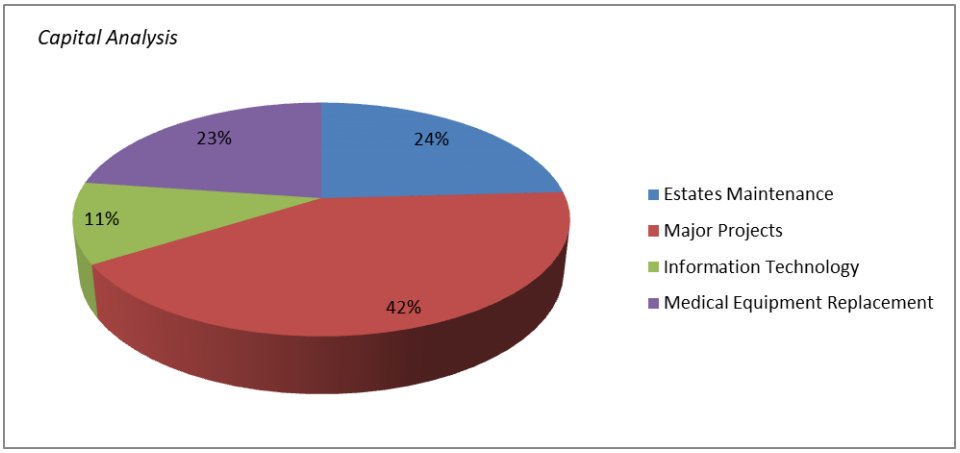
Operating expenditure (excluding impairments) for the year was £595m, the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to staff costs and reflects the ongoing difficulties the Trust has experienced in recruiting substantive staff.

In 2019-20, the Trust achieved £12.6m, being 50%, of its challenging target for performance and efficiency savings of £25m.



Capital Investment

In 2019-20, £27m was invested in the Trust's capital programme to maintain the asset base of the Trust as illustrated in the chart below, including over £6m being spent on the replacement of medical equipment.



Better Payment Practice Code (BPPC)

We aim to treat all suppliers ethically and we are working towards compliance with the Confederation of British Industry's BPPC target, which is 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 2019-20 we paid 74% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £	No.	Value £	No.	Value £
Invoices paid within 30 days	2,152	23,999,548.25	79,711	225,492,825.57	81,863	249,492,373.82
Invoices not paid within that 30 day period	2,201	11,203,321.94	65,215	76,055,807.80	67,416	87,259,129.74
Total Invoices	**4,353**	**35,202,870.19**	**144,926**	**301,548,633,37**	**149,279**	**336,751,503.56**
BPPC	**49.44%**	**68.17%**	**55.00%**	**74.78%**	**54.84%**	**74.09%**
Total amount of any liability to pay interest	0	0	3	2,648.82	3	2,648.82

Being a Good Corporate Citizen

The Trust works in a number of ways to control the impact it has on the environment and surrounding neighbourhoods. One key way of measuring our impact is through benchmarking as this helps to inform the direction for change and subsequent investment. The NHS Estates and Facilities dashboard provided by the NHS Improvement Model Hospital portal reports the Trust as out-performing its peer group for both energy consumption and cost, which given the age of the estate is a positive reflection on past investment decisions.

During 2019-20 the Trust has:

- Continued to maximise the benefits of the Combined Heat and Power (CHP) plants on its two hospital sites. First installed circa eight years ago, the Trust uses this equipment to generate over 50% of its own electricity. This reduces the Trust's overall carbon footprint as well as avoiding significant cost in the purchase of electrical energy from the National Grid. A further benefit is that the Trust reduces its impact on the local electrical infrastructure, releasing spare electrical capacity for the benefit of other developments within the surrounding areas. The use of CHP allows the Trust to reduce its energy bill by circa £1.25 million per year.
- The Trust has taken the decision to purchase renewable electricity from the National Grid for all of its major sites to further reduce its carbon footprint.
- Schemes to reduce water consumption are providing financial benefits and reducing the Trust's carbon emissions. The Trust has invested in equipment to better monitor water usage that will help identify areas of excessive usage and assist in identifying leakage.
- As part of our capital development programme we aim to construct all new buildings to achieve high levels of energy efficiency.
- We invest in the use of low energy LED lighting and install LED as standard in any new developments or refurbishment schemes. During 2018-19 the Trust was successful in

securing £294,000 from the NHS Energy Efficiency Fund (NEEF) and this funding was used to install further replacement LED lighting within the estate during 2019-20.

- We have reduced our use of 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 2020-21.
- 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 re-use or re-allocation 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.
- The Trust works with other health organisations in Lancashire and South Cumbria to share working practices which will promote greater efficiency and enhanced saving opportunities across a range of areas including transport, energy and utilities.

Social, community and human rights issues

Many of our departments have supported our work familiarisation programme for over ten years now. Students with learning difficulties from Midstream, Runshaw College, Cardinal Newman College, Preston's College and Sir Tom Finney School attend timetabled activities to learn about different job roles. Some sessions include a 'behind the scenes' tour. One example is the catering session where students get the chance to see how the kitchen staff prepares thousands of meals for staff, patients and visitors at the Trust. This programme runs twice a year at both sites seeing 60 students complete every 12 months, totalling over 450 students completing this programme since the first pilot. With the support from various departments we have been able to invite more colleges and schools to take part in this programme and expand it to a wider audience. Every programme ends with a celebration where students are awarded for their commitment. The programme continues to be extremely popular and very successful with both the Trust and the colleges involved.

We have continued with our commitment to offer work experience placements to people of all ages across Chorley, Preston and South Ribble; over 700 individual placements have been organised over the last 12 months. We are also supporting college curriculum by providing placements for students requiring work based hours as part of their study programme, in particular Health and Social Care students and those studying Sciences and IT. The winter pressure placement scheme continued this year and 120 students were given placements with us between January and March. The students are studying Health and Social Care at college and many of them want to go on to do their nurse training. These students have proven to be keen and have been receiving fabulous feedback from both staff and patients. With this in mind, Health Care Assistant (HCA) bank positions have been offered to those who completed a successful placement with us.

Since becoming a training provider for apprenticeships, the Trust has continued to exceed the public sector target for new starts each year. We continue to be amongst the top performing Trusts in the North. We offer a growing range of apprenticeships for both clinical and non-clinical roles in occupations from accountancy to pre-nursing. Apprenticeship programmes delivered during 2019 include using external training providers programmes, examples include:

- Nursing Associate
- Accountancy Taxation Professional

- Installation Electrician
- IS Business Analysist
- Customer Service – Preceptorship
- Business and Administration
- Pharmacy
- Pathology Laboratory Technician

We have now been an approved apprenticeship training provider for three years and undergone full financial audit as well as having an Ofsted New Provider Monitoring visit in August 2018 which determined that we were making reasonable progress. We are pending a full Ofsted inspection which is due at any time during 2020-21. We continue to see our Institute of Leadership and Management (ILM) Level 3 Team Leader/Supervisors and ILM Level 5 Operations/Departmental Manager apprentices completing with good results. This last year we have seen apprentices on our Senior Healthcare Assistant Level 3 completing with good results including distinctions.

In 2019 we introduced the new Learner Mentor apprenticeship to newly qualified staff nurses. This replaced the Mentorship programme that has now been withdrawn. This apprenticeship also offers support to our newly qualified staff nurses in supervising a variety of students, strengthens communication skills and provides new knowledge and skills regarding problem solving. Some of these learning outcomes help address CQC recommendations as well as providing our new staff Nurses with a good support mechanism whilst settling into their new roles.

We are scoping further opportunities for apprenticeships and how we can support staff to achieve Masters level qualifications through this route.

The Preparation for Nursing programme continues to provide a pipeline into Nurse training. 30 places are on offer each year via applications from students in their second year of the Health and Social Care programmes at Runshaw and Cardinal Newman Colleges. The programme runs for seven weeks and includes a range of activities to help the students make informed choices about nursing careers. The timetable has training embedded that is required for the delivery of patient care including moving and handling, infection control and basic life support. In addition to attending the course, the students commit to one shift a week as a ‘buddy’ to a HCA. Successful students will also be able to join our HCA bank.

We have continued to offer the Preston Widening Access Programme which supports young people to access a career as a doctor. This is another extremely popular and successful programme that now offers 40 places to A-level students from our local colleges and sixth forms who meet the widening participation criteria following an application process. This programme is in its sixth year and continues to be extremely popular, providing a much needed pipeline into a career in Medicine.

Our ‘Careers in the NHS’ event has continued as an annual event which is run at both Preston and Chorley sites where over 30 of our departments, both clinical and non-clinical, provide activities and give careers guidance to high school and college students. These events are hugely successful seeing hundreds of students and prospective employees through the door. We are also continuing to support careers events, provide careers advice, deliver assemblies and attend ‘mock interview’ days at local schools and colleges.

The Trust is committed to providing opportunities for NHS careers to people from all backgrounds and abilities. As a large employer we also take some responsibility to support the local community who are unemployed back into work. The Trust has proudly run the pre-employment programme since 2013. This programme runs for ten weeks and feeds into recruitment deficits within the Trust. The programme consists of a mixture of classroom and work based learning and is tailored for the

area where employment opportunities will be available upon successful completion. Every successful candidate will be guaranteed employment either on the Bank or in a substantive post.

The Trust has a Recruitment and Selection Policy which sets out the process for applications. This includes specific guidance on ensuring those with disabilities are given fair opportunity, such as ensuring appropriate adjustments are in place throughout the selection process. In terms of supporting existing staff the Trust has a Supporting Disability Policy that ensures sensitive, fair, consistent and compassionate treatment of staff. The policy sets out the requirement for managers to support members of staff to complete a Supporting Disability Agreement. This is designed to support our staff members and line managers to discuss their current health position, review any reasonable adjustments and understand what support is required in the workplace (and whether that has changed).

Since the launch of the LIFE Centre (Learning Inspirations for Future Employment), we have been busy supporting a variety of activities including visits from schools and colleges, networking events with our NHS partners, training the overseas nurses as well as hosting all our widening participation activity. Activities inspire the local community aged five years and upwards into NHS careers. The centre is a pan-Lancashire facility which is used by NHS organisations and public funded education providers to inspire NHS careers. LIFE is managed by the Widening Participation Team. Widening participation activity has increased significantly since the opening of LIFE. By running these programmes we are able to ensure the Trust fulfils its social responsibility including community engagement, aiding social mobility, equality and diversity and promotes the Trust as an employer of choice. Programmes prepare learners giving them the knowledge and experience needed to be recruited into vacancies at the Trust aiding recruitment and retention and helping to reduce agency costs. The Widening Participation Team and LIFE were announced as winners for Innovation in Learning at the international Learning Awards In February 2020.

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

Health and Safety Governance Group
The Health and Safety Governance Group is attended by Managers from all the Trust's clinical divisions and key corporate teams. The Health and Safety Governance Group report to the Finance and Performance Committee of the Board.

Health and Safety Joint Consultative Committee
The Health and Safety Joint Consultative Committee is a forum for engagement with staff representatives on safety matters, meeting the statutory requirements of the Safety Representatives and Safety Committees Regulations 1977 (as amended) and the Health and Safety (Consultation with Employees) Regulations 1996. The meetings are productive and create positive engagement from all.

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 being arranged and once complete will help to further up-skill the Trust in health and safety management.

Security

During 2019-20 the Security team has been 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.

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:

- New Fire Warden training packages have been created along with a fire extinguisher training package and practical training sessions.
- We have invested in new firefighting training equipment to assist with Fire Warden training.
- 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 done 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.

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, as 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 in 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 manging the Covid-19 response.

During 2019-20 major incident exercises took place to test the Trust's major incident plan. One to note was Exercise Tabanca, a multi-agency exercise including the Trust and other bodies, was undertaken in September 2019. In line with the recommendations set out in the MIAA audit report, an improved debriefing method will be incorporated following such exercises which will allow additional valuable information to be captured from all key participants to further improve the Major Incident Plan; these are currently being implemented.

An EPRR training strategy was developed by the Trust that was signed off in December 2019. The strategy captures the training requirements relating to EPRR across the whole Trust. This has been translated into a training schedule covering the financial year 2020-21. A number of training exercises took place during 2019-20 including training such as incident command training via an expert external trainer for strategic and tactical managers, loggist training and bed management major incident training. However, further work is taking place in line with the recommendations set out in the MIAA audit report in relation to communication of the EPRR training strategy, available EPRR training and reviewing staff compliance against core EPRR training.

In respect of prohibition or enforcement notices from regulating authorities, radiological protection in interventional radiology and nuclear medicine at the Trust was inspected by the Health and Safety Executive (HSE), CQC and the Environment Agency in October 2019. In total six breaches were identified by the HSE and the CQC but both have been satisfied with the Trust's response and the matter has been closed.

Political Donations
The Trust has neither made nor received any political donations during 2019-20.

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

Karen Partington
Chief Executive
18 June 2020

ACCOUNTABILITY REPORT
2019-20

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.

Dr Ebrahim Adia (Chairman) (I)
Appointment: 2 December 2019 to 1 December 2022

Ebrahim has a wide range of experience and qualifications. A former Senior Lecturer and Assistant Vice-Chancellor, his career has focused on higher education. He is currently Pro Vice-Chancellor at the University of Central Lancashire and a member of the Senior Executive Team and he Chairs the University's Ethics and Integrity Committee.

Ebrahim has served as a 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. Ebrahim is a Rapporteur for the Council of Europe, which is an organisation that upholds democracy, human rights and the rule of law.

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 ten years' post qualification 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 in the NHS.

Outside of the Trust, Tim is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee and acts as Principal Adviser to the Local Government Association. Tim is the Vice Chairman of the Trust and the Chair of the Trust's Audit Committee. He is also the independent member of the Freedom to Speak Up Team and a member of the Rosemere Management Committee.

Professor Paul O'Neill, Senior Independent Director (I)
Appointment: 4 March 2019 to 3 March 2022

Paul is Professor of Medical Education 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. His current major interest is 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 an active clinician 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 2020

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. 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 is a shareholder in GRG Consultancy (2015) Ltd. 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 Business, 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 was recently a Non-Executive Director at Cheshire and Wirral Partnership NHS Foundation Trust. Prior to that, she was Non-Executive Director and Vice Chairman at Southport and Ormskirk Hospital NHS Trust. She is particularly interested in clinical governance and is the Chair of the Trust's Safety and Quality Committee.

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 Chairman) at Kirklees Neighbourhood Housing and the equality champion. She is currently a Lay Leader at Bradford Health Research Institute.

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 successful 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 38 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 and co-Chair of the Major Trauma and Critical Care Operational Delivery Network (ODN).

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 Skailes, Medical Director
Permanent post – appointment from 1 March 2018

Gerry is an active clinician and continues to work as a Consultant in Oncology and was previously Deputy Medical Director of the Trust. 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 and has worked in medicine and surgery with operational experience in emergency care. Sarah was the Deputy Nursing, Midwifery and AHP Director at Lancashire Teaching Hospitals prior to this appointment and is the Executive Director with responsibility for maternity, children and safeguarding.

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 25 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, corporate communications 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.

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.

Board members whose term of office ended during 2019-20

Sue Musson, Chairman until 31 August 2019 (I)
Sue's Executive career encompassed a number of roles focused on economic development, business development and consultancy within the UK and Europe, including the roles of Managing Director of consultancy firm Firecracker Projects Limited, Partner of M&S Musson Partnership and Designated Member of Musson Projects LLP. She had considerable experience of dealing with change management, strategic planning, research and building sustainable partnerships with agencies such as local authorities and universities. She was a member of the ICP Board for Central Lancashire and a member of the ICS Board for Lancashire and South Cumbria. Outside of the Trust, she was also the Independent Chairman of 'Warrington Together', an integration programme to join up health and care in Warrington. Prior to joining the Trust, Sue was the Chairman of Southport and Ormskirk NHS Foundation Trust; she had also held NHS Non-Executive Director and Senior Independent Director roles at Alder Hey Children's NHS Foundation Trust and at Bridgewater Community Healthcare NHS Foundation Trust. She had served as a Patient Representative for the National Joint Registry for five years, a role that kept her close to the patient experience. Other than her involvement in Firecracker Projects Ltd, M&S Musson Partnership and Musson Projects LLP, Sue had no other significant commitments.

Sue resigned her position as Chairman of the Trust with effect from 31 August 2019 to take up a position as Chairman of another Trust.

Jeannette Newman, Senior Independent Director until 30 August 2019 (I)
Jeannette was a Non-Executive Director and later on Vice Chairman at Southport and Ormskirk Hospital NHS Trust from July 2012 to March 2017. Jeannette shared responsibility for overall governance of Southport and Ormskirk Hospital NHS Trust, setting the strategy, holding to account, seeking assurance and assessing risk. She Chaired several Committees over her term including the Audit Committee and then the Finance and Performance Committee. She led on strategic communications during a challenging time for Southport and Ormskirk Hospital NHS Trust. Prior to this she was Director of Finance for Central Lancashire Primary Care Trust and for Hyndburn and Ribble Valley Primary Care Trust. As the Director of Finance she was responsible for the financial management of the organisation both operationally and strategically. Jeannette was the Senior Independent Director of the Trust and the Chair of the Trust's Finance and Performance Committee until her resignation on 30 August 2019

Paul Havey, Finance Director / Deputy Chief Executive
Having worked at Finance Director level within the NHS for 25 years, Paul was responsible for the strategic leadership and management of the Trust's finances. He was also the Executive lead for Information Management and Technology and our senior information risk owner. Paul resigned from his post as Finance Director/Deputy Chief Executive in August 2019.

Gail Naylor, Nursing, Midwifery and AHP Director
Gail worked in a variety of clinical roles during her career, as well as leading and managing teams in a number of senior leadership positions in the NHS. Gail was previously the Director of Nursing and Midwifery at North Cumbria University Hospitals NHS Trust, and had the same role at Liverpool Women's NHS Foundation Trust for five years before that. Gail retired in July 2019.

Adrian Griffiths, Interim Chief Operating Officer
Adrian has 35 years' management experience in the NHS, and currently works as a professional interim, usually at Executive level. Adrian was Chief Operating Officer at Tameside Hospital NHS Trust for ten years until 2011, and has held interim Chief Operating Officer roles at Mid Yorkshire, South Manchester, and Great Western Hospital in Swindon, along with other senior management and consultancy roles. He was interim Chief Operating Officer at Lancashire Teaching Hospitals from July 2018 until April 2019. Adrian has considerable experience in performance and financial management, change management and the leadership of teams. He also has extensive Executive and Board level experience in a number of organisations. Adrian continues to work for the Trust as Service Development Director.

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 4 March 2019 for a three-year term.

Board meeting attendance summary 2019-20

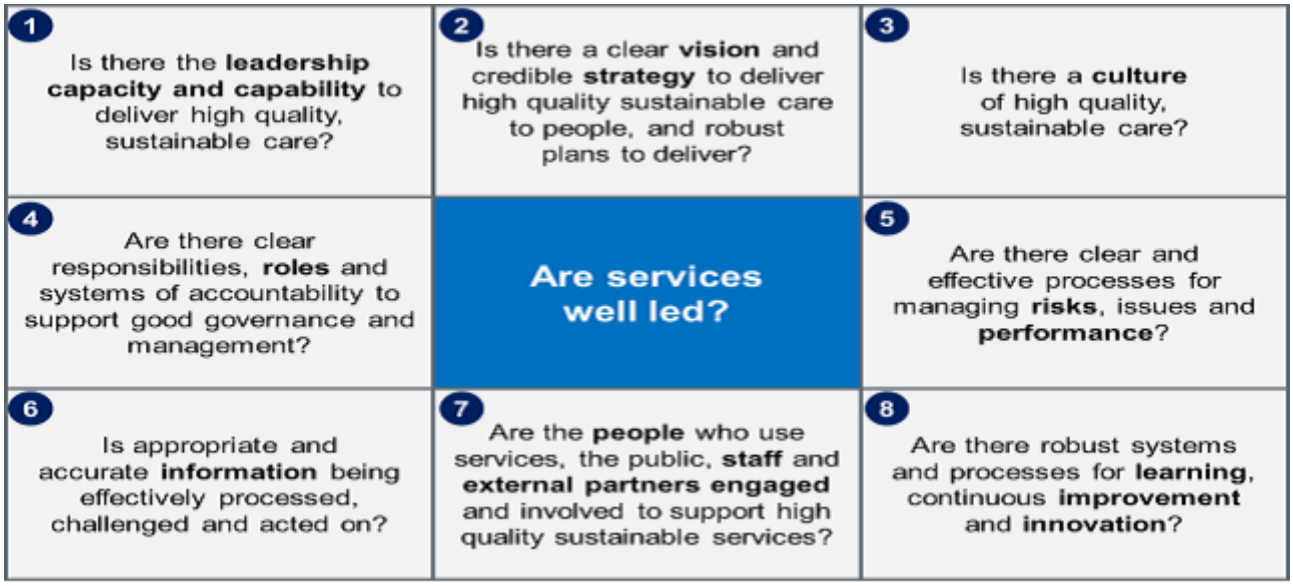
PRESENT	04/04/2019	06/06/2019	01/08/2019	03/10/2019	05/12/2019	06/02/2020	A	B	Percentage of meetings attended
Ebrahim Adia *(appointed December 2019)*					P	P	2	2	100%
Ailsa Brotherton	P	P	P	P	P	P	6	6	100%
Faith Button *(appointed May 2019)*		P	P	P	P	Ab	5	4	80%
Sarah Cullen *(appointed August 2019)*			P	P	P	P	4	4	100%
Adrian Griffiths	P						1	1	100%
Paul Havey	P	P	P				3	3	100%
Sue Musson	P	P	A				3	2	67%
Gail Naylor	P	P					2	2	100%
Jeannette Newman	P	P	P				3	3	100%
Paul O'Neill	P	P	P	P	P	P	6	6	100%
Karen Partington	P	P	P	Ab	P	P	6	5	84%
Ann Pennell	P	P	P	P	P	P	6	6	100%
Geoff Rossington	P	P	P	P	P	P	6	6	100%
Gerry Skailes	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	P	P	P	P	6	6	100%
Jim Whitaker	P	P	Ab	Ab	P	P	6	4	67%
Tricia Whiteside *(appointed September 2019)*				Ab	P	P	3	2	67%
Jonathan Wood				Ab	P	P	3	2	67%

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

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 2018. 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:



The Independent Review indicated a good level of awareness around the strengths of the organisation, as well as reflecting areas where greater improvement is required. Overall, the review highlighted 19 recommendations for improvement which the Trust incorporated into the Quality Improvement Plan. 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.

It is recommended the independent review takes place every 3-5 years and as such the Trust will be revisiting this through the office of the Company Secretary during 2020-21.

The Trust's leadership and governance arrangements were further tested, alongside the recommendations from the Independent Review in August 2019 by the CQC during their Well Led Inspection. During their inspection, the CQC rated the Trust 'Good' for Well Led. This was an

improvement on the previous Well Led Inspection in July 2018, when the CQC rated the Trust 'Requires Improvement'.

During their inspection, the CQC deemed Trust leaders to have the appropriate experience, capacity, and skills for their roles. While there were new appointments to the Board, leaders were positive about the changes and the contribution the new leaders had made. Leaders were, overall, visible and approachable and the Trust was committed to developing staff to become future leaders through development programmes. Leaders were also assessed as being knowledgeable about issues and priorities for the quality and sustainability of services and had a shared understanding of the risks and challenges.

With respect to managing risks, issues and performance the CQC assessed the Trust as having the processes to manage current and future performance. There was a comprehensive process to identify, understand, monitor and address current and future risks. The CQC did however deem there was a lack of clarity between the interface between the Board Assurance Framework and corporate risk register. Since the inspection, the Board Assurance Framework has been refined to address this lack of clarity and further work will continue in 2020-21 to further improve understanding of this. The CQC also concluded that performance issues were escalated to the Board and appropriate Committees of the Board through clear structures and processes. The Trust used information well to monitor performance across the organisation and had developed integrated performance reports which were aligned to the ambitions in the new strategy. Performance reports covered a mix of quality, operational and financial information. The Trust had processes to ensure that the information was accurate, valid, reliable, timely and relevant. The Trust was using and had processes to develop information technology systems to monitor and improve the quality of care. Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures were managed so that they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.

Since the Inspection, the Board continues to self-assess and further improve governance arrangements, most recently during a Board Workshop held in March during which the Board reflected on current ways of working and potential development opportunities.

The effectiveness of the Trust's governance structures also continued to be internally tested during 2019-20 via the Annual Internal Audit Programme with MIAA, the Trust's internal auditors, providing an overall opinion of moderate assurance, based on their work during 2019-20. In line with the governance framework, follow up to this continues to be monitored through the Audit Committee.

With respect to individual performance, a robust appraisal process is in place for all Board members and other senior Executives. The Chairman appraises the Chief Executive, and the Chief Executive carries out performance reviews of the other Executives. Annual performance reports of senior Executives are provided to the Appointments, Remuneration and Terms of Employment Committee (consisting of Non-Executive Directors). The Chairman undertakes an annual performance review of Non-Executive Directors using our Non-Executive Director competency framework and the outcomes of these appraisals are provided to the Nominations Committee (consisting of Governor representatives) as well as to the full Council of Governors. The Senior Independent Director undertakes the annual performance review of the Chairman.

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' meeting, Council of Governors' meetings and workshops, linkages with the Council sub-groups and an annual interactive forward planning session each year. During 2019-20 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) by maintaining a rota system and having a Governor attendance recorded within Board minutes;
(ii) there is Non-Executive Director representation at each of our core Governor sub-group 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;
(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 2019-20 we held a joint development session on Building Relationships and a further session on the Trust's End of Life Care Strategy and our organisational priorities for providing care to patients with Mental Health and Learning Disabilities; and
(vi) there are joint visits and events around the hospital, such as Fab Feedback Friday visits during which departments and teams are encouraged 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:

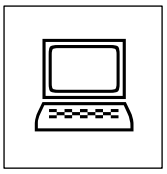
- **Assessing risk related to human trafficking and forced labour associated with our supply base**: we do this by supply chain mapping and developing risk-ratings on labour practices of our suppliers to understand which markets are most vulnerable to slavery risk.
- **Developing a 'Supplier Code of 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, 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 report on page 131 and within our annual governance statement on page 90.

Major service developments

Work is well underway to expand and refurbish our Critical Care Unit at Royal Preston Hospital. The new multi-million pound state-of-the-art unit means we are able to increase our bed capacity and will feature increased natural light and enhanced patient facilities, with a particular focus on rehabilitation. Facilities for visitors will include a kitchen, lockers and a rest room. Staff facilities are also being upgraded, with a brand new clinical skills room and a quiet space to encourage mindfulness in the workplace. The changes we are making to both patient and staff facilities will ensure our team has everything they need to provide patient care of the highest possible quality.

Critical Care refurbishment is underway

Work is also underway to reinstate the Birth Centre at Chorley and South Ribble Hospital after the service was temporarily halted there due to a discovery of asbestos in the building. We are also investing £17.5m to build a new Ophthalmology Centre on the Chorley site. The new unit will include dedicated outpatient and diagnostic space as well as three additional theatres to provide extra capacity for patients requiring a variety of day case procedures. This exciting new development will be in addition to current facilities at Royal Preston Hospital. The unit is expected to open in October 2021.

New Ophthalmology centre being built

During 2019-20 other major service developments included:

- Developing an innovative system that allows NHS Trusts to exchange patient's health and care information with each other and more than 300 GP practices in Lancashire and South Cumbria.
- Developing a world-leading diary style document that encourages patients to write about their progress, thoughts and feelings, what can be done to enhance their recovery and any issues they want to raise while receiving treatment.
- Opening a new Postnatal Transitional Care Unit to enable babies who need close monitoring or extra support to be cared for alongside their mothers.
- The Health Academy receiving Excellence Centre Status for our high-quality skills programmes and workforce development initiatives.
- Winning an Apprenticeship Employer of the Year Award.
- Our Adult Allergy and Clinical Immunology Service becoming a national Specialised Commissioned Centre meaning we are now better able to deliver cutting-edge care and innovation, have access to high-cost and new drugs and can deliver better patient care.
- Opening a new and improved fracture clinic which has better facilities and means all the team can work in one area.
- Our Maternity Services ranking in the top 10 in the country in the patient experience survey.

Research

Our strategic commitment to drive innovation through world-class research continues to go from strength to strength as 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 in four studies and have recruited over 2,100 new patients into studies and clinical trials.

When we were established in 2005 we were the first Trust in the country 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 are a regional leader in respect of our education, training and research and as the only National Institute of Health Research (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 education and research strategies.

In 2019-20 the Centre for Health Research and Innovation (R&I) has continued to grow and develop in line with the ambitious three year strategy (2019-22). Many new milestones have been reached, highlights include:

- The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2019-20, recruited to participate in research approved by a Research Ethics Committee was circa 2,122 (circa 2,500 in 2018/19). While this represents a slight decrease in numbers, they compare favourably against a national reduction in activity of circa 22%.
- In total, there are currently now 223 active research studies recruiting patients at the Trust.
- We have opened 62 new studies this year (74 in 2018/19 and 62 in 2017/18) which is creditable given the reduction in NIHR portfolio studies opening in this period.
- We continue to perform strongly against the Department of Health and Social Care benchmarks for the set up and delivery of clinical research in the NHS. 85% of trials achieved the NHS 40 calendar day benchmark (71% in 2018-19).
- The average occupancy in the Lancashire CRF stayed at an excellent 45% which is ahead of trajectory for Year 3. Given both the national fall in NIHR studies and the Covid-19 crisis, this is very creditable and is testimony to performing more high intensity experimental medicine studies.
- The Lancashire CRF has consolidated cross-sectoral funding to secure its sustainability and growth and is actively reviewing new partnerships.
- The 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 2019-20 across the partnership, bringing genuine newness in experimental medicine studies to Lancashire and South Cumbria.
- Alison Swan, Research Sister in the NIHR Lancashire CRF at Lancashire Teaching Hospitals, was shortlisted for the Nurse of the Year Award in the national Nursing Times Awards 2019.
- Our Lancashire CRF and Cancer teams successfully recruited a patient into a Phase 1 (B) clinical trial. This is a historic moment in the history of experimental medicine at the Trust. At the time of writing the Lancashire CRF are screening for the Trust's first ever First In Human (FIH) study and developing the processes to deliver our first Genetically Modified Organism (GMO) study.
- In the 2020 NIHR North West Coast Research and Innovation Awards, the Clinical Research team at Lancashire Teaching Hospitals were crowned winners of one award and were 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.
- The Lancashire CRF team was shortlisted for the **Transformation Award** for their collaborative approach to bringing experimental medicine research to Lancashire and South Cumbria. This comes following the NIHR's funding for the Lancashire Clinical Research Facility (LCRF) in 2017.

- The team was also shortlisted for the **Partnership in Innovation Award** for SRAVI (Speech Recognition App for the Voice Impaired). SRAVI is a communication app created in partnership with Liopa Ltd, a Belfast-based SME (Small and Medium Enterprise) and Queen's University Belfast Medical Research Group. Led by Dr Shondipon Laha and Mrs Jacqueline Twamley, the project involved the development of an app aimed at patients who have difficulties communicating vocally.
- NOVEL – Gynae Academic study: *Nonavalent prophylactic HPV vaccine (Gardasil® 9) after local conservative treatment for cervical intra-epithelial neoplasia: a randomised controlled trial.* Professor Pierre Martin-Hirsch is the Personal Investigator for this trial and we were the first site to open in the UK and also to recruit two patients. Pierre was also part of the Protocol Development Group for this study.
- There have been two Lancet (Citation Impact factor or 39) publications associated with research and the Trust from Drs Fiona Crossfill and Alison Birtle, the latter of which has first authorship. The Lancet is the fifth most cited journal in world medicine.
- Nichola Verstraelen, Clinical Team Leader for Research and Innovation, is participating in the first year of the NIHR 70@70 programme. The national programme has recruited 70 outstanding senior Nurses and Midwives who are committed to championing and embedding a research active culture across nursing and midwifery within the organisation. The programme will run for a period of three years and will enable applicants to share best practice and learnings in order to drive real change across research systems and strengthen the research voice and influence of Nurses and Midwives in NHS provider organisations. Nichola has made great strides forward in the first year and is committed to drive forward education for staff on how research is relevant to every day practice from an academic perspective (evidenced based care) and delivery where every member of staff will know how to access and refer patients to studies the research team are delivering.
- 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. Activities to date include:
  - Updates to training resource via MOOC (massive open online course) aimed at unlimited participation and open access via the web
  - Ensuring excellence in research programme continues to meet the needs of the Cancer Research Nurse workforce by :
    - Performing educational gap analysis.
    - Promoting excellence in cancer research access the whole fields of cancer research nursing in the UK (sharing experience of being a previous finalist for the award).
    - Helping organise the yearly excellence in cancer research event.
- We have been the first UK site to open and recruit in three commercial studies and one non-commercial, over the last year.
- 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. This includes our clinicians being invited to act as Chief Investigators. Likewise, the portfolio has widened to include more commercial work across a wider spectrum of clinical departments. Looking at studies coming through the pipeline, this trend is set to continue into the coming year, with an additional increase in the number of device trials.

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 and AHP (Allied Health Professionals) Strategy which are now both in their third year of implementation. This year introduced a Medical Leadership Strategy shaping a clinical leadership model that aims to provide excellent care with compassion to patients. Further information on these areas can be found in the Quality Report.

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

Our Patient Advice and Liaison Service (PALS) team work with clinical and departmental staff to try to resolve concerns at the earliest opportunity in order to avoid an escalation to the formal complaint process wherever possible. They 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 to access it
- acting as an early warning system for the Trust
- working in partnership with the PALS teams of other healthcare providers

Complaints

Consistent with the NHS regulations for complaints management introduced in April 2009, we agree with all complainants how an investigation into their complaint will be conducted and when they can expect to receive a written response. A review of how complaints are responded to considers the most appropriate method of communication rather than only the traditional written response. In some instances complainants wish to meet with the staff involved and receive a summary of the discussion. The organisation is currently working towards recording meetings where all parties wish this to take place. This ensures that the Trust is recognising the diversity of the population and avoids a ‘one size fits all’ approach, demonstrating a commitment to engagement and involvement. This will also support accuracy and detail of information provided during a meeting.

During 2019-20 the Trust received 457 formal complaints, a decrease of 253 (36%) on the 2018/19 position.

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

In 2019-20 the Trust received one formal complaint for every 1,329 patient episodes compared to one in 1,428 during 2018/19.

Year	No of complaints	Total episodes (IP/OP)	Ratio of complaints to episodes
2015-16	575	808431	1:1406
2016-17	595	790696	1:1329
2017-18	553	789643	1:1428
2018-19	710	815607	1:1148
2019-20	457	576447	1:1261

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In 2019-20, 99% of complainants received an acknowledgement within that timescale.

Of the 457 complaints received between April 2019 to March 2020: 372 (81%) related to care or services provided at the Royal Preston Hospital; 83 (18%) to care or services provided at Chorley and South Ribble Hospital; one (0.5%) to care or services provided off-site by the Specialist Mobility Rehabilitation Centre based at Preston Business Centre; and one (0.5%) related to other matters.

A total of 457 formal complaints were closed during April 2019 to March 2020. 97% of complaints received in 2019-20 were closed within the 35-day timescale with 48 complaints remaining open although within timescale.

Second letters are often received as a result of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. In 2019-20, the Trust received 25 second letters, one less than the number received in the previous financial year.

Year	Number of second letters	% of second letters
2015-16	52	9%
2016-17	38	6.4%
2017-18	40	7.2%
2018-19	26	3.6%
2019-20	25	5.4%

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in those instances where local resolution has not been achieved. Between April 2019 and March 2020 there were four cases where the PHSO determined that two complaints would be partially upheld; one not upheld and one explored and reached local resolution for the complainant. During this period the PHSO sent final reports for seven cases and the outcome of these were two upheld; three partially upheld and two not upheld: these cases were opened prior to April 2019. A further four cases continue to be ongoing and no final decision has yet been reached.

The main issues described in complaints related to communication, specifically where we failed to communicate to patients on their care, patient pathway issues such as delays and cancellations, clinical treatment or procedures undertaken, and issues relating to perceived poor staff attitude.

The Patient Experience and PALS Team have dealt with over 2,344 issues which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients. This is an increase of 23.82% on the same period last year, demonstrating a positive reflection of the move to locally resolve concerns, supporting the organisations strategy (Our Big Plan) and ensuring a positive patient experience.

In summary, during 2019-20 the Trust has consistently met the 35-day target of responding to complaints. The revision and implementation of Datix 2 Governance reporting system has allowed the Patient Experience and PALS Team to review the current management of complaints and streamline the process. This will provide an opportunity to ensure that there is a more complete understanding of the themes and trends, not just from complaints and concerns as it will include all of patient experience.

Over the past 12 months the Customer Care team, PALS team and Patient Experience team has been through a transformation resulting in a 'one-team' ethos with the formation of the Patient Experience and PALS Team – 'One Team'. This has allowed a clearer focus on bringing together a mixture of what matters to patients, making the process for raising complaints and concerns more streamlined. This work is continuously developing and forms part of Our Big Plan objectives to ensure a clear focus on team working to achieve the Trust's ambitions, specifically concerning 'Deliver a Positive Experience'.

In response to feedback received in 2019-20 the Trust has made changes in a number of areas to improve the quality of service provision. Some of the changes include:

- Consultation with patients and service users to change and redesign information for bereaved families
- Therapy services to provide ward based patient services and enhanced experience
- New patient magnet to signpost patients with Parkinson's disease
- Ward packs for patients with Parkinson's disease
- Alarm clocks for medications to ensure patients who have Parkinson's disease receive their medications on time
- AccessAble on the website for people with visual challenges and where English is not their first language
- Involvement with World Patient Safety Day
- Development of symbols on Quadramed for patients who have additional needs to support the NHS England (NHSE) Accessible Information Standard
- Development of Easy Read information for patients
- Outpatients Charter development
- Digitisation of patient appointment letters
- Purple Boxes on wards for patients with learning disabilities, dementia and mental health needs
- Introduction of the Patient Contribution to Case Notes (PCCN) diary for patients, carers and families
- The continuation of an inpatient Carers Charter in recognition of how carers can support their loved ones whilst in hospital
- Encouragement of patients to identify what matters most to them on any given day
- Implementation of magnets to identify specific individualised needs of patients displayed on ward boards behind the patient's bed
- Continuation of a Youth Forum for Children and Young People's Services
- Continuation of involvement in the Maternity Voices Partnership involvement

- Development and introduction of the 'Always Safety First' programme
- Continuation of Purple Socks campaign to support those patients who are at risk of wandering
- Access to the PALS on the Chorley site to ensure a safe, comfortable environment for patients to raise concerns
- Increased activity and reporting of the Friends and Family Test

Patient experience feedback

The Friends and Family Test (FFT) is a national key indicator of patient experience to gather information at the point of or after discharge. This assists the Trust in identifying 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.

During the period April 2019-20 feedback has been received from the following five key areas:

- Inpatients
- Outpatients
- Day case treatment
- Emergency department
- Maternity services

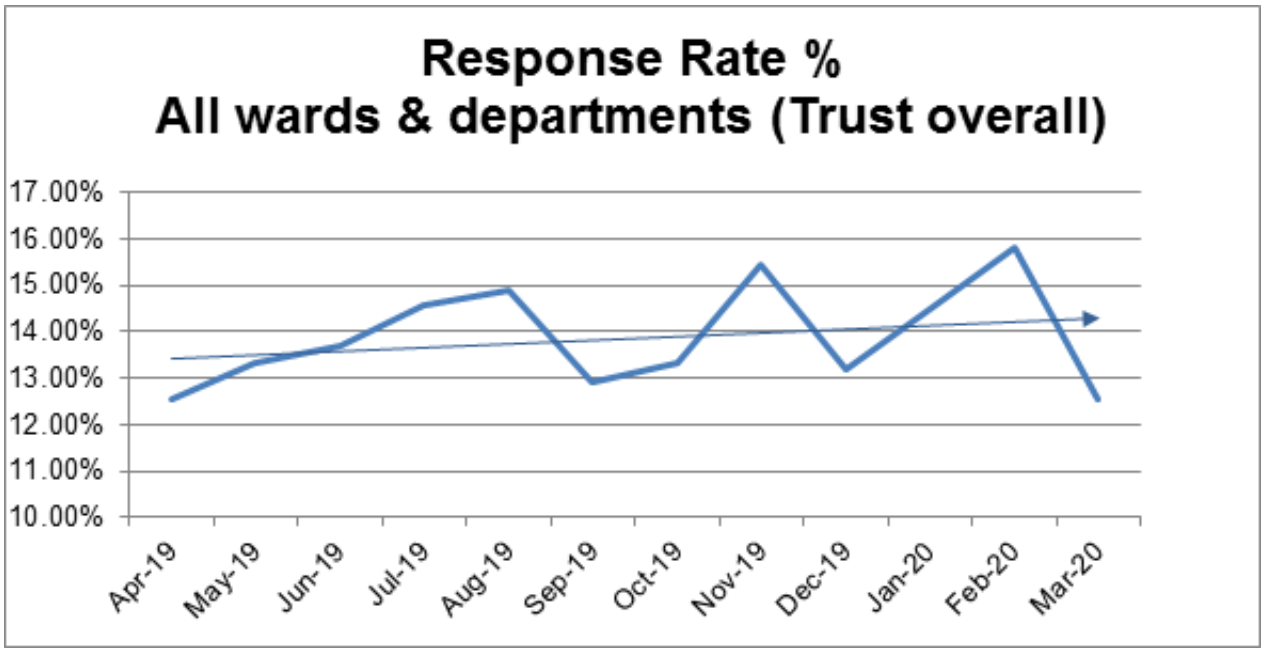
An established process to gather information from Children and Young People's services has been implemented, with the addition of Neonatal services in May 2019. Throughout 2019-20 work has continued with a range of departments across the organisation to make the FFT test more accessible, with a view to all areas using the FFT feedback. This has been successful and will continue to be rolled out within outpatient areas through working with staff and developing questionnaires to gather the FFT results and feedback, as well as tailoring the information to specific services.

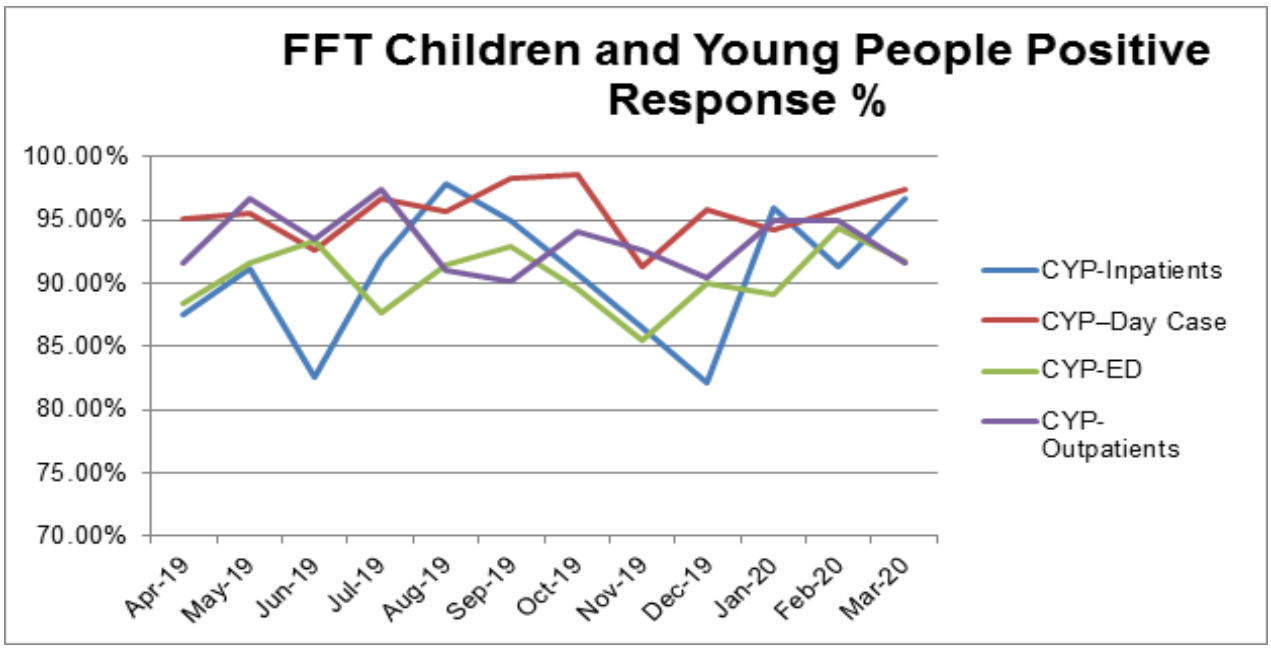
The wards and departments have engaged with the process across Chorley and Preston Hospitals and the FFT monthly results are visible for staff, patients and visitors, along with 'You Said, We Did' information based on the feedback provided. The FFT is part of the STAR accreditation framework and this has helped to raise staff awareness and understanding of how the FFT can support our patients, families and carers.

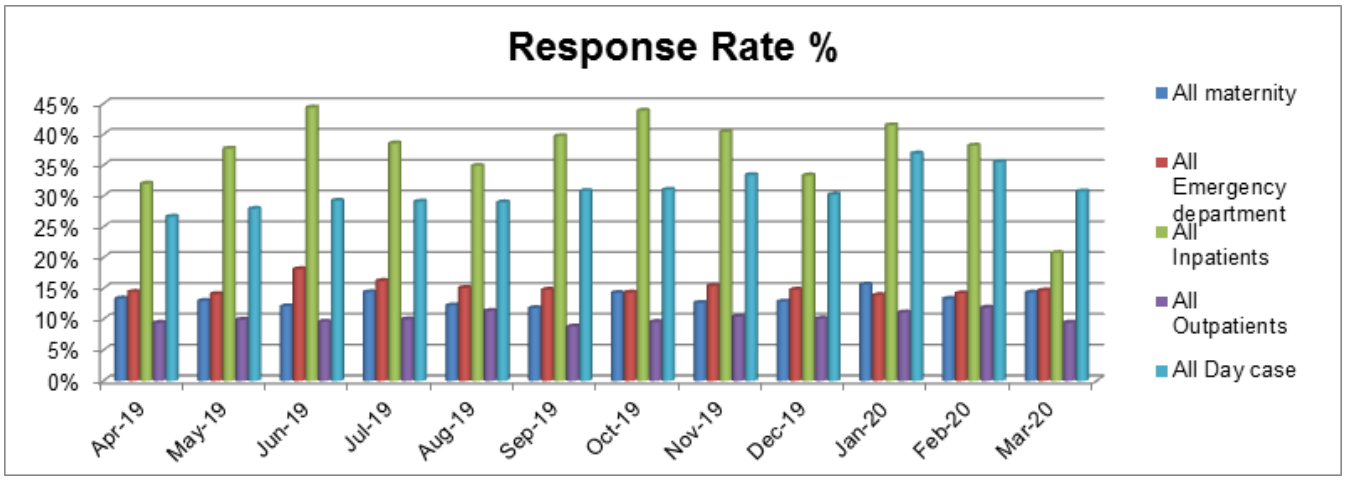
Throughout 2019-20 we have seen an increase in the overall response rate to FFT across the Trust. Some areas of concern have been highlighted with using Short Message Service (SMS) texts however this continues to be the largest feedback source along with paper surveys and individual voice mail. As we continue to develop technology in other areas throughout the Trust our data collection and reporting will become more efficient.

FFT performance is monitored on a monthly basis and is reported through the Trust's Safety and Quality Committee. The 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.

From April 2020 the FFT question will change nationally in line with NHSE guidelines. This will provide patients, families and carers with a better understanding of the FFT and allow them the opportunity to provide meaningful feedback on the services they have received. This change will provide organisations with the opportunity to provide more accurate reporting and understand what matters most to patients.


Response Rate %
All wards & departments (Trust overall)
17.00%
16.00%
15.00%
14.00%
13.00%
12.00%
11.00%
10.00%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20


FFT Children and Young People Positive Response %
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
CYP-Inpatients
CYP–Day Case
CYP-ED
CYP-Outpatients


Response Rate %
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
All maternity
All Emergency department
All Inpatients
All Outpatients
All Day case

National Adult Inpatient Survey

The National Picker Inpatient Survey 2018 provides analysis of the experiences of inpatients from July 2018. A total of 397 returned a completed questionnaire, giving a response rate of 33% which was a 1% increase on the 2017 survey. The results for the 2018 survey were released after the publication of the Quality Account for 2018-19 and are consequently presented in this year's report. Patient comments from the survey about the Trust as a whole 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, the Trust 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%

The National Adult Inpatient Survey for 2019 has been undertaken however the results are under embargo until the CQC give notice for publication. The survey will provide information about:

- Accident and Emergency all types of admission
- The hospital and ward
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Overall view of the hospital

Urgent and Emergency Care Survey

The Urgent and Emergency Care Survey provides analysis of the experiences of care provided in Type 1 Emergency Department from September 2018. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 department. It considers arrival, waiting, doctors and nurses, care and treatment, tests, pain, hospital environment and facilities, leaving the Emergency Department and overall experience. The survey is carried out every two years with the previous Urgent and Emergency Care Survey being undertaken in 2016.

A total of 35 questions were used in the 2018 survey: of these 28 questions can be compared historically to questions asked in 2016. Compared to the 2016 survey, Lancashire Teaching Hospitals has achieved a positive score change of 8 points and is ranked 47 out of the 69 Trusts surveyed, compared to 57 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, the Trust ranked best in the following areas:

- Told how they 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%

A total of 950 patients from Lancashire Teaching Hospitals were sent a questionnaire of which 252 returned a completed questionnaire, giving a response rate of 27% which is an increase of 4% from the 2016 survey. The average response rate from the 69 Trusts surveyed by Picker in 2018 was 30%.

Children and Young People's Survey

The Children and Young People's Survey 2018 provides analysis of the experiences from July 2018. The previous Children and Young People's survey was undertaken in 2016. The survey comprised three age-appropriate versions:

- Parent Version A – for parents/carers of inpatients and day case patients aged 0-7 years
- Child Version B – for young inpatients and day case patients aged 8-11 years and their parents/carers
- Young Person Version C – for young inpatients and day case patients aged 12-15 years and their parents/carers

A total of 64 questions were used in the survey, of these 61 can be compared to questions in the 2016 survey. A total of 255 questionnaires were completed which is a response rate of 21% and an increase of 2% from the 2016 survey. The average response rate for the 66 Trusts surveyed by Picker in 2018 was 26%.

Lancashire Teaching Hospitals has achieved a positive score change and is ranked 58 out of the 66 Trusts surveyed, compared to 65 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, the Trust 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 well in the patient surveys we have participated in however it is recognised that there is always room for improvement and the Trust aims to continually improve our services, in relation to feedback from our patients and service users.

National Cancer Patient Experience Survey

The Cancer Patient Experience Survey 2018 published in September 2019 provides analysis of the experiences of care provided for adults aged 16 or over with a confirmed diagnosis of cancer, discharged from an NHS Trust after an inpatient episode of day case attendance for cancer related treatment, in the months of April, May and June 2018. The survey is carried out annually with the previous Cancer Patient Experience Survey undertaken in 2017.

A total of 52 questions were used in the 2018 survey and of these 49 can be compared historically to questions in 2017. Compared to the 2017 survey rating of 8.8, Lancashire Teaching Hospitals has achieved a positive score change of 0.1% increase in the average rating provided by respondents when asked to rate their care, with an overall score of 8.9:

- 88% rated overall care as very good/good
- 87% rated overall always treated with respect and dignity by staff

When comparing the average results received across all other hospitals, the Trust ranked best in the following areas:

- Patient told they could bring a family member when first told they had cancer – 88%
- Patient definitely given enough support from health or social services during treatment – 60%
- Patient given a care plan – 40%

A total of 1,400 patients from Lancashire Teaching Hospitals were sent a questionnaire of which 853 returned a completed questionnaire, giving a response rate of 65% which is an increase of 1% from the 2017 survey. The average national response rate for the survey in 2018 was 64%.

This survey was undertaken by Quality Health on behalf on NHSE and next year the survey will be carried out by Picker.

National Maternity Survey

Maternity services have received positive feedback in an annual national survey for 2019, demonstrating continuous improvements from the previous survey.

The Trust was one of 63 maternity providers who participated in the survey during 2019. A total of 303 mothers from Lancashire Teaching Hospitals were sent a questionnaire. 298 mothers were eligible for the survey, of which 94 returned a completed questionnaire, giving a response rate of 32%. The average response rate for the 63 Trusts surveyed by Picker was 36%.

The results demonstrate an improved position for maternity services compared to the last national Picker survey in 2018. Lancashire Teaching Hospitals is now ranked 10 out of 63 Trusts nationally compared to 12 out of 68 Trusts surveyed in 2018.

The maternity services ranked significantly better than the last survey on the following three 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, the Trust 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%

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2019-20 a total of 5,214 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.

Additionally Executive and Non-Executive Directors 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.

Patient and public involvement activities

The National Health Service Act 2006 places a duty on healthcare organisations to make arrangements to involve patients and the public in service planning and operation. We consider effective patient and public involvement (PPI) to be key to delivering high quality care and we will continue to ensure patients and the public are involved in major service changes and developments. The Trust also recognises that PPI takes place at a number of levels, whilst feedback on service delivery and quality come from a variety of sources.

Good communication is the basis of ensuring that effective patient experience is at the core of our services. The promotion of this has prompted the organisation to look at the current systems in place and engage with service users to make improvements as to how we communicate effectively. As part of this many areas are seen as a key priority where work is being undertaken to enhance communication with patients, carers, relatives and visitors to our hospitals.

The Trust continues to work towards the Patient Experience and Involvement strategy. The continuation and momentum of this strategy is to provide an opportunity for the organisation to gather experience from a variety of sources and enable changes to be made based on the expectations of our service users.

The Patient Experience Improvement Group provides key stakeholders with a voice to express what matters most to them during a hospital experience. It provides an opportunity for patients, carers and visitors to really engage with healthcare and genuinely have a voice to support our local NHS.

One of the key developments this year has been the introduction and pilot of the Patient Contribution to Case Notes (PCCN). This is a diary provided to patients to encourage them to record their experiences of care, along with noting their feelings as part of their journey. The PCCN was based on an idea of one of the Consultant Oncologists, who recognised the need to put patients at the centre of their care and treatment and is constructed on a social model of involvement, where previously medical consideration of condition was potentially the only driver for care needs. The pilot has provided positive feedback from those who have been involved and is now being implemented in other areas of the Surgical Division and included on the Quadramed system as a requirement of Consultant ward rounds.

The Trust has continued to develop the NHSE Accessible Information Standard. As part of this ongoing work a flag is now included on the Quadramed patient record with symbols that relate to additional needs. This highlights to staff the need to explore any additional needs with patients and their carers to ensure that appropriate support is put in place at the earliest opportunity.

Volunteers

We are so very proud of the contribution made by our 700+ volunteers who provide invaluable support to many areas on our hospital sites. They dedicate their time so generously to support patients and their families/visitors and their contribution cannot be underestimated.

We want to continue to support them as they volunteer with us so we work hard to ensure we can retain them, as well as encouraging new volunteers to join us also.

Over the last 12 months, 92 volunteers have been recruited to the Trust in areas such as Ward Support, Paediatric Emergency Department, the Research Unit, Chaplaincy, Emergency Department, Bereavement Services and Patient Experience/PALS. We are working hard to develop new roles with a supporting role profile to outline the duties to modernise as our staffing and wards/departments also modernise.

NHS Improvement funding

In December 2019 we were awarded £25000 funding from NHSI which was allocated to support volunteering activity to help with winter pressures. We decided to support the creation of a Volunteer hub area in close proximity to our Emergency Department – a place our volunteers would 'own', be based and would volunteer from to provide services and support to our very busy Emergency Department teams.

Many existing volunteers chose to extend their voluntary roles to include this support, or indeed leave their other volunteer role to undertake this one. It has been such a success that we are now planning to use the funding to purchase new uniforms for existing and new volunteers for ease of identification and to create a sense of belonging.

We are investing in our marketing materials and branding to increase visibility of the roles of volunteers to support recruitment and to increase our numbers and the diversity of volunteers to support winter pressure in 2020/21.

Engaging new volunteers

During the year:

- We have engaged in careers events such as open days and jobs fairs and we accompany our Recruitment and Widening Participation colleagues to increase our visibility at events throughout Chorley, Preston, South Ribble and beyond to spread the word about hospital volunteering.
- Our volunteer roles continue to be promoted at local colleges across Preston and South Ribble and Job Centres in Preston and Chorley.
- We have had some real success engaging with students undertaking healthcare courses and recruiting them as volunteers. This enables them to gain invaluable skills and experience as well as helping us to develop relationships with them to encourage them to apply for paid roles when they qualify in their chosen profession.
- We have developed a new Volunteers Induction Handbook which will be distributed to all existing volunteers as well as new ones. It outlines everything our volunteers can expect when they support us which helps them understand the importance of the role they will play.
- We have been reviewing and updating the Trust website and media communications with regards to the promotion of volunteers to engage with a more diverse community and make it easier for volunteers to engage with us and find out about our opportunities.

Volunteer recruitment

- The process for recruitment of volunteers is continually being reviewed in response to feedback to simplify this where we can and reduce our time to hire so those individuals who are keen to give their time to support our patients and the Trust can commence volunteering with us as soon as possible.
- We now use our Trust recruitment system TRAC to manage and monitor all our volunteer recruitment so that we can do as much as possible online and make the process as easy as possible.
- Our volunteers can access eLearning modules online and this also now includes induction which is a new approach this year where they can log on via their own email addresses to undertake it. This does speed up our recruitment processes and ensures our volunteers can be volunteering as quickly as possible.
- Social media activity has really been increased over the last 12 months as a way of engaging with new and diverse audiences around opportunities to volunteer. Using all the Trust's channels on Facebook, Twitter, LinkedIn and Instagram we share our volunteering opportunities. This has encouraged people from all different backgrounds to put themselves forward to support our patients.
- We have developed a suite of new role profiles which outline all the different kinds of roles a volunteer can undertake. New ones are being developed all the time as we become more and more creative about how volunteers can support the Trust.

Looking after our volunteers

- We continue to engage with our volunteers on a regular basis once they have started with us. At three months, we undertake a telephone call or see volunteers personally to ensure the placement is meeting their needs and to check if there are any issues or concerns. The cumulative feedback on this so far has been very positive with volunteers seeming to be most content with their placement and support.

- If a volunteer chooses to end their placement we undertake a volunteer exit interview with them to understand their reasons. We have not completed many of these to date as often our volunteers continue to stay with us once they start volunteering.
- As a way of thanking our volunteers, we hold two Christmas lunches – one at Chorley and one at Preston. Our Chief Executive and other colleagues serve our volunteers their lunch which seems to be very much appreciated. As part of this, long service awards are given out for ten, 20 and 50 years' service. Some pictures of the lunches held in December 2019 are below:

- Volunteers are invited to attend our Big Conversation events for staff and contribute their thoughts and ideas. This year we will be running an engagement survey for our volunteers during the staff survey period and will share the outcomes and any actions we identify.
- Our volunteers are also kept informed about what is going on via newsletters, information on health and wellbeing initiatives and Library news so that they feel connected to, and part of, the Trust and can access some of the great benefits available to all our staff.
- Chorley Hospital Radio was presented with a 50 Year Certificate by the Hospital Broadcasting Association for continuous service to Chorley and South Ribble Hospital.
- A garden area on Ward 2A Neurosurgery was recently upgraded by a local college for patients and staff to sit in and relax; this is now maintained by one of the Trust's volunteers.
- We have started a new monthly newsletter to be shared with all volunteers to keep them up to speed with everything and also so they can make suggestions to us.

Identifying where volunteers are needed

- We are always looking for new opportunities for our Volunteers, so ward and department managers are regularly reminded to consider volunteers as a resource to support them.
- Our **Pets as Therapy Dogs** support our patients and have been busy this year, visiting wards and departments on a regular basis. They also visit, on request, any patient that the staff feel would benefit from a cuddle. Specially trained, they regularly visit the Critical Care Ward and children's area to give a much needed boost to aid recovery. Pictured is Iska at Christmas 2019 – who is very well loved across the Trust, and brought a smile to many faces over the Christmas period particularly!

- We have created more **Meet and Greet** volunteer opportunities after feedback from wards that more volunteer support would be welcomed especially now that there is open visiting on all wards.
- We are meeting with several departments to discuss their requirements and to assess what support individual wards would like. Ongoing recruitment is taking place for Surgical, Paediatric Wards, Theatre Areas and Outpatient Departments and we are currently developing our intranet so it is easier for our managers to use and find out about how to get a volunteer.
- The Volunteer Manager is a member of the Patient Experience Improvement Group which meets monthly to plan actions from feedback received with focus on solutions and patient experience – this provides such a valuable insight and has helped identify new volunteer placements.
- The role of Ward Beverage Volunteer to assist at mealtimes has also been extended to include dining support, this is to engage with a patient during meal times and encourage the patient through social interaction to eat and drink.
- We continue to work in partnership with the Royal Voluntary Service to provide additional volunteer support for patients with dementia and are working hard to develop the Dementia Champion role to undertake activities which enable our dementia patients to be occupied through support and volunteer-led activities on the wards.

Priorities for 2020-21

Our Volunteer Strategy forms part of our Trust Workforce and Organisational Development Strategy 2019-2021.

Some of our key areas of focus over the next 12 months are:

- Ensuring best use of volunteering to facilitate the release of additional nursing and clinical time and support the achievement of the Trust targets, e.g. 4-hour wait and discharge.
- Raising the profile of how volunteers proactively support service delivery ensuring our volunteers are embedded into clinical teams and proactively supported in the workplace.
- Developing the roles of Befriender, Distraction Therapy and Discharge Support Volunteer as part of existing ward volunteer roles.

- Continuing to ensure clear action plans are in place and are delivered for all aspects of volunteer compliance around recruitment checks, Disclosure and Barring Service (DBS) and mandatory training.
- Improving positive celebration of volunteering through case studies, awards, tweets, posters, and communications for an immersive and uplifting culture of volunteering.
- Developing a volunteer action plan as a result of Big Conversation feedback and conducting a bespoke volunteer engagement survey, and implement actions as a result.

Stakeholder relations

Efforts continue to promote good working relationships with stakeholders, including strengthening partners such as the local authorities and the CCGs. The development of clinical services and improvements to patient experience are also helped by strong collaboration with other acute hospitals in Lancashire and beyond.

The Central Lancashire Urgent Care Delivery Board has representatives from the Trust, the local CCGs, Lancashire and South Cumbria NHS Foundation Trust, Primary Care, North West Ambulance Service, 111 Service, the Voluntary sector, Lancashire County Council, NHSI and NHSE, and acts as a key vehicle to support collaborative working and allows strategic partners to look at issues collectively and identify joint solutions. This work includes examining ways in which unnecessary admissions and re-admissions can be prevented.

The Central Lancashire Quality Improvement Board (CLQIB) has representatives from the Trust, the local CCGs, Lancashire and South Cumbria NHS Foundation Trust, NHSI and NHSE. The purpose of the CLQIB is to (i) oversee the implementation of the Quality Improvement Plan for the Trust; (ii) to scrutinise the implementation of the Quality Improvement Plan to ensure it is calibrated with the required actions across the local health economy; and (iii) to contribute towards building a sustainable and 'outstanding' health and social care system for the local population. The CLQIB ran for half of the year until the end of quarter two and is now integrated into work on a partnership approach across the ICP and ICS.

Healthy relationships with the GP community are essential to the Trust and regular meetings are held with the Chairs of the local CCGs, as well as bi-monthly GP educational evenings. They have provided additional opportunities to enhance communications and work together to improve patient services and experience.

Clinical education and research play a key role in enhancing patient care and developing service innovation, and there are strong connections with a range of health education providers, as referenced elsewhere in this report, which allows us to maximise the benefits to patient services in relation to education, training, academia, research and innovation.

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 a shared medical staff bank.

We have also made great strides working with our partners to develop clinically and financially sustainable services for the future through the OHOC programme. The overarching aim of the OHOC programme, agreed in 2016, was to develop new models of care that are clinically and financially sustainable for the future within a more integrated health and care system, for the population of Chorley, Preston and South Ribble. The overarching aim of the OHOC programme is underpinned by the following aims:

1. To develop a more person-centred approach to health and social care, increasingly delivered within community, locality or home setting where appropriate.
2. To develop new models of health and social care for our local health economy, rebalancing the provision of services to reduce overdependence on acute hospital provision.
3. To encourage and enable people to take responsibility for self-management of their care with support from services to improve their health, wellbeing and quality of life.
4. To develop new models of health and care that are clinically and financially sustainable for the future and able to provide quality services that are safe, accessible, responsive and coordinated.
5. To create models of care which will work within an integrated health and care system, tailored to the needs of our population and delivered in the right place at the right time.
6. To ensure the process is clinically led and that new models of care are co-designed with the public, patients and partner organisations.

In order to achieve our aims, we believe we need to bring together all the different health and care organisations in Central Lancashire so that together we are developing the new model, where each element of the system works together on a population basis, effectively and in the best interests of our patients and local communities. The programme consists of representatives from NHS Greater Preston CCG, NHS Chorley and South Ribble CCG, Lancashire and South Cumbria NHS Foundation Trust, the Trust, local Councils, NHSE and Specialist Commissioners.

We have committed to a clinically-led design process, which has been validated through a robust governance structure and public engagement processes. We have brought together representatives from the whole health and social care economy including Consultants, GPs, Nurses, Allied Health Professionals, Pharmacists, Radiologists, Social Care workers, plus representation from district and county Councils and other public services, third sector and patients; meaning that the process to develop new models of health and care has benefited from significant clinical input. The programme is supported by a Transformation Unit, funded by the main partners, who act as an independent, dedicated team providing overall facilitation of the programme and its work streams, supported by specialist external advisers where required.

OHOC programme update

The OHOC Central Lancashire Acute Sustainability Case for Change was approved by the OHOC Joint Committee of CCGs in December 2018 and since this work has continued in line with NHSE guidance regarding *'Planning, assuring and delivering service change for patients'.* The OHOC Model of Care was subsequently approved unanimously on the 13 March 2019 by the OHOC Joint Committee of CCGs.

This provided the OHOC programme with a mandate to progress with the Options Development and Appraisal phase in 2019-20, including the development of a benefits and outcome framework and criteria for conducting options appraisal; informal external clinical assurance and associated modelling. Activity during 2019-20 has focused on the following two work streams:

1. Options Development and Appraisal
2. Development of a Pre-Consultation Business Case

The following options were subsequently developed and presented to the OHOC Joint Committee on 28 August 2019 where it was agreed that all 13 options should be subject to full modelling.

Option 1	Do nothing: Current Accident and Emergency
Option 2	Current Accident and Emergency plus system transformation
Option 3	Type 1 Accident and Emergency Department/existing service 24/7
Option 4 a,b,c,d,e	Enhanced Urgent Treatment Centre
Option 5 a,b,c,d,e	Urgent Treatment Centre

The modelling work has now been undertaken and work is progressing towards the completion of a Pre-Consultation Business Case and Consultation Plan for consideration by NHSE and the OHOC Joint Committee, which will include a proposed shortlist. Enhanced clinical scrutiny relating to the options has been commissioned via the Royal College of Emergency Medicine, the Care Professionals Board for Lancashire and South Cumbria, the Greater Manchester, Lancashire and South Cumbria Clinical Senate, and the central Lancashire clinical workshop. Modelling activities have also considered workforce, financial/activity, travel and access, and other relevant impacts from the options under consideration. The Health Scrutiny Committee for Lancashire has been engaged throughout this process and the requirement to consider substantial variation to current service provision.

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 that will be revisited once the Covid-19 pandemic situation has run its course.

This means that in 2020/21, the acute sustainability programme will continue to have due regard to the revised service model arising from the current public health emergency and how the pandemic situation develops from this point. The ongoing approach taken by the OHOC programme will reflect the relevant legislation and any advisory position received from the regulator in terms of the current situation. This will ensure that the CCGs' legal duties can be met at all times, working in partnership with all partners across the ICP, including Lancashire Teaching Hospitals. As part of the ongoing governance review, work is currently being undertaken to align the OHOC programme of work and its reporting processes to the new System Delivery Model.

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 interests 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.

Nominations Committee attendance summary

Members of the Nominations Committee are appointed annually from October to September
March 2019 to September 2020:

Name of Committee member	A	B	Percentage of meetings attended (%)
Sue Musson, Chairman	3	1	33%
Alistair Bradley, Appointed Governor	6	5	83%
John Daglish, Public Governor	6	6	100%
Steve Heywood, Public Governor	6	6	100%
Nicola Leahey, Public Governor	6	5	83%
Substitutes			
Eddie Pope, Appointed Governor	0	0	-
Huw Twamley, Staff Governor	0	0	-
Tim Watkinson, acted as Chairman	5	4	80%

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

October 2019 to March 2020:

Name of Committee member	A	B	Percentage of meetings attended (%)
Ebrahim Adia, Chairman	1	1	100%
Eddie Pope, Appointed Governor	1	1	100%
Steve Heywood, Public Governor	1	1	100%
Nicola Leahey, Public Governor	1	1	100%
Mike Simpson	1	1	100%
Substitutes			
Alison Slater, Staff Governor	0	0	-
Appointed Governor (to be confirmed)	-	-	-

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

Work of the Committee

During 2019-20, the Committee met on seven occasions, with the main focus of the Committee's work being the recruitment of a Non-Executive Director and the Trust Chairman. The Committee played a key role in both selection processes and an external recruitment agency was used for the Chairman's appointment.

Shortlisting of candidates for both processes involved (1) written report exercises, (2) governor/stakeholder groups, (3) group exercise/interviews, and (4) panel interviews. As part of the panels' assessments there was an evaluation of the following skills and competencies:

- Overall experience
- Understanding of the Non-Executive Director and Chairman role
- Personal values and integrity
- Strategic thinking
- Skills to bring to the Board
- Interpersonal skills

The panels comprised the Nominations Committee, the Chief Executive and the Strategy, Workforce and Education Director. The Trust Chairman led the interview panel for the Non-Executive Director interview process. For the Trust Chairman's appointment, the panel was Chaired by the Chairman of University Hospital Leicester NHS Trust and the North West Programme Director for NHSE and NHSI was in attendance. Following evaluation of each candidate's performance, the nominations Committee made appropriate recommendations to the Council of Governors to appoint Tricia Whiteside as Non-Executive Director of the Trust, and Ebrahim Adia as Chairman of the Trust, which were endorsed by the Council of Governors on 5 August 2019 and 29 October 2019 respectively.

In addition, the Nominations Committee met on 5 March 2020 to consider the re-appointment of Jim Whitaker as Non-Executive Director for a further three year term, which was formally endorsed by the Council of Governors.

Appointments, Remuneration and Terms of Employment Committee

All Non-Executive Directors are members of the Committee. The Chief Executive and Company Secretary 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 2019-20 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 *(appointed December 2019)*	1	1	100%
Sue Musson *(until August 2019)*	3	3	100%
Paul O'Neill	5	3	60%
Jeannette Newman *(until August 2019)*	3	2	67%
Ann Pennell	5	4	80%
Geoff Rossington	5	5	100%
Kate Smyth	5	3	60%
Tim Watkinson	5	4	80%
Jim Whitaker	5	1	20%
Tricia Whiteside *(appointed September 2019)*	2	2	100%

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

Work of the Committee

During 2019-20, the Committee met on five occasions which enabled it to:

- Review and approve the appointment to the Company Secretary post
- Consider and approve the selection process and appointment of the Finance Director/Deputy Chief Executive
- Receive the annual report on Executive Directors' performance reviews
- Consider and approve the Executive Directors' appraisal policy
- Consider and approve the salary for the Strategy, Workforce and Education Director following the change in portfolio and title for the post
- Consider and approve the pay policy for Very Senior Managers
- Consider succession planning for senior Executive Directors
- Consider and approve the proposal for implementation of an ICP Chief Information Officer post
- Receive an update on the appointment of the Integrated Care Partnership Chief Information Officer
- Receive and endorse the secondment of a Director of Integration post

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, and 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 2019-20 the Committee approved the appointment of the Finance Director/Deputy Chief Executive. Appointments of senior Executives involve a robust selection process, which involves stakeholder involvement. Typically, the selection process would involve the following steps:

With respect to stakeholder involvement in the selection process, our Director candidates would typically undertake a 'round robin' style session with a number of focus groups comprised of Executives, senior clinicians, senior managers, Governors and members of staff, and feedback would be provided on each candidate through a dedicated facilitator using a pro forma template. Additionally, candidates are invited to deliver a presentation on a topic that is advised to them in advance along with a written submission. Feedback from the presentation and from the focus groups would then be used to inform short listing decisions. Short listed candidates are invited to attend an interview, following which the panel will reach its final decision. When reaching its decision, the panel has regard to the candidate's interview as well as feedback received following the stakeholder session. Offers of employment are always made subject to receipt of satisfactory references and other necessary pre-employment checks.

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 award has been 1% for a number of years.

In 2018/19 the national pay award for Agenda for Change terms and conditions comprised of a 6.3% pay rise over three years awarded as follows:

- 3% in 2018-19
- 1.7% in 2019-20
- 1.67% in 2020/21

In December 2018, in line with national guidance, the Committee formally approved an uplift to the salary of each VSM post in line with the national pay award for staff on Agenda for Change terms and conditions.

Save for the application of the national pay award to the VSM posts in line with the national pay award for staff on Agenda for Change terms and conditions, there have been no other changes to remuneration of senior Executives. However, following the portfolio review for the Strategy, Workforce and Education Director in December 2018, the Appointments, Remuneration and Terms of Employment Committee reviewed remuneration for the role and an increase to salary was enacted from 1 April 2019.

Dr 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 Appointments, Remuneration and Terms of Employment (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

- Company Secretary*
- Director of Continuous Improvement

Details on membership of the Appointments, Remuneration and Terms of Employment Committee and individual attendance can be found on page 55 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 Agenda for Change 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 annually; current rates (2019-20) are: ▪ £12,791.00 p.a. for Non-Executive Directors ▪ £15,861.72 p.a. for the Audit Committee Chair and Vice-Chair ▪ £43,567.56 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 2019-20 are included on pages 21 to 24. Details of our Council of Governors are included on page 116, together with information on expenses paid to them in 2019-20.

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:

	2018-19	2019-20
Total number of Directors in office as at 31 March:	16	16
Number of Directors receiving expenses:	7	9
Aggregate sum of expenses paid to Directors (£00s):	£18	£84

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 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. 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

		2018/19				2019-20			
Name	**Title**	**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	7	5.0-7.5	185-190	180-185	200	2.5-5.0	185-190
Faith Button	Chief Operating Officer (from 1 May 2019)	0	0	0	0	130-135	0	0	130-135
Jonathan Wood	Finance Director / Deputy Chief Executive (from 1 August 2019)	0	0	0	0	110-115	0	110.0-112.5	220-225
Paul Havey	Finance Director/Deputy Chief Executive (up to 31 July 2019)	145-150	75	0	155-160	145-150	11,400	0	155-160
Geraldine Skailes	Medical Director	170-175	18	5.0-7.5	175-180	170-175	5,400	0	175-180
Gail Naylor	Nursing, Midwifery and AHP Director (up to 31 July 2019)	125-130	3	0.0-2.5	125-130	40-45	0	0	40-45
Sarah Cullen	Nursing, Midwifery and AHP Director (from 1 August 2019)	0	0	0	0	120-125	1,900	0	120-125
Karen Swindley	Strategy, Workforce and Education Director	115-120	0	0.0-2.5	115-120	130-135	0	82.5-85.0	215-220
Phebe Hemmings	Company Secretary (up to 2 June 2019)	75-80	0	0.0-2.5	75-80	20-25	0	12.5-15.0	35-40
Joanne Platt	Company Secretary (from 3 June 2019 and up to 16 March 2020)	0	0	0	0	50-55	0	50.0-52.5	100-105

Adrian Griffiths	Interim Chief Operating Officer (from 2 July 2018 and up to 30 April 2019)	110-115	0	0	110-115	10-15	0	0	10-15
Adrian Griffiths	Corporate Director (Project Support) (from 1 May 2019 up to 12 December 2019)	0	0	0	0	80-85	0	0	80-85
Adrian Griffiths	Service Development Director (from 6 January 2020)	0	0	0	0	30-35	0	0	30-35
Ailsa Brotherton	Director of Continuous Improvement (from 1 December 2018)	35-40	0	0	35-40	105-110	100	17.5-20.0	125-130
Sue Musson	Chairman (up to 31 August 2019)	40-45	31	0	45-50	15-20	0	0	15-20
Tim Watkinson	Acting Chairman (from 1 September 2019 and up to 1 December 2019)	0	0	0	0	5-10	0	0	5-10
Ebrahim Adia	Chairman (from 2 December 2019)	0	0	0	0	10-15	100	0	10-15
Tim Watkinson	Vice Chairman	15-20	0	0	15-20	15-20	0	0	15-20
Ann Pennell	Non-Executive Director (from 7 January 2019) Acting Vice Chairman (from 1 September 2019 and up to 1 December 2019)	0-5	0	0	0-5	10-15	100	0	10-15
James Whitaker	Non-Executive Director	0-5	0	0	0-5	10-15	0	0	10-15
Geoff Rossington	Non-Executive Director	0-5	0	0	0-5	10-15	400	0	10-15
Jeanette Newman	Non-Executive Director (up to 30 August 2019)	0-5	0	0	0-5	5-10	0	0	5-10

Kate Smyth	Non-Executive Director (from 4 February 2019)	0-5	0	0	0-5	10-15	0	0	10-15
Paul O'Neill	Non-Executive Director (from 4 March 2019)	0	0	0	0	10-15	200	0	10-15
Tricia Whiteside	Non-Executive Director (from 9 September 2019)	0	0	0	0	5-10	0	0	5-10

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	2.5-5.0	90-95	270-275	1,973	82	2,103	0
Jonathan Wood [(1)] Finance Director / Deputy Chief Executive	2.5-5.0	5.0-7.5	55-60	130-135	917	83	1,064	0
Geraldine Skailes Medical Director	0.0-2.5	0	75-80	195-200	1,571	17	1,626	0

Gail Naylor Nursing, Midwifery and AHP Director	0	0	55-60	175-180	1,267	0	0	0
Sarah Cullen [(2)] Nursing, Midwifery and AHP Director	0	0	25-30	50-55	0	244	366	0
Ailsa Brotherton Director of Continuous Improvement	0.0-2.5	0	50-55	0	689	34	740	0
Karen Swindley Strategy, Workforce and Education Director	2.5-5.0	5.0-7.5	40-45	95-100	747	100	865	0
Faith Button [(3)] Chief Operating Officer	0	0	30-35	75-80	0	523	570	0
Phebe Hemmings Company Secretary	0.0-2.5	0	5-10	0	46	1	55	0
Joanne Platt Company Secretary	0.0-2.5	0	0-5	0	0	33	42	0

Notes

(1) Jonathan Wood opted out of the NHS Pension Scheme on the 31st December 2019

(2) Sarah Cullen joined the Board in August 2019 and her accrued pension benefits at that point are not available, therefore the increases in benefits cannot be calculated

(3) Faith Button joined the Board in May 2019 and her accrued pension benefits at that point are not available, therefore the increases in benefits cannot be calculated

(4) Adrian Griffiths has opted out of the NHS Pension scheme and is therefore not receiving pension benefits in this employment

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 2019-20 was £180,000 – £185,000 (2018/19 was £180,000 – £185,000). This was 6.4 times (2018/19 – 6.4 times) the median remuneration of the workforce, which was £28,965 (2018/19 £28,050). In 2019-20, one employee (2018/19, two employees) received remuneration in excess of the highest-paid Director. In 2019-20 remuneration ranged from £2,642 to £189,559 (2018/19 the range was £2,760 to £212,682). 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:

Karen Partington
Chief Executive
18 June 2020

STAFF REPORT

Our people

As at 31 March 2020, we employed 8,479 substantive members of staff. This number is broken down as follows:

Staff Group	Headcount
Additional Clinical Services	1,860
Additional Professional, Scientific and Technical	272
Administrative and Clerical *(incl. NEDs)*	1,755
Allied Health Professionals	510
Estates and Ancillary	785
Healthcare Scientists	259
Medical and Dental *(excl. Lead Employer Doctors)*	675
Nursing and Midwifery Registered	2,363
Total	**8,479**

A comparison of our workforce over the past three financial years is provided below:

	2017/18 HC	% of Total HC	2018/19 HC	% of Total HC	2019-20 HC	% of Total
Age *(yrs)*						
Under 17	-	-	2	0.02%	26	0.31%
17 – 21	151	1.90%	158	1.95%	131	1.54%
Over 21	7,814	98.10%	7,943	98.03%	8,322	98.15%
Ethnicity						
White	6,591	82.75%	6,660	82.19%	6,859	80.89%
Mixed	99	1.24%	105	1.30%	114	1.34%
Asian or Asian British	969	12.17%	1,002	12.37%	1,140	13.44%
Black or Black British	106	1.33%	120	1.48%	135	1.59%
Other	119	1.49%	134	1.65%	145	1.71%
Not Stated	81	1.02%	82	1.01%	86	1.01%
Gender						
Male	1,739	21.83%	1,757	21.68%	1,881	22.18%
Female	6,226	78.17%	6,346	78.32%	6,598	77.82%
Recorded Disability	223	2.80%	242	2.99%	271	3.20%

As at 31 March 2020, 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

Appointment, Remuneration and Terms of Employment Committee, was one male and seven female. The gender split of our senior managers was nine male and eleven 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 2019):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2019	7,182
Adjusted FTE days lost *(to Cabinet Office definitions)*	88,498
Average sick days per FTE	12.3
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	2,624,337
FTE days recorded sickness absence	143,681

Source: *NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse*
Period covered: *1 January 2019 to 31 December 2019*

Sickness absence levels were a concern throughout the year with a 12-month average rate of 5.5% for the period 1 January to 31 December 2019, compared to 5.18% in the previous year. The absence rate did however start to show improvement in Quarter 4, with absence levels for January and February 2020, lower than those reported for the same periods last year. This can be attributed to more robust processes around attendance management as a result of new monitoring systems. In March 2020 the Covid-19 outbreak started to affect staff absence, although in the main due to self-isolation or shielding, rather than sickness.

In addition to the focus on attendance management, the health and wellbeing team continued to deliver proactive campaigns to support staff to manage their physical, psychological and emotional health. As mental health and musculoskeletal conditions remained the top two reasons for working days lost due to sickness, campaigns were predominantly themed to address these issues. New interventions included back care awareness workshops, themed mental health drop in sessions with our staff psychologist and a Mental Health Champion workshop. We were delighted to win the 2019 Personnel Today, Occupational Health and Wellbeing Award for 'Best Musculoskeletal Initiative'; and to be profiled as a 'Time To Change' case study for our commitment to promoting positive mental health at work. In addition, in March 2019 we were re-accredited with the Workplace Wellbeing Charter, achieving excellence in four of the eight standards.

The staff flu vaccination campaign ran from September 2019 to January 2020, with a total of 7,039 staff accessing the vaccine and uptake of 80.2% amongst front-line health care workers. This was a 5% improvement on the previous year's uptake. Although a direct correlation cannot be made, sickness absence due to *S13 Cold, Cough, Flu* during 2019 was marginally lower than during 2018 (0.369% and 0.371%, respectively).

The focus for the next year will be to further develop a holistic package of support for staff. This will include the implementation of Schwartz Rounds, an Employee Assistance Programme and financial wellbeing support. There has also been recent expansion of our staff psychology and counselling resources, which will enable more timely access to psychological therapies and provision of different interventions, such as group therapies.

Equality and diversity

Work has been progressing throughout the year which aligns with our People Plan aim to be inclusive and supportive. We have a number of commitments underpinning this aim, which 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 12 months, activity has been focused on raising the profile of inclusion across our organisation and educating our people on diversity and inclusion related topics. From a workforce and organisational development perspective, achievements include the following:

- Launched the National Rainbow Badge scheme with over 1,600 colleagues pledging their support in the first two months.
- Facilitated EDI (equality, diversity and inclusion) 'Big Conversations' to engage with our people around the results of our staff survey.
- Created an inclusion calendar noting key events to promote and share.
- Undertook promotional campaigns to educate our workforce around specific inclusion events such as Black History Month, Transgender Awareness, and Ramadan.
- Delivered two very successful 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,
- Attendance at Preston Pride which enabled us to engage with our LGBTQ+ colleagues and the wider community to listen and learn but also to promote our organisation as an inclusive employer. We flew the Pride flag across both hospitals sites through the months of February (to mark LGBT History Month) and September (to mark Preston Pride) which further demonstrated our support to our people and our wider community.
- Refreshed our mandatory training in respect of equality, diversity and inclusion incorporating elements such as micro-aggressions, supporting disability in the workplace and changing language relating to sexuality and gender.
- Promoted our Inclusion Ambassador forums to support black, Asian and minority ethnic (BAME) colleagues, LGBTQ+, those who are Living with Disability and Multi Faith.
- Improved our ranking in the Inclusive Employers Top 50 from 42 in 2018 to 21 in 2019.

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 regards to discrimination, harassment, bullying or abuse and protected characteristics.

- Annual equality impact assessment of the disciplinary, grievance and bullying and harassment policies and procedures if conducted, the purpose of which is to analyse if the polices have negatively impacted on any particular category of a protected characteristic and if the policies are also accessible and utilised by staff of a protected characteristic.
- Proactively engaging with areas where informal concerns are raised in respect of discrimination.
- The Freedom to Speak Up Champions continue to support colleagues who raise concerns from a range of professions and bands.

We have a Talent Management programme which has been in existence for approximately six years. It is open to all colleagues who are identified as a Rising Star following their appraisal discussion with their line manager. Being identified as a Rising Star indicates colleagues are exceeding performance requirements, are showing potential and are ready for the next career move. Our latest Workforce Disability Equality Standard (WDES) metric (2019) in respect of the percentage of staff who believe we provide equal opportunities for career progression or promotion indicates 80.2% of disabled colleagues believe we provide equal opportunities; this is an increase on the previous year's figure of 74.8% and is something we are continuing to work on through our Inclusion Ambassadors forum.

Now we have the facility to identify Rising Stars across our organisation through our online appraisal system, we will be able to review the profile of those who are being identified as Talent; this will enable us to assess whether we have to provide additional opportunities for colleagues who are living and working with disability.

Plans for the next 12 months include a revitalised 'Call It Out' campaign to re-establish our zero tolerance approach to bullying, harassment and discrimination and support the Freedom to Speak Up agenda, establishing a reverse mentoring scheme, the introduction of a talent management programme focused on supporting the career development of colleagues from marginalised groups, 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, attending the Windrush celebration and Preston Pride.

Ensuring equality and diversity of services is a key undertaking of our organisation. This year we have continued to work towards the Patient Experience and Involvement Strategy. We are now two thirds of the way through the strategy and continue to work towards what our community told us about ways in which we can improve the services we offer. Approximately 3,000 people were consulted in terms of what is good and what requires improvements in relation to our service provision. The consultation took into consideration the diversity of our community and involved a number of groups as part of the consultation process. Our Patient Experience Improvement Group continues to meet with representatives of our service users, carers and Governors. The group seeks to ensure that the improvements suggested from the consultation are implemented as appropriate. Other achievements for 2019-20 include:

- Links have been established to work with Deafway through service user involvement. This has led to exploring the use of tablets for virtual interpreters who support the deaf community during hospital appointments. This work will be piloted in the coming year.
- An Assistance Dogs Policy is in the final stages of development to support service users attending appointments. This has been developed with the assistance of people who have experience within this area.

- Involvement with Preston Pride to gather the views and opinions of the LGBTQ+ community and how the organisation can support effective care and treatment.
- Development of bereavement information provided to patients including a redesign of information. In the coming months providing information in alternative languages will be considered.
- Electronic flags developed for patients with dementia, learning disabilities and autism to identify where patients have additional support needs at outpatient appointments.
- Formation of an Easy Read Group to develop patient information suitable for service users with learning disabilities with user involvement.
- Involvement with the Men's Health Forum.
- Involvement with the Women's Health Forum.
- Continued involvement with the Maternity Voices Partnership.
- Involvement with the Live Healthier, Live Longer group.
- Continuation of the Youth Forum meetings.
- Attendance at the Annual General Meeting of Deafway.
- Involvement with the celebrations for Ramadan and attendance at Iftar in Chorley and Preston.
- Participation and analysis of the following national surveys: Inpatient; Children and Young People; Urgent and Emergency Care; Cancer Patient Experience and Maternity, all of which demonstrated improvements from previous years.
- Further development of ward magnets for the patient bedside boards, including Parkinson's following patient feedback regarding the need to ensure medication is taken on time.
- Development and implementation of specific ward packs for patients with Parkinson's disease.
- Involvement in the Eyewise 100 Voices campaign with NHSE and NHSI to find out the experiences of making appointments and using services for those who are losing their sight, to establish what improvements can be made.
- Implementation of Alarm clocks specifically for patients with Parkinson's disease to facilitate medication administration on time.
- AccessAble available on the Trust website for people with visual challenges and where English in not the service users first language. This provides an opportunity for documents on the website to be translated into the preferred language.
- Digitisation of patient appointment letters to allow easier electronic access although also ensuring, where necessary, a paper record is still available.
- Core Therapies and the University of Central Lancashire have been working together to identify what matters most for patients attending appointments and how to change the environment to support accessibility.
- Held 'Our Health Day' where members of the disabled community, their carers and external organisations were consulted in relation to services. The day also enabled the community to have a health check, some of who were signposted to receive further treatment.
- Continued to use 'Browsealoud' on the Trust website to ensure information is accessible for people who are partially sighted and those who require information in other languages, although this does not replace the need for interpreters who continue to be utilised in clinical settings, and as appropriate to the needs of people.
- Development of an Outpatients Charter.
- We now provide access to PALS on both of the main hospital sites for ease of access for patients and service users.

In the coming 12 months there will be full implementation of the NHSE Accessible Information Standard, along with implementation of virtual translation for those whose first language is not English. We will be implementing an Assistance Dogs Policy to support patient access across the organisation. We will continue to work towards strengthening the spiritual and religious services across the organisation. There will be a complete review of the Patient Experience and Involvement Strategy and a focus on areas which have not yet been achieved in order that by the end of 2021 all areas originally identified in the strategy will be compliant.

Staff engagement and consultation

Organisations that have higher levels of staff engagement deliver better care and so improving staff engagement is 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 but through a systematic, evidence-based approach to building a culture of engagement. Therefore the plan focused on the following:

- Maintaining a whole systems approach to the staff survey which includes communications, analysis, facilitation and action planning.
- Improving staff engagement and involvement at a team level through the team engagement and development programme (TED).
- Building more opportunities for our Board to be involved in the staff engagement agenda.
- Creating a sense of community across the organisation.
- Rewarding and valuing staff.

In the last 12 months there have been a number of achievements including:

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 ten for certain questions with the indicator score being the average of those.

The response rate to the 2019-20 survey among Trust staff was 49% (2018-19: 46%). Scores for each indicator together with that of the survey benchmarking group (average for NHS Acute Trusts) are presented in the table below.

	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.1	9.0	9.1	9.1	9.2	9.1
Health and wellbeing	5.9	5.9	5.9	5.9	6.1	6.0
Immediate managers	6.9	6.8	6.7	6.7	6.8	6.7
Morale	6.1	6.1	6.0	6.0	Not measured	Not measured
Quality of appraisals	5.6	5.6	5.4	5.4	5.4	5.3
Quality of care	7.4	7.5	7.4	7.4	7.3	7.4

Safe environment – bullying and harassment	8.1	7.9	8.0	7.9	8.3	8.0
Safe environment – violence	9.4	9.4	9.4	9.4	9.4	9.4
Safety culture	6.7	6.7	6.6	6.7	6.6	6.6
Engagement	6.9	7.0	6.9	7.0	7.0	7.0

- Nearly half our staff completed the survey, with 49% sharing their views which is slightly above the national average of 47%. 82% of areas within our organisation achieved the minimum response rate of 40%, this is important because it is the rate at which the results can be interpreted as representative of staff experience and are therefore more meaningful and demonstrate a strong level of staff voice across the organisation.
- Staff survey response rates have increased from 35% (2015) and have now been maintained in the upper 40% range for the past three years demonstrating a maintained uptake.
- Improvement in response rate in our Estates and Facilities division which typically has a lower uptake. This improved from 31% in 2018 to 44% in 2019.

Team Engagement and Development (TED)

- Increased uptake in teams utilising the TED approach to improve team effectiveness and engagement. Increasing from 37 teams in 2018-19 to 94 teams in 2019-20.
- Respiratory High Care case study highlights that through utilising the TED approach they have seen an improvement in team working and engagement measured through TED and have seen a positive impact on sickness, friends and family test results, complaints, incidents of harm, appraisal and training compliance, and a reduction of length of stay in the Emergency Department for patients on non-invasive ventilation requiring admission to the Respiratory High Care Unit.
- Core Therapies case study evaluation indicates significant uptake and implementation of TED with significant improvement in staff experience and engagement measures in the staff survey. Core Therapies cite impact of staff engagement, TED and 24 hours driving outcome measures.
- Uptake across clinical teams, non–clinical teams, front line teams, support teams and leadership teams.
- Established and implemented regular reporting mechanism for uptake of TED which is provided to Workforce Committee meetings and Trust Board.
- Established a ‘real team’ measure which provides a more reliable measure of team working linked to patient and staff outcomes.
- 86 team leaders trained in the TED approach in 2019-20 to build capacity in the system so they can lead, develop and engage their own teams.

24 hours in…Core Therapies

- Filmed and launched series three of 24 hours, which featured Core Therapies, along with a social media promotion campaign. This mini-series showcases the people behind the care, raises awareness of the different roles within the team, aims to create a sense of team, improve staff engagement, show our employment brand and values, improve the profile of the team and organisation externally and lastly support recruitment. The previous series included 24 hours in…Maternity and 24 hours in…Theatres.

- The Core Therapies project was initiated in July 2019 with various content released. The full content is being released via a schedule and to date we have had 12,000 views of the content and achieved a social media reach of 55,000. We have held two screening events and evaluation indicates the video content: is enjoyable, creates a sense of pride and feeling inspired, helps the viewer to learn more about the roles in Core Therapies, and lastly after watching the videos it improved the viewer's impression of the organisation as a place to work and receive care. Within the Core Therapies team there has been significant increases in staff satisfaction and experience in associated measures which include: recognition for good work, feeling the organisation values their work, recommending the organisation as a place to work and improved staff engagement levels.

Board engagement with the staff engagement agenda

The Board has been involved and led a series of activity which includes: Big Conversations focus groups exploring staff experience, Back to the Floor initiatives, Continuous Improvement and Always Safety First programmes, Our Big Plan launch and engagement events, Coffee Catch Up discussion groups centred on Our Big Plan and Careers, undergone their own team engagement and development via TED, hosted staff stories at Board and Workforce Committee meetings and Fab Feedback Friday whereby teams open their doors to senior leaders and Governors and share what it is like in their team, both the positive, negative, ideas for improvement and challenges. There have been improvements in staff experience related to senior manager involvement and communication within the annual staff survey. Evaluation of teams involved in Fab Feedback Friday showed an increase in relevant staff survey measures and participant feedback was positive around: increased awareness of senior team, feeling valued and increased profile of the team.

Thank You

This is an online peer-to-peer recognition tool which gives people the opportunity to say thank you and receive meaningful feedback. 'Thank You' sits in the online appraisal tool to support quality appraisal discussions and nurse revalidation. It was launched in July 2018 and to date 10,998 'Thank You' messages have been sent, increasing from 3,692 in year one (April 2018 to March 2019) to 6,754 in year 2 (April 2019 to Mar 2020). 61% of all 'Thank You' messages were sent and received by clinical staff demonstrating uptake from staff groups who may not regularly access a computer. This has increased from the previous year where uptake was evenly split between clinical and no-clinical staff.

Positive improvements have been in associated staff survey results: 73% of staff say their manager values their work (up from 71%), 47% say the organisation values their work (up from 46%) and 60% of staff say they are satisfied with the recognition they get for good work (up from 56%).

Other staff engagement mechanisms

In addition to this a range of channels and mechanisms that promote staff engagement and communication, and staff 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

- Coffee Catch Ups which are themed discussions designed to bring people together to share ideas, network and learn
- annual planning events
- Governors' listening events for members
- staff intranet
- social media
- use of multimedia methodology such as video, animation and blogs
- email accounts
- team brief
- staff magazine 'Connect'
- staff weekly Newsbite email
- staff bulletins
- 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 engagement levels

Our organisation and workforce are operating in an increasingly challenged climate due to increasing pressures and demands on our organisation and the health care system as a whole. Despite this staff engagement levels have remained stable from 2018 to 2019, which is 6.9 out of 10.

The staff engagement score measures three areas: motivation, involvement and advocacy. There are additional questions in the 2019 staff survey which relate to morale. There has been improvement in relation to staff motivation, staff involvement has remained stable, there are mixed results in relation to staff morale and advocacy has declined.

Motivation – staff experience has improved in relation to all three indicators: staff saying they look forward to going to work, staff feeling enthusiastic about their job, and staff saying time passes quickly when they are working.

Involvement – there has been a small improvement in staff saying they are able to make improvements happen at work, whilst staff saying there are opportunities for them to show initiative in their role and that they are able to make suggestions to improve the work of their team have remained stable and are above the national average.

Advocacy – there has been a small improvement in staff saying that care is the organisation's top priority. However there has been a decline in the percentage of staff who would recommend the organisation as a place to work or receive care and both these measures remain below the national average and continue a downward trend across 2017, 2018 and 2019.

Staff morale - overall there has been improvement in relation to involvement and relationships at work but more staff are indicating they are thinking of leaving the organisation. Specifically there has been an improvement in staff saying they are involved in changes that affect their team/department, staff feeling they have unrealistic time pressures, staff saying they have choice in

deciding how they do their work, staff saying relationships at work are unstrained, and staff saying their manager encourages them at work. However there has been a decline in the following areas: staff saying they will look for a job at a new organisation in the next 12 months and staff saying that as soon as they can find another job they will leave the organisation.

Overall staff experience has either remained stable or improved with improvement noted in the majority of areas prioritised within the annual staff survey action plan which includes: staff feeling valued, senior manager involvement and communication, quality of appraisals, raising concerns, reduction in bullying and harassment experienced by black, Asian and minority ethnic (BAME) and disabled staff, and staff relationships with, and support from, line managers.

Despite improvement in a range of staff experience areas, staff recommendation of the organisation as a place to work and receive care along with health and wellbeing measures have declined. Further exploration of staff experience and the causes have indicated the driving factors are: hygiene factors not fully addressed, system factors such as capacity, demand and flow, elements of organisational culture, and delays in counselling and clinical psychology support as a result of increasing demand exceeding capacity. Plans are in place to address these factors.

The plan will continue to be informed through staff feedback from the annual staff survey and staff involvement events which include Big Conversation focus groups, Rapid Improvement events and Coffee Catch Ups. It is also informed by research evidence and best practice.

Staff Survey – The Results

As already outlined, in summary staff experience remained stable or had shown improvements from 2018 to 2019. Statistically, significant improvement was seen in relation to the following key themes: Equality, Diversity and Inclusion, Immediate Managers, Morale, Quality of Appraisals and Quality of Care. There was no statistically significant deterioration in relation to any key themes. However, there was a decline against the following individual questions:

- Q4g – staff saying there are enough staff at the organisation for them to do their job properly has declined from 32% to 30% and is in line with the national average.
- Q10b – staff saying they work additional paid hours has increased from 36% to 39% and is in line with the national average.
- Q11b – staff saying in the last 12 months they have experience musculoskeletal (MSK) problems as a result of work activities has increased from 28% to 30% and is in line with the national average.
- Q21c – staff recommendation of the organisation as a place to work has decreased from 59% to 57% and is below the national average of 63%.
- Q21d – 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' has decreased from 66% to 63% and is below the national average of 71%.

Analysis of staff experience through a variety of channels indicates other factors may be driving staff experience such as: hygiene factors not fully addressed, inconsistent engagement from managers with organisational development and people management practices, system factors such as capacity, demand and flow, and finally elements of organisational culture, identified in the Culture Review and Survey.

Utilising the results

Following the publication of the 2019 staff survey results in March 2020 we have held two Big Conversation focus groups to explore the results and Inclusion Ambassador Forums, which seek to explore staff experience from an inclusion and diversity perspective, are ongoing. 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.

Priority areas to address are listed below:

- Health and Wellbeing
- Organisational Culture
- Addressing hygiene factors
- Supporting team engagement and local improvement

A one year staff survey action plan will be developed and supported with 'You Said, We Did' communications to respond to staff feedback. There will be a suite of actions to improve all areas of staff experience and the three year engagement and retention plans, which form part of the workforce and organisational development strategy, presents the strategic interventions designed to improve staff engagement over the next three years and will continually be informed by the annual staff survey and staff involvement events.

In light of the Covid-19 pandemic there will be new and emerging staff experience themes that we will seek to continually understand and respond to as part of our continually evolving plans.

Improving staff experience across the organisation

Whilst large parts of the staff engagement plans 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:

- By March 2020 all divisions, directorates and specialities received their local results along with a manger 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 are typically held to further support managers to understand their data, identify trends and feel more able to hold conversations with their teams. However, in 2020, in order to support teams to prepare for and respond to Covid-19 as well as complying with social distancing rules issued by the Government, these sessions were stood down and made available via an eLearning package.
- Managers have also been provided with support to use the staff survey and engage their team via the Core People Management programme which ran in 2017, 2018 and 2019.
- Each division agreed their own approach to sharing results in their area and holding 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 Big Plan.
    - A regular performance review of staff engagement will take place at the Divisional Improvement Forums.
    - The quarterly staff friends and family test survey will be altered to measure staff feedback at speciality level so the key indicator questions (recommend work and care) can be reviewed on a more frequent basis, particularly for hot spot areas.
    - A six-monthly staff survey update to the Workforce Committee will be introduced so that progress can be more frequently monitored.

Learning and Development

Compliance against Annual Trust Update (mandatory training) has increased by 2.4% (91.4% total) compared with 89% at March 2019. Performance is now above the target of 90%. Annual Trust Update, via eLearning, offers staff a flexible and convenient way to complete their training and has proved an extremely popular medium. 85% of staff now undertake Annual Trust Update in this way.

Due to the success of eLearning, the eLearning portfolio expansion has continued over the past 12 months. New eLearning courses include: 'Pain Management' 'Food Hygiene level 2' 'Parkinson's Medication' and 'Central Venous Access Team'.

Monthly training personalised emails (listing all employees' training requirements and compliance against each required event), real time training course flyers (displaying how many places are available on each course advertised in real time), automated confirmation of a training booking and automated course certificates all continue to be deployed and developed.

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 a high quality clinical skills sessions. The key achievements include:

- We delivered an additional 54 places on the three week Health HCA induction programme to support the target of 200 new HCA posts. Between April 2019 and March 2020 we achieved 234 new HCA starters.
- NHS Careers Plus students from Cardinal Newman College continue to achieve places on nurse training, paramedic training and direct entry onto Midwifery training.
- Further increased Aseptic Non-Touch Technique compliance from 81% last year to 93.4%.
- Expanded our 'Doctor for a Day' practical experience taster day for Year 13 students to a further two schools to include Lancaster Girls and Bolton Girls Schools.
- Increased Adult Basic Life Support compliance from 69% to 91.3% by delivering targeted sessions in clinical areas and additional drop in sessions.
- We held our celebratory event for our Patients as Educators, attended by around 60 patients.
- Widened Preceptorship programme to include attendance by newly qualified midwives, radiographers and physiotherapists.

- We created videos of simulated patient scenarios for Psychiatric conditions and Children's development conditions to be used in Manchester Medical School Observed/Objective Structured Clinical Examinations (OSCE). This resource has never been used before and was presented by Manchester Medical School at an international conference.
- Introduced Communication Skill sessions for inclusion in the Return to Work Training for doctors which have received very good feedback.

The Placements and Student Support team are the link between learners, placement areas and education providers. Learners from all clinical professions are supported by the team as well as aspirant learners to help them to access undergraduate training for their chosen profession. Some examples of the support offered by the team are:

- The Nursing Associate Apprenticeship continues to be delivered in partnership with University of Central Lancashire, our first cohort will qualify in June 2020 and we have since recruited to two more intakes in January 2020 and March 2020.
- Pre-registration nurse training is delivered in partnership with the University of Bolton, four cohorts have now qualified since the start of this partnership and there are currently 141 students on this programme.
- Pre-Nursing Apprenticeship training is delivered within the Trust via a level 3 apprenticeship. This is an 18 month programme to support healthcare assistants and allow them to gain the qualifications needed to enter nurse training.
- A Registered Adaptation Nurse Programme is being delivered via Global Health Exchange. We have so far supported 37 nurses to successfully gain their UK PIN number and a further 18 are working up to this level.
- Placements for Physician Associate students are offered within the Trust and several members of the team support examinations for the National OSCE for the Faculty of Physician Associates.
- Over 40 inter-professional teaching sessions are offered to our learners annually to complement the academic knowledge delivered by our university colleagues.
- There is a dedicated team to support all of our learners, in all aspects of welfare, pastoral, financial and professionalism whilst they are studying with us.
- Manchester Medical School have recently updated their undergraduate medical curriculum and the team has supported a re-write of the three year programme delivered within the Trust.
- Collaborative Learning in Practice (CLiP) is in place within the Trust
- The Grand Round has been revamped and re-launched to include all clinical staff and students within the Trust.

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 eRota system.

Directorates 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), this is 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 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 related to hours worked and any concerns related to safe working. Exception reports raised are highlighted through divisional Workforce Committees on a monthly basis.

Trust doctors who have been engaged through 2002 national terms and conditions are invited to monitor their working hours biannually, however uptake to monitoring is low.

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) ended the last financial year with a strong financial position. The service is a commercial entity and there have been reviews of contracts and pricing throughout the year. The major contracts currently held are with Lancashire and South Cumbria NHS Foundation Trust, Bridgewater Community Healthcare NHS Trust, North West Ambulance Service, University of Central Lancashire (students), Edge Hill University, Bolton University and Health Education England. There are however a range of other contracts and minor income generation schemes.

The service is a joint venture with Bolton NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust and it has been recognised that since commencement of the joint venture in 2014 activity levels have increased across the three partner Trusts in addition to commercial growth. A new staffing model has therefore been agreed which will increase costs, however it is expected that a proportion of this will be offset with continuing financial returns through income generation activities.

Staff costs

	Permanent	Other	2019/20 Total	2018/19 Total
	£0	£0	£0	£0
Salaries and wages	268,633	-	268,633	247,377
Social security costs	26,000	2247	28,247	25,863
Apprenticeship levy	1,338	116	1,454	1,275
Employer's contributions to NHS pensions	42,580	3681	46,261	30,139
Pension cost – other	111	50	161	76
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff	-	37,119	37,119	37,715
NHS charitable funds staff	-	-	-	-
Total gross staff costs	338,662	43,213	381,875	342,445
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	338,662	43,213	381,875	342,445
Of which				
Costs capitalised as part of assets	-	-	-	-

Consultancy costs	
2019/20	2018/19
£0	£0
661,000	778,000

Average number of employees (WTE basis)

	Permanent	Other	2019/20 Total	2018/19 Total
	Number	Number	Number	Number
Medical and dental	844	57	901	866
Ambulance staff	1	-	1	-
Administration and estates	580	20	600	668
Healthcare assistants and other support staff	2,435	299	2,734	3,102
Nursing, midwifery and health visiting staff	2,000	234	2,234	2,124
Nursing, midwifery and health visiting learners		-	-	-
Scientific, therapeutic and technical staff	919	10	929	656
Healthcare science staff	234	4	238	231
Social care staff		-	-	-
Other		-	-	-
Total average numbers	7,013	624	7,637	7,647
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 60 to 63 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 2020, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2020	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 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months:

Number. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	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 2019 and 31 March 2020:

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	0	0
£25,001 - £50,000	0	0	1

£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	5	0	0
Total number of exit packages by type	5	0	5
Total resource cost	£195,389.33	£0	£195,389.33

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	0	£0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
TOTAL	0	£0

Value of special severance payments approved by NHS Improvement

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

Trade Union Facility Time

Relevant union officials	
Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
34	28.41
Percentage of time spent on facility time	
Percentage of time spent on facility time during the relevant period	Number of employees
0%	17
1-50%	15
51-99%	0
100%	2
Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	
Total pay bill	£317,275,000
Total cost of facility time	£70339.22
Percentage of pay spent on facility time	0.00022%
Paid trade union activities	
Hours spent on paid facility time:	3372.25
Hours spent on paid trade union activities	506.25
Percentage of total paid facility time hours spent on paid TU activities	15.01%

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.	6, 26 – 28, 115
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.	21 – 24, 53 – 56, 120, 124, 125

Code ref.	Summary of requirement	See page(s):
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.	114 – 118
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.	115 – 117
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.	21 – 23
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.	21 – 24
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	21 – 23
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.	53 – 56
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 Chairman or Non-Executive Director.	52
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.	21
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.	30, 116, 117
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.	28, 29, 57, 92, 106, 107, 129
B.6.2	Where there has been external evaluation of the Board, 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.	106, 107
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).	29, 31, 88, 90. 93, 98, 110, 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.	29, 90, 92, 95, 107 – 109, 112, 113, 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.	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: ▪ the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; ▪ 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 ▪ 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.	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.	30, 54, 69, 92, 114, 118, 120 – 122
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.	119 – 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.	31, 118, 123
FT ARM	The annual report should include: ▪ a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; ▪ information on the number of members and the number of members in each constituency; and ▪ 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.	119 – 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.	26, 115

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

'Comply or explain' disclosures

The following table outlines those provisions where we did not fully comply with the provisions of the NHS Foundation Trust code of governance:

Code ref.	Provision	Explanation
D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the Chairperson and other non-Executives at least once every three years and when they intend to make a material change to the remuneration of a non-Executive.	When considering the remuneration levels of the Chairman and other Non-Executive Directors on behalf of the council of governors, the nominations Committee considered contemporary regional and national NHS benchmarking data. It considered that this was sufficient to meet its needs and that consulting external professional advisers would incur significant and unnecessary cost. The council of governors supported this approach when it considered the matter and considers that this approach is in line with the principles of 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;	70, 71
The Foundation Trust's policies in relation to disabled employees and equal opportunities;	17, 67, 68, 106, 117, 118
Information on health and safety performance and occupational health;	17, 18, 66, 78, 127
Information on policies and procedures with respect to countering fraud and corruption;	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	13, 14
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;	36 – 44, 51, 52, 68, 100, 103
Consultation with local groups and organisations, including the overview and scrutiny Committees of local authorities covering the membership areas	52, 105

Summary of disclosure	See page(s):
Any other public and patient involvement activities.	45, 101, 105, 106
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	12
Sickness absence data	66, 67
Details of serious incidents involving data loss or confidentiality breach	107, 108

Voluntary disclosures

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

Summary of disclosure	See page(s):
Sustainability / environmental reporting	14, 15
Equality reporting	67 – 70
Slavery and human trafficking statement (Modern Slavery Act 2015)	30, 31

NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

Single Oversight Framework

NHSI's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHSI has placed the Trust in segment 3. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHSI website.

During 2015/16 the Trust became in breach of its licence conditions and on 18 June 2015 NHSI (formally Monitor) accepted enforcement undertakings given by the Trust pursuant to powers under section 106 of the Health and Social Care Act 2012. NHSI (formerly Monitor) imposed an additional licence condition (relating to additional governance requirements) on the Trust pursuant to its 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.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given the finance and use of resources is only one of the give themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 scores				2018/19 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
	Liquidity	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Financial efficiency	Income and expenditure margin	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Financial controls	Distance from financial plan	[4]	[4]	[1]	[4]	[2]	[2]	[1]	[1]
	Agency spend	[3]	[3]	[3]	[3]	[2]	[2]	[1]	[1]
Overall scoring		[4]	[4]	[3]	[4]	[3]	[3]	[3]	[3]

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.

NHS Improvement, 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*.

Karen Partington
Chief Executive
18 June 2020

ANNUAL GOVERNANCE STATEMENT 2019-20

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 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and Accountability

The Trust has as a member of the Board, the Nursing, Midwifery and AHP Director to lead on governance, risk and the quality agenda. 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. The Chief Operating Officer is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs reporting.

The existing organisational management structure 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. The Trust Board is fully cognisant of the requirements of good governance including the requirements of the FT Code of Governance and this can be clearly evidenced through the agendas of the Board and its Committees. These arrangements are supported by a robust Internal Audit Programme which tests key aspects of the Trust's governance arrangements annually.

In line with the requirement for internal control of CQC registration conditions, a Governance structure is in place. This includes the necessary systems, processes and staff to deliver good governance at both corporate and divisional level. Corporately there is an established Directorate of

Governance and within each Division there are dedicated Governance teams all of whom are in post to support the organisation and the Trust Board in meeting its governance responsibilities.

The Governance Directorate's key objectives are to:

- Support the Trust's risk management arrangements;
- Continue to raise the profile of governance by ensuring governance and assurance remain on an equal footing with other organisational priorities;
- Ensure that governance, quality and safety are seen as the responsibility of all staff who, in discharging those responsibilities, have access to, and support from, an appropriately skilled and responsive governance support team;
- Ensure that the Trust's governance resource is targeted in the right place at the right time with an emphasis on outcomes rather than process and improved quality and safety; and
- Ensure that during a period of inevitable increased emphasis on cost effectiveness in healthcare, that this is not at the expense of reduced quality or poor governance in our organisation.

In line with the principles of devolution within the Trust, responsibility for the management/control and funding of a particular risk rests with the relevant Division/Directorate concerned. However, where action to control a particular risk falls outside the control/responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the Executive Management Group (previously the Integrated Governance and Risk Group) for further consideration, potential escalation to Trust Board or rejection to the appropriate function for continued action and oversight. It is also recognised that there are some risks where action to control and or assurance is reliant on external stakeholders for example the CCGs. Where this has been identified the risk is categorised as such to allow discussions by the Executive Management Group in support of cross boundary working.

The Trust has a unitary Board which consists of Executive and Non-Executive Directors and have an appropriate 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 background in finance, audit, IT, estates, commerce, quality and service improvement, health and social care, governance and risk and education. They are responsible for providing support, advice and other specialist skills to the Trust and the Board and ensuring that the interests of the local community are represented, monitoring and ultimately holding to account the Executive Management of the organisation. The Executive Directors and Corporate Directors, led by the Chief Executive, are responsible for the overall management of the Trust. Executive Directors individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to mitigate risks to the Trust's strategic objectives. Balancing risk against outcome, Non-Executive Directors are responsible for robustly challenging overly ambitious decisions proposed by Executive Directors.

The Committees of the Board, in turn, have responsibility for providing assurance in respect of the effectiveness of those controls. A system of Committee Chair reports to the Trust Board is in place to escalate risks or issues. Committees of the Board are well attended by Executive and Non-Executive Directors as well as by other key Trust staff. The Trust carries out an annual review and strengthening of its Committees of the Board at least annually. During 2019/20 the Trust also took

account of the recommendations arising from the external Well-Led Review commissioned in June 2018. This will ensure that the Board committee structure is able to meet the challenges to be faced by the organisation during 2019-20 and beyond. The effectiveness of the Trust's governance structures continued to be tested during 2019-20 via the Annual Internal Audit Programme and other external visits including Royal Colleges, various regulators and Commissioners.

Responsibility for assuring the performance of the Trust Board in discharging its responsibilities rests with the Council of Governors. Governors achieve this by feeding back to members and the public, information about the Trust, its vision, performance and strategic proposals made by the Board, seeking the views of members and the public on material issues or changes being discussed by the Trust; and communicating to the Board the interests of members and the public rather than just their own personal views. Governors then satisfy themselves that the Board has appropriately considered the interests of members and the public in their material strategic decision making.

Governors have three Working Groups, which report to the Council of Governors; the Buildings and Environment Group, Patient Experience Group, and Membership Group. The working groups have no delegated powers and are established to provide a mechanism for Governors to discuss and provide feedback to the Trust from the Trust's membership and the wider public on the continued improvement in our estate, buildings and general environment across all Trust sites, the quality of experience of our patients, and our Membership Strategy (as applicable), as well as a forum to receive updates about Trust developments. Each working group is attended by a key member of Trust management and a Non-Executive Director and is chaired by a Governor. In addition, Governors are members of the Nominations Committee who are responsible for making recommendations to the Council of Governors for the appointment, removal, remuneration, allowances and other terms of office of the Chairman and Non-Executive Directors of the Trust.

During 2019-20, the Trust has appointed a new Chair, a new Non-Executive Director and three new Executive Directors, including a new Nursing, Midwifery and AHP Director, Chief Operating Officer and Finance Director/Deputy Chief Executive. The Board have monthly development workshops for Executive and Non-Executive Directors with the programme including a mixture of operational, skills, knowledge and behavioural subjects. The performance of the Executive leadership team is reviewed and monitored through an annual appraisal process led by the Chief Executive to ensure skills; knowledge and capability to carry out roles are maintained. Annual performance reports of senior Executives are provided to the Appointments, Remuneration and Terms of Employment Committee. The Chair undertakes an annual appraisal of the Non-Executive Directors' performance and the appraisals are provided to the Nominations Committee and the Council of Governors

Training

A key priority for the Risk Management Team during 2019-20 was to review and improve the Trust's risk management training to ensure that it remains responsive to the needs of Trust staff. Through the comprehensive mandatory training programme, which includes governance and risk management awareness, staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience. The focus during 2019-20 was to follow up the recommendations made by MIAA at the end of 2018-19 as part of the organisational and divisional risk maturity review. As part of the Board Development sessions, a series of risk maturity workshops have taken place with the Executive and Non-Executive Directors. The output of these workshops has been the development of a Trust-wide risk appetite statement in line with the well-established 'As Low As Reasonably Practicable (ALARP)' Principle with priority placed upon

consistently delivering excellent care ahead of any other aim or objective. The alignment of the risk appetite statement to the Trust's ambition supports the 'Well-Led' aspect of the CQC requirements and the feedback from MIAA which highlighted that this could further develop the way risks are managed. To enhance the level of engagement and understanding of risk management, the Corporate Governance and Risk Management team have undertaken a series of risk maturity workshops across the Trust's four clinical divisions. Due to the impact of Covid-19, the series of workshops planned for corporate services have now been scheduled for quarter 1 of 2020-21. MIAA were due to re-audit against the recommendations made in the 2018-19 audit during quarter 4 of 2019-20 but this has been delayed due to the impact of Covid-19. However, the Trust is expected to demonstrate improvements in Divisional risk maturity ratings since the previous review when the follow up takes place at the start of quarter 1 of 2020-21.

There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which as above includes elements of governance and risk management training). 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.

Control Mechanisms

A single electronic IT Risk Management System is in place which links all key risk elements (including incident reporting, complaints and claims management) and which, in turn, informs the Trust's Risk Register. Lessons learned when things go wrong are shared throughout the organisation via a range of mechanisms including 'patient safety' alerts, 'lessons learned' newsletters, and through the forums such as the Learning 2 Improve Group. Further mechanisms for ensuring the sharing of transferrable lessons as well as good practice, will continue to be explored during 2020-21, including working with other organisations and learning from best practice elsewhere.

The Board routinely considers specific risk issues and receives minutes from all Committees of the Board including the Audit Committee, Safety and Quality Committee, Finance and Performance Committee, Workforce Committee, Education, Training and Research Committee and Charitable Funds Committee. The Safety and Quality Committee, on behalf of the Trust Board, routinely receives information on Serious Incidents (SI), including lessons identified and learned, following which a SI Report is considered by the Board along with a quarterly thematic review of SI's.

The Board considers at every Board meeting whether there are issues or risks to be escalated to appropriate economy forums, such as the ICP and ICS, the Central Lancashire Urgent Care Delivery Board or the CCGs and NHSI.

The Trust actively encourages networking and has strong links with relevant central bodies, e.g. National Health Service Resolution (NHSR), HSE, and acts on recommendations and alerts from these bodies as appropriate.

The Trust has established trusted relationship with the CQC and in accordance with registration requirements is proactive in escalating risks and concerns in respect of patient safety and quality concerns as they occur. The Trust shares actions taken or proposed and this approach provides assurance to our regulators that the Trust Board has appropriate oversight of its quality governance

and patient safety risks and responds quickly and effectively as indicated. The Trust routinely undertakes horizon-scanning in order to be appraised of and act upon the recommendations of relevant national high level enquiries through the use and monitoring of robust action plans.

The risk and control framework

The management of risk

The Risk Management Strategy is critically important to the Trust and is reviewed by the Trust Board annually. The strategy sets out our approach to the management of risk and the implementation of a system which assists in identification, assessment, treatment and monitoring of risk. The strategy provides the framework and plan by which the Trust can further develop its ability to meet the demands of effective risk management. 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.
- 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 risk management process is congruent with and reflective of The Risk Management Strategy. A systematic process for assessing and identifying risk is conducted at Divisional level. 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. However, where 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 or require significant financial investment or the risk is 'high' or 'significant' and simply cannot be dealt with at that level, such issues are escalated by the relevant Division by way of reporting to the Executive Management Group (previously the Integrated Governance and Risk Group) for consideration. These reports provide detailed analysis of risk and the actions to mitigate them, providing a rich source of detailed information and evidence of risk reduction. The Executive Management Group scrutinises these reports, seeks clarification from divisional representatives and, where appropriate, requests more in depth reports and additional evidence. As part of the reporting process, the Governance Team also highlight frequently

appearing risks for evaluation. The Group may escalate a particular risk to the appropriate Committee of the Board for further consideration.

The Trust also has in place a Board Assurance Framework (BAF), which is designed to assist the Trust in the control of strategic risk. Principal risks that impact on the Trust's ability to meet its strategic objectives are recorded on the BAF. During 2019-20, the Trust developed its strategy 'Our Big Plan, detailing what its key priorities are over the next three years, key risks associated with achieving 'Our Big Plan' are contained within its Board Assurance Framework. Each risk on the BAF is 'owned' by an Executive Director. Executive Directors individually and collectively have responsibility for providing assurance to the Board on the controls in place to mitigate such risks and the Board reviews the entire BAF at each meeting. Additionally, each risk on the BAF is aligned to a Committee of the Board, which reviews the risks assigned to it at each meeting. The Committees of the Board in turn have responsibility for providing assurance to the Board in respect of the effectiveness of those controls. The BAF was further refined during 2019-20 and this will continue into 2020-21 in response to internal audit recommendations, a monthly 'deep dive' has been introduced, which enables the Trust Board and its Committees to examine the detail of specific control issues and to seek the appropriate assurance. During 2019-20, the output of the BAF Deep Dives has led to a reduction in the number of principal risks, an amalgamation of multiples risks based on similar topic and a reduction in risk scores.

Risk management is embedded 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 divisional risk registers, the organisational risk register and the Board Assurance Framework.
- Board and Committees of the Board oversight of principal risks to the organisation's strategic aims and oversight by the Executive Management Group (formerly the Integrated Governance and Risk Group) of divisional risks.
- compliance with the mechanisms for the reporting of all accidents and incidents using our sophisticated online incident reporting system.
- all serious incidents are actively managed and monitored to ensure compliance with action plans and being open, and progress is monitored by the Board of Directors at each meeting.
- outcomes from complaints, incidents and claims are used to mitigate future risks and these outcomes are also aggregated to identify Trust-wide risks.
- risk management training and education for staff, including induction training, statutory and mandatory training. The requirement for risk management training is identified in our risk management training needs analysis, which details the type and level of training required by staff group and work area. A central record of all such training activity is maintained.
- an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- '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.

Throughout 2019-20 we have continued to strengthen our risk management arrangements, including through our monthly Executive Management Group (formerly Integrated Governance and Risk Group) meetings, which is an operational Group reporting into the Safety and Quality Committee. Executive Management Group meetings take place on a monthly basis and have strong

cross-divisional representation at every meeting so that lessons learned and assurances can be shared between Divisions. Furthermore, the Trust has representation at the newly established 'Governance, Assurance and Risk Network' for the North of England, which provides opportunity to share lessons learned and best practice with other providers.

During 2019-20, we strengthened our Integrated Performance Reporting and our Accountability Framework, which now include explicit links to strategic risk management and to agreed Key Performance Indicators (KPIs), which will be monitored through the business planning and performance management frameworks via the Divisional Improvement Forums (DIF). In addition, business case proposals do not proceed without an appropriate assessment of and therefore recognition/acceptance of the risks involved.

Principal risks

The most significant risks that threaten the achievement of the Trusts ambitions as identified within the Board Assurance Framework for 2019-20, related to:

- Availability of clinical and medical workforce.
- Availability and sustainability of operational and strategic capital.
- Operational capacity, demand and performance.
- Effectiveness of current system resilience and capacity.

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 agreed.

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.

The effectiveness of the Trust's governance structures was externally tested during 2019-20 via the CQC undertaking an inspection of the organisation during a three day unannounced inspection of Urgent and Emergency Care and Medicine at Royal Preston Hospital and Chorley and South Ribble Hospital and Surgery and Critical Care at Royal Preston Hospital on 2, 3 and 4 July 2019. A further two day announced inspection of Urgent and Emergency Care at Royal Preston Hospital on 8 and 9 July 2019. The Well-Led inspection took place on 6, 7 and 8 August 2019 and concluded with the Use of Resources inspection which took place on 8 July 2019.

The purpose of the inspection was to establish answers to five key questions:

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

The CQC published their Inspection Report and Use of Resources Report on 7 November 2019, with an overall view that the Trust 'Requires Improvement'. Overall, the Trust retained a rating of 'Requires Improvement', with 'Good' for caring and a new 'Good' for Well-Led. Although the Trust retained the same rating, four of the six services that were inspected this year are now rated as 'Good' which is a further improvement on last year. The services that were given a 'Good' rating this year are Surgery and Critical Care at Royal Preston Hospital and Medicine and Urgent and Emergency Care at Chorley and South Ribble Hospital. These Good-rated services now stand alongside Maternity, End of Life and Outpatients on both sites and Children and Young People services at Royal Preston Hospital which are already rated as 'Good'.

Urgent and Emergency Care services at Royal Preston Hospital have moved to 'Good' in the Effective and the Well-Led domains however are rated as 'Requires Improvement' overall. Medicine achieved a rating of 'Good' at Chorley and South Ribble Hospital but maintained the rating of 'Requires Improvement' at Royal Preston Hospital.

The CQC rated the Trust as good for Well-Led due to the following:

- **Leadership, capacity and capability**: Trust leaders were deemed to have the appropriate experience, capacity, and skills for their roles. While there were new appointments to the Board, leaders were positive about the changes and the contribution the new leaders had made. Leaders were, overall, visible and approachable and the Trust was committed to developing staff to become future leaders through development programmes. Leaders were also assessed as being knowledgeable about issues and priorities for the quality and sustainability of services and had a shared understanding of the risks and challenges.
- **Vision, values and a credible strategy**: The Trust has a clear vision, values and ambitions driven by quality and sustainability and have developed a new strategy which has well defined objectives and been developed in collaboration with people who use the service, staff and external partners. The Trust measures progress against the delivery of the strategy and it is well understood by staff and translated into divisional and service business plans. The Trust has also actively contributed to plans for the wider health and social care economy.
- **Culture**: Staff felt that generally the Trust was a good place to work. Most staff were positive about the organisation as a place to work and most staff groups felt respected, valued and supported by leaders. Staff were positive about improving services and patient focussed and that the Trust was committed to the wellbeing of staff which was supported through different initiatives and groups. The CQC felt that staff were honest and open and were encouraged to develop and were supported to do so by the development and education programmes.
- **Responsibilities, roles and systems of accountability to support good governance and management**: Since the previous inspection the Trust had reviewed its governance structures and the Board and other levels of governance in the organisation appeared to function effectively and interact with each other appropriately. Structures, processes and systems of accountability, were clearly set out, understood and effective. Staff and teams were clear about their roles and accountabilities.
- **Effective processes for managing risks, issues and performance**: The CQC assessed the Trust as having the processes to manage current and future performance. There was a comprehensive process to identify, understand, monitor and address current and future risks. The CQC did however deem there was a lack of clarity between the interface between the Board Assurance Framework and corporate risk register. Since the inspection, the Board

Assurance Framework has been refined to address this lack of clarity and further work will continue in 2020-21 to further improve understanding of this. The CQC also concluded that performance issues were escalated to the appropriate Committees and the Board through clear structures and processes. The Trust used information well to monitor performance across the organisation and had developed integrated performance reports which were aligned to the ambitions in the new strategy. Performance reports covered a mix of quality, operational and financial information. The Trust had processes to ensure that the information was accurate, valid, reliable, timely and relevant. The Trust was using and had processes to develop information technology systems to monitor and improve the quality of care. Clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures were managed so that they did not compromise the quality of care. Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.

- **Effective processes for processing, challenging and acting on appropriate and accurate information**: The Trust used information well to monitor performance across the Trust. The Trust had developed integrated performance reports which were aligned to the ambitions in the new strategy. Performance reports covered a mix of quality, operational and financial information. The Trust had processes to ensure that the information was accurate, valid, reliable, timely and relevant. The Trust was using and had processes to develop information technology systems to monitor and improve the quality of care.
- **Public, staff and stakeholder engagement**: The CQC concluded that the Trust engaged with others to improve and develop services. The service proactively engaged with staff, patients and local communities and hard to reach groups about their health and the services provided. The Trust also involved staff in decisions and changes which affected them. The Trust was working with stakeholders and partners across the ICS and ICP to improve services.
- **Robust systems and processes for learning, continuous improvement and innovation**: The Trust has a strong focus on education, research and innovation and collaborated well with other partners across the North West. The Trust continues to strengthen its focus on continuous improvement. The Trust continues to build its capacity so it had staff with the knowledge and skills to deliver improvements. The Trust is involved in external continuous improvement programmes and had plans to develop further over the next year. The Trust has systems, staff and facilities to support research and development with ambitions to develop further. Individuals and teams have received national recognition and been nominated for awards for improvements, initiatives and care. The Trust has strengthened its processes for sharing learning across the Trust.

The findings demonstrate the significant progress made since the last inspection, indicating the Trust has the correct components in place to move the other core domains and service lines to 'Good'. The inspection also found that despite some of the challenges, staff were kind and compassionate and this was demonstrated through the rating of 'Good' across the Core Domain of Caring.

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

The Trust received an overall rating of 'Requires Improvement' for Use of Resources, which is a review based on the Model Hospital profile, testing how well the Trust is utilising resources e.g. workforce, finance, medicines. The Use of Resources rating is the same as last year due to a deterioration of the Trust's financial position, pay costs and decline in operational productivity.

The decline in operational productivity is balanced against activity increasing year-on-year, particularly in emergency demand which had increased by 7% prior to the impact of the Coronavirus pandemic. However, it is recognised that Emergency Department attendances and emergency admissions to hospitals in England fell to their lowest figure on record in the face of Coronavirus. NHSE, which published the figures, noting the fall was 'likely to be a result of the Covid-19 response' and an indication that people have been staying away from Emergency Departments because of the Coronavirus outbreak. The Trust has an ageing infrastructure which adds capital pressure and impacts on the Use of Resources assessment.

There have been a number of initiatives since the last inspection with regard to the Use of Resources Inspection including, but not limited to the Continuous Improvement access and flow programme, Clinical Negligence Schemes for Trusts (CNST) compliance last year and on track for this financial year, increased prescribing pharmacists, improvement in recurrent savings for procurement and rollout of Electronic Prescribing and Medicines Administration (EPMA). However, we recognise the continued focus needed as a result of an overall rating of 'Requires Improvement' for Use of Resources on reducing Trust sickness absence, lack of capital, ageing condition of the estate, delayed transfers of care and improvement needed to deliver theatre productivity against increased non-elective activity.

Whilst we remain cognisant of the need to improve our overall rating of 'Requires Improvement' for Use of Resources, the CQC have recognised the intense pressure on health providers during the Coronavirus (Covid-19) pandemic. Although the CQC have paused routine inspections, including the Use of Resources assessment, the regulatory role and core purpose of keeping people safe has not changed and as such they have developed an emergency support framework. In support of being well-led and in recognition of a challenging operational and financial landscape due to the Coronavirus pandemic our Trust is following this framework. We are using and sharing information and having open and honest conversations with our regulators and undertaking regular weekly CQC engagement meetings (now moved to fortnightly by the CQC). It should be noted that the CQC emergency support framework is not an inspection and they will not be rating our performance but this framework supports us with our continued journey to achieving a CQC rating of 'Good'.

To deliver the recommendations in the CQC report the Trust received four 'Must Dos' as being in breach of the Health and Social Care Act 2008 and to continue embedding good governance, the Trust has developed a robust CQC Accountability and Improvement Framework to address the issues raised by the CQC, alongside wider contextual challenges. The delivery of the CQC recommendations is monitored through the Quality Improvement Plan, which is reported to the Trust Board via the Safety and Quality Committee on a monthly basis. The Trust's Director of Governance has in place a Governance, Regulation and Assurance Team who acts as the link between the CQC and the Trust on all operational regulatory improvement matters. Further details of the recommendations provided by the CQC can be found in the Quality Improvement Plan. The follow up of Use of Resources recommendations are monitored through the Finance and Performance Committee.

The Trust has also been inspected by the HSE, CQC and the Environment Agency in October 2019 with respect to radiological protection in interventional radiology and nuclear medicine. In total six breaches were identified by the HSE and the CQC but both have been satisfied with the Trust's response and the matter closed.

During 2019-20, there have been two Royal College visits commissioned by the Trust, one by the Royal College of Physicians to the Cardiac Catheter Laboratory Service and one by the Royal College of Surgeons to review the Neurosurgery Service. Following a series of recommendations, action plans were produced and these have been monitored via the Trust's Safety and Quality Committee. The Royal College of Surgeons have been satisfied with the follow up of the Neurosurgery Service and the review has been closed. The follow up of the Royal College of Physicians is due to take place in 2020-21. No concerns are anticipated with this follow up.

With respect to clinical audit, the Trust has an annual clinical audit and effectiveness plan for the year 2019-20 which incorporates national audits, corporate audits, audits associated with Trust wide priorities, audit of national guidelines as well as other audit priorities. 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 2019-20

The overall Head of Internal Audit opinion for the period 1 April 2019 to 31 March 2020 provides Moderate Assurance that there is an adequate system of internal control. However, the Head of Internal Audit Opinion has also noted in some areas weaknesses in design and/or inconsistent application of controls which puts the achievement of some of the organisation's objectives at risk.

The Audit 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, one provided High Assurance, five provided Substantial Assurance, two provided Moderate Assurance and one provided Limited Assurance relating to Business Continuity which management is continuing to address. There were no reports which provided No Assurance. The internal auditors also completed reviews of the Assurance Framework and Health and Safety but provided no overall opinion.

Review coverage has been across governance and leadership, financial performance and financial sustainability, quality, people and information and technology with 30 recommendations made overall as part of the reviews undertaken during 2019-20. All recommendations raised by MIAA have been accepted by the Trust and MIAA continue to undertake follow up reviews to ensure they are satisfied that recommendations have been met.

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, which was developed over several months with engagement and consultation with over 3,000 members of the public, Governors, staff and those with a vested interest in services, such as patients, carers and partner organisations. There are four aims of the strategy which are to deliver a positive patient experience; improve outcomes and reduce harm; create a good care environment; and improve capacity and patient flow. Implementation of the strategy and performance against the four aims will be measured as part of the Trust's governance arrangements and shared across the organisation and with Governors, HealthWatch and patient groups who will support the measurement processes for the next three years to provide assurance and identify and respond to any barriers that need to be overcome.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director. The Safety and Quality Committee is responsible for monitoring performance against the agreed annual quality objectives. The minutes of the Safety and Quality Committee are submitted to the Board, along with a Committee Chair's Report escalating items for consideration by the Board. The Safety and Quality Committee is supported by the Executive Management Group (formerly the Integrated Governance and Risk Group).
- 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. This report provides the opportunity for scrutiny and challenges on key quality objectives. This monthly report in turn informs the annual Quality Account.
- 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 oversees this agenda.
- The Safety and Quality Committee retains a challenge and assurance role in respect of mortality and the Audit Committee receives formal assurance in respect of clinical audit.
- STAR Quality Assurance Framework continues to be a vehicle by which all wards and outpatient areas are monitored.
- 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.
- The Nursing, Midwifery and AHP Director has responsibility for focusing on the quality of the patient experience and is the Board lead for quality and patient experience.
- 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.
- Complaints being responded to within ten days have consistently been achieved.
- Key risk issues are also discussed with Governors at formal Council meetings.
- A robust process for the management of all alerts that impact upon our patients and services including patient safety alerts, 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 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. Risks related to operational and quality breaches are managed in accordance with the requirements of the Trust Risk Management Strategy.
- The CCG undertake Quality Assurance visits at our Trust and provide feedback and recommendations with all feedback incorporated into our assurance framework processes.
- The contracting team supported by corporate governance monitor other service provision for example specialist commissioning, through the contract review process.
- The Trust Board during 2019 considered at every Board meeting whether there were safety and quality issues that needed to be escalated to the economy-wide CLQIB, which was established during 2017. The CLQIB ran for half of the year until the end of quarter 2 and is now integrated into work on a partnership approach across the ICP and ICS. In addition, risks relating to emergency care and urgent care were escalated to the Central Lancashire Urgent Care Delivery Board for further discussion and resolution.

Capacity and Flow

During 2019-20 the Trust continued to experience significant operational pressures. The Trust has failed to achieve its objectives in relation to Accident and Emergency waiting times during all quarters, the 18-week incomplete access target (though reduction in backlogs made), and did not consistently hit the 62-day cancer treatment. This was largely due to significant pressures within the Emergency service throughout 2019-20 that adversely impacted on access standards compliance and delivery of the Trust's elective care programme, which is consistent with the position nationally.

The Trust has taken a number of steps to mitigate risks around these issues, through focused and dedicated work to bring performance back into compliance. This has involved internal work as well as collaborative work with other partners in the local health economy, such as:

- The national Emergency Care Intensive Support Team engaged by the Trust to offer support and guidance around the emergency care programme.
- The national Intensive Support Team engaged by the Trust to offer advice and guidance in the management of the elective care programme.
- A health economy wide action plan is in place 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.
- During 2019-20 the Trust set up a range of Continuous Improvement and transformational work streams of which patient flow has a significant work plan attached.
- Our Trust continues to be part of the Flow Coaching Academy and there have been a number of staff who have recently graduated.

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 2020-21.

Financial Sustainability

The Trust remains in breach of its NHSI Licence conditions and has a single oversight framework segmentation of 4, which means the Trust is receiving mandated support from NHS Improvement through the Enhanced Oversight regime. This is due to continued financial pressures and the inability to maintain and improve financial sustainability, efficiency and compliance with sector controls. Unprecedented operational pressure has seen increased cancellations of elective activity resulting in reduced income. The Trust has also experienced a significant reliance on premium agency staffing costs mainly due to medical and qualified nursing vacancy rate, and the need to insource additional expensive unplanned capacity to meet demand and improve flow.
The reported year-end operating deficit, before national monies and technical items, is £58m. Whilst the Trust achieved £12.5m savings in 2019/20, this was 50% of our challenging savings target for the year (£25m) and, of the total delivery; £6m represents non-recurrent savings achieved and places additional pressures on the 2020-21 savings target.

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

i. *Liquidity:* Due to deficits in the current and previous years the Trust's financial standing is based upon working capital loans and facilities therefore we continued to be reliant on external financial support throughout 2019-20 and into 2020-21. We plan to access significant working capital loans of £68.5m during 2020-21 and our loans of £90.6m are due for repayment during 2020-21. Whilst we have an expectation that this will be renegotiated before the expiry date, and the Trust's draft operational plan has been completed on the basis of the loans transferring to PDC, should this not be the case, the Trust will not have sufficient cash resources to repay the loan.

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. We along with our local partners are together seeking sustainable solutions through the OHOC programme; during 2019-20 we have been 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 may be required.

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

We have continued to develop our systems and processes to help us deliver an improvement in the financial performance, including:

- 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;
- 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;
- fortnightly Divisional Improvement Forums attended by members of the Executive Team to ensure that Divisions meet the required level of performance for key areas;
- working with a Finance Improvement Director;
- 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 issue.
- we have further strengthened 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 and NHSI which gave a positive assurance on our approach.
- the Trust has continued to utilise its Business Improvement Team to support robust planning and delivery of the Trust's financial improvement programme;
- 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 continues to have in place a 'Quality Impact Assessment' and robust governance systems that require clinical approval of all cost improvement programme schemes.

In addition, NHSE and NHSI have established a joint oversight framework for ICPs. These frameworks are monitored through monthly meetings to review things like operational performance (constitutional standards) and financial performance. Similarly the ICP has developed its planning framework based on ICPs.

Going concern

The Trust Audit Committee considered the appropriateness of the accounts being prepared on a going concern basis. The Audit Committee deemed it appropriate for the accounts to be prepared on this basis, and in reaching this decision it considered the publication in November 2019 of 'A revised UK auditing standard on Going Concern, ISA 570', and the increased focus on the issue of going concern caused by recent enforcement cases and well-publicised corporate failures, and drew on the views of management and the external auditors to support this conclusion. However, there are matters referred to in the Performance section of the Annual Report, (to avoid duplication not included in the Annual Governance Statement), that represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business.

The Integrated Care System (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. 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. 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 of the challenges associated with any proposed reconfiguration and the interdependences and risks which may impact on the Trust as a result of decisions 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. This has been approved by the Workforce Committee and noted at Board through positive escalation. The workforce plan has taken into account changes to services, investment and cost improvement plans, recruitment successes, turnover, and predictive workforce supply. It has also considered 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. The talent management pathway has also been utilised to develop a succession plan 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. The plan is maintained on an ongoing basis and is updated every six months to ensure ongoing compliance with *'Developing Workforce Safeguards'* recommendations and to support the development aims of the organisation. In addition to this, developing workforce safeguards reports are presented to the Safety and Quality Committee.

Patient and Public Involvement

The Trust ensures that public stakeholders are involved in understanding the risks which impact upon them by a variety of means: the principal amongst these being the operation of the Council of Governors and the holding of Board meetings in public. The Council meets at least four times per year in public and on each occasion receives a comprehensive report on performance and risks to delivery of our key targets. These reports are published along with the rest of the Council papers on the Trust internet site.

We have in place a Patient Experience and Involvement Strategy which clearly sets out our commitment to involving patients, carers and the public at various levels and informing them of Trust developments. This is carried out using a number of different approaches, including the use of our membership as well as engaging with local organisations, NHS agencies, statutory organisation, voluntary and community groups, local school and colleges. Additionally, the Trust engages actively with the Health Overview and Scrutiny Committees and continues to collaborate closely with HealthWatch.

The OHOC programme has provided significant opportunity during 2019-20 for public involvement to develop new models of care that are clinically and financially sustainable for the future within a more integrated health and care system, for the population of Chorley, Preston and South Ribble. In 2019-20, we had a number of Solution Design Events, which brought together approximately 480

attendees, representatives from the whole health and social care economy including Consultants, GPs, Nurses, Allied Health Professionals, Pharmacists, Radiologists, Social Care workers, plus representation from district and county Councils and other public services, third sector and patients and public involvement has continued throughout 2019-20. During 2019-20 through the programme we have held four formal public engagement events and numerous smaller engagement sessions, such as at local GP surgeries, libraries, community groups, colleges and schools and continue to engage with our Council of Governors through a standing items on the agendas of all Council of Governors' meetings.

The Trust's comprehensive internet website provides the public with ready access to information across all areas of Trust activity and the organisation also uses its newsletter (Trust Matters) for members to inform the public of new developments and items of interest.

Conflicts of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust as part of its Code of Business Conduct) within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

In accordance with equalities legislation, the Trust has in place an equality strategy which includes the organisation's objectives and intentions in relation to all protected characteristics. Equality impact assessments continue to be undertaken for all policies, service developments and estates and facilities developments. The Trust also continues to promote and develop its consultation with staff, patients and the public. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with

Sustainable Development Management Plan

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Board effectiveness

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 of their leadership

and governance using the Well-Led Framework the Board commissioned Deloitte to undertake an independent review of its governance in 2018 and continues to use the report arising from this review to self-assess and further improve governance arrangements. This includes undertaking a further self-assessment in a Board Workshop held in March, reflecting on current ways of working and potential development opportunities.

The final report indicated 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.

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

Furthermore, at Committees of the Board level, we carry out annual effectiveness reviews to ensure that each Board Committee structure is able to meet the challenges to be faced by the organisation for the following year. During the reviews the Committee evaluates its function and specific duties to determine whether (i) such duty or function is high or low impact, and (ii) whether the Committee is effective in carrying out its function or discharging its duties. As part of this review, the terms of reference and cycle of business for each committee are refreshed.

The effectiveness of the Trust's governance structures continued to be internally tested during 2019-20 via the Annual Internal Audit Programme. MIAA, the Trust's internal auditors, provided an overall opinion of moderate assurance, based on their work during 2019-20.

Information governance

Risks to data security are managed through dedicated information risk and information governance policies. Lancashire Teaching Hospitals NHS Foundation Trust's information governance assessment report through the Data Security and Protection Toolkit (DSPT) submission for 2019-20 is 'standards met'. This demonstrates an achievement for the Information Governance Team as the Trust remains consistent with information governance compliance.

During 2019-20, four incidents were taken through the Information Commissioners Office (ICO). No further action was required as the Trust has been able to demonstrate that actions have been implemented and robust policies and procedures are in place.

Information risk management is an essential component of Trust processes and is an integral part of good management practice so that we embed information risk management in a practical way into

business processes and functions. This is achieved through regular training and awareness for all staff. Incident management is a part of that process 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.

There are robust and effective systems, procedures and practices to identify, manage and control information risks.

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.

Through 2020-21 the Trust will work towards demonstrating continued compliance through the Data Security and Protection (DSP) Toolkit to display they are implementing the ten data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the GDPR, Data Protection Act and NHS national standards.

In line with NHSE and NHSI published guidance to reduce the burden and release capacity for NHS providers to support the management of the Covid-19 pandemic, the Trust met the standards for the 2019-20 submission and as such continues to be designated as ‘Standards Met’ during the period of the Covid-19 pandemic.

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 NHSE England National Command and Control support, was declared.

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

- Establishing bi-weekly strategic planning group meetings and daily tactical meetings.

- Engaging in the regional emergency preparedness, resilience and response (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 infection prevention and control 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 to ensure staff receive up to date information.
- Continuing to monitor patient safety risks through recognised systems and processes.

The emergence of Covid-19 in 2019-20 has made an impact in some areas of the Trust's risk and control framework, including delays to some year-end reporting, for example,

- The impact of Covid-19, on the finance department resources, has complicated the year-end production and audit of the financial statements due to 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.
- The delivery of the full 2019-20 Internal Audit Plan by MIAA has been impacted by the Covid-19 pandemic. The majority of reviews have been delivered in accordance with the schedule agreed with the Audit Committee at the start of the financial year, including approved plan variations. This position has been reported within the progress reports across the financial year or reports have been sent directly to Audit Committee members. There were six reviews which were either at draft report or fieldwork stage which have been delayed as a result of the Covid-19 pandemic. It is anticipated that MIAA will be able to include a number of these reviews within the financial opinion to be issued in May 2020. Given the stage of these reviews, MIAA have evaluated that the outcomes will not impact on the overall audit opinion.

Covid-19 has also led to the re-configuration 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 that will be revisited once the Covid-19 pandemic situation has run its course. In March 2020 the Covid-19 outbreak started to affect staff absence, although in the main due to self-isolation or shielding, rather than sickness.

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.

In order to provide additional assurance on the effectiveness of governance during the Covid-19 pandemic the Business As Usual Group benchmarked the Trust against the MIAA publication 'Governance checklist during Covid-19' and all elements of good governance were being enacted. The Business As Usual Group has since been stood down as the Trust is maintaining business continuity plans through existing governance structures and through re-instatement of all Committees of the Board. To ensure the Trust is maintaining control over decision making in light of Covid-19, the Trust has implemented a Critical Decisions Log.

Response to Covid-19 and financial governance

Maintenance of financial control remains critical during the Trust's response to Covid-19 with no new revenue business investments entered into. NHSI supported the Trust with arrangements to access capital in relation to the Covid-19 response. Any claims are clearly linked to delivery of our Covid-19 response and capable of being delivered within the expected duration of the outbreak.

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.

Although, the Quality Account is no longer a mandated requirement this year due to Covid-19, the Trust business continuity arrangements have allowed the report to be prepared.

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 2019 to March 2020.
- Clinical Governance Committee minutes and papers for the period April 2019 to March 2020.
- Papers relating to quality reported to the Board over the period April 2019 to March 2020.
- The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
- The 2019 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 2019-20, 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 infection prevention and control 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 2020-21 with the introduction of a revamped Integrated Performance Report which will bring information and risks together in one place.

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, 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 2019-20 is that Moderate Assurance can be given that there is an adequate system of internal control. However, Moderate 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 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;
- 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 CQC Inspection Report, particularly Well-led element 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 2019-20. 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 2020-21, whilst responding to the 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 Board Assurance Framework in line with the Risk Management Strategy.

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

Karen Partington
Chief Executive
18 June 2020

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 2019-20, 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 & Western Lancashire Racial Equality and Diversity Council, the Trust's Volunteers, the Universities of Central Lancashire, Lancaster and Manchester, and the Trust's Youth Forum; and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Borough 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 sub-groups 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 2019, the terms of office of eight public Governors and one staff Governor (representing non-clinical staff) came to an end. 1,369 votes were cast in the public election and 362 votes were cast in the election for staff Governor representing non-clinical staff. This represents a turnout of 12% and 15.5% respectively. At the end of March 2020, the terms of office of eight public Governors and two staff Governors (representing nurses and midwives and allied health professionals and healthcare scientists) came to an end. 1,105 votes were cast in the public election, 265 votes were cast in the election for staff Governor representing nurses and doctors and 224 votes were cast in the election for allied health professionals and healthcare scientists. This represents a turnout of 10.2%, 8.1% and 11.2% respectively.

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; holding a number of Governor awareness events and pre-election workshops to encourage members to stand for election; displaying posters and using 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 54. In addition,

there are three core Governor working groups which have been established to consider specific areas in more detail than is possible at formal Council meetings. The groups focus on: our buildings and environment, our membership; and our patients' experiences. All groups have clear terms of reference and report their activities to the 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 sub-groups. 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 by maintaining a rota system, as attendance at Board meetings is a way in which Governors can view Non-Executive Directors providing challenge and scrutiny to the Executive Team. Non-Executive Directors now 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 established a lead Governor role, and during 2019-20 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.

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 2019-20, which were quarterly meetings (April 2019, July 2019, October 2019 and January 2020) and a further extraordinary council meeting was held in August 2019. The table below shows Governors' attendance at such Council meetings:

Name of governor	Term of office	Type of governor	A	B	Percentage of meetings attended (%)
Pav Akhtar	01/04/18 – 31/03/21	Public	5	4	80%
Takhsin Akhtar	01/04/19 – 31/03/22	Public	5	4	80%
Rebecca Allcock	26/06/14 – 31/03/20	Staff: other healthcare professionals and healthcare scientists	5	4	80%
Angela Allison*	01/04/19 – 31/03/22	Public	4	1	25%
Peter Askew	01/04/19 – 31/03/22	Public	5	5	100%
Frank Batin*	01/04/17 – 31/03/20	Public	1	1	100%
Alistair Bradley	18/05/19 – 17/05/22	Appointed	5	2	40%
Helen Bradley*	01/04/11 – 31/03/20	Staff: nurses and midwives	4	2	50%
John Daglish	15/07/11 – 31/03/20	Public	5	4	80%
Margaret France	01/04/17 – 31/03/20	Public	5	4	80%
Hazel Hammond	01/04/19 – 31/03/22	Public	5	4	80%
Dylis Hayton	01/04/14 – 31/03/20	Public	5	4	80%
Steve Heywood	01/04/16 – 31/03/19	Public	5	5	100%
Javed Iqbal	01/05/19 – 02/05/20	Appointed	5	1	20%
Ken Jones**	01/04/11 – 31/03/20	Public	5	2	40%
Sue Jones**	23/05/19 – 22/05/20	Appointed	4	1	25%
Trudi Kay	01/04/19 – 31/03/22	Public	5	5	100%
Nicola Leahey	01/04/11 – 31/03/20	Public	5	5	100%
Karen Leckie	01/04/18 – 31/03/21	Public	2	1	50%
Lynne Lynch	01/04/15 – 31/03/21	Public	5	4	80%
Janet Miller	01/04/17 – 31/03/20	Public	5	5	100%
Shirley Murray	08/04/19 – 31/03/22	Appointed: representing volunteers	5	3	60%
Janet Oats	01/04/19 – 31/03/22	Public	5	5	100%
Eddie Pope	15/06/17 – 11/07/21	Appointed	5	3	60%
Gurvinder Sahota	10/11/15 – 09/11/21	Appointed	5	0	0%
Michael Simpson	01/04/19 – 31/03/22	Public	5	4	80%
Alison Slater	01/04/19 – 31/03/22	Staff	5	3	60%
Teri Stephenson*	18/10/18 – 17/10/21	Appointed	1	1	100%
Huw Twamley	01/04/18 – 31/03/21	Staff: doctors and dentists	5	2	40%
Karen Walton*	03/07/18 – 02/07/19	Appointed	1	0	0%
No governor currently represented for the Universities of Central Lancashire, Lancaster or Manchester					
No governor currently represented for the Youth Forum					
No governor currently represented for the Older Adults (third sector)					

A = maximum number of meetings the Governor could have attended during 2019-20
B = number of meetings the Governor actually attended during 2019-20
**Stood down as a Governor during 2019-20*
***Unable to attend all meetings because of exceptional circumstances due to ill health*

Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2019-20:

- Ebrahim Adia, Chairman
- Faith Button, Deputy Operations Director
- Sarah Cullen, Nursing, Midwifery and AHP Director
- Paul Havey, Finance Director/Deputy Chief Executive

- Sue Musson, Chairman (until 31 August 2020)
- Jeannette Newman, Non-Executive Director
- Paul O'Neill, Non-Executive Director
- Karen Partington, Chief Executive
- Ann Pennell, Non-Executive Director
- Geoff Rossington, Non-Executive 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

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 sub-groups 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 sub-group 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. Eight 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 2019-20, our Governors have participated in a number of workshops, including the following topics:

- Cyber Security: this session provided Governors with an overview of cyber security and was provided by the Trust's Information Management and Technology team.
- Joint development session between the Board of Directors and the Council of Governors: the workforce team shared their commitment to equality, diversity and inclusion priorities.
- Joint development session between the Board of Directors and the Council of Governors: the Governors reviewed the implementation of the Automatic Number Plate Recognition system to identify lessons learned to take forward to future projects.
- The annual forward planning process: we held an interactive forward planning workshop with Board members and Governors to review and provide input to 'Our Big Plan', the Trust's corporate strategy.

- Council of Governors' Effectiveness Review and Council Development Plan: following a survey of Governors undertaken to inform the annual Council Effectiveness Review two workshops to present and consider the findings to Governors were held. NHS Providers led on the session as independent facilitators. The workshop also provided training for Governors on communications and engagement.
- Continuous Improvement including Digitisation: this session provided Governors with an update on the Trust's Continuous Improvement Programme and an overview of Datix, the Trust's electronic incident reporting system, and Quadramed, the electronic patient record system.
- Equality, Diversity and Inclusion: a further interactive session was held with Governors to provide background and context to the importance of diversity and inclusion within our organisation. Governors were able to understand what constitutes discrimination and explore cognitive bias, its impact and ways to mitigate bias. At the end of the session, Governors were asked to pledge their support to the diversity and inclusion agenda: commit to action.
- Widening Participation: the team informed Governors of the programmes that they deliver to support NHS recruitment.

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 2018-19 and 2019-20 the following expenses were claimed by our Governors:

	2018-19	2019-20
Total number of Governors in office (as at 31 March)	29	25
Total number claiming expenses:	13	11
Aggregate sum of expenses (£00s):	£51	£45

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 or alternatively contact the Company Secretary email: 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
- Blackpool
- Bolton
- Bury
- Cheshire East
- Cheshire West
- Cumbria
- Halton
- Knowsley
- Liverpool
- Lancashire
- Manchester
- Oldham
- Rochdale
- Salford
- Sefton
- St. Helens
- Stockport
- Tameside
- Trafford
- Warrington
- Wigan
- Wirral

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, 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 2020	31 March 2019	Difference	% Difference
Public	10873	11389	- 516	- 4.53%
Staff	8282	7773	509	+ 6.54%
Total Membership	**19155**	**19,162**	**- 7**	**0.03%**

During 2019-20 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 4.5% reduction in the number of public members during 2019-20 compared with membership figures for 2018/19. Recruitment activity has been focused on targeting under-represented 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, it 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 the Governors have the support and are equipped with the skills to represent the members effectively when working with the Trust Board and Non-Executive Directors.

Review of 2019-20

We produce Trust Matters, our member's magazine, twice a year, this provides up to date information to them 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 how they have helped influence decision-making and service development with their views and feedback.

Through the magazine, we take the opportunity to ask members if they would like Governors to visit them in the community, as a consequence, Governors visited several community groups throughout 2019-20 and they were able to listen to their views; provide feedback to the Trust's senior management, recruit new members and raise the Governor profile and membership.

Our annual members meeting was held in October 2019; the event provided members with a summary of the Trust's performance plans for the year ahead and included a question and answer session with the Trust's senior management. The meeting was held in conjunction and a focus on the Parkinson's Team, this gave opportunity to highlight the amazing work they do and the services they provide in addition to Governors being able to discharge their statutory duties in representing the interests and views of our members and the wider public. Members were able to meet and chat with staff, Governors and senior managers before visiting the numerous information stands which were all themed around Parkinson's disease. Members observed two informative presentations, delivered by a senior clinician with support from his colleagues. Following the presentations there was further time for members to visit the display stands and learn more about the innovative services provided by our Parkinson's team.

In partnership with the communications department, 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 with the details as appropriate.

Through the bi-annual members' magazine that we produce, we ask Foundation Trust members if they would like Governors to visit the community groups that they may be associated with. It is intended that Governors attending will speak directly to members of the public and listen to their views so that they can feedback to senior management at the Trust; they may also recruit new members and help to raise the Governor profile.

The 18th consecutive Health Mela was hosted by the University of Central Lancashire and organised by the National Forum for Health and Wellbeing (NFHW) with support from Lancashire Teaching Hospitals and a wide range of other healthcare organisations. Governors along with many of our staff supported the event in order to promote the Trust and share information about its services.

We continue to work collaboratively with our partners via OHOC, a transformation programme to improve the health and wellbeing of everyone in our communities. Forthcoming engagement opportunities will be promoted to Foundation Trust members (public and staff) and the wider public via posters, flyers, social media, Trust Matters members' magazine and email communications.

As evidenced in the engagement work outlined above, 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

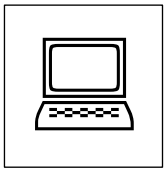
In accordance with our membership management and engagement strategy, the age, gender, ethnic origin and socio-economic grouping of members is monitored. Membership figures are also analysed against the profile of our patients and the census data for our membership area. Our externally sourced comprehensive 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 2019-20 to ensure there is representation from across the North West area of Lancashire.

Given the size and general representation of our membership, our primary aim is to focus resources on engaging with existing members as opposed to seeking to recruit vast amounts of members. One section of the membership where there continues to be under-representation is young people and ethnic minority groups. During 2019-20 and following the review of the membership management and engagement strategy, 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
Telephone: 01772 524412

Members can contact governors direct via:
Email: 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 2019-20. 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; with Tricia Whiteside taking over from Jeannette Newman, following Jeannette Newman's resignation as a Non-Executive Director and Tricia Whiteside's appointment. Each member has been 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 Chairman 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 Chairman 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 Chairman 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 five times between 1 April 2019 and 31 March 2020 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 top issues have included:

i. achieving financial plans;
ii. delivering against targets and indicators set within regulatory and compliance frameworks;

iii. managing adequate and safe staffing levels, including the management of proper controls over reported sickness; and latterly; and
iv. responding to the impact of Covid-19.

While the responsibility for the management of these issues is not within the terms of reference of the Audit Committee, we have targeted our work plan around the systems and processes which support the management of the first three of these key issues, all of which feature in the Trust's strategy 'Our Big Plan'. For Covid-19 we have considered the guidance promulgated by Health Financial Management Association (HFMA) regarding governance and financial control, drawing on additional support and guidance form internal audit, and have largely exercised our role through our engagement as Non-Executive members of the Trust Board when these matters have been considered, rather than through separate meetings of the Audit Committee.

Financial Reporting

The Audit Committee has reviewed the Trust's performance as outlined in the 2019-20 annual financial statements and has discussed with management the reasons for the main changes compared to the financial statements for 2018/19.

In doing this the Committee has had 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 2019-20 highlighted as significant audit opinion risks:

(i) the valuation of land and buildings,
(ii) the recognition of NHS and non-NHS income,
(iii) management override of controls, and
(iv) fraudulent expenditure recognition.

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 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 expressed some concern at the value of transactions processed following the application of single tender waivers and have requested that this be subject to internal audit review in the 2020/21 financial year.

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) Emergency Preparedness
(ii) Completeness of Patient Records/Patient Risk Assessments
(iii) Financial Systems
(iv) Management of Apprenticeship Funding
(v) Data Protection and Security Toolkit and a GDPR Readiness Assessment
(vi) P22 Critical Care Scheme Management
(vii) Data Security and Protection Toolkit
(viii) Compliance with the Referral to Treatment Patient Access Policy
(ix) Medical Devices
(x) Health and Safety

The following reviews were included within the Internal Audit programme but the internal auditors were unable to finalise these reviews due to the impact of Covid-19:

(i) Agency Staffing
(ii) Medical Assessment Unit Culture Survey
(iii) Risk Maturity Follow Up data
(iv) Safeguarding Workforce Standards
(v) 3rd Party Contract Monitoring
(vi) Consent

However the internal auditors have completed the majority of the 2019-20 Internal Audit Plan and feel able to provide an opinion on that basis. In the main, this work was completed prior to Covid-19 beginning to impact.

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, one has provided High Assurance, five have provided Substantial Assurance, two have provided Moderate Assurance and one has provided Limited Assurance. There were no reports which provided No Assurance.

The internal auditors also completed reviews of the Assurance Framework and Health and Safety but provided no overall opinion.

The Director of Internal Audit has provided an overall opinion of Moderate Assurance based on the work of internal audit during 2019-20.

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 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 achieving its financial plans and meeting its operational targets. The Committee was particularly concerned with regards to the maintenance of adequate controls over establishments in particular Directorates within the Trust, with a consequent difficulty in maintaining expenditure within agreed budgets. The Committee will continue to seek assurance on the steps being taken to ensure improvements can be made in 2020-21 and beyond, whilst recognising the exceptional year we have just started 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

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.

KPMG LLP was re-appointed as the Trust's external auditors, with effect from 1 April 2015 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 auditor are subject to approval by the Committee in accordance with the NHS Foundation Trust code of governance. The option to extend for a further two-year term was exercised by the Trust at the end of 2017/18, and this was extended further for the audit of the 2020/21 accounts due to the introduction of a new Code of Audit Practice that comes into force from 1 April 2020, as the requirements within this new Code were not known at the time a re-tendering process would have taken place. The decision to extend the contract was taken with the support of the Audit Committee and formally ratified by the Council of Governors.

In addition to attending the Audit Committee, KPMG attend and report to the Council of Governors their findings for the year and have made themselves available for Governor workshops and briefings. 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

Our internal audit function is provided by MIAA, and again it is the role of the Committee to provide oversight of their 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. 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.

The appointment of internal auditors is the responsibility of the Committee. Our internal audit services were subject to a comprehensive market testing exercise in January 2016 and the Audit Committee awarded the contract to MIAA who were reappointed for a three-year term with effect from 1 April 2016, and the Committee has taken the option to extend the contract for a further two-year term.

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 2019-20 the anti-fraud specialist has completed the work programme in accordance with the agreed plan.

Audit Committee attendance summary from 1 April 2019 to 31 March 2020

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chairman)*	4	4	100%

Jeannette Newman	2	2	100%
Ann Pennell	5	3	60%
Jim Whitaker	5	4	80%
Tricia Whiteside	3	3	100%

A = maximum number of meetings the member could have attended during 2019-20
B = actual meetings attended during 2019-20
**Tim Watkinson was in attendance at the meeting on 20 September 2019 as he was Acting Chairman of the Trust therefore the Committee Chair was taken by Jim Whitaker.*

Audit Committee effectiveness

The Committee undertakes a self-assessment on an annual basis, with the last self-assessment taking place on 23 April 2019, as reported in my Annual Report last year. The next self-assessment is due to be completed as soon as this is practical, but has been delayed through re-prioritising work within the Trust as a consequence of Covid-19. 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
18 June 2020

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

Karen Partington
Chief Executive
18 June 2020

Lancashire Teaching Hospitals NHS Foundation Trust

QUALITY REPORT
2019-20

Key - Our Ambitions

Consistently deliver excellent care		Fit for the future	
	• Improve outcomes and reduce harm • Improve capacity and patient flow • Deliver a positive experience • Create a good care environment		• Continually improve the way we work • Modernise service delivery
Deliver value for money		**A great place to work**	
	• Safely reduce costs • Get the right income for the services we provide • Generate income • Reduce waste		• Promote Health and Wellbeing • Inform, listen and involve • Value each other • Develop people

PART 1
Chief Executive's Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1 April 2019 to 31 March 2020.

The National Health Service continues to face unprecedented challenges to ensure we have a service fit for the future, balancing finite funding and staffing resources against an increase in complex care requirements. Lancashire Teaching Hospitals NHS Foundation Trust faces the same challenges.

In August 2019, the Care Quality Commission (CQC) conducted an inspection of our hospitals with our overall rating of 'Requires Improvement' remaining the same as the previous year. However, inspectors recognised our improvement with two of the five overall key areas now rated as 'Good' compared to just one the previous year. Equally, Chorley and South Ribble Hospital has been rated as 'Good' overall, compared to 'Requires Improvement' last year.

Striving to continually improve, we have invested in our Continuous Improvement (CI) team and we are confident that our improvement methodology will enable us to be successful in delivering goals to meet ambitious improvements in the quality of care we deliver for all our patients.

Equally, we continue to work in partnership 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 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 as part of the Our Health Our Care programme.

Although our financial deficit has increased due to continued growth in demand, rising costs and workforce shortages we have continued to make incremental improvements to our operational efficiency.

We have now completed the first year of Our Big Plan which sets out our strategic direction of travel up until 2022. The strategic, planning, performance and risk processes have been 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. The year has seen a number of exciting developments, with staff and partners participating in Big Plan team and organisational events, making Big Plan goals, reflections and pledges. We acknowledge that the year ahead will present us with challenges but we will continue to see continued focus on delivering the strategy in order to provide excellent care to our patients.

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

education awards, our own maternity ward television series, accolades in innovation, research and clinical trials and much, much more.

I would like to thank all our staff and local partners for their dedication and support throughout the year, especially in what has proven to be a difficult end to 2019-20 and ahead of the unprecedented challenges Covid-19 presents moving forwards.

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.

Karen Partington
Chief Executive
18 June 2020

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 - 2022.
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	
	• Improve outcomes and reduce harm • Improve capacity and patient flow • Deliver a positive experience • Create a good care environment		• Continually improve the way we work • Modernise service delivery
Deliver value for money		**A great place to work**	
	• Safely reduce costs • Get the right income for the services we provide • Generate income • Reduce waste		• Promote Health and Wellbeing • Inform, listen and involve • Value each other • Develop people

The *Big Plan* is enabled through the commitments in the *Nursing, Midwifery, Allied Health Professional 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

The *Big Plan* and the strategies can be found on our Trust Internet site.

Priorities for Improvement 2019 - 2022

Our *Big Plan* has committed to delivering a wide range of improvements over a three year period (2019 - 2022). The following key priorities were identified and reported in 2018-19, have continued into 2019-20 and will continue into year 2 (2020-21).

***Big Plan* 3 Key Priorities:**

- A 5% reduction in the number of grade two hospital acquired pressure ulcers in year one and a further 5% in year two.
- A yearly 5% reduction in patient falls causing major or above harm.
- A STAR status of 50% of wards and departments rated as silver in year one with 25% of those rated as gold standard in year two 2020-21.

Additional Priority (2017-18)

- A 10% increase in the numbers of reported clinical incidents to reflect a safe organisation better able to learn and thereby improve care.

- **A 5% annual reduction of hospital acquired grade two pressure ulcers**
  This was not achieved in 2018-19 or in 2019-20 due to a number of reasons which includes but not limited to the complexity and frailty of patients and the increase in the number of patients admitted to hospital.

  The pressure ulcer improvement project is now part of our continuous improvement *Always Safety First* collaborative, this remains a key priority. This measure will change in 2020-21 as a result of the national guidance relating to pressure ulcer reporting changing. Moving to measuring all hospital acquired pressure ulcers.

- **A yearly 5% reduction in patient falls causing major or above harm over three years 2019-2022.**
  The number of all falls has continued to reduce:
  - The total number of falls **with major and above harm** (severe, death) reduced from 14 inpatient falls in 2018-19 to 11 in 2019-20 which is a reduction of 21.43%.
  - The end of year **all falls** incident rate decreased by 6.89% from 1234 falls in 2017-18 to 1150 falls in 2018-19 and 1143 falls in 2019-20 which is a further reduction of 0.61%.

- **A STAR status of 50% of wards and departments rated as silver in year one (2019-20) with 25% of those rated as gold in year two (2020-21)**
  23% of wards and departments have achieved having a silver STAR rating in the 2018-19 reporting period which has increased to 43% in the current reporting period 2019-20. The impact of Covid-19 has affected the ability to undertake the STAR audits which has impacted the ability to deliver this measure, due to the need to divert resources and focus on the preparations for the pandemic.

Additional Priority (2017-18)

- **A 10% increase over three years in the numbers of reported clinical incidents to reflect a safe organisation better able to learn and thereby improve care**
  In 2017-18, 19395 incidents were reported. In 2018-19 21,525 incidents were reported which represented an 11% increase. For the current period 2019-20, 26,373 incidents have been reported.

  Our total number of incidents reported is increasing which highlights a good reporting culture. The level of harm detailed in these incidents is reducing, with more low harm and no harm incidents and a reduction in incidents resulting in severe harm or death which provides assurance of a healthy risk profile

Our priorities from 2018-19 will continue for 2019-20, reflecting the three year performance objectives and aspirations of our *Big Plan* and associated strategies. These will continue to be monitored and managed through the arrangements described in the relevant documents and supported by the Continuous Improvement team.

Continuous Improvement

At the beginning of 2019, the Continuous Improvement (CI) team consisted of a Director of Continuous Improvement, a Head of Continuous Improvement, a Senior Nursing Fellow and a Project Manager. We have invested in the CI team to ensure adequate resources to implement the CI strategy at pace, with the additional team members being recruited towards the end of the calendar year 2019.

It should be noted that whilst the CI programme of work is ongoing, due to the Covid-19 pandemic, some activity has been deferred to enable the team to support Covid-19 preparations. However the full Continuous Improvement programme will continue upon recommencement of hospital business as usual.

Our CI team have updated the local strategy to reflect the organisation's successes, which include a Trust wide programme, securing a position on the Health Foundation funded Flow Coaching Academy (FCA) programme and leading our own local Flow Coaching Academy and finally, securing training from Sheffield Teaching Hospitals NHS Foundation Trust to establish a local Microsystem Coaching Academy (MCA). Our strategy has a deliberate

approach to undertake improvement at macro, meso and micro system levels presented in Figure 2 below.

Figure 2 Continuous Improvement Strategy Levels

System Level Improvement

An organisational wide patient safety improvement programme *Always Safety First* is in progress which aims to reduce avoidable harm through a patient safety collaborative approach, focused on improving the areas outlined below. The safety programme provides our response to the National NHS Patient Safety Strategy and continues to be developed. We are also collaborating with BAE Systems sharing and learning from safety experiences in both organisations. The Quality Account priorities for improvement carried forward from 2018-19 to 2019-20 will continue for 2020-21, as part of the three year *Big Plan* and are integral to this improvement collaborative.

We are committed to improving the following priorities and anticipate improved outcomes as the programme develops.

#AlwaysSafetyFirst

- Pressure Ulcers
- Falls
- Venous Thromboembolism (VTE)
- Health Care Associated Infections, Clostridium *Difficile*
- Medicines Management
- Deteriorating Patient
- Safeguarding Deprivation of Liberty Standards (DoLs), learning disabilities and mental health
- Children's Safety
- Transfers of Care and Discharge
- Invasive Procedure Safety Checks

We held a launch event in December 2019 which was attended by over 90 staff and team members engaged in the programme. Learning session one was held in February 2020 which brought together staff from the 25 participating teams from across our organisation. Their initial focus is on improving risk assessments across the collaborative, through redesign and testing of new improved processes with the aim of improving outcomes for patients.

The programme team has currently suspended the delivery of the face to face learning sessions and improvement consultations in response to the Covid-19 pandemic. However this will resume later in 2020-21, adopting virtual meeting forums.

Pathway Level Improvement

The first wave of coaches have completed their training and graduated from the Flow Coaching Academy Programme on 13 February 2020. Five big rooms (Colorectal Cancer, Discharge, Frailty, Inflammatory Bowel Disease and Sepsis) are fully established and focused on the delivery of improvements.

The quality improvement measures we are using to improve patient care and experience 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.

- Discharge – particular initiatives include; development of a discharge toolkit, better communication with patients, improved estimated date of discharge planning and collaborative working across sectors.

Progress and results will be presented at a CI conference later in 2020 which will showcase the work completed this year and to formally launch our local Lancashire and South Cumbria Flow Coaching Academy.

Our CI team have developed an evaluation plan for the programme to outline the impact and successes, focusing on key outcomes which have been achieved. 30 new Flow Coaches are being trained to increase capability of the workforce and 14 new pathways will commence later in 2020-21, these are:

- Brain Cancer
- Chemotherapy
- Enhanced Care
- Deteriorating Patients
- Gynaecology
- Neurosurgery
- Nutrition
- Respiratory

- End of Life
- Endoscopy
- ENT
- Stroke
- Urology
- Vascular

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 reported 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 are completing their training and will graduate from the Microsystem Coaching Academy programme in summer 2020.

Six areas have been selected and are commencing their microsystem coaching which are; 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 – reducing the time patients spend in escalation beds.
- Chorley MAU – reducing the time it takes from transfer to admission ward.
- Preston PAU – clinic capacity and utilisation.
- Ward 8 – efficiency of observations leading to reducing risk.
- Theatres – efficiency of stock, leading to overall cost reduction.
- Critical Care – utilising Healthcare Assistants to aid patient recovery.
- Ward 15 – reduction of pressure ulcers.

In 2020-21, we will run our own local Microsystem Coaching Academy; all improvement will be 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 launching 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 also supports the feedback we received from Mersey Internal Audit Agency (MIAA) 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. This supports the CQC and Mersey Internal Audit Agency (MIAA) feedback.

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." (Approved by the Board on 5 December 2019)

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.

These symbols are presented throughout this report to link the work streams to the ambitions.

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 2019-20 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 46 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 46 relevant health services.

1.2 The income generated by the relevant health services reviewed in 2019-20 represents 100 % of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2019-20.

Participation in Clinical Audits

2.0 During 2019-20 47 national clinical audits[1] and four 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% 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 2019-20 are as follows:

Table 1 Audit and Confidential Enquiries – Eligible for Participation

National Clinical Audit	
Project Name	**Provider Organisation**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)
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)
BAUS Urology Audit - Radical Prostatectomy	British Association of Urological Surgeons (BAUS)

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

Care of Children in Emergency Departments	Royal College of Emergency Medicine (RCEM)
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
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons (BAETS)
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians (RCP)
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD Registry Ltd
Major Trauma Audit	Trauma Audit Research Network (TARN)
Mandatory Surveillance of bloodstream infections and Clostridium *Difficile* infection	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)
Mental Health - Care in Emergency Departments	Royal College of Emergency Medicine (RCEM)
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 Diabetes	NHS Digital
National Audit of Seizure Management in Hospitals (NASH3)	University of Liverpool
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)	Barts. Health NHS Trust
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 Ophthalmology Audit (NOD)	Royal College of Ophthalmologists (RCOphth)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)
National Prostate Cancer Audit	Royal College of Surgeons (RCS)
National Smoking Cessation Audit	British Thoracic Society (BTS)
National Vascular Registry	Royal College of Surgeons (RCS)
Neurosurgical National Audit Programme	Society of British Neurological Surgeons
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England (PHE)
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)
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust
UK Parkinson's Audit	Parkinson's UK

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 2019-20
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD: Studies collecting data during 2019 - 20 • Out of Hospital Cardiac Arrest • Dysphagia in Parkinson's Disease • Acute Bowel Obstruction • Long Term Ventilation

2.3 The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2019-20 are as follows:

Table 2 Audit & Confidential Enquiries – Participated

National Clinical Audit	
Project Name	**Participated**
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes
BAUS Urology Audit - Cystectomy	Yes

BAUS Urology Audit - Female Stress Urinary Incontinence	Yes
BAUS Urology Audit - Nephrectomy	Yes
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes
BAUS Urology Audit - Radical Prostatectomy	Yes
Care of Children in Emergency Departments	Yes
Case Mix Programme (CMP)	Yes
Child Health Clinical Outcome Review Programme	Yes
Elective Surgery - National PROMs Programme	Yes
Endocrine and Thyroid National Audit	Yes
Falls and Fragility Fractures Audit programme (FFFAP)	Yes
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes
Major Trauma Audit	Yes
Mandatory Surveillance of bloodstream infections and Clostridium *Difficile* infection	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes
Mental Health - Care in Emergency Departments	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Audit of Care at the End of Life (NACEL)	Yes
National Audit of Dementia (Care in general hospitals)	Yes
National Audit of Seizure Management in Hospitals (NASH3)	Yes
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Cardiac Audit Programme (NCAP)	Yes
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 Ophthalmology Audit (NOD)	No
National Paediatric Diabetes Audit (NPDA)	Yes
National Prostate Cancer Audit	Yes
National Smoking Cessation Audit	Yes
National Vascular Registry	Yes
Neurosurgical National Audit Programme	Yes
Perioperative Quality Improvement Programme (PQIP)	Yes
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes
Serious Hazards of Transfusion: UK National	Yes

Haemovigilance Scheme	
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes
Surgical Site Infection Surveillance Service	Yes
UK Cystic Fibrosis Registry	Yes
UK Parkinson's Audit	Yes

National Confidential Enquiries	Participated
Clinical outcome review programmes / National Confidential Enquiries	
Maternal, Infant and New-born Clinical Outcome Review Programme MBRRACE-UK	Yes
Child Health Clinical Outcome Review Programme	N/A
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD:	
Studies collecting data during 2019-20	
• Out of Hospital Cardiac Arrest	Yes
• Dysphagia in Parkinson's Disease	Yes
• Acute Bowel Obstruction	Yes
• Long Term Ventilation	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 2019-20, 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 3 Audit and Confidential Enquiry – Case Submission

Project Name	Clinical Cases Required	Actual Number submitted
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	As met criteria: 5 patients per week during audit period (1 August 2019 – 31 January 2020)	Royal Preston Hospital (RPH) 90 cases Chorley District Hospital (CDH 2 cases
BAUS Urology Audits – Cystectomy Nephrectomy Percutaneous Nephrolithotomy (PCNL) Radical Prostatectomy	No set number, as met criteria	Hospital Episode Statistics (HES) for 2016, 2017 and 2018 combined RPH <u>Cystectomy</u> 90 % of cases <u>Nephrectomy</u> 100% of the total 269 cases <u>PCNL</u> 63 cases (total number of procedures performed) <u>Radical Prostatectomy</u> 86 % of the total of 258 cases
Care of Children in Emergency Departments	As met criteria: 5 cases per subsample	RPH 106 cases CDH 15 cases

	per week for audit period (1 August – 31 January 2020)	
Case Mix Programme (CMP)	No set number, as met criteria	2018/19 dataset 1631 Admissions RPH/CDH
Elective Surgery - National PROMs Programme	No set number of questionnaires for completion, as patients met criteria	Data for Hip replacement 1st Apr 2018 – 31st Mar 2019 (final). Published Feb 2020 Hip replacement 153 Hip replacement primary 127 Revision 26 Knee replacement 133 replacement primary 124 Knee revision 9
Endocrine and Thyroid National Audit	No set number, as met criteria	CDH 21cases (2018 data)
Falls and Fragility Fractures Audit programme (FFFAP)	No set number, as met criteria	RPH/CDH 10 cases (100%)
Maternal, Newborn and Infant Clinical Outcome Review Programme	No set number, as met criteria	Early Neonatal deaths – 9 Late Neonatal Deaths – 0 Post Neonatal deaths – 0 Stillbirths –18
Major Trauma Audit	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	688 Jan 18 – Jul 19 Case ascertainment percentage 93%-100%
Medical and Surgical Clinical Outcome Review Programme	No set number, as met criteria	Out of Hospital Cardiac Arrest 13 cases Dysphagia 6 cases Acute Bowel Obstruction 7 cases Long Term Ventilation 3 cases
Mental Health - Care in Emergency Departments	As met criteria: 5 cases per week during audit period (1 August – 31 January 2020)	RPH 71 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	No set number, as met criteria	COPD 681 cases Asthma 161 cases Asthma (Paediatrics) Started 1 June 2019 RPH 117 cases
National Audit of Cardiac Rehabilitation (NACR)	No set number, as met criteria	Greater Manchester, Lancashire & South Cumbria

		data: Total programmes 19 NACR registration 15 % registered 79
National Audit of Breast Cancer in Older People (NABCOP)	No set number, as met criteria	Patients ≥ 50 yrs. in 2017 158 cases
National Audit of Care at the End of Life (NACEL)	40 cases per site	RPH 40 cases (100%) CDH 40 cases (100%)
National Audit of Dementia (Care in general hospitals)	Audit not undertaken nationally this year due 2021	Data collection for this audit did not take place this year
National Audit of Seizure Management in Hospitals (NASH3)	Audit not undertaken nationally this year	Data collection for this audit did not take place this year
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Audit not undertaken nationally this year	Data collection for this audit did not take place this year
National Cardiac Arrest Audit (NCAA)	No set number, as met criteria	RPH 84 cases CDH 18 cases
National Cardiac Audit Programme (NCAP)	No set number, as met criteria	Heart Failure 380 cases MINAP 212 cases
National Diabetes Audit – Adults	No set number, as met criteria	Inpatient audit 102 cases for the case note audit i.e. all in-patients with diabetes on the audit day, and 64 patient questionnaires were completed Insulin Pump Audit 140 cases
National Emergency Laparotomy Audit (NELA)	No set number, as met criteria	RPH 105 cases
National Gastro-intestinal Cancer Programme	No set number, as met criteria	Latest figures 1st Apr 2016 – 31st Mar 2018 2019 report 118 cases
National Joint Registry (NJR)	No set number, as met criteria	749 cases
National Lung Cancer Audit (NLCA)	No set number, as met criteria	Latest figures 1st Apr 2017 – 31st Mar 2018 2019 report 278 cases
National Maternity and Perinatal Audit (NMPA)	No set number, as met criteria	Latest data from Apr 1016 - March 2017 3910 births
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	No set number, as met criteria	RPH NICU from 1st January 2018 to 31st December 2018. 2019 report 390 babies admitted
National Paediatric Diabetes Audit (NPDA)	No set number, as met criteria	RPH 210 cases
National Prostate Cancer Audit	No set number, as met criteria	Latest figures 1st April 2017 – 31st Mar 2018 2019 report 264 cases
National Smoking Cessation Audit	No set number, as met criteria	RPH 98 cases CDH 125 cases

Perioperative Quality Improvement Programme (PQIP)	No set number, as met criteria	Approx. 15 cases per quarter to date 50
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	No set number, as met criteria	The CQUIN finished in March 2019 so no data submitted
Sentinel Stroke National Audit programme (SSNAP)	No set number, as met criteria	721 cases
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	No set number, as met criteria	Contributed 15 reports Wrong Blood in Tube (WBIT) = 7 Incorrect Blood Component Transfused (IBCT) = 1 Near Miss = 1 Sample Processing Error (SPE) = 1 Special Requirement Not Met (SRNM) = 1 Right Blood Right Patient (RBRP) = 2 Transfusion Reaction = 2
Society for Acute Medicine's Benchmarking Audit (SAMBA)	No set number, as met criteria	RPH 23 cases CDH 21cases
Surgical Site Infection (SSI) Surveillance Service	No set number, as met criteria. Mandatory for Hip and Knee ops under PHE for SSI	April 2018 to March 2019 Hip 232 cases, 0 SSI Knee 240 cases, 0 SSI
UK Parkinson's Audit (Speech and Language Therapy)	At least 10 cases during audit period	11 cases (100%)
Vascular Registry	No set number, as met criteria	Abdominal aortic aneurysm (AAA) 68 cases Carotid endarterectomy 83 cases Lower limb bypass 203 cases Lower limb angioplasty 1023 cases Lower limb amputation 103 cases

2.5/6 The reports of national clinical audits were reviewed by the provider in 2019-20 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 4 Audit and Confidential Enquiry – Intended Actions

Title of Audit	Intended Actions
National Seven Day Services Autumn 2019	A number of work streams are ongoing that will support achieving the 4 priority standards for 7 Day services, including: • Continuous Improvement programme of works aligned to support the clinical strategy and improving the efficiency and effectiveness of clinical staff working on the wards. • The business cases for expansion of therapy services across 7 days should be further developed and presented

	for approval. Oversight of these work streams is provided through the Non-Elective Programme Board. We contribute to the 6 monthly national 7 Day service data collection exercise, the results of which are reported through the Clinical Governance and Safety and Quality Committee's. The last audit carried out showed an improvement as follows: Standard 2 - Patient reviewed by Consultant or equivalent within 14 hrs of admission (Weekend) has increased from 82.00% to 94.00% (the standard is 90%). Standard 2 - Patient reviewed by Consultant or equivalent within 14 hrs of admission (Mon-Fri) has increased from 63% to 86% (the standard is 90%).
Mouth Care Matters - 6 Month Audit (12 month follow up audit)	• Improve recording of mouth care in the patient's notes. - Recording of mouth care is now documented on the Patient Safety and Repositioning Chart. Through education, promote the use of the form to record mouth care.
National Emergency Laparotomy Audit (NELA) - 2018 Report. Published 2019	• To assess whether the new expansion of the Critical Care Unit (CrCu) Unit will improve Critical Care capacity with regards to the lower than average CrCu admission rate. - Expansion of the new Unit is under way. • Continue the assessment of the surgical patients by the geriatrician. - A new Geriatrician started in October 2019 who will be in reaching into other surgical areas.
National Maternity Perinatal Audit (NMPA) April 2016 to March 2017 data. Published 2019	• Reduce the induction rate of labour. - Review induction of labour guidelines. • Improve rate of 3rd/4th degree tears. - Review of perineal trauma guideline. - Devise a Lancashire Teaching Hospitals perineal care bundle using available evidence. • Increase rate of VBAC after primary caesarean section. - Recommence midwife led VBAC clinic for primary CS.
Sentinel Stroke National Audit programme – Radiology. Published 2019	• Develop Standard Operating Procedure (SOP) for computed tomography (CT) to improve timings. - A SOP is being developed for CT. All the other aspects of the audit are corporate management issues but the audit data will be used to help e.g. in acquiring AI software (RAPID), in developing a business cases for neuro x-ray machine (end of life in 2 years) and the audit data will help to develop a business case for thrombectomy service.
National Prostate Cancer Audit (NPCA). Published 2019	• To conduct prostatectomies using robotic surgery. - We have transitioned to robotic surgery and since May 2017 all prostatectomies are being performed robotically with a robust mentorship programme that includes operative videos review. - We are prospectively auditing our outcomes.
National Chronic obstructive pulmonary disease (COPD) Audit	• Add discharge bundle to Quadramed so this can be recorded automatically. - This is currently being pursued.

2019/20 (Quarterly reports, National report to be published 2021)	
NPDA National Paediatric Diabetes Audit 2017-2018. Published 2019	• 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. • Smoother transition to pump therapy needed. - Negotiating contract with Clinical Commissioning Group (CCG) for smoother transition to pump therapy. • Prepare Business Case for more multi-disciplinary staff (Dietitian and Team leader). - Recruited.
British Thoracic Society Non-Invasive Ventilation (NIV) Audit. Published 2019	• Create a Standard Operating Procedure (SOP) for patients requiring NIV to ensure the safe management of those requiring respiratory high level care. - SOP developed for patients requiring NIV on a ward. • Improve transfer times from Emergency Department to the Respiratory High Care Unit (RHCU) for patients requiring NIV. - There is an NIV bleep held by RHCU staff 24 hours a day so that ED staff can contact RHCU staff quickly when a patient requires NIV. • Create an SOP for patients requiring NIV in ED to ensure the safe management of those requiring respiratory high level care. - SOP introduced for patients requiring NIV in ED. • There should be consultant-led ward rounds at the weekend, as well as during the week. - We have introduced consultant-led ward rounds at the weekend which helps to identify step downs and accommodate admissions more quickly. • Review the use of the NIV bleep to see whether this has helped to improve transfer times from ED to RHCU. - An audit of transfer times of NIV patients from ED to RHCU has been undertaken and demonstrated improved transfer times since the introduction of the bleep.
National Smoking Cessation Audit Published 2019	• Provide a dedicated inpatient smoking cessation service to make it easier for patients to access. - An inpatient smoking cessation practitioner is currently available for one morning a week on Ward 23. • A smoking assessment should be undertaken and documented for all inpatients. - Smoking assessment is on Quadramed and RPH have now moved to online documentation to increase reliability.
National Audit of Dementia 2018 (Report published 11th July 2019)	Along with adherence to the national recommendations the following local actions have been or will be completed: • Developed a dementia webpage on the intranet which provides staff with information on caring for patients with dementia, including training, new initiatives and the

	resources that are available to them. • All patients who may have additional needs are given a blue tray to alert staff that they may have additional needs or may require reasonable adjustments. We also have adaptive meal equipment that makes it easier for dementia patients to use, such as plate guards, foam tubing for cutlery and non-slip mats. • We are continually introducing initiatives that allow staff to quickly and easily identify dementia patients. Examples of these are the Forget-Me-Not document that has recently been updated. Forget-Me-Not magnets for above patient beds, and Forget-Me-Not wristbands. • An enhanced handover prompt for dementia patients is being developed for wards that admit high numbers of dementia patients.
Re-audit of Management of Pancreatitis 2019: Are We Complying with NCEPOD Guidelines?	• Ensure that all surgical colleagues are aware of the pancreatitis pro-forma which prompts the correct management as per the NCEPOD guideline. - The supervising consultant has emailed the pancreatitis pro-forma to all other surgical consultants and juniors so that the surgical team is aware of the pro-forma.
NCEPOD: Young People's Mental Health (2018). Report published 2019	• Accountable leads to be identified. • Children's mental health operational group to be established with Lancashire Care Foundation Trust Child and Adolescent Mental Health Services (CAMHS) and Lancashire Teaching Hospitals, this will provide the forum to discuss and drive action plans for the NCEPOD recommendations. - Work is currently underway.
NCEPOD: Peri-operative Management of Surgical Patients with Diabetes (2017). Published 2018	• The Trust Guideline on 'Peri-operative Management of Diabetes Mellitus' is in the process of being reviewed, and the NCEPOD recommendations will be considered for inclusion. - The Trust Guideline on 'Peri-operative Management of Diabetes Mellitus' is in the process of being reviewed and the NCEPOD recommendations will be included. • Compare our local results against the national results contained in the NCEPOD report. - A snapshot audit on Peri-operative Monitoring of Diabetic Patients Undergoing Elective Surgery at Lancashire Teaching Hospitals was completed and presented in the anaesthetic audit meeting on 16th April 2019.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	• This year's SHOT recommendations concentrated on the way incidents are reported and investigated. - This coincided with the new Datix upgrade. The circulation of divisional safety newsletters as learning opportunities is now being used for blood transfusion learning opportunities.

2.7/8 The reports of 429 local clinical audits were reviewed by the provider in 2019-20 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 5 Audit and Confidential Enquiry – Resulting Actions

Audit	Implementation of the Colorectal Ward Round Pro-forma
Action – Complete	• Introduce a specific ward round pro-forma/template to improve documentation.
Audit	The Quality of the Ward 4 handover session
Action – Complete	• Shifts between Responsible Medical Officers and Core Trainees/Specialist Registrars should overlap so a detailed handover can be done.
Audit	Documentation of Antenatal booking bloods in woman's records
Actions – Complete	• Community team leaders to disseminate to staff to ensure that booking appointment pro-formas are completed and given to the Ante Natal Clinic clerical staff to enter onto the system in all cases in order that all bookings appear on Quadramed. • All notes and MUMS will be updated at the time of the appointment with the woman and NOT in advance.
Audit	Venous Thromboembolism (VTE) diagnosis and management in antenatal and postnatal period
Action – Complete	• The time at which Low-Molecular-Weight Heparin (LMWH) is administered post-delivery needs to be reviewed.
Audit	Hyperacusis and auditory processing disorder (APD)
Action – Complete	• Children referred for hyperacusis over the age of 6 years and capable of undergoing APD assessment need to be assessed in the APD pathway.
Audit	Audit of Intensive Care Discharge Summary awareness among foundation doctors
Action – Complete	• To hold brief teaching sessions for foundation trainees including how to access electronic discharge summaries; or to include this information within existing teaching sessions.
Audit	Shoulder Dystocia (SD)
Action - Complete	• Create a post shoulder dystocia checklist to ensure appropriate management and documentation.
Action - In Progress	• Continue to have up-to-date SD training highlighting the Royal College of Gynaecologist and LTHTR guidelines in particular the 'HELPERR' mnemonic for manoeuvre sequence.
Audit	Ears Nose and Throat (ENT) Template on Ward Rounds to improve General Medical Council (GMC) mandatory requirements for documentation
Action - Complete	• To create and implement a template for the ENT ward round.
Audit	Fluid balance in Subarachnoid haemorrhage (SAH) patients – in the first 72 hours of admission
Actions - Complete	• Update the guidelines. • Staff education and training with regards to the change in the guideline.
Audit	Re-audit of Surgical Site Infections in Colorectal Patients 2019
Action - In Progress	• As per NICE guidelines, chlorhexidine should be first choice of antiseptic skin preparation.

Audit	Are urine dips being routinely undertaken in acute urology admissions at Royal Preston Hospital, and are they appropriately documented and actioned?
Actions - Complete	• Create a pathway or guideline for staff to follow for urology patients.
Audit	Community Palliative Care Team Mortality Review (April 2019)
Actions - Complete	• Amend referral form to Community services. • Discuss with Hospital Palliative Care Team (HPCT) enhanced triage information to enable triage. • Review letter template re: Electronic Palliative Care Coordination System (EPaCCS) codes.
Action - In Progress	• Include audit of General Practitioner letters in next mortality review.
Audit	Amputation in Complex Regional Pain Syndrome
Action - In Progress	• The development of a pathway for these patients in the perioperative period.
Audit	Assessing each theatre to check whether the emergency guideline folder in the anaesthetic room is present and fully populated
Actions - Complete	• An emergency guidelines folder will be made for the recovery areas. • An easier to read/follow anaphylaxis flowchart to be created using the most up to date material from AAGBI Quick Reference Guide.
Audit	Last Days of Life Mini Audit: Ribblesdale Ward (oncology)
Actions - Complete	• Complete TELC COD education for nursing staff on Ribblesdale ward. • Promote and support the use of the last days of life (LDOL) nursing care plan and intentional-rounding chart. • Promote and support the use of the Verification of Death nurse checklist for care after death.
Audit	Last Days of Life Mini Audit: Ward 18 (Cardiology)
Actions - Complete	• Improve the use of formal documentation for dying patients on Ward 18. • Provide Care of Dying education for nursing staff on Ward 18 for those who have not already received it.
Action - In Progress	• All Cardiology Consultants on Ward 18 should undertake Care of Dying training.
Audit	Last Days of Life Local Mini Audit: Ward 21 (Stroke)
Actions - Complete	• Increase the number/percentage of staff on Ward 21 who have received TELC Care of the Dying training. • Promote and support the use of the "Verification of Death" nurse checklist for care after death. • Increase the use of the Medical Assessment Plan for dying patients.
Audit	Re-audit of intravenous fluid therapy in adults in ICU
Actions - Complete	• Continue with educating doctors and nursing staff about the

	NICE guidelines on intravenous fluid therapy. • Change over to EMPA prescriptions from current paper prescriptions Fluid maintenance.
Audit	Diabetic Specialist Nurse (DNS) Clinic Nurse Activity for November 2019
Actions - In Progress	• Re-instate diabetes hubs with all GP practices involved which will resolve confusion for secondary care clinicians, making it easier to discharge to appropriate hubs in the future. • Undertake proactive discharge of patients in secondary care that fall in the tier 2 category. • Move tier 3 services to primary care supported by Lancashire Care Foundation Trust diabetes nurses.
Audit	Compliance in Special Care Dentistry to Dental Record Keeping Standards
Action - Complete	• Staff engagement for correct use of template and importance of radiograph assessment documentation.
Actions - In Progress	• Basic Periodontal Examination (BPE) probes are to be available as standard for all new patient assessments. • Charting labels for general anaesthetic (GA) notes to ensure accurate documentation. • Amendment of current new patient template to include addition of BPE, tooth wear, and radiographic reporting.
Audit	Staff knowledge of how to support patients with dysphagia
Actions - In Progress	• For staff to increase awareness of International Dysphagia Diet Standardisation Initiative (IDDSI), specifically relating to the diet and fluid descriptors. • To support staff by increasing awareness of the location of specific SLT guidelines. • To support staff to increase their confidence around supporting patients with swallowing difficulties. • To carry out a further audit, to measure any change in staff knowledge and confidence after they have receiving further training and support around IDDSI.
Audit	Saving Babies Lives- Element 5- Antenatal Corticosteroids (Aug19-Dec19)
Action - Complete	• Review current pre-term guidelines and amend these to reflect the new regional guideline and SBLv2.
Action - In Progress	• Develop risk assessment process for all women to be performed at booking to assess for risk of preterm birth using SBL.
Audit	0-2 Years Speech and Language Therapy (SLT) Feeding Clinic: 2018-19 Referrals and Discharges
Actions – Complete	• Seek commissioning for 2-18 years feeding service. • Develop service proposal.
Audit	Post-resuscitation care of patients following cardiac arrest
Actions - In Progress	• Consider creation of 2 pathways for post-arrest patients - a Targeted temperature management (TTM) pathway for those who fulfil the criteria, those who don't to commence Devastating Brain Injury pathway. • TTM implementation to be re-enforced through education. • Need to remember to order somatosensory evoked potentials (SSEP's) on admission to be performed 72hrs post-arrest and

	prevent delays later on.
Audit	Stroke Rehabilitation Core Therapies Patient Feedback
Actions - In Progress	• To ensure that 100% of stroke survivors or their Next of Kin (NOK) have been provided with access to the ward handbook and e-learning tool which gives an explanation of the role of physiotherapy and Occupational therapy that all stroke survivors with ongoing rehabilitation goals identified under SSNAP (national stroke audit) criteria have verbal discussions re the same and are provided with a written copy of the goals set at their bedside weekly. • Ensure that 95% of patients in the next 6 months feel that their therapy treatment is explained to them. • Ensure that over 80% of patients feel that their discharge plans have been discussed with them. • Stroke survivors are provided with ongoing exercises which they are discharged with (where appropriate) in addition to goals and provision of the stroke e-learning tool.
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	• To continue to audit each month to ensure compliance with the SBLv2.
Action - In Progress	• Ensure the findings from the SBL 2 are shared with staff.

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 2019-20, that were recruited during that period to participate in research approved by a research ethics committee was 2085.

Research Recruitment

Lancashire Teaching Hospitals NHS Foundation Trust has recruited 1774 patients to NIHR portfolio adopted studies in 2019-20. It granted NHS permission for 61 new portfolio studies to commence during that time. The Trust recruited a further 311 participants to non-portfolio studies. In total, there are currently 197 active research studies recruiting patients.

Research Governance

In 2019-20 the Department of Health Benchmarks for the set up and delivery of clinical research in the NHS were changed to 62 days for non-commercial and 80 days for commercial studies. These figures are a measure from site selection to first participant recruited. We performed well compared to other Trusts in the North West Coast region, 52% for non-commercial and 50% for commercial studies. This reflects the increase in complex early phase studies that we have begun to take on over the course of this year.

Commissioning for Quality and Innovation

4.0 A proportion of Lancashire Teaching Hospitals NHS Foundation Trust's income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed between Lancashire Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2019-20 and for the following 12-month period are available electronically at http://www.lancsteachinghospitals.nhs.uk/cquin

During 2018-19 Lancashire Teaching Hospitals NHS Foundation Trust received income of £7.4 million on achieving quality improvement and innovation goals through the CQUIN payment framework. The value offered for CQUIN was reduced nationally for all providers in 2019-20.

In 2019-20, we agreed to deliver CQUIN in the following subject areas:-

- Clinical Utilisation Review (CUR)
- Medicines Optimisation
- Spinal Surgery Multidisciplinary Team
- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People and Antibiotic Prophylaxis in Colorectal Surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening and Brief Advice
- Three High Impact Actions to Prevent Hospital Falls
- Same Day Emergency Care – For Pulmonary Embolus, Tachycardia, Community Acquired Pneumonia

Due to the national Covid-19 pandemic it was decided by the commissioning organisations to use all available information submitted during quarters one, two and three and make a settlement payment based on these quarters. Lancashire Teaching Hospitals NHS Foundation Trust therefore received £4.7 million, as CQUIN income.

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 CQC 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 2019-20.

Lancashire Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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.

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
Overall trust	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.

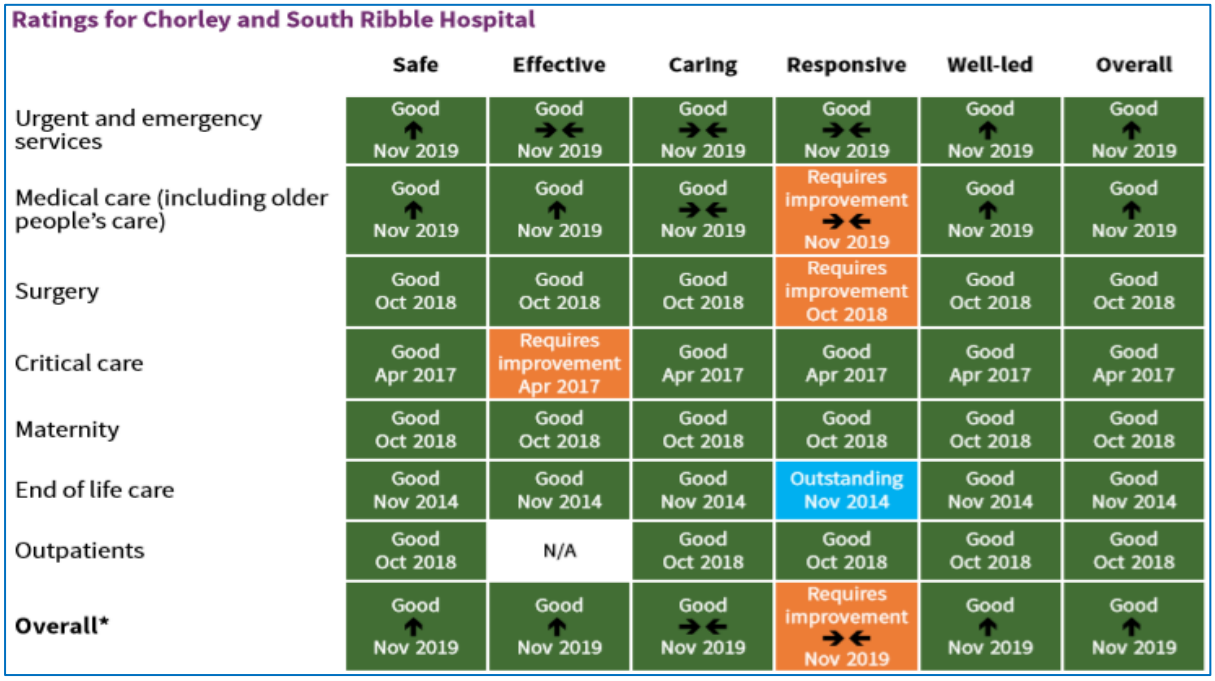
Figure 5 Service Results for Royal Preston Hospital

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
Overall*	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
Overall*	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 nine service lines, with six service lines improving in 2018 and three service lines improving in 2019.

During the inspection, the CQC noted a number of areas of good practice. These include:

- Our approach to the *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 Accountability and Improvement Framework in place following the 2018 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.

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. Regular relationship meetings continue to be held.

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 2019-20 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:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.1% for accident and emergency care

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

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

9.0 Lancashire Teaching Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2019-20 was 100% complete and was graded Green.

10.0 Lancashire Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit completed by the Audit Commission during 2019-20. The Trust was subject to an external clinical coding quality assurance audit during 2019-20, completed by the North West Coding Collaborative. Results indicate a high level of coding quality and completeness:

- Primary Diagnosis 92%
- Secondary Diagnosis 93.6%
- Primary procedure 92.86%
- Secondary procedure 97.63%

NHS Number coverage is better than the national average across all datasets, GP Practice coverage is above or at the national average for 2019-20.

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.
- Continued development of our Integrated Performance Report aligned to the *Big Plan* ambitions and CQC Domains.
- Rolling audit programme aimed at all staff groups, clinical and non-clinical with a focus on raising awareness of the importance of good data quality across all data collections.
- 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.

Learning from Adult, Child and Neonatal Deaths

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 two 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 at the end of this section.

27.1 During 2019-20, 1733 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:

- *445* in the first quarter
- *371* in the second quarter
- *392* in the third quarter
- *525* in the fourth quarter

Data source: Trust data warehouse

27.2 By 31 March 2020, 770 case record reviews and six Strategic Executive Information System (StEIS) investigations have been carried out in relation to the 1733 of the deaths noted above.

In two 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:

- 213 in the first quarter (plus 2 StEIS investigations – deaths avoidable)
- 162 in the second quarter
- 159 in the third quarter (plus 4 StEIS investigations – deaths unavoidable)
- 236 in the fourth quarter

Data source: Trust MR Database and Datix

27.3 Two, representing 0.11% of the patient deaths during the (2019-20) 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:

- 2 representing 0.44% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for fourth quarter

Data source: Trust MR Database and Datix

These numbers have been calculated using the Structured Judgement Review (SJR) Mortality Review process and the StEIS process.

27.4 Learning from the deaths identified in 27.3

- Every patient needs a risk-benefit analysis of anticoagulation with any clinical change and a clear plan document in the medical record.
- Comprehensive record keeping and inclusion of necessary information when requesting referrals from other specialities.

27.5 Actions in relation to the learning in 27.4

- A clear escalation process has been defined within the Medicine's Management Policy (TP-140) so we can provide assurance that issues and concerns are communicated to a patient's parent medical team.
- Lessons Learned communications have been produced and shared throughout the Division and across our organisation.
- Undertaken a thematic review of the associated serious incident cases to identify any themes which will be shared with the Learning To Improve Group.
- Implementation of a daily check as part of the Neurosurgical Medical Team ward round, to evidence the review and consideration of the associated risks in withholding anti-coagulant medication.

- Teaching session to be delivered to the Neurosurgical Medical and Nurse Practitioner teams regarding the increased clinical risks related to the omission/continuation of Direct Oral Anti Coagulants.
- Sharing of the incident and initial lessons learned via the speciality's Audit, Mortality and Morbidity, Safety and Quality, and Directorate Meetings.
- Escalating concerns to be highlighted as focus of the week.
- Training to be provided to medical and nursing staff for recognition of hypertension.
- E-Vital Signs to be available in graph form on Quadramed replicating the NEWS 2 format.
- Incident and learning to be shared with MAU Team and Consultant for Critical Care Services and a training package to be rolled out.
- Incident to be shared with the General Practitioner via the Clinical Commissioning Group (CCG) to investigate management of hypertension prior to hospital admission.
- Post-take ward document to include alcohol history as mandatory.

27.6 Assessment of the impact of actions described in 27.5

- We will continue to monitor the effectiveness of actions related to recognition of deterioration and escalation and communication across medical teams through the Learning to Improve Group.

27.7 Two case record reviews and 11 Serious Investigations were completed after 1 April 2019 which related to deaths which took place before the start of the reporting period (in 2018/19). The two case record reviews became Serious Investigations and are included in the 11 investigations above.

27.8 Two representing 0.11% of the patient deaths (in 2018-19) 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 calculated using the Structured Judgement Review (SJR) Mortality Review process and the Serious Incident investigation (StEIS) process.

Learning from the two deaths which occurred in 2018-19 but are reported in this current reporting period is presented below:

- Severity of alcohol withdrawal must be determined using a combination of history of alcohol use, clinical assessment and a CIWA- Ar score.
- Signs and symptoms of tachycardia hypertension and hallucinations should be considered as 'red flags' for severe alcohol withdrawal.
- All patients at risk of alcohol withdrawal must be referred to the HALS team and speciality teams.
- Consistent and reliable means of communicating actions that nurses are expected to take following ward rounds.
- We need to improve responsiveness to information and concerns raised by relatives specifically, the recording and handover of those concerns.

- We require clearer guidance for management of patients presenting to the Emergency Department with vertigo.

Actions taken

- A revised Alcohol Withdrawal policy and guidance has been produced.
- Training for all doctors and registered nurses for the management of alcohol withdrawal has been undertaken and continues.
- Auditing the implementation of the guidance is in progress.
- The development of a vertigo protocol for patients presenting to the Emergency Department (ED) to support clinicians in assessment and management of patients.
- Expansion of ED and Rapid Assessment and Treatment (RATS) senior cover to improve early identification of potential stroke in complex patients.

Assessment of the impact of the action

- Our staff have increased their knowledge for management of alcohol withdrawal from training as stated in evaluations.
- The audit has demonstrated some improvements in the application of the CIWA score.

27.9 Four representing 0.12% of the patient deaths during 2018-19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Adult Mortality Summary

The deaths judged 'to be more likely than not to have been due to problems in the care provided to the patient' relates to four deaths for the 2018-19 period, two were reported in the 2018-19 Quality Account and the additional two which have been subject to investigation in this current reporting period 2019-20. In addition two patients are reported for the period 2019-20 which equates to six cases in the last two reporting periods.

Child Deaths

We have had two child deaths in 2019-20 both at the Royal Preston Hospital site. Both children died in the Emergency Department. We have had no expected child deaths in hospital in 2019-20 because all these children died at home, at Derian House Children's Hospice or in a Tertiary hospital.

Table 6 Child Deaths 2019-20 Royal Preston Hospital

Quarter	No. Deaths	Unexpected	Location
Q1	1	*In line with information governance requirements where the numbers referenced are 5 or less the detail is not included to ensure no patient can be identified*	Emergency Department

Q2	0		
Q3	1	*In line with information governance requirements where the numbers referenced are 5 or less the detail is not included to ensure no patient can be identified*	Emergency Department
Q4	0		

Data source: LTHTR Data

We have a new policy regarding the management of child death which has been written in line with recent changes to the Child Death Overview Panel (CDOP) policy. The policy includes definitions of expected and unexpected deaths and procedures are in place for both including the Joint Agency Response for the management of sudden unexpected death in children. We record all child deaths in the incident management system Datix which informs our safeguarding team who complete form A and then inform CDOP. The practitioners who hold information on the child complete form B and this form is also completed for any children who die outside of the organisation but are known to the local services. Our named doctor for safeguarding reviews all child deaths and establishes whether a child death review meeting is required. Following the child death review meeting the child death analysis form C is completed and returned to the coroner and CDOP panel.

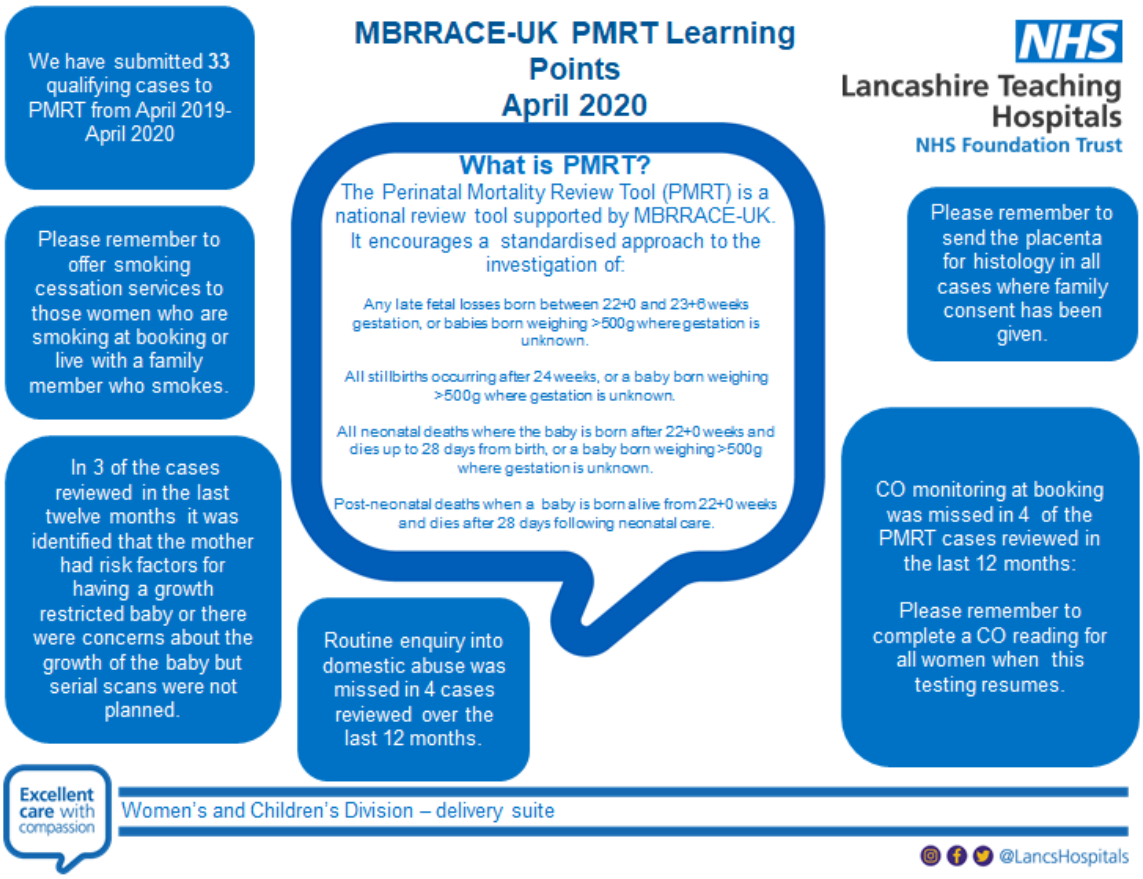
Our Women's and Children's Divisional governance team supports the administration and monitoring of actions and learning from child deaths. In addition to the statutory child death reporting, we hold morbidity meetings to review any children who have died outside of the Trust but who were known to our services. This includes children who were stabilised and transferred to paediatric intensive care and children known to paediatricians or the paediatric outreach team.

We have received positive feedback on the new policy from the chair of the Child Death Overview Panel in 2020 and have been requested to share this with other Trusts and one of the Paediatric Consultants received a good practice letter from the CDOP chair in relation to the quality of information included within a child death reporting form B.

Perinatal Mortality

We use the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. Since April 2019 we have reported 33 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 bi-monthly for review and discussion. Formal assurance is provided in a summary report to the Board following submission of a detailed report to the Trust's 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 presented below.

Figure 7 MBRRACE-UK Learning Points



Data source: PMRT and LTHTR Data

Stillbirths

During the period 1 April 2019 until 31 March 2020 our reported incidence of stillbirths were 3.8 per 1000 births. We undertake analysis of the data on a monthly basis using local and regional data to benchmark performance. Table 20 in Appendix I p.233 demonstrates the distribution of the stillbirth incidence during the period and Table 21 also in Appendix I p.233 highlights our performance benchmarked with our regional peers within the strategic clinical network.

We provide assurance that the local stillbirth incidence is less than the regional mean and aligns with the crude rate and incidence, reported in the last MBBRACE report. Assurance is also provided that the reported peak in the incidence of stillbirth noted during the month of February 2020 included fetocide termination for medical reasons.

Further information related to deaths is also presented in the Mortality Monitoring section on p.204 as well as progress with the implementation of the Medical Examiner Function on page 207.

2.3 Reporting Core Indicators

Our performance is measured against a range of patient safety, access and experience indicators identified in the NHS Improvement (NHSI) Compliance Framework and the Acute Services Contract.

During 2019-20 we continued to experience significant operational pressures resulting in non-compliance in relation to some key standards. This was primarily due to whole health economy system pressures and continued high bed occupancy throughout the year. A health economy 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 2019-20 we continued to expand the scope of the Continuous Improvement and transformational work streams. Patient flow has a significant work plan attached to this work stream. Work has been undertaken in redesigning pathways around Urgent and Emergency Care settings, including Ambulatory Care at both hospital sites and the Emergency Observation Unit at Royal Preston Hospital. This has involved Urgent and Emergency Care Value Stream Analysis.

During 2019-20 overall we achieved compliance against two of the eight cancer waiting times standards within the Risk Assessment Framework. In addition we have maintained performance against a range of other measures identified in the Acute Services Contract.

However, we have failed to achieve our objectives in relation to Accident and Emergency Waiting Times throughout the year, the 18 week incomplete access target, and the 62 day cancer treatment standard. This was largely due to significant pressures of emergency admissions putting pressure on the bed occupancy of the organisation which adversely impacted elective operations and waiting times.

The summary position detailing performance against key targets 2019-20 is shown in Table 7 on the next page.

Table 7 Performance against Key Targets

Indicator	National Target	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	86	81.46	Not Achieved	% - Cumulative to end Mar 2020 Position includes both ED and UCC locations. Target based on agreed Trajectory to Mar 2020
Cancer - 2 week rule (All Referrals) - New method	93	92.5	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 2 week rule - Referrals with breast symptoms	93	83.3	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 day target	96	93.4	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	86.6	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.3	Achieved	% - Cumulative to end Mar 2020
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	97.0	Achieved	% - Cumulative to end Mar 2020
Cancer - 62 day target - total	85	70.3	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 62 day target - Day 38 reallocations	85	72.1	Not Achieved	% - Cumulative to end Mar 2020
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	78.7	Not Achieved	% - Cumulative to end Mar 2020
MRSA	0	0	NA	% - Cumulative to end Mar 2020
C.difficile Infections	<84	108	Not Achieved	Cumulative to end Mar 2020
C.difficile infection avoidable (Lapses in care)	0	50	Not Achieved	Cumulative to end Mar 2020
18 weeks - Referral to Treatment - Incomplete Pathways	79.2	77.95	Not Achieved	% - sum of Apr-Mar in 2019-20 Target based on agreed Trajectory to Mar 2020
% of patients waiting over 6 weeks for a diagnostic test	<1	5.0	Not Achieved	% - Cumulative to end Mar 2020

Source: LTHTR data

Table 8 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 from NHS Digital for each Performance Indicator presented

Table 8.1 Summary Hospital-Level Mortality Indicator (SMHI)

12. Summary Hospital-Level Mortality Indicator (SMHI)	October 2016- September 2017	October 2017- September 2018	November 2018- October 2019
(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period	Trust = 1.0562	Trust = 0.9713	Trust = 0.9845
	National average = 1.0	National average = 1.0	National average = 1.0
	Low = 0.73	Low = 0.69	Low = 0.68
	High = 1.25	High = 1.26	High = 1.20
	Banding = 2	Banding = 2	Banding = 2
(b)the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period	Trust = 38.8% National = 31.5% High = 59.8% Low = 11.5%	Trust = 46.3% National = 33.6% High = 59.5% Low = 14.2%	Trust = 53.0% National = 36.0% High = 59.0% Low = 11.0%

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, despite being slightly higher during the most recent period; it is an indicator of the continued quality of care and treatment provided to patients within the organisation.
- The Palliative Care coding has improved over the periods provided above, as a result of the ongoing extensive work of the Palliative Care team seeing more patients at end of life. The Palliative Care coding is higher than the national average. Higher levels of Palliative Care coding lower the SHMI and during December 2018 to November 2019 (the current period available via Doctor Foster Intelligence) the Palliative Care adjusted SHMI is 80.93 which is lower than expected.

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) process which promotes learning from deaths.
- Continuing to monitor mortality rates including the SHMI, escalate if there are any areas of concern and provide monthly reports to the End of Life Care and Mortality and Safety and Quality Committees.
- If mortality alerts are raised we will continue to investigate this through the relevant speciality using SJR mortality review.
- We have started to incorporate learning from deaths into the Trust '*Learning to Improve'* framework and included in the Learning from Deaths bulletin which will be strengthened in 2020-21.
- A lead Medical Examiner was appointed for NHS England Northwest in September 2019 who is also the Trust Lead Medical Examiner appointed in October 2019. Our Lead Medical Examiner has appointed independent Medical Examiners, these are now in post and will enable increased reviews and learning from deaths in 2020-21.

Further information related to SHMI and the Medical Examiner Function is found on pages 204 to 207.

Table 8.2 Patient Reported Outcome Measures

18. PROMS; The Trust's patient reported outcome measure scores for:		April 2016- March 2017			April 2017- March 2018			April 2018- March 2019		
		EQ5D (Health gain)	Oxford score	Aberdeen score	EQ5D (Health gain)	Oxford score	Aberdeen score	EQ5D (Health gain)	Oxford score	Aberdeen score
(i) Groin hernia repair Average case mix adjusted scores	*National	0.086	NA	NA	Discontinued data collection nationally 1/10/17 Final data April 16 – March 17			Discontinued data collection nationally 1/10/17 Final data April 16 – March 17		
	High	0.135								
	Low	0.006								
	Trust	NA								
(ii) Varicose vein surgery Average case mix adjusted scores	*National	0.092	NA	-8.25	Discontinued data collection nationally 1/10/17 Final data April 16 – March 17			Discontinued data collection nationally 1/10/17 Final data April 16 – March 17		
	High	0.155		2.1						
	Low	0.02		-18.1						
	Trust	NA		NA						

(iii) Hip replacement surgery. (Primary) Average case mix adjusted scores	*National	0.44	21.7	NA	0.46	22.7	NA	0.46	22.7	NA
	High	0.54	25.1		0.56	26.2		0.53	25.4	
	Low	0.31	16.4		0.40	18.8		0.35	18.8	
	Trust	0.38	20.3		0.45	21.9		0.48	23.0	
(iv) Knee replacement surgery (Primary) Average case mix adjusted scores	*National	0.32	16.5	NA	0.33	17.3	NA	0.34	17.3	NA
	High	0.40	19.9		0.41	20.6		0.39	20.0	
	Low	0.24	12.5		0.23	13.1		0.27	13.8	
	Trust	0.28	14.8		0.33	16.9		0.36	17.8	

national score described in guidance as "national average" (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 and Oxford scores for both hip and knee replacements have improved again in this successive reporting period and the Trust remains within expected range in comparison with national peers.
- National PROMS data for groin and varicose vein surgery is no longer obtained, this ceased on 1 October 2017.

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.
- Further increasing uptake of the PROMS questionnaire through annual review of the process.

Table 8.3 Child Readmissions within 30 days of Discharge

19. The percentage of patients aged: • **0 to 15 and** • **16 or over** **Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period**	**2015-2016**	**2016-2017**	**2017-2018**
0-15 years	Trust = 14.9	Trust = 15.2	Trust = 15.3
	England = 11.5 High = 80.5 Low = 2.6	England = 11.6 High = 68.4 Low = 1.6	England = 11.9 High = 32.9 Low = 1.3
16 years and over	Trust = 12.2	Trust = 12.5	Trust = 12.9
	England = 13.4 High=94.1 Low = 1.3	England = 13.6 High=69.2 Low =0.9	England = 14.1 High= 46.4 Low =1.8

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

- The national data provided by NHS Digital has been updated since the last reporting period which was related to years 2009-2012 and now related to readmissions within 30 days where as this was previously 28 days.
- The 0-15 year's readmissions are higher than the national average for England however there is a wide variation from the highest lowest scores which affects the average. The Trust remains lower than the national highest rates.
- The re-admissions rate for patients 16 years and over is lower than the average for England.
- Although the rate is rising through successive periods it is in line with the national picture and could be related to patients with long term conditions requiring more frequent admissions.

Lancashire Teaching Hospitals NHS Foundation Trust intends to review and monitor readmission rates and respond where improvements are required.

Table 8.4 Responsiveness to Personal Needs

	2016-2017	2017-2018	2018-2019
20. The Trusts responsiveness to the personal needs of its patients during the reporting period	Trust = 64.1	Trust = 65.9	Trust = 66.2
	National = 68.1 High=85.2 Low = 60	National = 68.6 High=85.0 Low = 60.5	National = 67.2 High=85.0 Low = 58.9

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

- The Trust responsiveness to the personal needs of patients continues to improve 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:

- Continuing to improve and consistently deliver excellent care by responding to feedback from patients and families through the Friends and Family test as well as national and local surveys.
- The STAR performance also drives continuous improvement in our services being responsive to the personal needs of patients.

Table 8.5 Staff Recommendation as a Provider of Care

	2017	2018	2019
21. %age 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	Trust = 67	Trust = 65	Trust = 63
	National (Acute Trusts) = 70 High = 84 Low = 47	National (Acute Trusts) = 71 High = 87 Low = 40	National (Acute Trusts) = 71 High = 87 Low = 40

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

- Staff feedback obtained through a range of channels tells us that concern around the demand on our services, working environment and staffing levels affects staff satisfaction with the care they are able to provide to our patients.

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

- Alignment of our staff engagement and continuous improvement programmes. We have a well-established continuous improvement strategy which aims to transform our services at system, pathway and ward/department level and we are working collaboratively with integrated care system partners to address the demand and capacity challenges we face. We are proactively involving clinical and non-clinical staff in our improvement journey and a key action for the next 12 months will be to develop teams undertaking continuous improvement projects through utilisation of our Team Engagement and Development toolkit.
- Attraction, resourcing and retention interventions through new methods of marketing posts are being tested with wider utilisation of social media, international recruitment campaigns and widening participation schemes are being further developed. We have implemented 'Fresh Eyes Forums' to better understand new starter experience and a revised on-boarding programme, 'Stay Conversations' and improved exit interview process will be launched in 2020-21.
- Focusing on behaviours underpinned by the values of our organisation through continue cultural improvement work.

Table 8.6 Venous Thromboembolism Risk Assessment

23. %age of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Q3 2017- 2018**	**Q4 2017 -2018**	**Q4 2018 -2019**
	Trust = 96.1%	Trust = 96.2%	Trust = 95.7%
	National = 95.4% High = 100% Low = 76.1%	National = 95.2% High = 100% Low = 67%%	National = 95.7% High = 100% Low = 74%%

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

- Risk assessment is standardised in the Electronic Patient Record.

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

- Participating in a Getting It Right First Time (GIRFT) Survey for Venous Thromboembolism (VTE) prevention and reporting of the Hospital Acquired Thrombosis (HAT) due for completion at the end of March 2020.
- Including VTE in the Always safety first programme of work and increased focus at inpatient level to improve outcomes for patients.
- The VTE Assessment on Quadramed is being enhanced to improve compliance with completion rates, with an 'app' being developed for the medical staff to improve compliance.

Table 8.7 Clostridium *Difficile* Infection

24. The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period	**2016-2017**	**2017-2018**	**2018-2019**
	Trust = 18.9	Trust = 20.0	Trust = 17.8
	National = 13.0 High = 82.6 Low = 0	National = 14.0 High = 91.0 Low = 0	National = 12.2 High = 79.7 Low = 0

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

- Hospital onset Clostridium *Difficile* continued to remain lower that the Trust annual objective during 2018-19 according to the NHS Digital data which is stipulated for the Quality Account.
- However the annual trajectory for Clostridium *Difficile* was set at 84 cases for 2019-20. This has been exceeded locally and we report to our Safety and Quality Committee on a monthly basis. The Quality

Account requires reporting to be presented as a representation of per 100,000 bed days. The total number of Clostridium *Difficile* cases is presented to the Trust Board.

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

- Continuing Post Infection Reviews (PIRs) which is a multidisciplinary approach to investigate each hospital onset Clostridium *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.

Further information on Clostridium *Difficile* can be found on page 193.

Table 8.8 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	**Apr 2017-Sep 2017**	**Oct 2017-March 2018**	**Oct 2018-March 2019**
(i)Rate of Patient Safety Incidents per 1000 Bed days	Number = 6390 Rate/1000 bed days = 43.4 National Rate/1000 bed days = NA High Rate/1000 bed days = 69 Low Rate/1000 bed days = 23.1	Number = 6506 Rate/1000 bed days = 43.6 National Rate/1000 bed days = NA High Rate/1000 bed days = 69 Low Rate/1000 bed days = 23.1	Number = 7250 Rate/1000 bed days = 52.4 National Rate/1000 bed days = NA High Rate/1000 bed days = 95.9 Low Rate/1000 bed days = 16.9
(ii) % of Above Patient Safety Incidents = Severe/Death	Severe harm or death	Severe harm or death	Severe harm or death
	Trust Number = 39 Percentage of all incidents= 0.26%	Trust Number = 62 Percentage of all incidents= 0.42%	Trust Number = 60 Percentage of all incidents= 0.43%
	National = NA	National = NA	National = NA

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

- We have improved education regarding the reporting of incidents and near misses, along with making improvements to the reporting systems to make it easier to report in a timely manner.
- 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.
- Our guidance and policies have been refined to be clearer for staff.

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:

- Development of an incident dashboard within the Trust's Datix system for improved incident analysis and action plan development.
- Continued support of the established Learning Bank and *Learning 2 Improve* framework for sharing

learning across the Trust.
- Increased analysis of near miss, low and moderate harm incidents to identify learning and prevent more serious harm incidents.

2019-20 data is presented on page 201.

Clinical Standards for Seven Day Hospital Services

A refreshed Board Assurance Framework for seven day hospital clinical services was issued by NHS Improvement (NHSI) in December 2018, requiring all Trusts to provide Board level assurance every six months through completion of a standardised template capturing performance against all ten Clinical Standards (submitted in June and November 2019). We have taken a number of actions over the last 12 months to support the delivery of high quality seven day clinical services:

- Development of the medical staffing model to expand the numbers of hours consultants are on site and increase the number of speciality ward rounds.
- Remodelling of Surgical Assessment Unit processes.
- Improvements to the discharge processes to support patient flow.
- Improvements to the availability and utilisation of the multidisciplinary team to support patient care (e.g. expanding the provision of pharmacy services across seven days).

Priority Clinical Standards

From the start of the year we continued to use the methodology for data collection that NHSI mandated in 2015. The performance captured in the submissions to NHSI in June 2019 and November 2019 indicated improvements in two of the priority standards firstly Standard 2 'First Consultant review within 14 hours of admission' (emergency admissions) and secondly Standard 8 'Daily Consultant review'. Each submission was reviewed by the Safety and Quality Committee prior to submission, and these reviews identified the desire to enhance the data collection methodology in order to increase the numbers of patients audited to provide greater assurance of performance. Work has been completed to develop the Quadramed Electronic Patient Record so that electronic data collection is possible for all emergency admissions. We rolled out the use of electronic clinical documentation across all adult services during the winter months and completed in December 2019. A summary of March 2020 data is captured in Table 9 below:

Table 9 Seven Day Services Audit Data

	Standard 2 – First Consultant Review within 14 hours	Standard 8 – Daily Consultant Review
Adult Services*	65% (n=2.5K)	54% (n=57K)
Paediatric Services**	80% (n=20)	100% (n=52)

Source: LTHTR data

*combination of electronic and manual data collection March 2020
**manual data collection December 2019

We undertook a review in March 2020 which identified variability in the use of electronic clinical documentation which impacts on the positive capture of performance related to these two clinical service standards. A number of actions were agreed to support improvements in performance by:

- Identifying and implementing appropriate changes to the Quadramed forms to support robust capture of performance for the seven day clinical service standards (complete).
- Establishing a 'Clinical Documentation Application' in the Business Intelligence (BI) Portal to enable clinical teams to track performance in a range of key clinical metrics (complete).
- Adding key clinical metrics including seven day services standards in the Divisional Performance Packs to facilitate discussions on clinical performance between the Executive Team and Divisional Triumvirate (complete).
- Working with the Medical Leadership Teams to ensure our clinical staff use the forms appropriately in Quadramed (in progress).
- Supporting Paediatric Services to adopt the use of electronic clinical documentation (in progress).
- Further developing the clinical pathways and models to support timely reviews seven days a week, as captured in the Continuous Improvement Programme of work.

Continuous Improvement Clinical Standards

We capture a broad range of data to monitor progress towards meeting the six continuous improvement seven day clinical service standards. This includes:

- Hospital falls
- Medicines reconciliation
- Patient experience (STAR audits)
- Delayed discharges
- Length of stay
- Medication errors
- Friends and Family test
- Discharges before midday
- Mortality Rate
- Readmissions

We review performance relating to the priority standards on a monthly basis. The next six monthly seven day clinical services report (all ten standards) is due to be submitted in June 2020.

Freedom to Speak Up

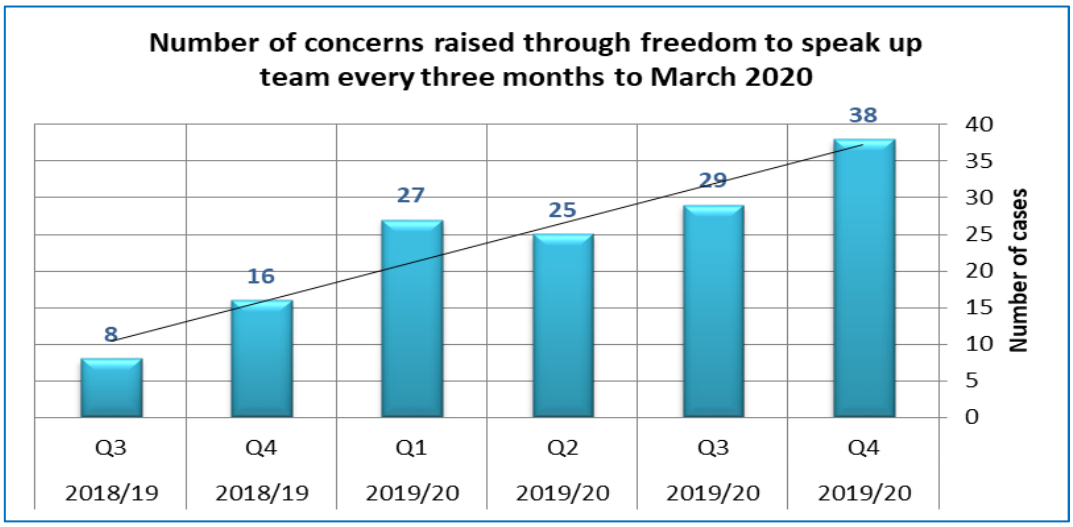
Following publication of Sir Robert Francis' Freedom to Speak Up Review (2015) and in the shadows of the Gosport (2018) and East Kent (2019) enquiries, we have reviewed our processes and systems for inviting, listening and responding to concerns raised by staff.

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. During 2019-20 119 concerns were raised in this way, a significant increase on the previous year when only 26 concerns were raised. This increase is largely due to increased staff awareness of the role and improved access, due to strengthening of the Guardian role and expansion of a network of Champions who support the Guardian. 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.

Figure 8 Freedom to Speak Up Concerns Raised



Source: LTHTR data

Table 10 Freedom to Speak Up Cases

2018/19	Cases per quarter	Total cases
Q1	2	2
Q2	0	2
Q3	8	10
Q4	16	**26 (2018/19 total)**
2019/20		
Q1	27	27
Q2	25	52
Q3	29	81
Q4	38	**119 (2019/20 total)**

Source: LTHTR data

Our Guardian also ensures that staff do not suffer detriment after raising concerns and provides assurance to the Board that we are responsive to concerns. Where staff experience detriment, our Guardian has access to the Chief Executive and through this route can afford protection to staff. Trust policy, whilst encouraging staff to seek internal resolution, 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 and can be shared with the Trust's *Raising Concerns Group.* All concerns raised through Datix, via the 'Valuing Your Voice' webpage, through the FTSU Guardian, Champions and any other routes are recorded and shared at the Group's quarterly meeting where any trends and themes are identified and acted upon. A quarterly report to the Board of Directors provides 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 the Trust will publish an early resolution policy designed to replace the grievance policy and encourage a less adversarial way of addressing some staff concerns.

In 2019 we launched the '*Call It Out with Compassion'* campaign to highlight the unacceptability of bullying and harassment and rude behaviours. Following this successful awareness raising campaign, 2020 will see a focus on the impact of such behaviours on staff wellbeing, confidence and loyalty.

Medical and Dental Workforce Rota Gaps

Our Human Resources Department monitor vacant posts through a monthly vacancy gap analysis and continue to provide an annual report on rota gaps and plans for improvement, as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b.

Table 11 Medical Vacancies March 2020

Grade	Vacant	Filled	Grand Total	Vacancy Rate
Deanery				
FY1	1	53	54	1.85 %
FY2	2	53	55	3.64 %
ST1-2	9	106	114	7.02 %
ST3+	14	138	152	9.21 %
Trust				

Junior Clinical Fellow	10	34	44	22.73 %
Senior Clinical Fellow	20	54	74	27.03 %
SAS	16	76	92	17.39 %
Consultant	43	402	445	9.66 %
Grand Total	**114**	**916**	**1,030**	11.07 %

Source: LTHTR data

Our Medical Workforce team provide monthly reports to the Divisional Workforce Committees which includes the detailed status of each vacancy. Specialities and departments are also provided with a monthly report to support services and 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 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 faster shortlisting, Skype interviews and supporting candidates to transition into the NHS.
- Sourcing 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, which has been applied on a number of occasions.
- Implementation of Associate Consultant posts to support retention of existing middle grade doctors by providing career progression. We appointed four Associate Consultants in 2018-19 with two further appointed in 2020.
- Continue to develop quality job planning to ensure fully reflective of activity.
- Utilising medical and dental banks to reduce reliance on agency workers and reduce cost. This has enabled us to utilise our own doctors to work additional hours and therefore improves quality of care because doctors are familiar with patients and the hospital. There are currently approximately 160 medical bank workers working regular shifts.
- Working with the lead employer to improve rotation information to ensure early identification of vacant posts where possible.

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. This is being led by the Nursing Midwifery and AHP Director and Medical Director and supported by the Continuous Improvement Team. 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's Safety Triangulation Accreditation Review (STAR) programme
- National Safety Thermometer performance for adults and children
- Falls prevention
- Infection prevention and control related to Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium *Difficile*
- Medication Safety
- Safeguarding adults and children
- Progress with the Birth Centre
- Incidents and Never Events
- Duty of Candour

Clinical Effectiveness:

- The *Getting it Right First Time* (GIRFT) programme
- Mortality Monitoring
- The Medical Examiner function and impact on effective care
- Pressure Ulcer prevalence and programmes to reduce incidence
- Nutritional support for effective patient care

Patient Experience:

- Patient Involvement and Surveys
- Friends and Family Feedback
- Staff Survey
- Concerns, Complaints and Compliments
- Patient Stories, Communication and the Youth Forum

Safety Triangulation Accreditation Review (STAR)

We designed the STAR Quality Assurance Framework in 2017 by 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:

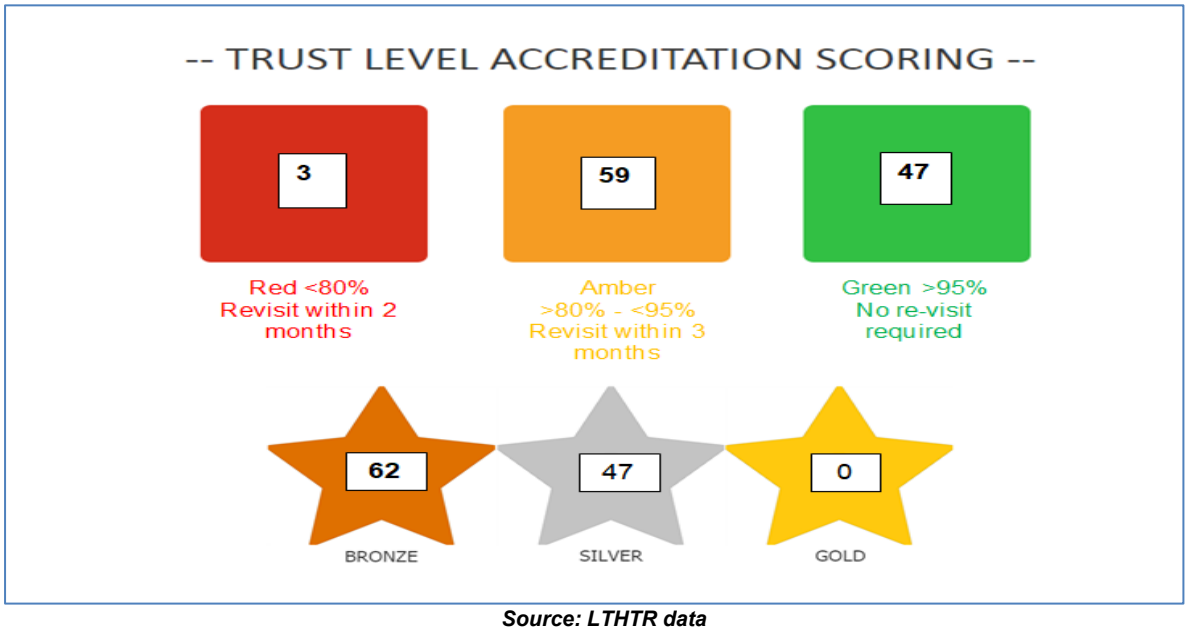
- STAR Monthly Reviews – 16 audit questions are undertaken by the Matron or Professional Lead for each area.
- STAR Accreditation Visits – an in-depth CQC style audit is undertaken by the Quality Assurance Team with support from staff, Governors and volunteers from across the Trust.

In 2019-20 there are 112 clinical areas participating in this safety programme which is audited monthly using the Trust audit system *Audit Management and Tracking* (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 2020 a total of 109 areas had STAR visits completed and three new off-site areas are awaiting their first STAR visit. These have resulted in the following scores:

Figure 9 STAR Accreditation Scores



Source: LTHTR data

We currently have 43% of areas achieving a silver star in comparison to our *Big Plan* aim of 50% silver by the end of March 2020. As highlighted previously Covid-19 has affected the ability to deliver this measure due to diverting resource and focus into preparations for the pandemic, thus deferring the STAR audit visits.

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 three 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 4 clinical areas which have successfully maintained three consecutive silver stars and are progressing onto a gold star.

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 12 15 Step Challenge Results

	A Very confident	B Confident	C Not very confident	D Not confident at all
Trust Overall	74	32	2	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.

Continuous improvement of the STAR Quality Assurance Framework has also included:

- A STAR monthly report produced and presented at the Nursing Midwifery and Allied Health Professional Board.
- Commencement of a 'buddy' peer review system for ward or department managers and professional leads to support STAR visits on their 'buddy' areas, which improves objectivity.
- Matrons and professional leads peer reviewing the STAR monthly reviews within their divisions.
- Increasing the Divisional teams to be included in the STAR visits and be invited for feedback at the end of each visit.
- An escalation of concerns process has been developed, to ensure any immediate risks or serious concerns are dealt with urgently and wards or departments receive the support they may require.
- A Mersey Internal Audit Agency (MIAA) review of the STAR action plan to improve shared learning from STAR was completed in December 2020. Improvement actions include the development of a STAR page within the Learning Bank and features within the Learning Bulletin, and the progression of development of an improved Business Intelligence (BI) dashboard to improve capture of themes and trends. This is in progress.
- Development of a BI and Information Technology (IT) system to collect data and provide evidence for each element or question within the STAR visits to promote data analysis.
- A Silver Star celebration event was held in October 2019 with future celebration events and engagement events planned.

NHS National Safety Thermometer

The National Safety Thermometer is a measurement tool for improvement that focuses on adult inpatients, children and maternity.

Adult Inpatients

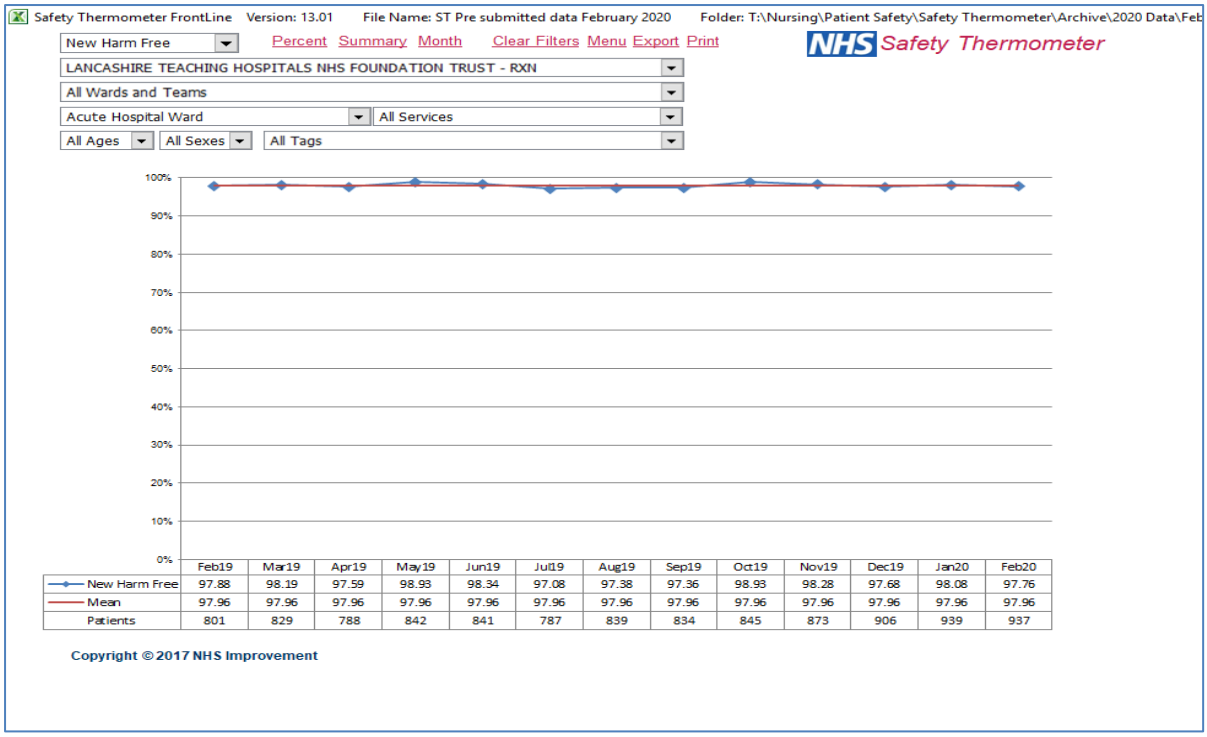
The four most commonly occurring harms are identified within the adult inpatient NHS Safety Thermometer these include:

- Pressure ulcers
- Falls
- Catheter Associated Urinary Tract Infection (CAUTI)
- Venous Thromboembolism (VTE)

We collect data through a point of care survey on a single day each month on 100% of patients. The outcomes highlight if there are harms related to these areas and action can be taken to improve patient care.

We continue to maintain stable levels of performance with all elements of the Safety Thermometer programme with the 2019-20 performance at 98% harm-free hospital care which is in line with the national target of 98% is presented in Figures 10 and 11 below. Nationally the data collection for the Safety Thermometer was discontinued in March 2020.

Figure 10 Adult NHS Safety Thermometer – All Harms Combined Percentage



	Feb19	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20
New Harm Free	97.88	98.19	97.59	98.93	98.34	97.08	97.38	97.36	98.93	98.28	97.68	98.08	97.76
Mean	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96	97.96
Patients	801	829	788	842	841	787	839	834	845	873	906	939	937

Data Source – NHS National Safety Thermometer

Figure 11 Adult NHS Safety Thermometer –Individual Harms (Percentage)

Dashboard | Percent | Clear Filters Menu Export Print | NHS Safety Thermometer

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST - RXN

All Wards and Teams

Acute Hospital Ward | All Services

All Ages | All Sexes | All Tags

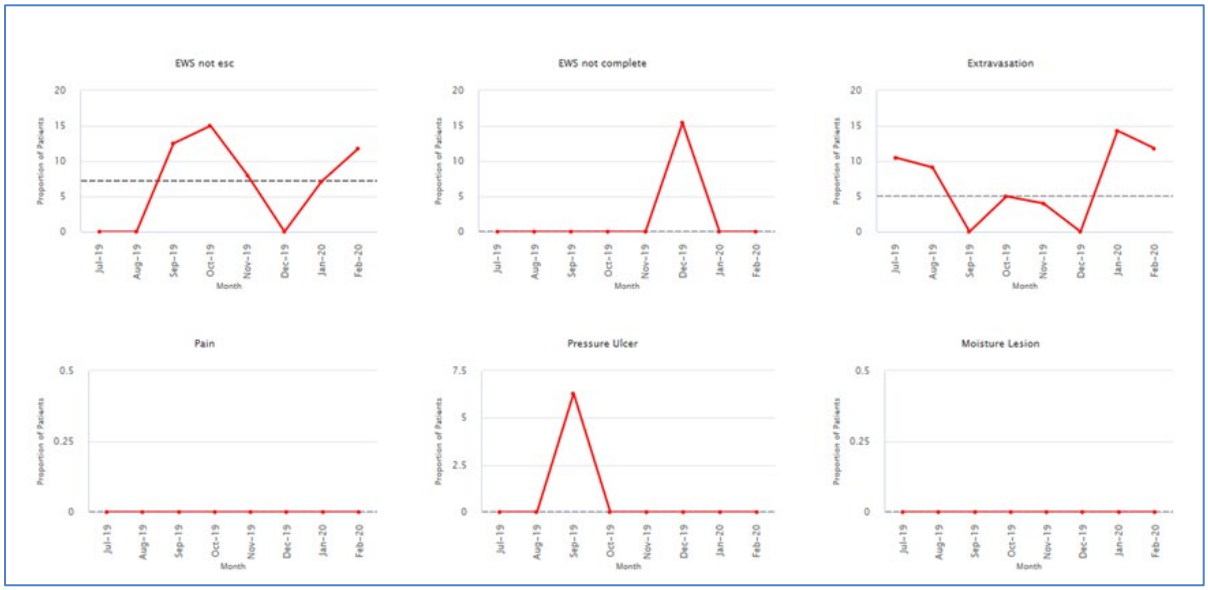
	Feb19	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20
Harm Free	93.51	93.37	94.42	96.67	95.12	94.79	93.92	94.48	96.57	94.96	94.48	95.53	94.45
Pressure Ulcers - All	5.99	6.03	4.57	2.73	4.28	3.68	4.41	4.44	2.60	4.01	4.42	3.73	4.80
Pressure Ulcers - New	1.87	1.33	1.40	0.59	0.83	1.40	1.07	1.68	0.47	0.69	1.21	1.28	1.49
Falls with Harm	0.12	0.00	0.13	0.36	0.12	0.76	0.72	0.60	0.12	0.34	0.55	0.32	0.21
Catheters & UTIs	0.25	0.24	0.25	0.12	0.12	0.25	0.72	0.24	0.47	0.11	0.11	0.21	0.00
Catheters & New UTIs	0.00	0.12	0.13	0.00	0.12	0.13	0.48	0.00	0.24	0.11	0.11	0.11	0.00
New VTEs	0.12	0.36	0.76	0.12	0.59	0.64	0.48	0.60	0.24	0.57	0.44	0.21	0.53
All Harms	6.49	6.63	5.58	3.33	4.88	5.21	6.08	5.52	3.43	5.04	5.52	4.47	5.55
New Harms	2.12	1.81	2.41	1.07	1.66	2.92	2.62	2.64	1.07	1.72	2.32	1.92	2.24
Sample	801	829	788	842	841	787	839	834	845	873	906	939	937
Surveys	40	41	39	41	39	42	43	42	41	43	46	48	46

Data Source – NHS National Safety Thermometer

Children and Young People (CYP) NHS Safety Thermometer

We commenced use of the Safety Thermometer for Children and Young People (CYP) in July 2019 to increase the focus on quality within children and young people services. This assesses any inpatient with an Early Warning Score (EWS) completed, triggered and not escalated; extravasation; patients in pain, any pressure ulcer, any moisture lesion. The results for the CYP safety thermometer are presented below in Figure 12 and in Table 13.

Figure 12 Children and Young People (CYP) NHS Safety Thermometer LTHTR



Data Source – NHS National Safety Thermometer

Table 13 Children and Young People (CYP) NHS Safety Thermometer Comparison

Indicator	LTHTR	All Organisations
Early Warning Score Not escalated	11.8%	3.0%
Early Warning Score Not complete	0%	3.9%
Extravasation	11.8%	1.1%
Pain	0%	4.4%
Pressure Ulcer	0%	0.5%
Moisture Lesion	0%	0.5%
Harm Free Care	76.5%	87.6%

Data Source – NHS National Safety Thermometer

In response to the CYP safety thermometer audit outcomes we have implemented a number of actions to reduce incidents.

- We have produced ward based communications to raise awareness of Paediatric Early Warning Score (PEWS) and the need for consistently good documentation. This is also part of the *Always Safety First* programme.
- We have revised the template for intravenous devices and fluid balance to promote improvement and minimise extravasation.
- Pressure ulcers in children are usually caused from medical devices e.g. nasogastric tubes and oxygen face masks. We are developing the hourly intentional-rounding template to include checking sites when devices are in place.

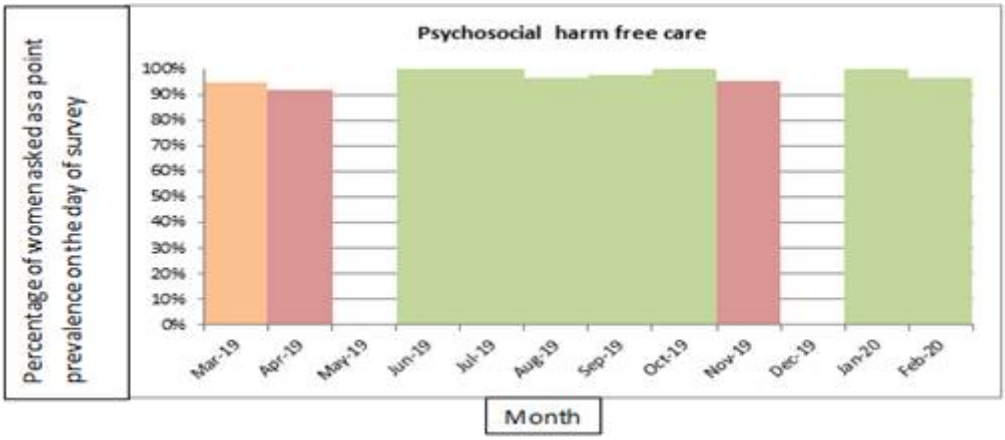
Maternity NHS Safety Thermometer

The maternity safety thermometer is a national point of care survey which takes place one day a month and is a small sample of approximately 10% of the mothers on the audit day. It focuses on key indicators of physical and psychological harm relating to maternal and newborn safety namely, perineal trauma, postpartum haemorrhage, infection, neonatal Apgar scores and Neonatal Unit (NNU) admissions, separation from baby and psychosocial safety. The maternity safety thermometer collates the reported psychosocial perspectives of women relating to maternal perceptions of:

- Concern about safety during labour and birth that is not taken seriously
- Left alone at a time that worried them
- Babies and mums being separated after birth without consent from the mother

Our results for the year to date highlight a positive response to the perceptions of women in relation to their psychosocial needs as detailed in Figure 13 below.

Figure 13 – Maternity Psychological Safety Thermometer



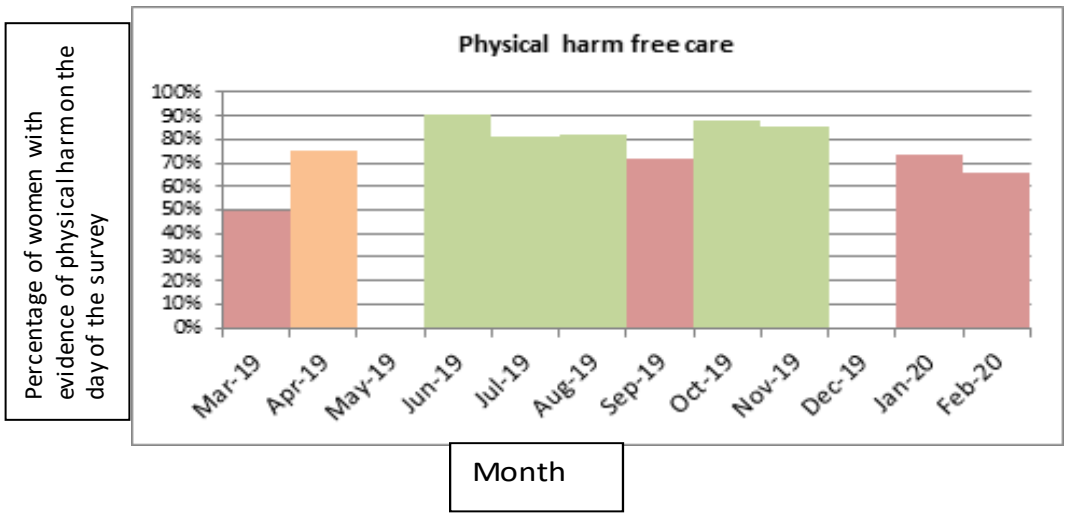
Data Source – NHS National Safety Thermometer

The point of prevalence survey also reports physical harm free care outcomes which these include:

- Maternal infection within 10 days of birth
- 3rd and 4th degree tears
- Estimated blood loss >1000mls
- Term babies admitted to neonatal unit
- Term babies with Appearance, Pulse, Grimace, Activity, and Respiration (APGAR) <7 at 5 minutes

The reported physical outcomes for the past twelve months reflect a higher incidence of severe tears and post-partum haemorrhage within the sampled population that had also been noted on the maternity dashboard.

Figure 14 Maternity Physical Safety Thermometer



Data Source – NHS National Safety Thermometer

This is a point of care survey so if a high proportion of a very small sample reported they experienced a physical harm this will reflect in the findings. The results are therefore

interpreted in triangulation with the maternity dashboard and other measures at the Maternity Safety and Quality Committee. The incidence of both indicators has been reviewed in detail and actions to reduce the incidence of these factors include the collation and implementation of a perineal care bundle to reduce the incidence of severe tears and a detailed analysis of the incidence of post-partum haemorrhage to identify areas of further learning.

Falls Prevention

Falls prevention is another of our key priorities and remains a complex challenge due to the wide range of influencing factors requiring multifactorial patient assessments and implementation of variable, individualised falls prevention measures.

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).

Prevention of falls is a complex problem with older hospital patients being particularly vulnerable because of:

- 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 six 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. These include:

- Trust wide use of non-slip socks (safe footwear).
- Introduction of 'Falls Prevention' and 'Enhanced Levels of Care' e-learning packages.
- A new falls assessment and prevention plan compliant with NICE guidance.
- 'Call Don't Fall' patient information cards and posters.
- Post fall rapid review (Swarm).
- Quarterly falls prevention information posters for staff.
- Staff training for medical students, healthcare assistants, assistant nurse practitioners, registered nurses and student nurses.
- Rapid improvement events with divisions and wards.

- Development of Enhanced Levels of Care (ELC) guidance, including e-learning and trial of supporting documentation.
- Introduction of anti-embolic stockings with a grip sole.
- Co-ordinating a health economy wide falls collaborative for central Lancashire.
- Environment check for wards.
- Harm free care meetings.
- Review of falls questions for the new Datix system.
- Development of a Datix dashboard for falls incidents.
- Review of falls with severe or above harm at the Serious Incident (SI) panel at the CCG.
- Learning cascaded via the Learning to Improve Bulletin, including learning about the spinal immobilisation equipment 'scoop-stretcher' and the importance of checking lying and standing blood pressures.

During 2019-20 we implemented additional falls prevention improvements including our 'falls, moving and handling and bedrails assessments' which are being reviewed as part of an *Always Safety First* Breakthrough Series Collaborative, which commenced in February 2020 by our Continuous Improvement Team.

We have also participated in a national CQUIN programme for three high impact interventions to prevent hospital falls for inpatients aged 65 years or over. The three high impact interventions include:

- Lying and standing Blood Pressure (BP) to be measured at least once.
- No hypnotics, antipsychotics or anxiolytics medications to be given or rationale for giving these should be documented.
- Mobility assessment documented within 24 hours of admission, including mobility aid provided.

The results of the CQUIN are presented below in Table 14. However the quarter 4 results have not been published to date due to the Covid-19 pandemic.

Table 14 Falls CQUIN Programme Results

CQUIN (CCCG7): Three high impact actions to prevent hospital falls:	Results for all three actions completed
Quarter 1	1%
Quarter 2	2%
Quarter 3	**15%**
Quarter 4	Delayed due to Covid-19

Data Source – NHS National Falls CQUIN data

Participation in the CQUIN programme has initiated several improvement actions including:

- Mandatory field for completion of lying and standing blood pressure for all patients aged 65 years or over built into the e-vital signs on Quadramed with a reminder that this must be done.

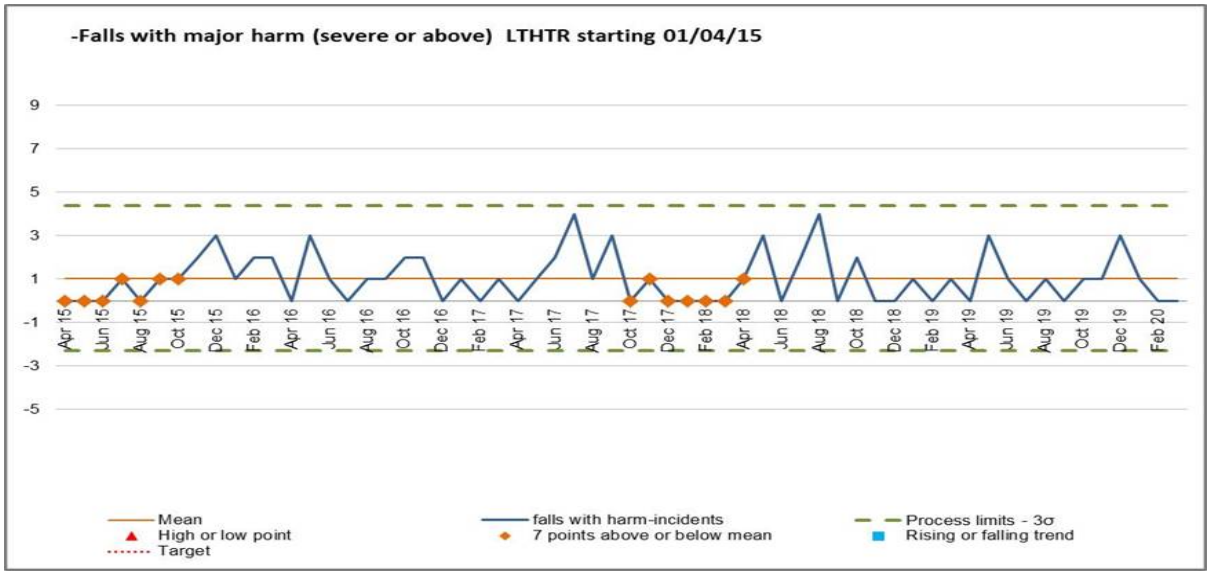
- Mandatory rationale for medical staff when prescribing any hypnotic, antipsychotic or anxiolytic medication built into the Electronic Prescribing Medicines Administration system (EPMA) in Quadramed.
- Feature on our Learning Bulletin on the importance of checking a patients lying and standing blood pressure.
- Posters sent to all wards and departments explaining the Royal College of Physicians' (RCP) guidance for completion of lying and standing BP and the CQUIN programme standards.
- Promotion and awareness of the three high impact actions during divisional harm free care meetings.
- Improvements in the gathering of audit data via the Business Intelligence Team.
- Potential development via the Business Intelligence Team of a phone application for checking compliance with lying and standing BP at ward level.

We are currently undertaking the Royal College of Physicians' Falls and Fragility Fracture Audit Programme based on the National Audit of Inpatient Falls which is a continuous audit of any inpatients sustaining a fractured femur during the admission period. The audit reviews if a NICE compliant post-fall protocol was followed including:

- Checks for signs or symptoms of potential for spinal injury prior to movement.
- Manual handling method used to move the patient.
- Documented evidence that the patient had a medical assessment following the fall.

The falls prevention programme of work is having a positive impact as evidenced by the end of year falls' statistics in particular for moderate or above harm. This has reduced by 18.52% from 27 falls resulting in moderate or above harm in 2018-19 to 22 falls resulting in moderate or above harm in 2019-20. The total number of falls with major and above harm (severe, death) has reduced from 14 inpatient falls resulting in major or above harm in 2018-19 to 11 inpatient falls resulting in major or above harm in 2019-20 which is a reduction of 21.43%.

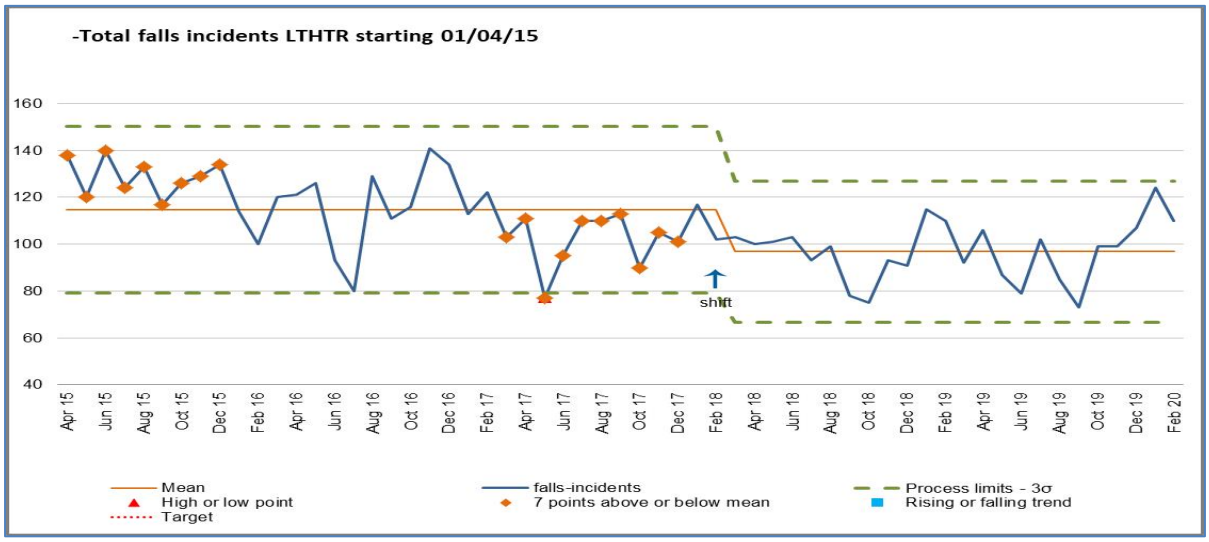
Figure 15 Total Inpatient Falls with Major or Above Harm 2015- 20



Source: LTHTR data

We have reported all falls incidents and falls with harm since April 2015 and this is presented in Figure 16. Overall since 2016-17 the Trust has achieved a 23.55% reduction in total falls from 1495 falls to 1143 falls in 2019-20. The end of year falls incident rate has decreased by 0.61% from 1150 falls in 2018-19 to 1143 falls in 2019-20.

Figure 16 Total Inpatient Falls April 2015–20



Source: LTHTR data

This demonstrates successful completion of our *Big Plan* target for falls prevention which is to achieve a 5% reduction in major and above harm caused by falls. This does not however negate the requirement to continually focus on reducing all falls.

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. Some *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 and two cases of community onset MRSA.
- In 2019-20 there has been one incident of hospital onset MRSA bacteraemia and two cases of community onset MRSA.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention and Control to identify causes and actions for future prevention.

Clostridium *Difficile* Infection

Clostridium *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 Clostridium *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 Clostridium *Difficile*.

The prevention of Clostridium *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 the last reporting period.

Our 2019-20 performance measures include both Hospital Onset Healthcare Associated (HOHA) cases and Community Onset Healthcare Associated cases (COHA), the latter being cases where the patient had been discharged from the Trust within four weeks of the diagnosis of Clostridium *Difficile* infection.

During 2019-20 there have been 130 cases against the yearly objective of 84

- Hospital Onset Healthcare Associated = 109
- Community Onset Healthcare Associated = 21

Of the 130 cases for the hospital onset cases there were lapses in care identified for 69 cases, no lapses in care in 28 cases and 12 are still under review. Of the community onset cases 21 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, Infection Prevention and Control Doctor, 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 patient's care.

Our review process facilitates a greater understanding of the individual cause of the Clostridium *difficile* cases to determine whether there were any lapses in the quality of care provided in order to take 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 Clostridium *Difficile* infection.

It should be noted a lapse in care is any area of care that has not met the required standard, even if not contributing to the incidence in the patient. It is recognised all lapses are an opportunity to learn from and positively influence the outcome for patients as a whole. Focus on learning from lapses in care are triangulated in the Trust Antimicrobial

Management Group and Divisional Infection Prevention and Control meetings and have focused on antimicrobial stewardship, hand hygiene, environmental hygiene and timely isolation of patients with symptoms of diarrhoea. Hospital onset Clostridium *Difficile* review is undertaken during our monthly meetings with the CCG leading to a health economy wide approach to learning.

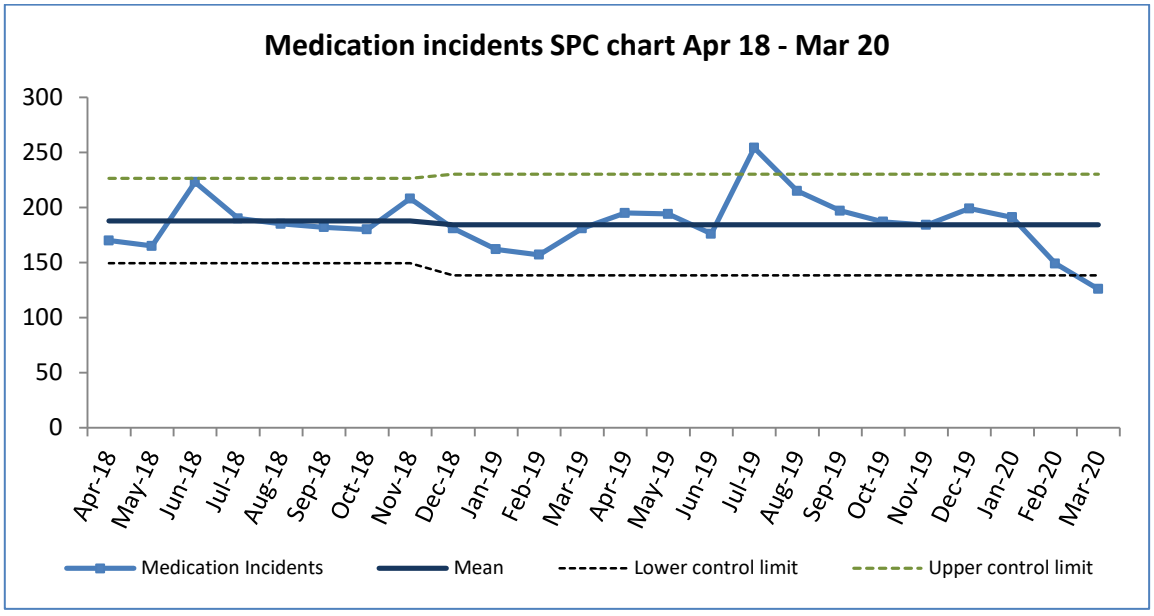
In response to the rise in Clostridium *Difficile* those ward areas of increased incidence were subject to additional deep cleans and an action plan produced to reduce the incidence. Additional scrutiny of these actions was invited and provided by NHS Improvement with conformation of appropriate actions in place being established.

Medication Safety

Medication errors have significant implications on patient safety. Error detection through an active management and effective reporting system (Datix) discloses medication errors and encourages safe practices. 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. A continued focus on improving the reporting culture has kept reporting the number of incidents within control limits. In March this year the number has dropped below the lower control limit which is evident in Figure 17 and is due to the impact of the Covid-19 pandemic. Our medications safety team are working to address this reduction in reporting.

The system we use to monitor incidents has been adapted and input fields optimised to facilitate more accurate data capture and trend analysis. Our monthly performance is reported to the Medicines Governance Committee and details low harm themes and trends and a detailed update of medication risks on the Risk Register.

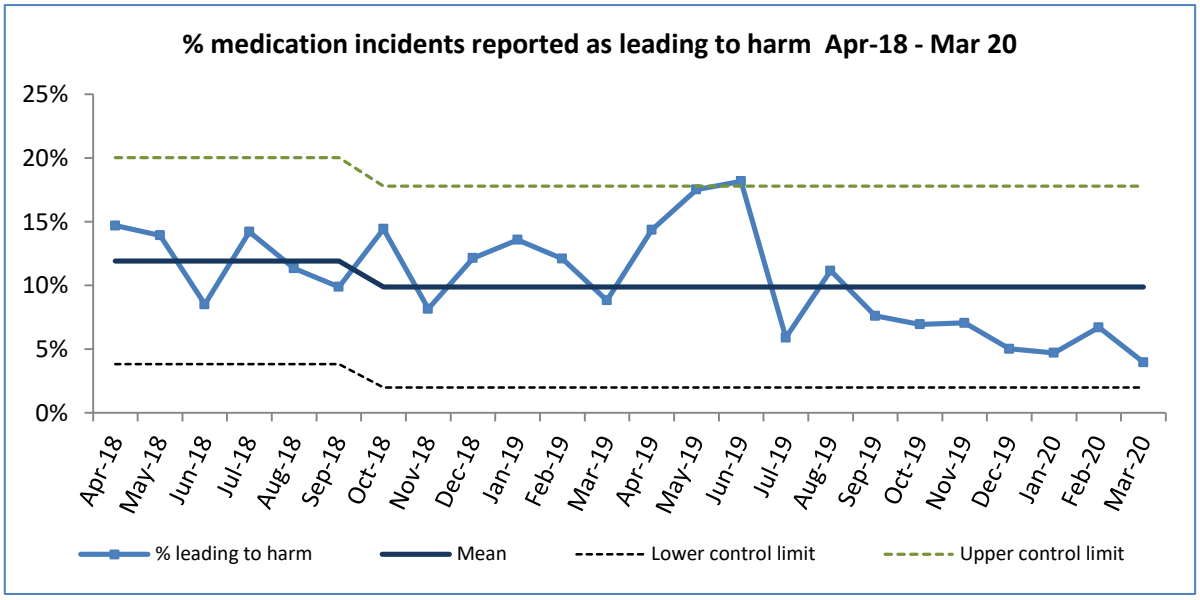
Figure 17 Medication Incidents Reported



Source: LTHTR data

Historically there have been approximately 20-25 medication harm events a month. In the last six months this has reduced to 10-15 a month, the majority of which are low harm incidents. 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 (MSO). Early impact interventions are identified and disseminated prior to the outcome of formal investigations. 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.

Figure 18 Medication Incidents Leading to Harm



Source: LTHTR data

We have a network of medication safety champions, supported by the Medications Safety Officer (MSO). Our champions are link nurses from each clinical area, that meet monthly on both sites to share learning from errors, implement change and act as an education forum. The medicines safety champions are responsible for disseminating education and monthly updates on medication safety with their ward teams. Our MSO is a member of our Learning to Improve Group and a Faculty member for the *Always Safety First* Collaborative, acting as lead for the Medication Safety work stream associated with this Breakthrough Series Collaborative to drive continual improvement in medications safety.

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.

Performance during 2019-20 shows some fluctuation. In the spring/summer of 2019 an Electronic Prescribing and Medicines Administration (EPMA) system was introduced to wards across Royal Preston Hospital. While there are many benefits including on medicines reconciliation embedding the system has had some challenges.

In the future we plan to capture the ability to monitor medicines reconciliation using the EPMA system to help direct resource and improve performance. A pharmacy service has been introduced to the Emergency Department (ED) including Non-Medical Prescriber (NMP) pharmacists that support GIRFT with respect to medicines.

Table 15 Percentage of Medicines Reconciled within 24 hours of Admission

	2015/16	2016/17	2017/18	2018/19	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4
Percentage of medicines reconciled within 24 hours of admission	66%	62%	73%	76%	78%	61%	73%	69%

Source: LTHTR data

Safe Storage of Medication

Quarterly audits of all inpatient areas are carried out by our pharmacy department and assured via the STAR accreditation scheme. Improvements in meeting the medicines storage standards have been demonstrated in 2019-20 and the escalation process is in place to ensure additional support is given. The audit has recently been extended to include clinic and department areas and compliance is currently at 92% across all areas this is a 4% improvement on 2018-19.

Antibiotic Prescription and Administration

There are a range of metrics used to demonstrate good antimicrobial stewardship to promote safety in the management of antibiotics which are:

- Documented Indication on the Prescription
- Compliance with guidelines
- Compliance with guidelines or recommended by microbiology
- Compliance with stop/review date on the prescription

We undertake quarterly antibiotic prescription and administration point prevalence audits and the results have remained >90% compliant with documented indication on the drug chart and antimicrobial choice compliant with guidelines or recommended by microbiology. The results are presented in Table 16 below.

Table 16 Antimicrobial Stewardship Point Prevalence Audit Results

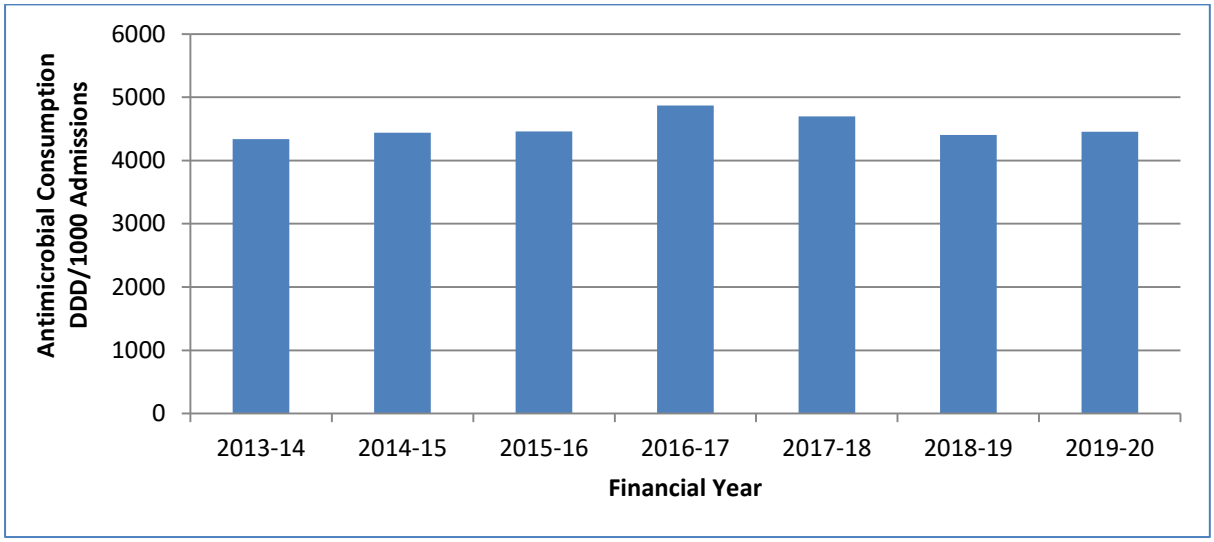
	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with stop/review date on Prescription
Trust Wide Q1 2019-20	93	93	95	89
Trust wide Q2 2019-20	93	87	90	85
Trust wide Q3 2019-20	91↓	90↑	92↑	83↓
Trust wide Q4 2019-20	95↑	89↓	91↓	60↓

Source: LTHTR data

Unfortunately there has been a decrease in compliance with stop/review date on the prescription chart in 2019-20. This is likely due to the roll out of Electronic Prescribing and Medicines Administration (EPMA) in the last quarter across the Preston site. In 2020-21 our pharmacy team will be working with prescribers and the EPMA system on how best to develop electronic prescribing to positively impact antimicrobial stewardship at the Trust without negatively impacting patient safety through prematurely stopping antimicrobials.

We have developed an antimicrobial whiteboard within the system to easily identify patients on antimicrobials and over 40 prescribing order sets linked to the antimicrobial guidelines. In 2020-21 we will aim to embed the use of these into prescribing practice and further develop reporting within the EPMA system in the shape of an antimicrobial dashboard.

Figure 19 Total Antimicrobial Consumption (DDD/1000 admissions) 2019-20



Source: LTHTR data

Antimicrobial consumption (i.e. the amount of antimicrobials used measured against the number of admissions) in 2019-20 we have seen a slight increase from 2018-19, although is still below that of previous financial years. We will continue to work with prescribers to promote judicious use of antimicrobials throughout the Trust and continue to monitor antimicrobial consumption as a way to measure the impact of this.

In 2020-21 we are participating in the antifungal stewardship CQUIN, to improve diagnostics and guidelines for invasive fungal infections. A baseline assessment has been performed of fungal diagnostics against the mycology society guidelines and produced guidelines for prophylaxis and treatment of fungal infections in haematology patients and treatment of invasive Candidaemia.

Safeguarding Adults

Safeguarding adult improvements which were required during 2019-20 have been delivered and we are now fully compliant with the CCG Section 11 Audit with the exception of adult safeguarding training level 3 not yet reaching 90%. The plan to be compliant by May 2020 is underway although the recent pandemic will inevitably have an impact on this plan.

There is evidence of a healthy reporting culture supported by robust training data in all other areas of safeguarding training. Adult Safeguarding activity data is presented in Appendix I Table 23 p.234.

The mental health, learning disability, autism and dementia team work alongside our Safeguarding team, Trust multidisciplinary teams and multi-agency partners to enhance the care of vulnerable patients (both adults and children) with a diagnosis of mental health, learning disability, autism or dementia.

Patients who have a diagnosis of mental health, learning disability, autism or dementia are admitted on a daily basis for both elective and non-elective admissions. Our specialist team aim to develop services within the Trust in response to needs, national guidance and policies and support the processes of safeguarding, mental capacity and acting in the best interest of the patient.

A significant amount of patient involvement activity contributing towards improving the experiences of patients in these groups has occurred during 2019-20 which has included:

- Introducing a Learning Disability Hospital Passport and Hospital Communication book.
- Development of Easy Read Information and leaflets.
- The development of a Reasonable Adjustment flag on Electronic Patient Records to identify patients more easily.
- Developing an increased network of Dementia Champions within the organisation.
- Working with the Patient Advice and Liaison Service (PALS) and the outpatient departments to ensure all appointment letters have the option for patients and families to contact the hospital and highlight the need for fast-tracking and reasonable adjustments due to a diagnosis of dementia.
- Working on the development of a Special Educational Needs and Disabilities (SEND) folder within Electronic Patient Records to ensure all SEND information and Education, Health and Care Plans (EHCP's) are available.

Safeguarding and promoting the health and welfare of patients is central to providing our mission to deliver '*Excellent care with compassion'*. We promote collaborative working between professionals and agencies to protect or prevent vulnerable people from harm, neglect or risk of harm and have regard to their views, wishes, feelings and beliefs in deciding any action.

Safeguarding Children

Our Children Safeguarding Team are available across the paediatric, neonatal, maternity wards and emergency department on a daily basis and operate a 9.00am to 5.00pm telephone duty system, where one of the safeguarding practitioners is available to support staff with safeguarding children and receive approximately 150-250 enquires per month. We make between 20-30 referrals to Children's Social Care each month and 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 has introduced a new child safeguarding risk assessment for all children who attend the Emergency Department or the Paediatric Assessment Unit. The risk assessment is completed by the nurse at triage to help identify any safeguarding concerns and appropriate actions to take. We are one of the first initial sites to introduce the Child Protection Information Sharing system (CP-IS) and have recently supported NHS England in moving towards the second stage of identifying pregnant mothers whose unborn who may be subject to a Child Protection plan.

Following lessons learnt from local and national Child Safeguarding Practice Reviews (CSPR) and child deaths, we have recently been focusing on promoting Safer Sleep. This work has included raising awareness during national patient safety week with staff on the Paediatric Ward coming into work in their pyjamas and through a planned training event in April 2020 by the Lullaby Trust. This work will help to ensure that we embed lessons following serious incidents by increasing staff knowledge and confidence in providing parents with Safer Sleep advice particularly for staff within Paediatrics, Neonates and Maternity.

Child safeguarding training compliance has remained above 95% for level two and 91% for level three since April 2019. The training packages have recently been updated following the publication of the new Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (4th Edition) (2019).

Our Child Safeguarding team have been involved in two Child Safeguarding Practice Reviews for the central area in 2019-20, which are awaiting publication however the initial learning has resulted in the following actions:

- Raising awareness of the 'Think Family' approach regarding the importance of assessing the impact of parental presentation on children particularly within the family home for Midwifery services and the Emergency Department.
- The development of a risk assessment to be completed on Emergency Department triage with specific questions around caring responsibilities.
- Improvements have also been made to the training packages which now include how to complete domestic abuse risk assessment and the need to do this at the time of domestic abuse disclosures.
- We are also implementing resources to help families cope with crying babies and the importance of never shaking babies following the national increase in babies receiving traumatic head injuries.

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.

Maternity Birth Centre

Following the closure of the former birth centre building at Chorley and South Ribble Hospital in March 2019 due to the presence of asbestos, it was necessary to relocate all affected services and staff to alternative locations on the Chorley and Preston hospital sites. This affected the Chorley Birthing Centre in particular but also included antenatal services, gynaecology clinics and diagnostic services such as ultrasound, hysteroscopy and colposcopy.

In October 2019 we received confirmation that a Department of Health bid to re-provide a free standing Birthing Centre at Chorley and South Ribble Hospital had been formally approved. The work is now in progress to reinstate the birthing services at a location within the Chorley site that was previously used by Busy Bees Nursery. The new Chorley Birth Centre will provide a freestanding birthing option for families and supplement the Preston Birthing Centre. Up to 500 women per year will be able to use this facility for their birthing experience and additional midwifery community based clinics will also be offered from the centre.

This will enable all birthing options to be offered to all families again in 2020 and ensure we remain aligned to the strategic aim to be 'Fit for the Future'. We anticipate the new Birthing Centre will open at the end of October 2020.

Figure 20 Repurposing Busy Bees for the new Chorley Birth Centre

Source: LTHTR

It was anticipated that the new Birthing Centre would be completed by September 2020. Unfortunately, the Chorley Birth Centre completion has been delayed until end of October due to the Covid- 19 pandemic. However we are still taking bookings for the new Birthing Centre and have formed a continuity of carer Chorley Birth Centre Team to support the families throughout their pregnancy journey.

During this interim period we continue to deliver the best possible care for our patients using the existing Preston Birth Centre facilities and continue to work with our Maternity Voice Partnership and staff groups to co-design the birthing environment in order to optimise the birthing experience for all families who will use our new service.

Maternity Safety and Quality

We monitor key safety and quality performance indicators for birth settings which are presented in Table 22 located in Appendix I p.234. This demonstrates that there has been a sustained improvement in the one to one care in labour rates in both the midwifery led and consultant led birth setting over the past year. We have achieved this through the reconfiguration of the support worker establishment to provide additional support within the intrapartum areas.

The incidence of women choosing to give birth in our midwifery led birth settings has improved since February 2020 and is likely to improve further now bookings have commenced for September 2020 births, which are due to take place in the new Birthing Centre. A sustained improvement has also been noted over the past year in the midwife to birth ratio which is a national calculation used to provide assurance of safe staffing levels.

Incidents and Never Events

Incidents

Our incident data has been presented in Part 2 of this report with a rationale for the data and actions taken/planned. The levels of harm from incidents in 2019-20 are presented below.

Table 17 Level of Harm Related to Incidents

Level of Harm	Number of Incidents
No Harm	18,459
Low Harm	6,682
Moderate Harm	1,094
Severe Harm	129
Death	9
Total	**26,373**

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 2019-20 we reported three Never Events in the following categories:

- Retained foreign object – one
- Wrong site surgery – two (one case occurred in 2018-19 period but the incident was identified and subsequently reported 2019-20 period)

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 and Learning System (NRLS). Learning from both systems is shared nationally.

A forensic panel review of Never Events was undertaken in July 2019. The Never Events were analysed retrospectively by a panel which included the Deputy Medical Director, Deputy Nursing, Midwifery and AHP Director and Consultants independent of the cases. The findings resulted in the development of a Procedural Patient Safety Framework which focusses on a 'Learning to Improve' culture aiming to embed sustained change and gain assurance of this. 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. Going forward the Never Events will be added to the 'Learning to Improve' programme to ensure that actions and learning are embedded over time. Of the three never events in this reporting period 2019-20, 2 investigations have been completed and one remains ongoing.

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).

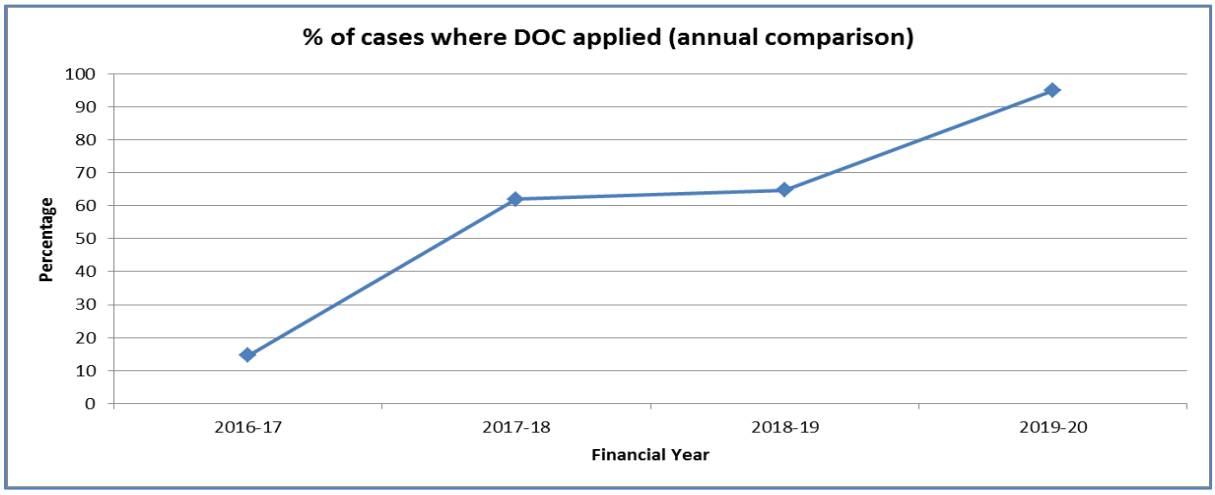
The investigation of incidents where actual or potential for harm has occurred, is carried out within a culture of openness and transparency with an absolute commitment to explaining and apologising to patients who have suffered harm. This is a key aspect of us delivering excellent care with compassion.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

The CQC highlighted during their inspection in 2018 and 2019 that Duty of Candour was not always addressed in a timely way and consequently we have taken action to promote early identification of the need to apply Duty of Candour. In the year 2019-20 we identified 366 cases where Duty of Candour was applicable. Of those 366 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 348 occasions (95%). The remaining 18 cases (5%) 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 it too acutely unwell to receive the letter but will be delivered once the condition improves
- Patient or appropriate person is untraceable

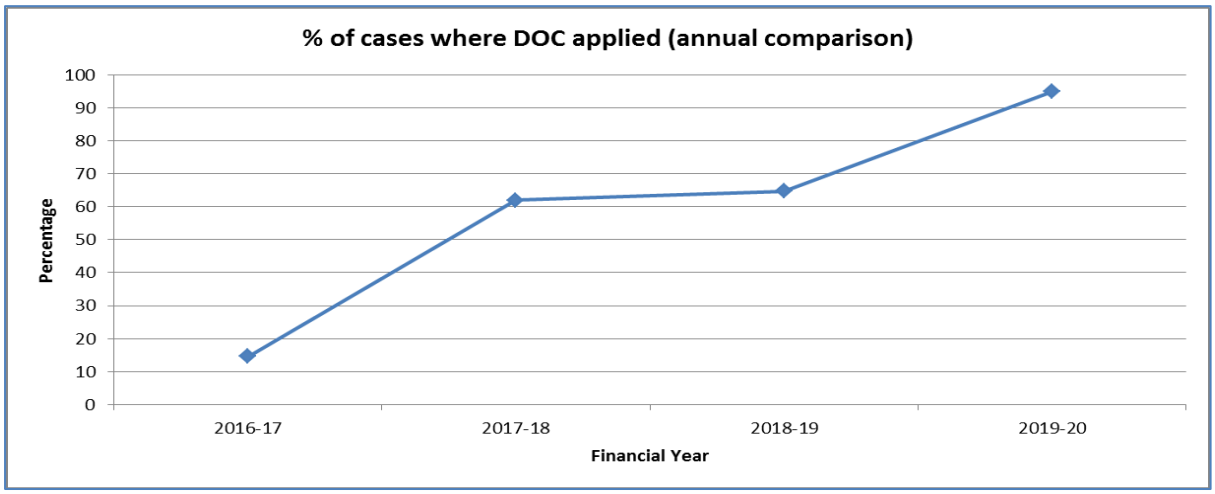
Figure 21 Percentage of Cases with DOC Applied (Annual Comparison)



Source: LTHTR Datix data

Of the 348 occasions where Duty of Candour has been undertaken, 297 cases (85.3%) were achieved either verbally or in writing within ten working days of the incident being reported. This is a significant improvement compared to 2018-19 where only 64.8% of cases had Duty of Candour carried out within ten working days of the incident being reported.

Figure 22 Percentage of Cases with DOC Applied in ten Working Days



Source: LTHTR Datix data

Figure 22 demonstrates a strong trend of improvement over the last four 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.

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. We also learn from the deaths of patients and change practice where required. These aspects of effective care are presented together with additional markers such as tissue viability and nutrition.

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.

We have employed a Trust Lead Manager for GIRFT who oversees all the visits and subsequent implementation plans. Since this role commenced in May 2019 a new process has been rolled out to ensure that there is maximum attendance at the specialty deep dive visits and rolling three monthly review meetings following visits to ensure that the actions within the implementation plans are reviewed and updated accordingly.

To date there have been 22 deep dive visits with a further three scheduled in 2020. A revisit also took place in February 2020 for Cranial Neurosurgery, for which the report is awaited.

The GIRFT programme enables the organisation to benchmark with other similar hospital services and share the learning. Our GIRFT Lead has linked in with the Continuous Improvement and Finance teams to ensure that this programme is also aligned with all of our strategies to ensure the Trust continues to provide efficient and cost effective care and treatment.

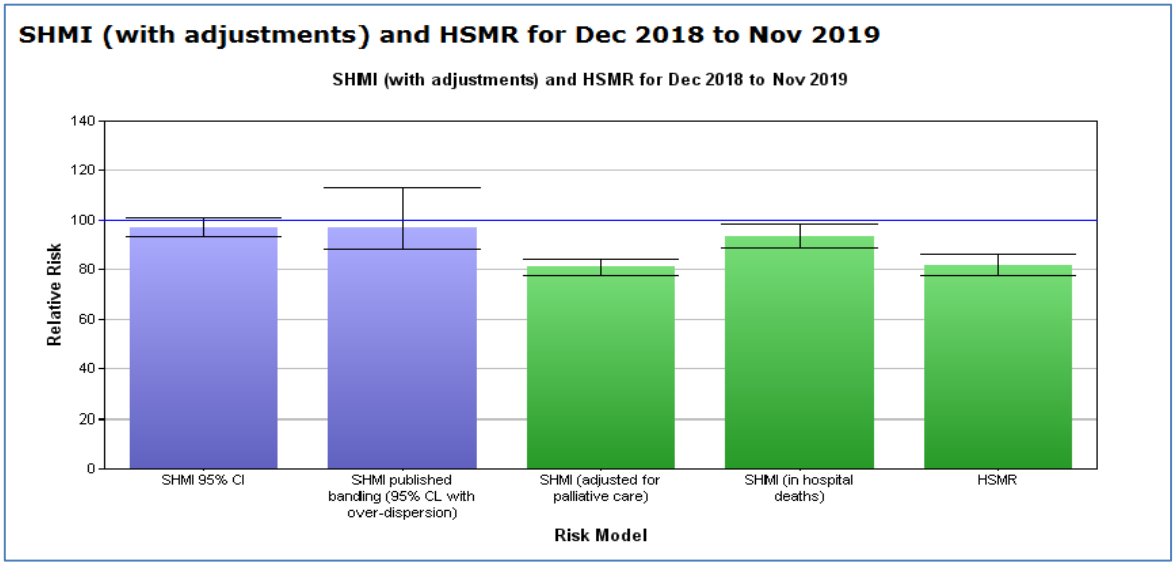
Mortality Monitoring

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 relate to both the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR).

The SHMI measures mortality in patients who die in hospital or 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 for the most current period available being the 12 months of December 2018 to November 2019 is 97.02 and remains within expected range as was the case during the previous reporting period 2018-19. When the SHMI is adjusted for palliative care it is 80.93 which is lower than expected and as such an improved performance for 2019-20.

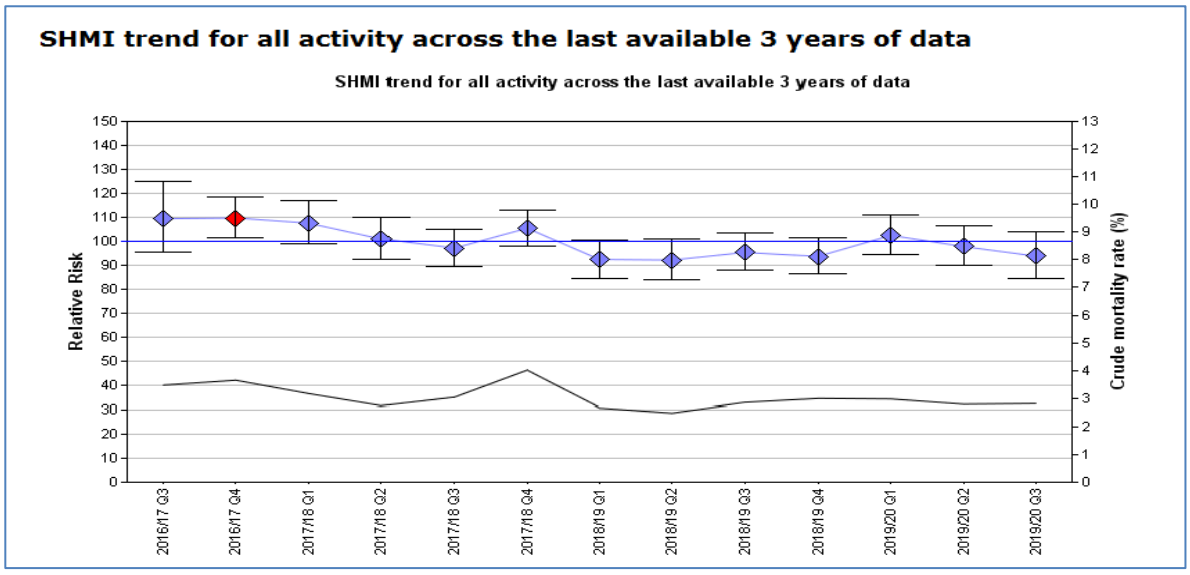
Figure 23 Summary Hospital Mortality Indicator (SHMI) Dec 18 – Nov 19



Source: Dr Foster Intelligence

The SHMI trend for the last three years is presented below which demonstrates the rate being continually within expected range.

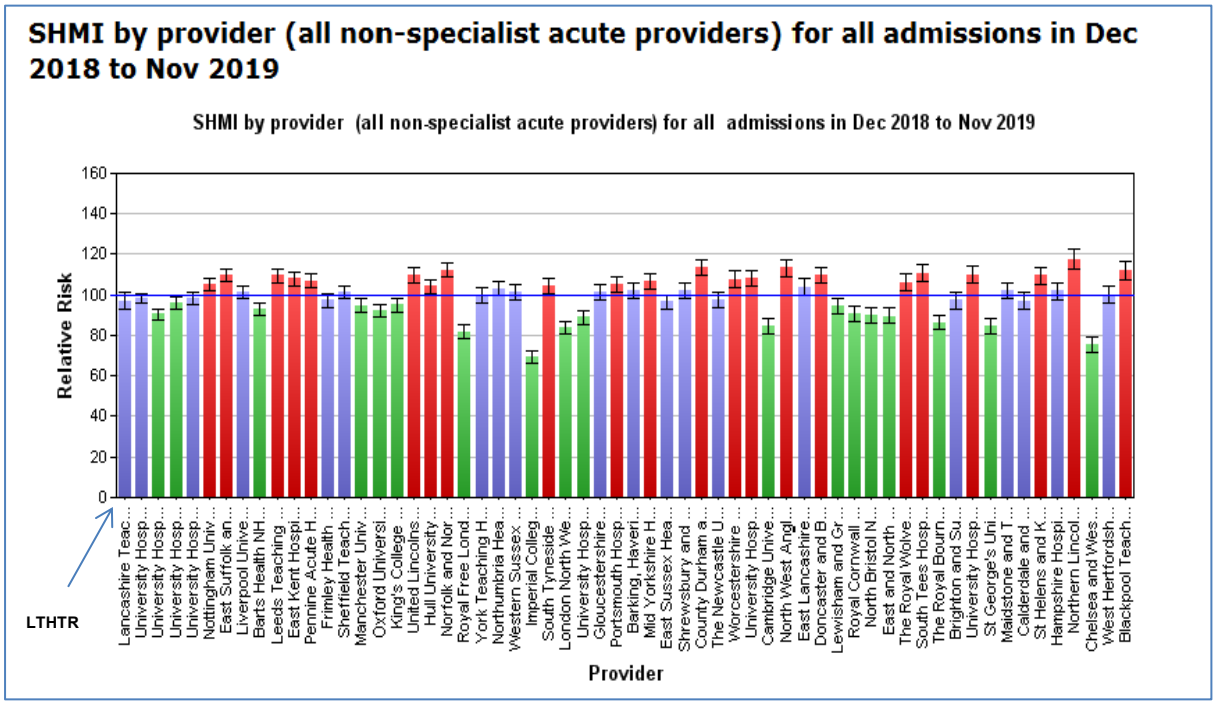
Figure 24 Summary Hospital Mortality Indicator 3 Year Trend



Source: Dr Foster Intelligence

We can compare our SHMI with national peers and this is presented in Figure 25 below: our organisation is shown first 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 25 Summary Hospital Mortality Indicator Peer Comparison



Source: Dr Foster Intelligence

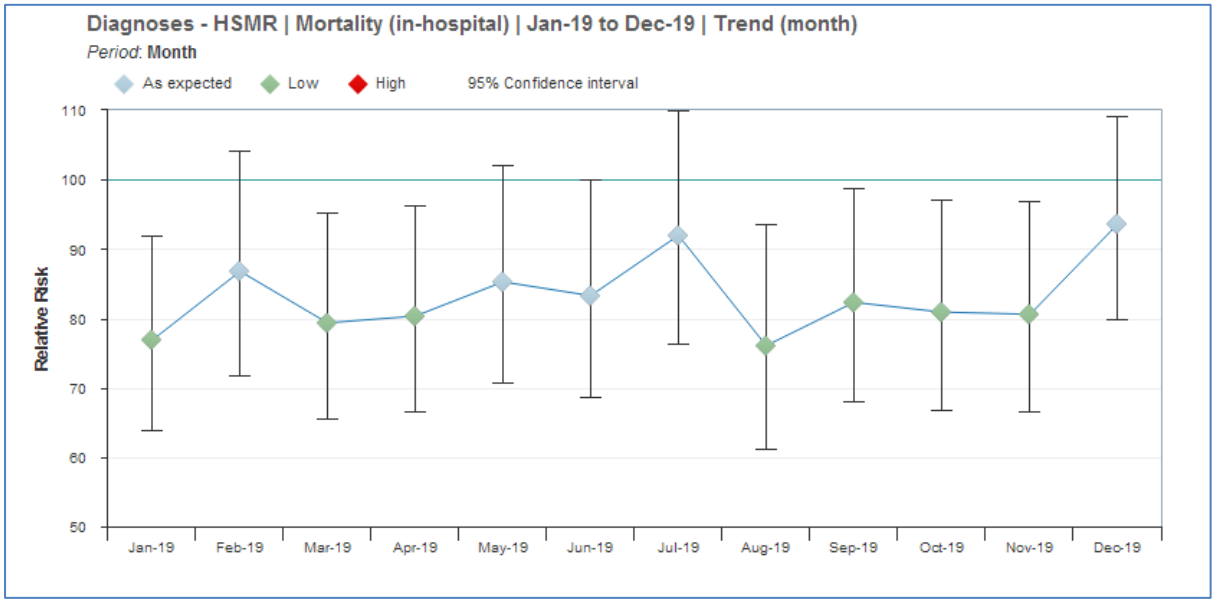
In addition we monitor mortality rates using the Hospital Standardised Mortality Rate (HSMR) which is derived from data based on 56 diagnostic groups that account for 80% of all hospital deaths.

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 most current 12-month HSMR data relates to the period January to December 2019 and our HSMR is 83.2 which remains lower than expected and remains stable in relation to the HSMR of 83.8 in the previous reporting period 2018-19. Our HSMR for the month of December 2019 is 93.6 which is within expected range and could be a reflection of seasonal rises in mortality.

The figure below demonstrates the continued HSMR trend of mortality being either ‘within expected’ or ‘lower than expected’ range.

Figure 26 Hospital Standardised Mortality Rate Jan 2019 – Dec 2019



Source: Dr Foster Intelligence

Although our overall mortality remains within expected range there have been intermittent early warning alerts (Negative CUSUM alerts) in relation to intracranial injury during 2017-18 which has been investigated and reported in the previous reporting period 2018-19. The investigation suggested that this was as a result of the case mix of major trauma and specialist neurosurgery high risk patients and not as a result of care and treatment issues and there was no cause for concern.

In the current reporting period we have had an alert for Chronic Renal Failure (CRF) which has been investigated and the outcome again demonstrated that the care and treatment was not a cause for concern. The issue related to the classification of elective admissions because the group of patients had been admitted for urgent care from an outpatient appointment and recorded as elective rather than an emergency admission. The admission classification impacts on the way data is adjusted and triggered the alert. The issue is being resolved to address the alert.

We continually monitor both the SHMI and HSMR and where alerts are raised they will continue to be highlighted with the relevant clinical teams for a Structured Judgement Review (SJR) of case notes. Relevant action would be taken where appropriate and learning from the deaths shared at a local level at Morbidity and Mortality meetings.

Medical Examiner Function

The Medical Examiner (ME) system is being 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 are 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) will be supported by Medical Examiner Officers (MEOs) who will have the clinical knowledge, skills and experience.

The Medical Examiner role is to:

- 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 in the specialities with a minimum of 20% of cases in each speciality per year. Specialties which undertake 100% Mortality Reviews e.g. Critical Care, ED, Neonatal and Child deaths will continue as previously.
- Escalate cases which require a Rapid or Serious Incident Review.
- Liaise with the Mental and Learning Disabilities team when a death occurs in a patient with either serious Mental Health or Learning Disabilities. These cases will be subject to an internal Primary Review and the latter feed into the national Learning Disabilities Mortality Review (LeDeR) programme for a multiservice review.

The Medical Examiner service will also support early detection of any clinical governance issues through this additional layer of scrutiny into the review of deaths and in the longer term the national ambition is that the service will be a statutory and independent function. A lead Medical Examiner was appointed for NHS England Northwest in September 2019 who is also our Lead Medical Examiner appointed in October 2019. Additional Medical Examiners have been appointed who are in post and will increase the number of reviews and learning from deaths in 2020-21.

Tissue Viability – Pressure Ulcer Incidence

Pressure ulcer incidence is an indicator of safety and quality and has been one of the four indicators measured within the NHS Safety Thermometer. Reducing pressure ulcers has been and continues to be a priority for improvement in the care of our patients.

We have an established programme focussing on prevention and management of pressure ulceration, which includes:

- Robust early risk assessment and identification of pressure ulcers on admission to hospital, this can often indicate further support for the patient may be required in the community.
- Availability of high specification equipment to support patients during acute illness, this includes appropriate trolleys in the Emergency Department, airflow mattresses, electronic bed frames and protection aids.
- We have implemented the use of *SEM* scanners in a number of clinical areas which are a hand-held, portable, skin tissue assessment device that detects early, pressure-induced tissue, allowing preventative strategies to be put in place.
- Registered Nurse staffing levels have a direct impact on the incidence of pressure ulcers, so we undertakes monthly staffing reports to identify early red flags in areas where additional support may be required to prevent harm occurring to our patients.
- Our specialist Tissue Viability team work with staff in all areas to educate, respond to and support patients who are at risk of developing pressure ulcers.
- We have been working collaboratively with community colleagues enacting the 'react to red' campaign in hospital and the community setting.

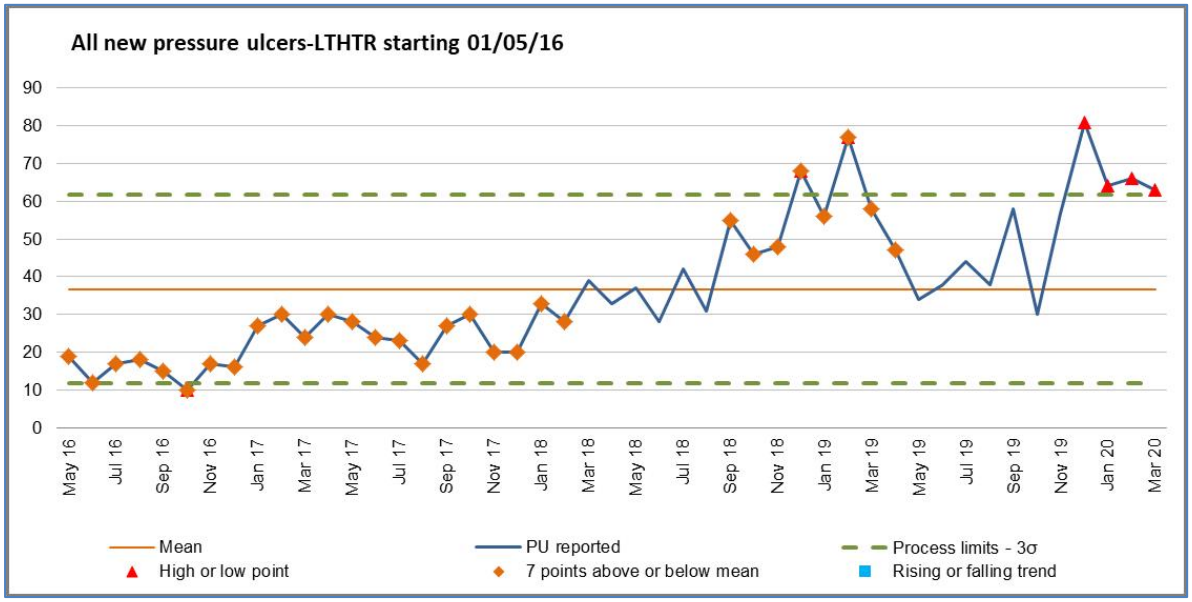
Since September 2018, an increase in hospital acquired pressure ulcers occurred due to variable factors. There was a reduction in the numbers of new pressure ulcers during the summer months, demonstrated in the Statistical Process Control (SPC) Chart on the next page but this has not been sustained.

In order to review our current pressure ulcer prevention practice and develop actions for improvement, a pressure ulcer prevention collaborative involving ward areas with the highest rates of new pressure ulcers has been planned as part of our *Always Safety First* agenda.

The programme is focused on standardising practice, measuring performance of critical interventions and learning lessons from areas where lapses in care occur. A review of the risk assessment process and how this informs pressure ulcer prevention interventions for patients is currently in progress.

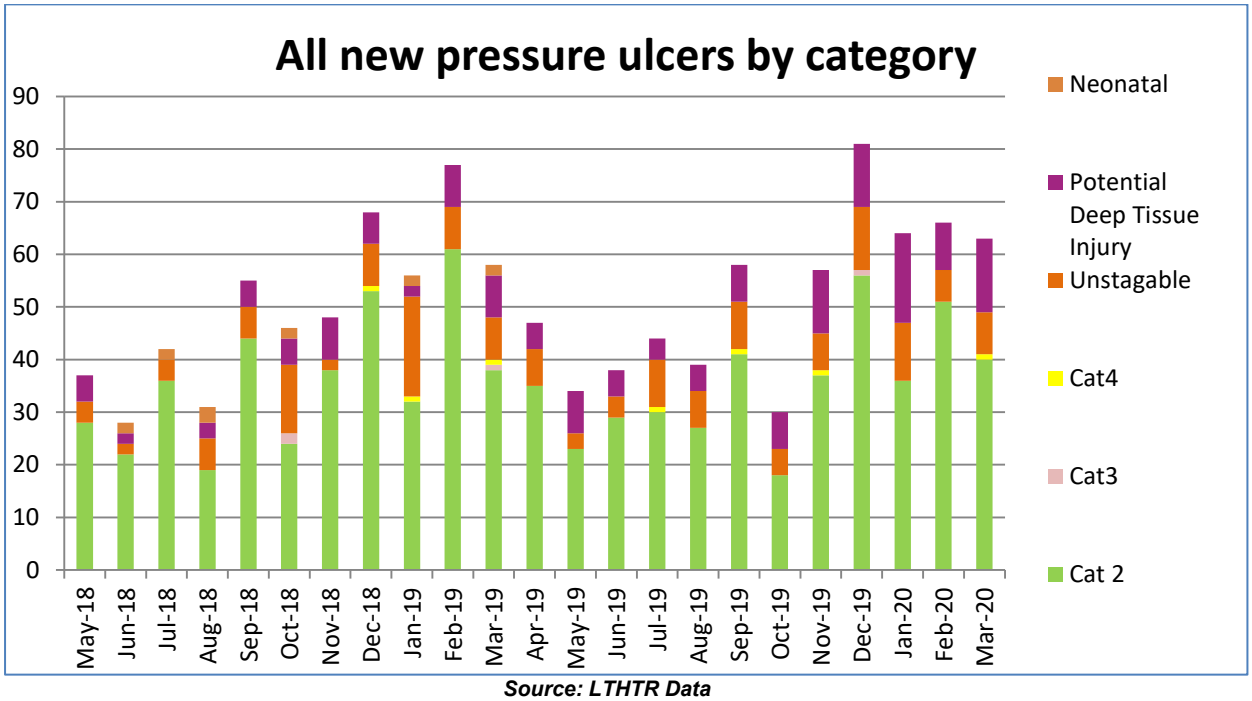
The SPC chart and bar chart below in Figures 27 and 28, present the numbers of individuals developing a new pressure ulcer and the category of harm.

Figure 27 Incidence of Pressure Ulcers – SPC Chart



Source: LTHTR Data

Figure 28 Pressure Ulcers by Category – Bar Chart



Source: LTHTR Data

We acknowledge that there has been an increase in the overall number of patients with pressure ulcers which has also occurred due to a number of reasons which includes but not limited to the complexity and frailty of patients and the increase in the number of patients admitted to hospital.

Nutrition

The provision of high quality nutritional support is complemented by our seven day Integrated Nutrition and Communication Service (INCS) who have lead 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.

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 have introduced instrumental bedside swallowing assessments using fibreoptic endoscopes, speeding up decision-making and provision of appropriate nutrition. They have also increased follow up of patients at 28 days post discharge, developed a neonatal speech therapy team and also advise on feeding.

Across both hospital sites all wards continue

- To receive a 'snack tray' that offers a range of snacks to encourage patients to eat and increase their nutritional intake. This is in addition to the snacks available on the hospital menu.
- Catering services also support the wards offering monthly 'tea parties' with the provision of home-made cakes.
- Catering services are supported by the dietetics team in nutritional analysis of patient recipes to encourage a comprehensive balanced diet with increased choice of some items.
- The catering department also offer provision of adaptive cutlery to support patient feeding where required.

We are fully compliant with legislation relating to allergens and our catering services provide support with allergen information, should that be requested, by either the patient or the ward staff.

Our Speech and Language Therapy department continue to comply with international dysphagia descriptors and with national standards relating to soft, pureed and liquidized diets.

During 2019-20 the services key priorities were to:

- Ensure documentation relating to 'MUST' assessment and discharge information was standardised.
  One audit has already been completed and refinements made to the Electronic Prescribing Medicines Administration (EPMA), and another audit will be undertaken to review its impact.
- Review compliance with the international dysphagia framework.
  This is currently being reviewed.
- Review 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.
- Roll out the NGT e-competencies to beyond critical care.
  This new system has been tested in critical care, is being reviewed and then will be rolled out to the rest of the organisation.
- Work with the *Learning to Improve* Group to continue to refine opportunities for NGT safety.
  This is a monthly meeting where opportunities to improve NGT safety are identified. Their recommendations are then taken to the divisional team to consult with, and this is currently in its first phase of this process.
- Working with EPMA, refine the documentation of NGT management.
  The testing of NGTs and documentation of Chest X-rays has highlighted some areas which can be improved and we are currently re-testing some of these.
- Establish a pilot difficult feeding service for over two years.
  This is currently being scoped with Speech Language Therapy (SLT), the Women's and Children's Division and the CCG commissioners. Its intention is to implement a pilot to be reviewed after 12 months.

Review of Quality Performance – Experience of Care

Improving patient experience is always a 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 influences how we provide our services and gives us opportunities to reflect on our practice to ensure developments are consistent and appropriate to meet the needs of our service users and carers.

Over the past year we have increased our involvement and engagement with patients, carers and external organisations to continue to develop our commitment to improve patient experience. Our *Patient Experience and Involvement Strategy 2018-2021* has provided a clear focus on what matters most to our community and we have continued to meet with key stakeholders, patients, carers and local organisations to ensure that the strategy is realised from the initial consultations.

The strategy 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

Implementation and governance of the strategy is monitored through our Patient Experience and Improvement Group and through our Safety and Quality Committee where complaints and feedback are discussed.

Our Patient Experience Improvement 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:

- Friends and Family Test Feedback
- Complaints and concerns intelligence
- NHS Choices
- National Patient Surveys
- Patient Stories
- Patient and Public Involvement

During 2019-20 we participated in several national Patient Surveys including:

- Maternity Survey
- National Inpatient Survey
- Emergency Department Survey
- Children and Young People's Survey
- Cancer Survey

National Maternity Survey

Our Maternity services have received positive feedback in an annual, national survey for 2019; demonstrating continuous improvements from the previous survey.

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 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 last national Picker survey in 2018. We are now ranked 10 out of 63 Trusts nationally compared to 12 out of 68 Trusts surveyed in 2018.

Our maternity services ranked significantly better than the last 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 are very pleased to be ranked within the top 10 of the Picker surveyed organisations. The focus on working with partners through the Maternity Voices Partnership and increase in Midwives is translating into improved experiences for women.

National Adult Inpatient Survey

The National Picker Inpatient Survey 2018 provides 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. Our results for the 2018 survey were published after the publication of the Quality Account for 2018-19 and are consequently presented in this year's report. Patient comments from survey about the Trust as a whole 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%

The National Adult Inpatient Survey for 2019 has been undertaken however the results are under embargo until the CQC give notice for publication. The survey will provide information about:

- Accident and Emergency all types of admission
- The hospital and ward
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Overall view of the hospital

Urgent and Emergency Care Survey

The Urgent and Emergency Care Survey provides analysis of the experiences of care provided in a Type 1 Emergency Department from September 2018. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 department. It considers arrival, waiting, doctors and nurses, care and treatment, tests, pain, hospital environment and facilities, leaving A&E and overall experience. The survey is 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 can be compared historically to questions in 2016. Compared to the 2016 survey, we achieved a positive score change of eight points and ranked 47 out of the 69 Trusts surveyed, compared to 57 out of 75 Trusts in 2016:

- 80% rated care as 7/10 or more
- 97% treated with respect and dignity
- 97% doctors and nurses listed 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 are demonstrating some improvement within Urgent and Emergency Care, however we acknowledge that the experience of patients is significantly affected by the waiting time and the environment the care is delivered in. Several improvements have taken place to positively influence patient experience in this area. These include; environmental improvements through significant capital improvements and expansion of the ED, increase in nurse staffing and priority focus on flow pathways throughout the hospital aiming to reduce the time patients spend in the ED. The latter is not yet having the desired impact, however work continues in this area.

Children and Young People's Survey

The Children and Young People's Survey 2018 report provides analysis of the experiences from July 2018. The previous Children and Young People's survey was undertaken in 2016. The survey is comprised of three age-appropriate versions:

- Parent Version A – for parents/carers of inpatients and day case patients aged 0-7 years
- Child Version B – for young inpatients and day case patients aged 8-11 years and their parents/carers
- Young Person Version C – for young inpatients and day case patients aged 12-15 years and their parents/carers

A total of 255 questionnaires were completed which is 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 are ranked 58 out of the 66 Trusts surveyed, compared to 65 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 the children's survey. This is a significant area of focus. Enhanced leadership across the Multidisciplinary team, training, feedback and the development of a new Women's and Children's division aims to deliver significant improvements in this area

Cancer Patient Experience Survey

The Cancer Patient Experience Survey (2018) was published in September 2019 and provides analysis of the experiences of care provided for adults aged 16 or over with a confirmed diagnosis of cancer. The survey included patients discharged from a NHS Trust after an inpatient episode or day case attendance for cancer related treatment, in the months of April, May and June 2018. The survey is carried out annually with the previous Cancer Patient Experience Survey undertaken in 2017.

A total of 1400 patients were sent a questionnaire of which 853 returned a completed questionnaire, giving a response rate of 65%, an increase of 1% from the 2017 survey. The average national response rate for the survey in 2018 was 64%.

A total of 52 questions were used in the 2018 survey, of these 49 can be compared historically to questions in 2017. Compared to the 2017 survey rating 8.8, we had an increased score of 0.1 in the average rating provided by respondents when asked to rate their care, with an overall score of 8.9:

- 88% rated overall care as very good/good
- 87% rated overall always treated with respect and dignity by staff

When comparing the average results received across all other hospitals; we ranked best in the following areas:

- Patient told they could bring a family member when first told they had cancer – 88%
- Patient definitely given enough support from health or social services during treatment – 60%
- Patient given a care plan – 40%

The Trust continues to perform well compared to peers in Cancer patient experience. This survey was undertaken by Quality Health on behalf of NHS England, next year the survey will be carried out by Picker.

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a national key indicator of patient experience to gather information at the point of or after discharge. This helps 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. During the period 2019-20 feedback has been received from the following 5 key areas:

- Inpatients
- Outpatients
- Day case treatment
- Emergency department
- Maternity services

We have implemented a process to gather information from Children and Young People's services, with the addition of Neonatal services in May 2019. Throughout 2019-20 we have continued to work with other departments across the organisation to make the FFT test more accessible, with a view to all areas using the FFT feedback. This has been successful and will continue to be rolled out within outpatient areas through working with staff and developing questionnaires to gather the FFT test results and feedback, as well as tailored information that is specific to services.

Our wards and departments have engaged with the process across Chorley and Preston hospitals and the FFT monthly results are visible for staff, patients and visitors, along with 'You Said, We Did' information based on the feedback provided. The FFT is part of our STAR accreditation framework and this has helped to raise staff awareness and understanding of how the FFT can support our patients, families and carers.

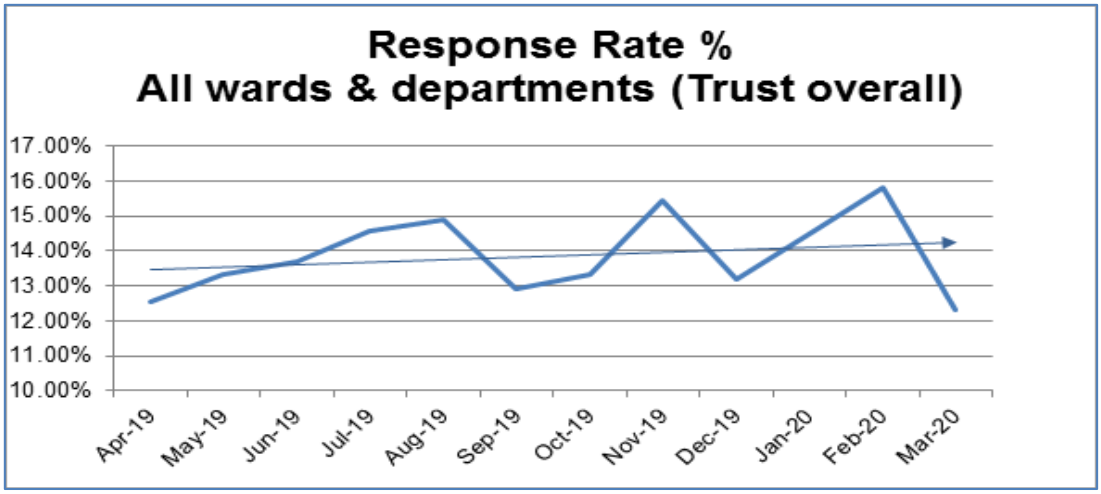
Throughout 2019-20 we have seen an increase in the overall response rate across the organisation. Some areas of concern have been highlighted as a result of using Short Message Service (SMS) text service. This continues to be the largest feedback source along with paper surveys and Instant Voicemail Messaging. As we continue to develop technology in other areas throughout the Trust our data collection and reporting will become more efficient.

We monitor FFT performance on a monthly basis and this is reported to the Safety and Quality Committee. The reports have been adapted to ensure an accurate reflection and analysis of the feedback is recorded and reported. A more in-depth quarterly report is also provided.

From April 2020 the FFT question will change nationally in line with NHS England guidelines. This will provide patients, families and carers with a better understanding of the FFT and allow them the opportunity to provide meaningful feedback on the services they have received. This change will provide organisations with the opportunity to provide more accurate reporting and understand what matters most to patients.

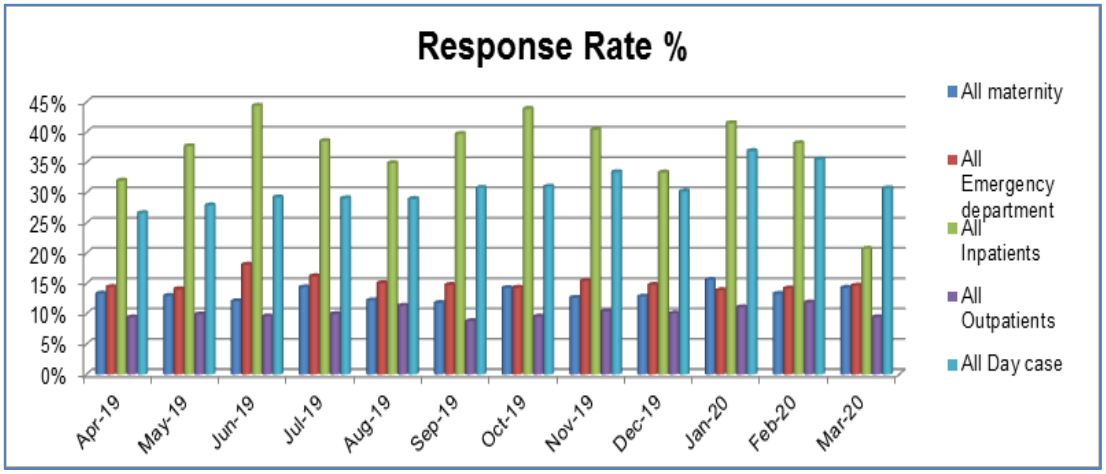
The overall response rate is on an upward trajectory as shown in Figure 29 below and response rates by area are presented in Figure 30 with the Children and Young Peoples FFT in Figure 31.

Figure 29 FFT Overall Trust Response Rate



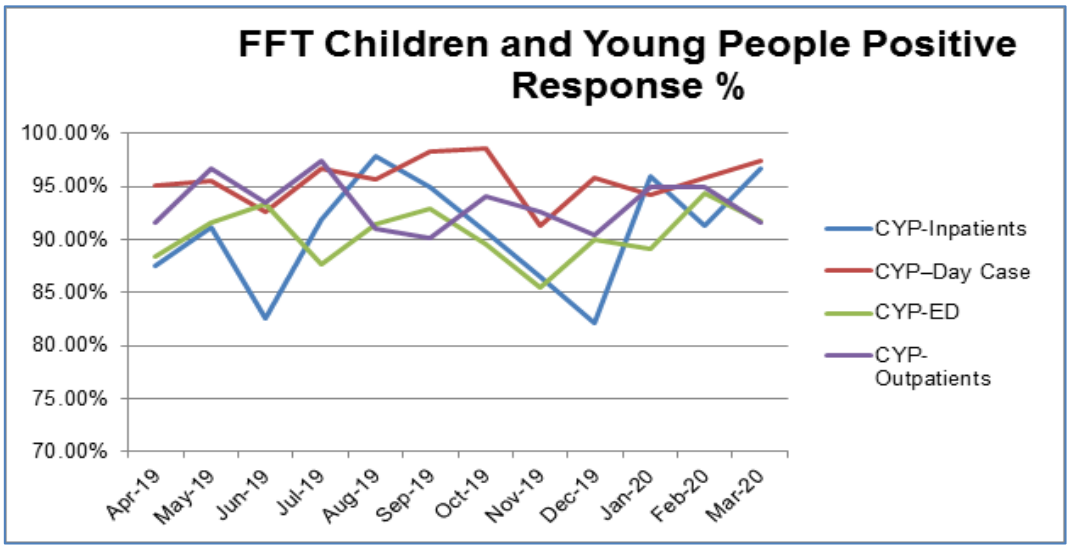
Source: LTHTR data

Figure 30 FFT Response Rate by Area



Source: LTHTR data

Figure 31 FFT Children and Young People Response Rate



Source: LTHTR data

Staff Survey

Improving staff experience continues to be a high priority for us particularly as the evidence base indicates an association with positive staff experience resulting in improved patient outcomes and other indicators of organisational performance. We continue to operate in an environment of national staff shortages across a range of roles and creating a great place to work is vital to support our ability to be able to attract and retain staff.

The staff 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 zero to ten, with zero being the lowest and ten being the highest) and this remains the same from 2018.

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. Both measures have deteriorated and remain below national average as presented in Table 18 below. This is despite other aspects of staff experience either remaining stable or improving.

Table 18 NHS Staff Survey – Recommendation of the Trust

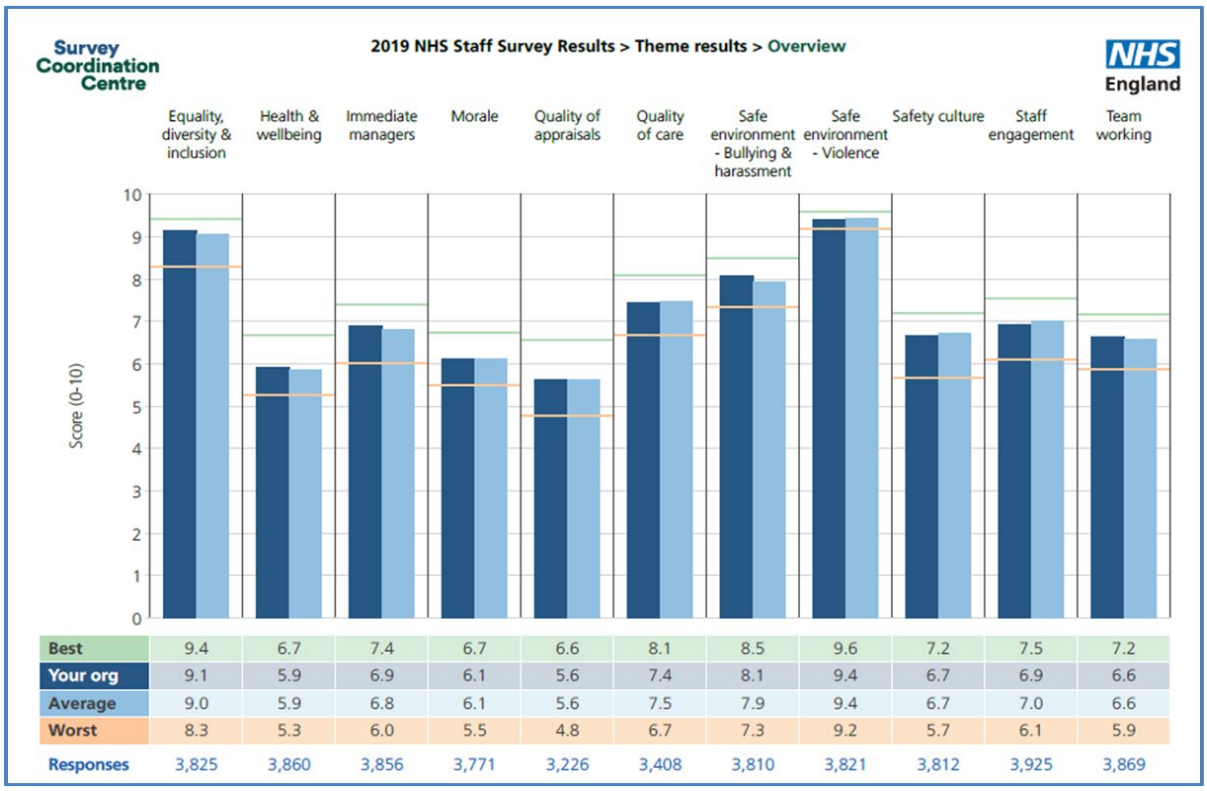
	LTHTR 2017	LTHTR 2018	LTHTR 2019	Movement from 2018	National average 2019	Comparison to national average
I would recommend my organisation as a place to work	60%	59%	**57%**	↓	63%	↓
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	66%	65%	**63%**	↓	71%	↓

Source – National Staff Survey

We were aiming to explore these results further through Big Conversation focus groups during March 2020 which commenced but were then postponed due to the Covid-19 pandemic. A recent analysis of qualitative comments associated with these questions in the quarterly Staff Friends and Family Test and analysis of other staff feedback channels have identified that factors such as work environment, car parking, catering facilities and system factors like demands on our healthcare services are driving staff dissatisfaction. We have an action plan developed to address these issues.

Figure 32 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 ten, with zero being the lowest and ten being the highest.

Figure 32 NHS Staff Survey Results Bar Graph



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.1	5.9	6.9	6.1	5.6	7.4	8.1	9.4	6.7	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	3,825	3,860	3,856	3,771	3,226	3,408	3,810	3,821	3,812	3,925	3,869

Source – National Staff Survey

Our organisational performance benchmarks closely to the national average for acute Trusts. Equality, Diversity and Inclusion and Safe Environment – Violence, are the areas scoring the highest and Quality of Appraisals and Health and Wellbeing are where we score the lowest.

We have improved in five out of the ten areas of equality, diversity and inclusion, immediate managers, morale, quality of appraisals and quality of care, with the other five remaining stable. This is a better position than the 2018 results, where we saw deterioration or no change.

Complaints, Concerns and Compliments

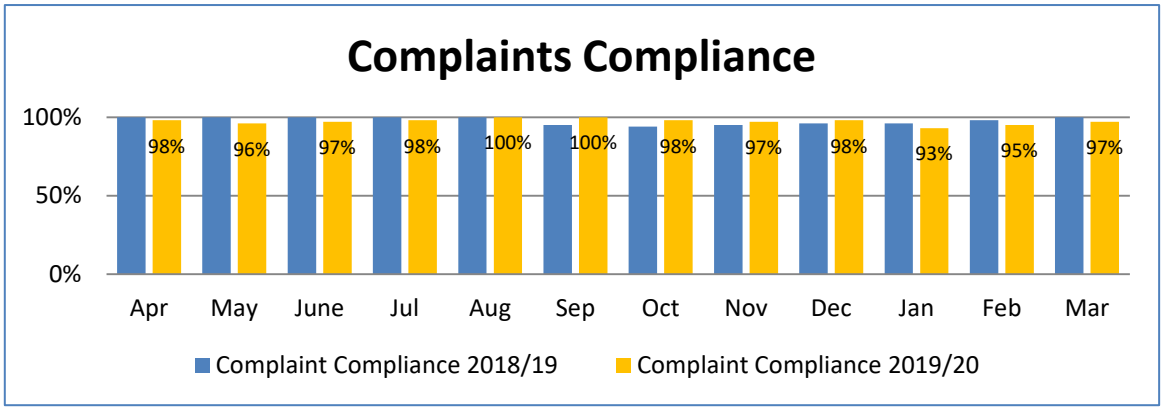
The NHS Complaints Regulations determine that we should acknowledge all complaints within three working days of receipt. In the last financial year, 99% of complaints received by our PALS Teams have had an acknowledgement within that timescale.

Second letters may be received as a result of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. Within the period 2019-20, we received 25 second letters which is a 13.79% reduction on the previous year.

During 2019-20 we had four cases where the Parliamentary Health Service Ombudsman (PHSO) determined that two complaints would be partially upheld; one not upheld and one explored and reached local resolution for the complainant. During this period the PHSO sent

final reports for seven cases and the outcome of these were two upheld; three partially upheld and two not upheld, these cases were opened prior to April 2019. A further four cases are ongoing and no final decision has yet been reached.

Figure 33 Complaints Answered within the 35 day Period 2019-20



Source: LTHTR Datix

We have had a 36.35% decrease in complaints since the previous reporting period 2018-19. When considered in terms of the ratio of complaints to patient contact, we received one complaint for every 1261 inpatient and outpatient events during 2019-20, compared to one complaint for every 1329 patient episodes during 2018-19. The trend in the ratio of complaints to patient contacts over the past four years is detailed below:

Table 19 Ratio of Complaints to Patient Contacts

Year	No of complaints	Total episodes (IP/OP)	Ratio of complaints to patient contacts
2015-16	575	808431	1:1406
2016-17	595	790696	1:1329
2017-18	553	789643	1:1428
2019-20	457	576447	1:1261

Source: LTHTR Datix

Of the 457 complaints we received in 2019-20, 372 (81%) related to care or services provided at the Royal Preston Hospital, 83 (18%) to care or services provided at Chorley and South Ribble Hospital and one (0.5%) to care or services provided offsite by the Specialist Mobility Rehabilitation Centre (based at Preston Business Centre), and a further one (0.5%) 'other' complaint.

Our complaints by Division were

- Medicine 153 (33%)
- Surgery 200 (44%)
- Women's and Children's 43 (9%)
- Diagnostics and Clinical Support 44 (9%)
- Corporate Services 15 (3%)
- Facilities and Services 2 (1%)

We closed a total of 399 formal complaints during 2019-20 of which 97% were closed within the timescales. Currently 48 complaints remain open although within permitted timescales.

The outcomes of our closed complaints were 72 (18%) were upheld, 157 (39%) were partly upheld and 169 (42%) were not been upheld. One remaining complaint was withdrawn.

Patient Experience and Patient Advice and Liaison (PALS) Service

Our Patient Experience and PALS Teams have dealt with over 2344 issues in 2019-20, which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients. This is an increase of 23.82% on the same period last year, demonstrating a positive reflection of the move to locally resolve concerns, supporting the Big Plan to promote a positive patient experience.

In 2019-20 we consistently met the 35 day target of responding to complaints. The revision and implementation of the Datix 2 Governance reporting system has enabled our Patient Experience and PALS Team to review the current management of complaints and streamline processes to achieve our targets. This development will also provide an opportunity to ensure that there is a more complete understanding of the themes and trends, not just from complaints and concerns but will include all aspects of patient experience.

Our Customer Care, PALS and Patient Experience teams have been through a transformation during 2019-20 resulting in a 'one-team' ethos with the formation of the Patient Experience and PALS Team – 'One Team'. This has allowed a clearer focus on bringing together what matters to our patients, making the complaints and raising concerns process more streamlined. This work is continuously developing and forms part of the Big Plan objectives to promote team working to achieve our ambitions, specifically to 'Deliver a Positive Experience'.

Compliments

We receive formal and informal compliments from patients and their families in relation to their experience of care. During 2019-20 a total of 5214 compliments and Thank You cards were received by wards, departments and through the Chief Executive's office.

Patient Stories

We always 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 has delivered a patient story to the Board and there have also been two staff stories. 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. The Continuous Improvement Methodology 'Big Rooms' also include patients stories at the start of every weekly session and the Divisions are using patient stories at Divisional level meetings.

Communication and Involvement in Care

Good communication is the basis of ensuring that effective patient experience is at the core of our services and key to our Patient Experience and Involvement Strategy. Our strategy involves providing opportunities for us to gather experiences from a variety of sources and enable changes to be made based on the expectations of our service users. As part of this we are working with many service areas to enhance communication with patients, carers, relatives and general visitors to our hospitals.

Our Patient Experience Improvement group provides an environment for our key stakeholders to have a voice and express what matters most to them during a hospital experience. It provides an opportunity for patients, carers and visitors to really engage with healthcare and genuinely have a voice to support our local NHS.

One of the key developments this year has been the introduction and pilot of the Patient Contribution to Case Notes (PCCN). This is a diary provided to patients to encourage them to record their experiences of care, along with noting their feelings as part of their journey. The PCCN was based on an idea of one of the Consultant Oncologists, who recognised the need to put patients at the centre of their care and treatment, based on a social model of involvement, where previously medical consideration of condition was potentially the only driver for care needs. The pilot has provided positive feedback from those who have been involved and is now being implemented in other areas of our Surgical Division and is included on the Electronic Patient Record (Quadramed) system as a requirement of the Consultant ward rounds.

We have continued to develop the NHS England Accessible Information Standard and as part of this ongoing work a flag is now on Quadramed with symbols that relate to additional needs. This will highlight to staff the need to explore these additional needs with patients and their carers to ensure that appropriate support is put in place, at the earliest opportunity.

Youth Forum

We are proud to host a Youth Forum to enable young people in the locality to come to the hospital on a monthly basis. The young people listen to the views of others and work together to make the experience of being in hospital better. Under supervision the youth walk around the areas for children and young people in hospital and have also undertaken our 15 Step Challenge on the children's ward. The Youth Forum have implemented a number of improvements including the Children's High Dependency Unit being redecorated in a beach theme and provided support packages which include craft materials for children while in hospital.

To find out more please see the video on Vimeo https://vimeo.com/385462089

Summary of Improvements from Patient Feedback

In response to feedback received in 2019-20 we have made changes in a number of areas to improve the quality of our service which have included:

- Consultation with patients and service users to change and redesign information for bereaved families.
- Therapy services to provide ward based patient services and enhanced experience.
- New Patient Magnet to signpost patients with Parkinson's disease and getting medications on time.
- Ward packs for patients with Parkinson's disease.
- Alarm clocks for medications to ensure patients who have Parkinson's disease receive their medications on time.
- AccessAble on the website for people with visual challenges and where English is not their first language.
- Involvement with World Patient Safety Day.
- Development of symbols on Quadramed for patients who have additional needs to support the NHS England Accessible Information Standard.
- Development of Easy Read information for patients.
- Outpatients Charter development.
- Digitisation of patient appointment letters.
- Purple Boxes on wards for patient with learning disabilities, dementia and mental health needs.
- Introduction of the 'Patient Contribution to Case Notes' (PCCN) diary for patients, carers and families.
- The continuation of a Carers Charter in recognition of how carers can support their loved ones whilst in hospital.
- Encouragement of patients to identify what matters most to them on any given day.
- Implementation of magnets to identify specific individualised needs of patients displayed on ward boards behind the patient's bed.
- Continuation of a Youth Forum for Children and Young People's Services.
- Continuation of involvement in the Maternity Voices Partnership involvement.
- Continuation of Purple Socks campaign to support those patients who are at risk of wandering.
- Access to the Patient Advice Liaison Service (PALS) on the Chorley Hospital site to ensure a safe, comfortable environment for patients to raise concerns.
- Increased activity and reporting of the Friends and Family Test.

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 from 2019-20 and highlighted that these priorities for improvement will continue in 2020–21, in line with the three year performance measures included in the *Big Plan*. Our account has presented a review of activity in relation to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

Our Safety and Quality Committee promote a safety and quality culture in which staff are supported and empowered to improve services and care. The committee provides the Board of Directors with assurance about 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;
- monitoring performance and progress of CQUIN programmes and contractual quality schedule indicators; and
- 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. Governors also attend our Patient Safety Collaborative and Patient Experience Improvement group as active members.

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 2019-20 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care and excellent experience.

Annex 1:
Statements from External Stakeholders

Chorley and South Ribble and Greater Preston Clinical Commissioning Groups' Response to the Lancashire Teaching Hospitals Quality Account 2019-20

NHS 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 Quality & Performance Committee and will be shared with associate commissioners.

The CCG welcomes the key priorities in the 'Big Plan' (pressure ulcer reduction, decrease in falls with harm, improvement in STAR accreditation levels and improved clinical incident reporting). The CCG acknowledge that the 'Big Plan' spans 2019-2022, and note the decrease in the number of falls with harm along with the improved levels of reported clinical incidents. Notably, pressure ulcer incidence has remained a challenge for the Trust despite a number of internal improvement programmes. The CCG would like to see further improvements in this area and support the continued focus on this.

The CQC rating in November 2019 remained as 'requires improvement' although the Trust retained their 'good' rating across the board for 'caring' and moved to a 'good' rating in well-led. It is positive to note that the Trust is addressing learning priorities at a system level via the Always Safety First collaboration and the Flow Coaching Academy. The CCG notes that they continue to receive regular updates in relation to progression of the CQC action plan and recognise the work to ensure VTE risk assessments achieve the optimum level (a CQC must do). The CCG will continue to work in partnership with the Trust to 'sense check' any improvement initiatives at their Quality Visits and will continue to focus on the hospital experience for patients requiring care within the remit of the Mental Capacity Act.

It is disappointing that 3 Never Events have been reported in 2019-20. Notably, senior medical and nursing staff continue to engage with the CCG Serious Incident Review panel, however, it would be beneficial to understand how learning from these incidents can be further embedded across the organisation. The CCG Director of Quality and Performance now attends the Trust's Safety and Quality Committee which demonstrates a high degree of collaboration and will ensure additional assurance can be gained in relation to patient safety.

The CCG acknowledges that the Summary Hospital Mortality Indicator (SHMI) remains within the expected range and the Hospital Standardised Mortality Rate (HSMR) is lower than expected. It is noted that the coding of patient deaths with palliative care is higher than the national average (acknowledging the work in relation to this from the palliative care team). The CCG would like to see an increased number of mortality reviews within the Division of Medicine in 2020-21. This will give an additional level of assurance in relation to the actions already identified as a result of 'Learning from Adult, Child and Neonatal deaths' detailed within the Quality Account.

In relation to the NHS constitutional targets; the Trust failed to achieve the A&E 4 hour standard (resulting in high numbers of patients remaining in the department for prolonged periods), 18 week referral to treatment time, 6 week diagnostic target and key cancer targets (2 week waits and 62 day treatment). The CCG recognise the impact that operational challenges have had on this performance, but also acknowledge the impact this has had on staff and patients. Notably, recent changes to working practice (as a result of COVID-19) have significantly improved the numbers of patients affected by a 'delayed transfer of care'; the CCG would like to build on this progress and further improve discharge processes for patients to ensure that these take place in a safe and timely manner.

The CCG note that the National Staff Survey highlighted improvements in a number of areas, however, it is concerning to note that staff recommending the Trust as both a place to work and as a provider of care were below the national average. The CCG recognise that, when undertaking Quality Visits, the staff have always been open, honest and caring in their interactions, consequently would like to see the progress against the Trust action plan to address staff concerns during 2020-21.

The marked increase in Freedom to Speak Up reporting would appear to demonstrate that staff feel that they have a safe route to follow should they have any concerns, although the CCG would like to understand any improvements that have been implemented as a result of this increase.

National patient surveys have highlighted variable results in relation to patient experience. Notably the Maternity Survey has scored exceptionally well with a ranking of 10th out of 63 Trusts nationally. The CCG feel this is reflective of the leadership within the midwifery team. Although the Children and Young People survey did show a slightly improved position the overall ranking was disappointing to note. The CCG acknowledge the changes that have been implemented since the survey took place and are working with the Trust to drive forward the required improvements in children's services.

The CCG welcome the contributions made to improving care from the Patient Experience Improvement Group, the Youth Forum and the pilot scheme of Patient Contribution to Case Notes. The CCG acknowledge the decrease in the numbers of complaints during 2019-20, however, feel it would be useful to detail any learning themes from complaints in order to further enhance the learning from patient feedback detailed within the Account

During 2019/20, NHS England mandated the following CQUIN schemes:

- ***Antimicrobial Resistance*** (Lower Urinary Tract Infections in Older People; Antibiotic Prophylaxis in Colorectal Surgery)
- ***Staff Flu Vaccinations***
- ***Alcohol and Tobacco*** (Screening; Tobacco brief advice; Alcohol brief advice)
- ***Three high impact actions to prevent Hospital Falls***
- ***Same Day Emergency Care*** (Pulmonary Embolus; Tachycardia with Atrial Fibrillation; Community Acquired Pneumonia)

It is acknowledged that nationally the Trust was not required to participate in CQUIN during Quarter 4, therefore, the full year impact of these schemes cannot be recognised. However, it is positive to note the high levels of staff being vaccinated for flu along with the achievements in Same Day Emergency Care; this achievement will be beneficial for patient experience and will assist with capacity challenges.

The CCG acknowledge that the Trust has faced a difficult year in relation to operational and staffing challenges, along with the requirement to work within the financial constraints of the current health economy. Notably examples of innovative practice have emerged during the COVID-19 pandemic (some of which appear to have had a positive impact on outcomes and targets). The CCG would like to build on these changes and further improve patient pathways, which are both timely and effective. We look forward to an enhanced collaborative partnership in 2020-21 which will improve the quality, safety and experience for patients within the future NHS structures.

Yours sincerely

Denis Gizzi
Chief Accountable Officer

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 2019-20 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 2019 to March 2020
    - Papers relating to quality reported to the Board over the period April 2019 to March 2020
    - Feedback from commissioners
    - 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 patient survey – 1 June 2019
    - The 2019 national staff survey – 18 February 2019
    - 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

Chairman Date: 18 June 2020

Chief Executive Date: 18 June 2020

Appendix 1

Table 20 Trust Maternity Dashboard April 2019 – March 2020

Maternity dashboard	Red flag	Green flag	Apr 2018 – Mar 2019	Apr 2019 - Mar 2020												Change on preceding 12 months
			Total	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	
Late 2nd trimester (16+0 - 23+6) singleton loss			**41**	4	1	3	5	4	3	2	4	3	3	1	2	**35**	⇩
Stillbirths rate (per 1,000 births)	>4.2	≤4.2	**3.5**	0.0	5.2	2.6	2.8	5.5	2.9	2.8	2.9	2.9	2.8	13.8	3.0	**3.8**	⇧
Intrapartum stillbirths %	>0.00 %	= 0.00%	**0.05 %**	0.0 %	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.02 %**	⇩

Table 21 Crude and Stabilised and Adjusted Mortality

For stillbirth, neonatal, and extended perinatal mortality rates excluding congenital anomalies by NHS Trust (England), Health Board (Scotland and Wales), Health and Social Care Trust (Northern Ireland), and Crown Dependency based on place of birth: United Kingdom and Crown Dependencies, for births in 2017 FOR TRUSTS AND HEALTH BOARDS WITH A LEVEL 3 NICU

Organisation	Total births[§]	Rate per 1,000 births[§]									
		Stillbirth[†]			Neonatal[‡]			Extended perinatal[†]			
		Crude	Stabilised & adjusted		Crude	Stabilised & adjusted		Crude	Stabilised & adjusted[#]		
				95% CI			95% CI			95% CI	
ENGLAND Average for comparator group			3.55			1.42			4.96		
Lancashire Teaching Hospitals NHS Foundation Trust	4,425	4.29	3.66	3.04 to 4.56	1.13	1.35	0.88 to 2.13	5.42	4.99	4.32 to 6.36	

Table 22 Maternity Specific Safety and Quality Indicators

Metric	Red flag	Green flag	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Average/ month
Births			344	382	382	358	365	340	353	346	339	359	289	337	350
Stillbirth rate (per 1,000 births)	> 4.2	≤ 4.2	0.0	5.2	2.6	2.8	5.5	2.9	2.8	2.9	2.9	2.8	13.8	3.0	3.9
Examination of the newborn completed within 72 hours	< 95%	≥ 95%	94%	99%	93%	98%	98%	96%	96%	96%	96%	96%	95%	94%	96%
Breastfeeding initiation	< 70%	≥ 70%	73%	72%	76%	73%	72%	68%	72%	70%	73%	74%	72%	75%	72%
Births per Funded clinical midwife WTE	> 28	≤ 26	26	28	29	26	27	26	26	26	25	26	23	25	26.1
Women giving birth in a midwife-led setting	< 25.0%	≥ 25.0%	22%	24%	27%	24%	25%	19%	21%	24%	21%	19%	25%	25%	23%
Home birth	< 1.7%	≥ 1.7%	2%	3%	3%	3%	4%	1%	3%	1%	2%	1%	2%	2%	2%
One-to-one care in labour in Delivery Suite	< 95%	= 100%	93%	95%	94%	98%	95%	98%	100%	98%	100%	100%	98%	98%	97%
One-to-one care in labour in Preston Birth Centre	< 95%	= 100%	91%	88%	87%	96%	95%	98%	94%	99%	98%	95%	100%	100%	95%
One-to-one care in labour in Chorley Birth Centre	< 95%	= 100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
One-to-one care in labour overall	< 95%	= 100%	92%	93%	92%	98%	95%	98%	99%	98%	99%	99%	98%	99%	97%
Supernumerary Coordinator												100%	100%	100%	100%

Table 23 Adult Safeguarding Activity

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Total safeguarding enquiries to the Team	93	25	96	38	96	40	72	23	65	43	80	26
Complex Cases currently managed by SG					6	3	5	4	4	6	5	0
Total referrals to Adult Social Care	65	22	63	19	60	22	91	42	64	22	65	22
Referrals against the Trust	10	10	10	10	9	15	19	17	14	10	*	*
No. substantiated referrals/alerts	4	3	1	2	0	4	1	0	0	0	0	0

* Data not available at this time due to Covid pressures

Glossary of Abbreviations

AHP	Allied Health Professionals
BAETs	British Association of Endocrine and Thyroid Surgeons
BAUS	British Association of Urological Surgeons
BI	Business Intelligence
BTS	British Thoracic Society
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach team
CDH	Chorley District Hospital
CDOP	Child Death Overview Panel
CMP	Case Mix Programme
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRF	Clinical Research Facility
CS	Caesarean Section
CUR	Clinical Utilisation Review
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLs	Deprivation of Liberty Safeguards
ECAP	Essentials of Care Audit Programme
ED	Emergency Department
ELC	End of Life Care
EMB	Ethambutol Endometrial Biopsy
EPMA	Electronic Prescribing and Medicines Administration
EWS	Early Warning Score
FCA	Flow Coaching Academy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up (FTSU) guardian
GIRFT	Getting It Right First Time
HDU	High Dependency Unit
HRA	Health Research Authority
HSMR	Hospital Standardised Mortality Ratio

HQIP	Healthcare Quality Improvement Partnership
IBD	Inflammatory Bowel Disease (Programme)
ICNARC	Intensive Care National Audit and Research Centre
ICU	Intensive Care Unit
IG	Information Governance
INCS	Integrated Nutrition and Communication Service
LeDeR	Learning Disability Mortality Review Programme
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MAU	Medical Assessment Unit
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MCCDs	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
ME	Medical Examiner
MEO	Medical Examiner Officer
MINAP	Myocardial Ischaemia National Audit Project
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin Resistant Staphylococcus Aureus
MSO	Medications Safety Officer
MSU	Midstream Specimen of Urine
MUST	Malnutrition Universal Screening Tool
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NACEL	National Audit of Care at the End of Life
NAOGC	National Audit of Oesophago-gastric Cancer
NASH	National Audit of Seizure Management in Hospitals
NBOCA	National Bowel Cancer Audit
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCASRI	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NELA	National Emergency Laparotomy Audit

NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NJR	National Joint Registry
NRLS	National Reporting and Learning System
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
PALS	Patient Advice and Liaison Service
PAS	Patient Administration Systems
PEWS	Paediatric Early Warning Score
PICANET	Paediatric Intensive Care Audit Network
PCCN	Patient Contribution to Case Notes
PCNL	Nephrolithotomy
PHSO	Parliamentary and Health Service Ombudsman
PMRT	Perinatal Mortality Review Tool
PQIP	Perioperative Quality Improvement Programme
PROMS	Patient Reported Outcome Measures
RCEM	Royal College of Emergency Medicine
PIR	Provider Information Request
PPH	Postpartum Haemorrhage
PREM	Patient Reported Experience Measure
PROMs	National Patient Reported Outcome Measures programme
RCOA	Royal College of Anaesthetists
RCOG	Royal College of Obstetricians and Gynaecologists
RCOPHTH	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPSYCH	Royal College of Psychiatrists
RCS	Royal College of Surgeons
RPH	Royal Preston Hospital
SAM	Society for Acute Medicine

SAMBA	Society for Acute Medicine Benchmarking Audit
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusions
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
STAR	Safety Triangulation Accreditation Review
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
TIA	Transient Ischaemic Attack
VBAC	Vaginal Birth After Previous Caesarean
VTE	Venous Thromboembolism

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW
2019-20

KPMG

Independent auditor's report

to the Council of Governors of Lancashire Teaching Hospitals Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements 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 and the Trust's affairs as at 31 March 2020 and of the Group and Trust's income and expenditure for the year then ended; and

— the Group and the Trust's financial statements 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, the NHS Foundation Trust Annual Reporting Manual 2019-20 and the Department of Health and Social Care Group Accounting Manual 2019-20.

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 and Trust 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.

Overview		
Materiality: Group financial statements as a whole	£9.0m (2019:£9.0m) 1.65% (2019: 1.86%) of operating income	
Risks of material misstatement		**vs 2019**
	Going Concern	◄►
Recurring risks	Valuation of land and building assets	◄►
	Revenue recognition	◄►
	New: Expenditure recognition	▲

2. Material uncertainty related to going concern

	The risk	Our response
We draw attention to note 1.3 to the financial statements which indicates that the Trust has planned a further deficit for 2020/21, excluding impairments and support funding, which is dependent also on the achievement of Productivity and Efficiency Target (PET) savings. Current forecasts indicate a planned deficit of £75.3m for 2020/21, including a PET target of £14.8m. In April 2020, the DHSC published reforms to the NHS Cash Regime, which include the provision for existing interim revenue loans, including working capital facilities, to be repaid through additional Public Dividend Capital (PDC) issued to providers. This would mean that £220.2 million of the Trust's outstanding loan balances with DHSC of £230.2 million will be 'converted' to PDC during 2020/21. While this mitigates the issue of viability of repayment of existing loans as at 31 March 2020, the Trust's forecasts include the receipt of additional revenue support funding of £68.6 million in 2020/21 alone. The April 2020 Cash Regime guidance referred to above confirms that any additional revenue support provided would be in the form of PDC. However, in the context of a pause in financial planning across the DHSC due to the Covid-19 pandemic and the lack of an agreed financial plan and control total, the Trust does not have any written guarantees that all required revenue support will be provided by DHSC for the foreseeable future. These events and conditions, along with the other matters explained in note 1.3, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality** The financial statements explain how the Board has formed a judgement that it is appropriate to adopt the going concern basis of preparation for the Group and Trust. That judgement is based on an evaluation of the inherent risks to the Group's and Trust financial plan and how those risks might affect the Group's and Trust's financial resources or ability to continue operations over a period of at least a year from the date of approval of the financial statements. The risk for our audit is whether or not those risks are such that they amount to a material uncertainty that may cast significant doubt about the ability to continue as a going concern. If so, that fact is required to be disclosed (as has been done) and, along with a description of the circumstances, is a key financial statement disclosure.	Our procedures included: **Funding assessment:** — We inspected and challenged the assumptions in the 2020/21 forecast to ensure that the correct assumptions were included regarding current funding arrangements and the assumptions for the remainder of the year were appropriate. — We inspected DHSC confirmations of the amount of loan to be converted to PDC post year end. **Our NHS experience:** — We assessed the likelihood of NHS Improvement transferring services to other NHS bodies using our own NHS experience. — We assessed the likelihood of DHSC providing future funding in the form of PDC. **Assessing transparency:** — We assessed the completeness and accuracy of the matters covered in the going concern disclosure.

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. Going concern is a significant key audit matter and is described in section 2 of our report. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of Land and Buildings 2019/20: £219.0 million; 2018/19: £210.9 million (net book values) *Refer to page 125 (Audit Committee Report), Note 1.11 (accounting policy) and Note 9 (financial disclosures)*	**Subjective valuation** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). A review is carried out each year to test assets for potential impairment or revaluation. The Trust's accounting policy requires an annual review for impairment, a periodic desk top valuation (at least every three years) and a full valuation (usually in five yearly intervals). The last full valuation was in 2018/19 (as at 31 March 2019). The valuation is undertaken by an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Valuations are inherently judgmental. There is a risk that the methodology, assumptions and underlying data, are not appropriate or correctly applied. In 2019/20, the Trust commissioned a desktop valuation from an external valuer as at 31 March 2020. As a result, the net book value of land and buildings assets was revised to £219.0 million. Given the materiality and the judgement involved in determining the carrying amounts of land and buildings, this has been identified as a key audit risk. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. Following RICS published guidance issued to the profession, material uncertainty clauses have been noted within valuation reports due to the impact of Covid-19. Appropriate disclosure will be required to note this uncertainty.	Our procedures included: — **Assessing valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the Department of Health Group Accounting Manual 2019/20. — **Methodology choice:** We critically assessed the assumptions used in preparing the desktop valuation of the Trust's land and buildings to ensure they were appropriate. — **Test of detail:** We critically assessed the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken. — **Accounting analysis:** We undertook work to understand the basis upon which any movements in the valuation of land and buildings had been classified and treated in the financial statements and determined whether they had complied with the requirements of the Department of Health Group Accounting Manual 2019/20, supplemented by additional guidance issued by NHS Improvement in April 2020. — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in the valuation of land and buildings. Specifically, we also considered the adequacy of disclosures made around the uncertainty caused by the Covid-19 pandemic on market data used to underpin the valuer's assumptions, and management's consideration of these factors when arriving at the year-end valuation figures.

3. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Recognition of income from patient care activities Income from patient care activities (£485.0 million; 2018/19: £440.0 million) *Refer to page 125 (Audit Committee Report), Note 1.6 (accounting policy) and Note 2 (financial disclosures).*	**Subjective estimate** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. Mis-matches can occur for a number of reasons, but the most significant arise where: — the Trust and Commissioners record different accruals for completed periods of healthcare which have not yet been invoiced; or — income relating to partially completed period of healthcare is apportioned across the financial years and the Commissioners and the Trust make different apportionment assumptions. Where there is a lack of agreement, mis-matches can also be classified as formal disputes as set out in the relevant contract.	Our procedures included: — **Test of detail:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via agreement to appropriate third party confirmations; — **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income recorded in the Trust's financial statements to the expenditure balances recorded within the accounts of Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising income from Commissioners; — **Test of detail:** We considered the impact of any identified audit adjustments on the delivery of the Trust's control total and reconciled the year-end performance to the original plan to understand any deviations.

3. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Expenditure recognition Other Expenditure (excluding staff and executive directors costs) (£207.0 million; 2018/19: £181.7 million) Accrued expenditure (Payables) (£18.1 million; 2018/19: £12.3 million) *Refer to page 125 (Audit Committee Report), note 1.10, (accounting policy) and notes 3 and 13 (financial disclosures – Annual Accounts)*	**Effects of irregularities** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of non-pay expenditure, including accrued non-pay expenditure at year-end.	Our procedures included: – **Test of detail:** We inspected all material items of expenditure in the March and April 2020 cashbooks and evaluated whether these had been accounted for correctly by reference to when the service had been delivered; – **Test of detail:** We inspected all material items of expenditure in the April 2020 bank statements to identify if there were any unrecorded liabilities that should have been accounted for in the 2019/20 financial statements; – **Test of detail:** We agreed a sample of individual accruals to supporting documentation to confirm the method of calculation and to confirm inclusion in the correct period; – **Test of detail:** We agreed a sample of journals posted before and after the year end to supporting documentation to confirm inclusion in the correct period and to critically assess whether any manual adjustments to expenditure were appropriate; – **Test of detail:** We agreed a sample of other creditor balances to supporting documentation and post year-end cash payments to agree the correct treatment as a payable at year-end; and – **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to other providers and other bodies within the AoB boundary.

4. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £9.0 million (2018/19: £9.0 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.65%) (2018/19: 1.86%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

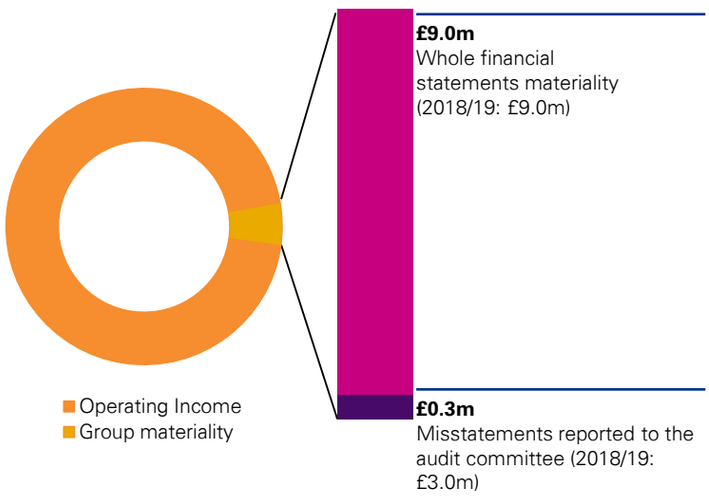
Materiality for the parent Trust's financial statements as a whole was set at £8.9 million (2018/19: £8.9 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.63%) (2018/19: 1.88%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018/19: £0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's two (2018/19: two) reporting components, we subjected two (2018/19: two) to full scope audits for group purposes. The components within the scope of our work accounted for 100% of group income, 100% of the deficit for the year, and 100% of total assets.

Operating Income
£545.9m (2018/19: £484.8m)

Group Materiality
£9.0m (2018.19: £9.0m)



5. We have nothing to report on the 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.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 88, 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 parent 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 parent 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

KPMG

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) 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.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is adverse

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we were unable to satisfy ourselves that, in all significant respects, Lancashire Teaching Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

The Trust reported a deficit of £49.6 million for the year ended 31 March 2020, and the requirement for external financial support has continued throughout 2019/20, with £59.3 million of interim revenue support loans drawn down during the year.

Due to the global Covid-19 pandemic, operational planning was suspended for 2020/21 and therefore plans were not finalised. The draft plan submitted in March 2020 indicated a forecast deficit of £75.3m, and the Trust plans to access significant further interim revenue support of £68.6 million during 2020/21.

The Trust achieved Productivity and Efficiency Target (PET) savings delivery of £12.6m in the year, compared to a target of £25.0m. Of the total delivery, around half (£6.3m) represents non-recurrent savings achieved and places additional pressures on the 2020/21 savings targets. The Trust has appropriate systems and processes for tracking and monitoring the achievement of these schemes through the year, however the timely identification of feasible savings schemes to achieve this stretching £25m target was not achieved.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions.

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 Schedule 10 paragraph 1(d), 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, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Sustainable resource deployment – management of Trust cash position and delivery of cost improvements	There is a risk that the Trust will have insufficient cash to meet its working capital requirements in 2019/20 and over the medium term. At the time of our audit planning, in month 7, the Trust reported a year-to-date operational deficit of £32.2m against a plan of £28.0m, with the key drivers of this £4.2m underperformance being additional cost pressures associated with escalated beds, reduced outpatient activity and increasing fill rates for nursing agency staff. There was consequently a significant risk that the year-end control total will not be achieved, including underperformance against PET schemes, which would likely result in a reduction in the PSF / Financial Recovery Fund (FRF) monies available to the Trust during 2019/20.	Our work included assessing the adequacy of the Trust's arrangements for: — Accessing the cash support required from the Department of Health and Social Care; — Managing working capital, including the processes for forecasting and monitoring cash flows and delivering savings; — Developing a long term financially sustainable plan for the Trust; — Identifying recurrent cost improvements and monitoring their delivery; and — Addressing slippage in PET delivery. **Our findings on this risk area:** The Trust delivered £12.6m of its required £25m cost improvement plan savings in 2019/20, with around half of this delivery relating to non-recurrent savings. The Trust has appropriate systems and processes for tracking and monitoring the achievement of these schemes through the year, however the timely identification of feasible savings schemes to achieve this stretching £25m target was not achieved. The Trust's current 2020/21 financial plans show a forecast deficit of £75m (which does not assume any receipt of PSF and FRF funding). This includes the assumption of further DHSC working capital cash support during the financial year in order to support the in-year deficit. While the cash regime guidance circulated by DHSC in April 2020 indicates that further interim revenue support will be in the form of PDC rather than loans, this will result in an incremental cost pressure arising from servicing increased PDC dividends. Without DHSC cash support, the Trust simply would not be able to continue to operate. The Trust's operating performance and the outcome of its 2019 CQC inspection indicates that there will be additional cost pressures associated with enacted the required improvements to performance, quality and safety, which will make delivery of cost improvements more challenging. Whilst the Trust and its local health economy partners have identified efficiency schemes that could support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

Significant Risk	Description	Work carried out and judgements
Informed Decision Making	The Trust continues to be listed as having additional licence conditions, issued in May 2018. These revised enforcement undertakings were put in place by NHS Improvement, which superseded those agreed in June 2015. The current undertakings relate principally to the financial sustainability of the Trust. The Trust CQC inspection report in November 2019 resulted in an overall rating of 'Requires improvement', albeit with improvements noted and the 'Well led' rating increasing from 'Requires Improvement' to 'Good'.	Our work included assessing the adequacy of the Trust's arrangements for: — Monitoring progress against the recommendations and agreed actions in response to the 2019/20 CQC report and rating of 'Requires improvement'; — Monitoring progress against the undertakings agreed with NHS Improvement in May 2018; and — Providing robust and comprehensive financial information to the Trust Board pertaining to performance against financial targets, and the reasons for shortfalls against these targets, in order to enable informed decision making to take place. **Our findings on this risk area:** We have reviewed the arrangements in place to monitor progress against the CQC's findings in its 2018 report, as well as the licence conditions refreshed in May 2018. We have considered the mechanisms through which progress in both respects is reported to the Trust Board and externally to NHS Improvement. We noted that there are appropriate arrangements in place to monitor these action plans. We have also reviewed the form and content of reporting to Trust Board around the Trust's financial position and performance. We are satisfied that appropriate reporting is available to the Board to support decision making. We are therefore satisfied that the Trust's arrangements in respect of Value for Money sub-criterion *Informed Decision Making* were adequate during 2019/20.

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 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

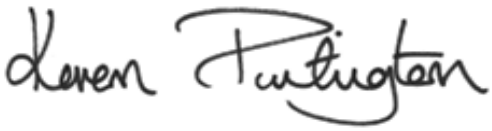
Timothy Cutler
for and on behalf of KPMG LLP

Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE
24 June 2020

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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 18 June 2020

Consolidated Statement of Comprehensive Income

		Group	
	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	2	484,994	440,040
Other operating income	2.5	60,678	44,754
Operating expenses	3	(589,545)	(524,469)
Operating deficit from continuing operations		**(43,873)**	**(39,675)**
Finance income	7.1	188	154
Finance expenses	7	(4,712)	(3,209)
PDC dividends payable		(1,203)	(2,484)
Net finance costs		**(5,727)**	**(5,539)**
Other gains	7.4	42	83
Deficit for the year		**(49,558)**	**(45,131)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	4	(1,596)	(7,755)
Revaluations		2,955	8,065
Total comprehensive expense for the period		**(48,199)**	**(44,821)**
Deficit for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(49,558)	(45,131)
TOTAL		**(49,558)**	**(45,131)**
Total comprehensive expense for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(48,199)	(44,821)
TOTAL		**(48,199)**	**(44,821)**

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. The Trust qualified for £11million of Support Funding (see note 2.5 for more information) in 2019/20 although none in 2018/19, and also received a net income of £0.1million (2018/19 £0.1million) related to donated assets. Without these elements the deficit of the Trust would have been £58.4million (2018/19 £50.4million) as shown in the table below.

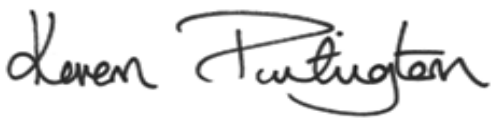
Deficit for the year	(49,558)	(45,131)
Remove support funding	(11,048)	-
Remove impairment costs	2,314	(5,249)
Remove net donated income	(133)	(64)
Revised trading deficit	**(58,425)**	**(50,444)**

The notes form part of these accounts.

Statements of Financial Position

	Note	Group 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2020 £000	Trust 31 March 2019 £000
Non-current assets					
Intangible assets	8	3,454	3,702	3,454	3,702
Property, plant and equipment	9	265,766	254,807	265,757	254,798
Receivables	11	8,501	5,840	8,501	5,840
Other assets		-	-	-	-
Total non-current assets		**277,721**	**264,349**	**277,712**	**264,340**
Current assets					
Inventories	10	15,786	14,111	14,163	13,161
Receivables	11	37,521	32,710	35,699	32,262
Cash and cash equivalents	12	7,108	2,981	6,855	2,376
Total current assets		**60,415**	**49,802**	**56,717**	**47,799**
Current liabilities					
Trade and other payables	13	(56,585)	(53,901)	(52,648)	(51,806)
Borrowings	15	(221,155)	(26,256)	(221,155)	(26,256)
Provisions	17	(526)	(791)	(526)	(791)
Other liabilities	14	(6,207)	(4,937)	(6,207)	(4,937)
Total current liabilities		**(284,473)**	**(85,885)**	**(280,536)**	**(83,790)**
Total assets less current liabilities		**53,663**	**228,266**	**53,893**	**228,349**
Non-current liabilities					
Trade and other payables	13	-	-	-	-
Borrowings	15	(10,775)	(142,584)	(10,775)	(142,584)
Other financial liabilities		-	-	-	-
Provisions	17	(3,287)	(1,532)	(3,287)	(1,532)
Other liabilities	14	-	-	-	-
Total non-current liabilities		**(14,062)**	**(144,116)**	**(14,062)**	**(144,116)**
Total assets employed		**39,601**	**84,150**	**39,831**	**84,233**
Financed by					
Public dividend capital		228,579	224,782	228,579	224,782
Revaluation reserve		46,713	46,450	46,713	46,450
Income and expenditure reserve		(235,691)	(187,082)	(235,461)	(186,999)
Total taxpayers' equity		**39,601**	**84,150**	**39,831**	**84,233**

The notes on pages 255 to 288 form part of these accounts.



Name: **Karen Partington**
Position: **Chief Executive**
Date: 18 June 2020

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
Taxpayers' and others' equity at 1 April 2019	**224,782**	**46,450**	**(187,082)**	**84,150**
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	-	-	(147)	**(147)**
Public dividend capital received	3,797	-	-	**3,797**
Taxpayers' and others' equity at 31 March 2020	**228,579**	**46,713**	**(235,691)**	**39,601**

Consolidated Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018	**222,033**	**46,914**	**(142,642)**	**126,305**
Deficit for the year	**-**	**-**	**(45,214)**	**(45,214)**
Other transfers between reserves	-	(774)	774	**-**
Impairments	-	(7,755)	-	**(7,755)**
Revaluations	-	8,065	-	**8,065**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	2,749	-	-	**2,749**
Taxpayers' and others' equity at 31 March 2019	**224,782**	**46,450**	**(187,082)**	**84,150**

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
Taxpayers' and others' equity at 1 April 2019	**224,782**	**46,450**	**(186,999)**	**84,233**
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**
Taxpayers' and others' equity at 31 March 2020	**228,579**	**46,713**	**(235,461)**	**39,831**

Consolidated Statement of Changes in Equity for the year ended 31 March 2019

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018	**222,033**	**46,914**	**(142,642)**	**126,305**
Deficit for the year	**-**	**-**	**(45,131)**	**(45,131)**
Other transfers between reserves	-	(774)	774	**-**
Impairments	-	(7,755)	-	**(7,755)**
Revaluations	-	8,065	-	**8,065**
Other recognised gains and losses	-	-	-	**-**
Public dividend capital received	2,749	-	-	**2,749**
Taxpayers' and others' equity at 31 March 2019	**224,782**	**46,450**	**(186,999)**	**84,233**

Statements of Cash Flows

	Note	Group 2019/20 £000	Group 2018/19 £000	Trust 2019/20 £000	Trust 2018/19 £000
Cash flows from operating activities					
Operating deficit		(43,873)	(39,758)	(43,873)	(39,675)
Non-cash income and expense:					
Depreciation and amortisation	3	15,565	13,236	15,565	13,236
Net impairments	4	2,314	(5,249)	2,314	(5,249)
Income recognised in respect of capital donations	3	(475)	(461)	(475)	(461)
Increase in receivables and other assets		(7,528)	(7,953)	(5,706)	(7,505)
Increase in inventories		(2,677)	(2,266)	(1,002)	(1,316)
Increase in payables and other liabilities		3,629	6,566	484	4,471
Increase in provisions		1,500	82	1,500	82
Net cash flows from / (used in) operating activities		**(31,545)**	**(35,803)**	**(31,193)**	**(36,417)**
Cash flows from investing activities					
Interest received		188	154	188	154
Purchase of intangible assets		(670)	(749)	(670)	(749)
Purchase of PPE and investment property		(24,930)	(16,143)	(24,930)	(16,134)
Sales of PPE and investment property		53	89	53	89
Receipt of cash donations to purchase assets		475	442	475	442
Net cash flows from / (used in) investing activities		**(24,884)**	**(16,207)**	**(24,884)**	**(16,198)**
Cash flows from financing activities					
Public dividend capital received		3,797	2,749	3,797	2,749
Movement on loans from DHSC		63,552	51,325	63,552	51,325
Movement on other loans		111	89	111	89
Capital element of finance lease rental payments		(803)	(747)	(803)	(747)
Interest on loans		(4,382)	(2,791)	(4,382)	(2,791)
Other interest		(3)	-	(3)	-
Interest paid on finance lease liabilities		(110)	(169)	(110)	(169)
PDC dividend paid		(1,606)	(2,339)	(1,606)	(2,339)
Net cash flows from financing activities		**60,556**	**48,117**	**60,556**	**48,117**
Increase / (decrease) in cash and cash equivalents		**4,127**	**(3,893)**	**4,479**	**(4,498)**
Cash and cash equivalents at 1 April - brought forward		**2,981**	**6,874**	**2,376**	**6,874**
Cash and cash equivalents at 31 March	12	**7,108**	**2,981**	**6,855**	**2,376**

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 2019/20 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.

The Trust has 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 are in place from 1st April to 31st July 2020, 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 have been frozen as of 31st March 2020, and will be replaced by Public Dividend Capital as at that date, in a transaction due to take place in September 2020. This means that the Trust no longer faces uncertainty regarding repayment of these previous temporary financing arrangements. The new arrangement will also provide for further PDC advances rather than loans to Trusts in financial distress, the permanent nature of 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. This work includes the acceptance of the Trust into the HIP2 capital schemes reviewing the hospital sites in the longer term although in the short term the Trust's expectation is that services will continue to be provided from the existing hospital sites.

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 forseeable 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. However the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern, and therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

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 2019/20 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 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. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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 exisitng 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 2020 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 adandoned 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	12	84
Plant & machinery	1	15
Transport equipment	6	7
Information technology	1	10
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:

	Min life Years	Max life Years
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 2020.

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 liabilites (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 FReM.

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 that the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assesment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

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 2019/20.

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 2021, 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 1.27% 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.

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)

	2019/20 £000	2018/19 £000
Acute services		
Elective income	76,719	74,980
Non elective income	139,234	120,909
First outpatient income	23,877	24,424
Follow up outpatient income	35,428	32,783
A & E income	12,801	12,601
High cost drugs income from commissioners (exc. pass-through costs)	29,709	22,071
Other NHS clinical income	148,960	143,355
All services		
Private patient income	599	481
Agenda for Change pay award central funding*	-	5,398
Additional pension contribution central funding**	14,079	-
Other clinical income	3,588	3,038
Total income from activities	**484,994**	**440,040**

* Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, 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:	2019/20 £000	2018/19 £000
NHS England	185,332	151,146
Clinical commissioning groups	295,005	279,711
Department of Health and Social Care	74	5,475
Other NHS providers	201	213
NHS other	141	-
Local authorities	-	-
Non-NHS: private patients	342	179
Non-NHS: overseas patients (chargeable to patient)	257	302
Injury cost recovery scheme	3,479	2,843
Non NHS: other	163	171
Total income from activities	**484,994**	**440,040**
Of which:		
Related to continuing operations	484,994	440,040
Related to discontinued operations	-	-

2.3 Overseas visitors (relating to patients charged directly by the provider

	2019/20 £000	2018/19 £000
Income recognised this year	257	302
Cash payments received in-year	73	33
Amounts added to provision for impairment of receivables	-	108
Amounts written off in-year	51	10

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

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	480,337	430,857

2.5 Other operating income (Group)

	2019/20 Contract £000	2018/19 Contract £000
Other operating income from contracts with customers		
Research and development	2,591	2,740
Education and training	22,100	20,009
Non-patient care services to other bodies	6,763	7,206
Provider sustainability fund (PSF)*	2,454	-
Financial recovery fund (FRF)*	5,182	-
Marginal rate emergency tariff funding (MRET)*	3,412	-
Income in respect of employee benefits accounted on a gross basis	-	-
Other income**	17,701	14,338
Other non-contract operating income		
Receipt of capital donations	475	461
Total other operating income	**60,678**	**44,754**
Of which:		
Related to continuing operations	**60,678**	**44,754**
Related to discontinued operations	**-**	**-**

* The Trust has received income from each of the Provider sustainability fund, the Financial recovery fund and the Marginal rate emergency tariff funding, together known as support funding. The equivalent funds in 2018/19 were known as Sustainability and transformation funding and the trust did not qualify to recieve any of those in that financial year.

** Items within other income that exceed £1m include:

	£000	£000
Pharmaceutical sales	2,529	2,543
Car Parking	4,339	2,950
Catering Income	1,322	1,365

3 Operating expenses (Group)

	2019/20 £000	2018/19 £000
Staff and executive directors costs (see note 5.1)	382,516	342,862
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	55,179	51,242
Supplies and services - clinical (excluding drugs costs)	49,857	46,672
Premises	29,665	25,839
Clinical negligence	18,525	19,452
Purchase of healthcare from non-NHS and non-DHSC bodies	14,971	11,389
Depreciation on property, plant and equipment	14,400	11,454
Supplies and services - general	8,524	9,662
Establishment	3,384	3,184
Net impairments	2,314	(5,249)
Transport (including patient travel)	2,149	2,091
Education and training	1,465	1,290
Amortisation on intangible assets	1,165	1,782
Other	1,007	364
Legal fees	689	571
Consultancy costs	661	778
Insurance	633	208
Inventories written down	513	9
Rentals under operating leases	491	25
Increase in other provisions	381	130
Movement in credit loss allowance: contract receivables / contract assets	286	(88)
Remuneration of non-executive directors	164	145
Research and development	152	151
Redundancy	142	-
Change in provisions discount rates	100	91
Purchase of healthcare from NHS and DHSC bodies	-	290
Internal audit costs	120	120
Audit fees payable to the external auditor	-	-
audit services - statutory audit	79	77
other auditor remuneration (external auditor only)	13	11
Total	**589,545**	**524,469**
Of which:		
Related to continuing operations	589,545	524,469
Related to discontinued operations	-	-

3 Operating expenses (Trust)

	2019/20 £000	2018/19 £000
Staff and executive directors costs (see note 5.1)	381,875	342,445
Drug costs (drugs inventory consumed and purchase of non-inventory	55,877	51,242
Supplies and services - clinical (excluding drugs costs)	49,857	46,672
Premises	29,639	25,820
Clinical negligence	18,525	19,452
Purchase of healthcare from non-NHS and non-DHSC bodies	14,971	11,815
Depreciation on property, plant and equipment	14,400	11,454
Supplies and services - general	8,532	9,652
Establishment	3,384	3,184
Net impairments	2,314	(5,249)
Transport (including patient travel)	2,149	2,091
Education and training	1,465	1,290
Amortisation on intangible assets	1,165	1,782
Other	1,010	362
Legal fees	689	522
Consultancy costs	661	778
Insurance	611	196
Inventories written down	513	9
Rentals under operating leases	491	25
Increase in other provisions	381	130
Movement in credit loss allowance: contract receivables / contract assets	286	(88)
Remuneration of non-executive directors	164	145
Research and development	152	151
Redundancy	142	-
Change in provisions discount rates	100	91
Purchase of healthcare from NHS and DHSC bodies	-	290
Internal audit costs	113	120
Audit fees payable to the external auditor		
audit services - statutory audit	79	77
other auditor remuneration (external auditor only)	-	11
Total	**589,545**	**524,469**
Of which:		
Related to continuing operations	589,545	524,469
Related to discontinued operations	-	-

3.1 Other auditor remuneration (Group)

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	11
Total	**-**	**11**

3.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

4 Impairment of assets (Group)

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,314	(5,249)
Impairments of charitable fund assets	-	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**2,314**	**(5,249)**
Impairments charged to the revaluation reserve	1,596	7,755
Total net impairments	**3,910**	**2,506**

5.1 Employee benefits (Group)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	268,633	247,377
Social security costs	28,247	25,863
Apprenticeship levy	1,454	1,275
Employer's contributions to NHS pensions	46,261	30,139
Pension cost - other	161	76
Temporary staff (including agency)	37,119	37,715
Total gross staff costs	**381,875**	**342,445**
Recoveries in respect of seconded staff	-	-
Total staff costs	**381,875**	**342,445**
Of which		
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 2019/20 there was 1 early retirement from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £8k (£180k in 2018/19).

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 rule sof the schemes can be found on the NHS Pensions website at 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 desinged 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 Governement 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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 liabilites 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 als 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%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

6 Operating leases (Group)

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	491	25
Total	**491**	**25**

	31 March £000	31 March £000
Future minimum lease payments due:		
- not later than one year;	491	25
- later than one year and not later than five years;	-	-
- later than five years		
Total	**491**	**25**
Future minimum sublease payments to be received	-	-

7.1 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2019/20 £000	2018/19 £000
Interest on bank accounts	130	154
Other finance income	58	-
Total finance income	**188**	**154**

7.2 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2019/20 £000	2018/19 £000
Interest expense:		
Interim loans from the Department of Health and Social Care	4,278	2,648
Normal course of business loans from DHSC	273	340
Other loans	58	50
Finance leases	110	169
Interest on late payment of commercial debt	3	-
Total interest expense	**4,722**	**3,207**
Unwinding of discount on provisions	(10)	2
Total finance costs	**4,712**	**3,209**

7.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under	3	-

7.4 Other gains (Group)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	42	83
Total gains on disposal of assets	**42**	**83**
Total other gains	**42**	**83**

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 £49.6million (2018/19 £45.1million). The Trust's total comprehensive expense for the period was £48.2million (2018/19 £44.8million).

8 Intangible assets 2019/20

Group & Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Gross cost at 1 April 2019 - brought forward	**15,569**	**-**	**15,569**
Additions	645	272	**917**
Gross cost at 31 March 2020	**16,214**	**272**	**16,486**
Amortisation at 1 April 2019 - brought forward	**11,867**	**-**	**11,867**
Provided during the year	1,165	-	**1,165**
Amortisation at 31 March 2020	**13,032**	**-**	**13,032**
Net book value at 31 March 2020	**3,182**	**272**	**3,454**
Net book value at 1 April 2019	**3,702**	**-**	**3,702**

Intangible assets 2018/19

Group & Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Gross cost at 1 April 2018 - brought forward	**14,820**	**-**	**14,820**
Additions	749	-	**749**
Gross cost at 31 March 2019	**15,569**	**-**	**15,569**
Amortisation at 1 April 2018 - brought forward	**10,085**	**-**	**10,085**
Provided during the year	1,782	-	**1,782**
Amortisation at 31 March 2019	**11,867**	**-**	**11,867**
Net book value at 31 March 2019	**3,702**	**-**	**3,702**
Net book value at 1 April 2018	**4,735**	**-**	**4,735**

9 Property, plant and 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
Valuation/gross cost at 1 April 2019 -	**21,830**	**189,126**	**1,986**	**107,527**	**205**	**40,062**	**1,584**	**362,320**
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)**
Valuation/gross cost at 31 March 2020	**20,395**	**192,989**	**7,888**	**115,239**	**205**	**43,573**	**1,656**	**381,945**
Accumulated depreciation at 1 April 2019 -	**-**	**2,042**	**-**	**73,157**	**147**	**30,617**	**1,550**	**107,513**
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)**
Accumulated depreciation at 31 March	**-**	**2,276**	**-**	**79,027**	**163**	**33,156**	**1,557**	**116,179**
Net book value at 31 March 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**99**	**265,766**
Net book value at 1 April 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**34**	**254,807**
Net book value at 31 March 2020								
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
NBV total at 31 March 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**90**	**265,757**

The difference between the group position (this page) and the Trust position (next page) relates to furniture and Fittings in the shops owned by the subsidiary company Lancashire Hospitals (Pharmacy) Limited shown in the shaded column above

9 Property, plant and equipment - 2019/20

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 -	**21,830**	**189,126**	**1,986**	**107,527**	**205**	**40,062**	**1,575**	**362,311**
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)**
Valuation/gross cost at 31 March 2020	**20,395**	**192,989**	**7,888**	**115,239**	**205**	**43,573**	**1,647**	**381,936**
Accumulated depreciation at 1 April 2019 -	**-**	**2,042**	**-**	**73,157**	**147**	**30,617**	**1,550**	**107,513**
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)**
Accumulated depreciation at 31 March	**-**	**2,276**	**-**	**79,027**	**163**	**33,156**	**1,557**	**116,179**
Net book value at 31 March 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**90**	**265,757**
Net book value at 1 April 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**25**	**254,798**
Net book value at 31 March 2020								
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
NBV total at 31 March 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**90**	**265,757**

9 Property, plant & equipment - 2018/19

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
Valuation / gross cost at 1 April 2018 - as	**21,830**	**176,539**	**201**	**99,742**	**205**	**34,934**	**1,538**	**334,989**
Additions	-	10,250	1,785	7,944	-	5,128	21	**25,128**
Impairments	-	(7,907)	-	-	-	-	-	**(7,907)**
Reversals of impairments	-	152	-	-	-	-	-	**152**
Revaluations	-	10,092	-	-	-	-	-	**10,092**
Reclassifications	-	-	-	(25)	-	-	25	**-**
Disposals / derecognition	-	-	-	(134)	-	-	-	**(134)**
Valuation/gross cost at 31 March 2019	**21,830**	**189,126**	**1,986**	**107,527**	**205**	**40,062**	**1,584**	**362,320**
Accumulated depreciation at 1 April 2018 -	**-**	**1,834**	**-**	**67,229**	**129**	**28,694**	**1,523**	**99,409**
Provided during the year	-	3,430	-	6,074	18	1,923	9	**11,454**
Impairments	-	1,849	-	-	-	-	-	**1,849**
Reversals of impairments	-	(7,098)	-	-	-	-	-	**(7,098)**
Revaluations	-	2,027	-	-	-	-	-	**2,027**
Reclassifications	-	-	-	(18)	-	-	18	**-**
Disposals / derecognition	-	-	-	(128)	-	-	-	**(128)**
Accumulated depreciation at 31 March	**-**	**2,042**	**-**	**73,157**	**147**	**30,617**	**1,550**	**107,513**
Net book value at 31 March 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**34**	**254,807**
Net book value at 1 April 2018	**21,830**	**174,705**	**201**	**32,513**	**76**	**6,240**	**15**	**235,580**
Net book value at 31 March 2019								
Owned - purchased	21,830	185,340	1,986	32,305	51	9,445	34	**250,982**
Finance leased	-	758	-	-	-	-	-	**758**
Owned - donated	-	986	-	2,065	7	-	-	**3,058**
NBV total at 31 March 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**34**	**254,798**

9 Property, plant & equipment - 2018/19

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as	**21,830**	**176,539**	**201**	**99,742**	**205**	**34,934**	**1,538**	**334,989**
Additions	-	10,250	1,785	7,944	-	5,128	12	**25,119**
Impairments	-	(7,907)	-	-	-	-	-	**(7,907)**
Reversals of impairments	-	152	-	-	-	-	-	**152**
Revaluations	-	10,092	-	-	-	-	-	**10,092**
Reclassifications	-	-	-	(25)	-	-	25	**-**
Disposals / derecognition	-	-	-	(134)	-	-	-	**(134)**
Valuation/gross cost at 31 March 2019	**21,830**	**189,126**	**1,986**	**107,527**	**205**	**40,062**	**1,575**	**362,311**
Accumulated depreciation at 1 April 2018 -	**-**	**1,834**	**-**	**67,229**	**129**	**28,694**	**1,523**	**99,409**
Provided during the year	-	3,430	-	6,074	18	1,923	9	**11,454**
Impairments	-	1,849	-	-	-	-	-	**1,849**
Reversals of impairments	-	(7,098)	-	-	-	-	-	**(7,098)**
Revaluations	-	2,027	-	-	-	-	-	**2,027**
Reclassifications	-	-	-	(18)	-	-	18	**-**
Disposals / derecognition	-	-	-	(128)	-	-	-	**(128)**
Accumulated depreciation at 31 March	**-**	**2,042**	**-**	**73,157**	**147**	**30,617**	**1,550**	**107,513**
Net book value at 31 March 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**25**	**254,798**
Net book value at 1 April 2018	**21,830**	**174,705**	**201**	**32,513**	**76**	**6,240**	**15**	**235,580**
Net book value at 31 March 2019								
Owned - purchased	21,830	185,340	1,986	32,305	51	9,445	25	**250,982**
Finance leased	-	758	-	-	-	-	-	**758**
Owned - donated	-	986	-	2,065	7	-	-	**3,058**
NBV total at 31 March 2019	**21,830**	**187,084**	**1,986**	**34,370**	**58**	**9,445**	**25**	**254,798**

10 Inventories

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Drugs	4,332	3,567	2,709	2,617
Work In progress	-	-	-	-
Consumables	11,328	10,422	11,328	10,422
Energy	126	122	126	122
Total inventories	**15,786**	**14,111**	**14,163**	**13,161**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £68,041k (2018/19: £63,428k). Write-down of inventories recognised as expenses for the year were £513k (2018/19: £9k).

11 Receivables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Contract receivables	29,878	28,872	29,878	28,424
Contract assets	2,279	4,391	2,279	4,391
Allowance for impaired contract receivables/assets	(2,993)	(4,192)	(2,993)	(4,192)
Prepayments	2,493	2,681	2,479	2,681
PDC dividend receivable	392	-	392	-
VAT receivable	2,810	732	1,002	732
Other receivables	2,662	226	2,662	226
Total current receivables	**37,521**	**32,710**	**35,699**	**32,262**
Non-current				
Contract assets	7,929	5,840	7,929	5,840
Allowance for other impaired receivables	(1,728)	-	(1,728)	-
Other receivables	2,300	-	2,300	-
Total non-current receivables	**8,501**	**5,840**	**8,501**	**5,840**
Of which receivable from NHS and DHSC group bodies:				
Current	24,395	23,224	24,395	23,224
Non-current	1,300	-	1,300	-

11.1 Allowances for credit losses

	Group		Trust	
2019/20	**Contract £000**	**All other £000**	**Contract £000**	**All other £000**
Allowances as at 1 Apr 2019 - brought forward	**4,192**	**-**	**4,192**	**-**
New allowances arising	301	-	301	-
Changes in existing allowances	(11)	-	(11)	-
Reversals of allowances	(4)	-	(4)	-
Utilisation of allowances (write offs)	243	-	243	-
Allowances as at 31 Mar 2020	**4,721**	**-**	**4,721**	**-**

	Group		Trust	
2018/19	**Contract £000**	**All other £000**	**Contract £000**	**All other £000**
Allowances as at 1 Apr 2018 - restated	**-**	**4,556**	**-**	**4,556**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	4,280	(4,556)	4,280	(4,556)
Changes in existing allowances	(88)	-	(88)	-
Allowances as at 31 Mar 2019	**4,192**	**-**	**4,192**	**-**

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	
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
At 1 April	**2,981**	**6,874**	**2,376**	**6,874**
Net change in year	4,127	(3,893)	4,479	(4,498)
At 31 March	**7,108**	**2,981**	**6,855**	**2,376**
Broken down into:				
Cash at commercial banks and in hand	18	18	18	18
Cash with the Government Banking Service	7,090	2,963	6,837	2,358
Total cash and cash equivalents as in SoFP	**7,108**	**2,981**	**6,855**	**2,376**
Total cash and cash equivalents as in SoCF	**7,108**	**2,981**	**6,855**	**2,376**

13 Trade and other payables

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Trade payables	13,185	18,254	9,283	16,168
Capital payables	12,706	11,064	12,706	11,064
Accruals	18,140	12,316	18,105	12,316
Social security costs	3,923	3,692	3,923	3,685
Other taxes payable	3,532	3,408	3,532	3,408
PDC dividend payable	-	11	-	11
Other payables	5,099	5,156	5,099	5,154
Total current trade and other payables	**56,585**	**53,901**	**52,648**	**51,806**
Of which payables from NHS and DHSC group bodies:				
Current	6,698	5,045		
Non-current	-	-		

14 Other liabilities

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	6,207	4,937	6,207	4,937
Total other current liabilities	**6,207**	**4,937**	**6,207**	**4,937**

15 Borrowings

	Group & Trust	
	31 March	31 March
Current	**£000**	**£000**
Loans from DHSC	220,249	25,129
Other loans	390	324
Obligations under finance leases	516	803
Total current borrowings	**221,155**	**26,256**
Non-current		
Loans from DHSC	9,987	141,325
Other loans	308	263
Obligations under finance leases	480	996
Total non-current borrowings	**10,775**	**142,584**

The DHSC has confirmed that existing interim loans will be repaid during 2020/21 by means of PDC advance to the Trust. Therefore all such loans have been re-classified as payable wihtin one year at the balance sheet date.

Reconciliation of liabilities arising from financing activities (Group & Trust)

2019/20	**Loans from DHSC £000**	**Other loans £000**	**Finance leases £000**	**Total £000**
Carrying value at 1 April 2019	**166,454**	**587**	**1,799**	**168,840**
Cash movements:				
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)**
Non-cash movements:				
Application of effective interest rate	4,551	58	110	**4,719**
Other changes	-	3	-	**3**
Carrying value at 31 March 2020	**230,236**	**698**	**996**	**231,930**

2018/19	**Loans from DHSC £000**	**Other loans £000**	**Finance leases £000**	**Total £000**
Carrying value at 1 April 2018	**114,617**	**498**	**2,542**	**117,657**
Cash movements:				
Financing cash flows - payments and receipts of principal	51,325	89	(747)	**50,667**
Financing cash flows - payments of interest	(2,741)	(50)	(169)	**(2,960)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	168	-	58	**226**
Application of effective interest rate	2,988	50	169	**3,207**
Other changes	97	-	(54)	**43**
Carrying value at 31 March 2019	**166,454**	**587**	**1,799**	**168,840**

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 2020	31 March 2019
	£000	£000
Gross lease liabilities	**1,077**	**1,938**
of which liabilities are due:		
- not later than one year;	570	880
- later than one year and not later than five years;	507	1,058
Finance charges allocated to future periods	(81)	(139)
Net lease liabilities	**996**	**1,799**
of which payable:		
- not later than one year;	516	803
- later than one year and not later than five years;	480	996

17 Provisions for liabilities and charges analysis - Group & Trust

	Other	Total
	£000	£000
At 1 April 2019	2,323	**2,323**
Change in the discount rate	100	**100**
Arising during the year	1,814	**1,814**
Utilised during the year	(281)	**(281)**
Reversed unused	(133)	**(133)**
Unwinding of discount	(10)	**(10)**
At 31 March 2020	**3,813**	**3,813**
Expected timing of cash flows:		
- not later than one year;	**526**	**526**
- later than one year and not later than five years;	**842**	**842**
- later than five years.	**2,445**	**2,445**
Total	**3,813**	**3,813**

Clinical negligence liabilities
At 31 March 2020, £345,889k was included in provisions of NHS Resolution in respect of clinical

18 Contingent assets and liabilities

	Group & Trust	
	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(166)	(159)
Gross value of contingent liabilities	**(166)**	**(159)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(166)**	**(159)**
Net value of contingent assets	**-**	**-**

19 Post Balance Sheet Events

There are no post balance sheet events

20 Contractual capital commitments

	Group & Trust	
	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	27,337	10,100
Total	**27,337**	**10,100**

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, seperation 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 consititution
- 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

	Income	Expenditure	Receivable	Payable
	£000	£000	£000	£000
East Lancashire Hospitals NHS Trust	1,640	5,006	1,159	1,330
Health Education England	20,675	207	284	-
HM Revenue and Customs	-	29,701	1,002	7,454
NHS Blackburn with Darwen CCG	5,728	-	172	51
NHS Blackpool CCG	9,526	-	77	455
NHS Chorley and South Ribble CCG	106,354	50	2,110	439
NHS East Lancashire CCG	9,564	7	64	220
NHS England	185,111	1	10,207	1
NHS Fylde and Wyre CCG	21,038	-	382	-
NHS Greater Preston CCG	122,119	49	3,592	-
NHS Morecambe Bay CCG	12,746	35	117	126
NHS Pension Scheme	-	46,261	-	4,387
NHS Resolution	-	18,914	-	-
North West Ambulance Service NHS Trust	60	270	7	64

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:

	Income	Expenditure	Receivable	Payable	Relationship
	£000	£000	£000	£000	
Chorley Borough Council	1	-	-	-	Member of Council of Governors
Lancashire County Council	2	49	5	22	Member of Council of Governors
Preston Council	-	-	-	75	Member of Council of Governors
South Ribble Borough Council	4	-	1	19	Member of Council of Governors
UCLAN					Member of Council of Governors

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 2020, 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	231	200	8
The Rosemere Cancer Foundation Charity	1131583	295	265	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 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	**40,327**	40,327	**40,327**
Cash and cash equivalents	6,855	**6,855**	6,855	**6,855**
Total at 31 March 2020	**47,182**	**47,182**	**47,182**	**47,182**

Carrying values of financial assets as at 31 March 2019	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	32,940	**32,940**	32,940	**32,940**
Cash and cash equivalents	2,376	**2,376**	2,376	**2,376**
Total at 31 March 2019	**35,316**	**35,316**	**35,316**	**35,316**

22.2 Carrying values of financial liabilities (Group)

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	**230,236**	230,236	**230,236**
Obligations under finance leases	996	**996**	996	**996**
Other borrowings	698	**698**	698	**698**
Trade and other payables excluding non financial liabilities	45,193	**45,193**	45,193	**45,193**
Provisions under contract	-	**-**	-	**-**
Total at 31 March 2020	**277,123**	**277,123**	**277,123**	**277,123**

Carrying values of financial liabilities as at 31 March 2019	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	166,454	**166,454**	166,454	**166,454**
Obligations under finance leases	1,799	**1,799**	1,799	**1,799**
Other borrowings	587	**587**	587	**587**
Trade and other payables excluding non financial liabilities	44,702	**44,702**	44,702	**44,702**
Provisions under contract	-	**-**	-	**-**
Total at 31 March 2019	**213,542**	**213,542**	**213,542**	**213,542**

22.3 Maturity of financial liabilities

	Group		Trust	
	31 March £000	31 March £000	31 March £000	31 March £000
In one year or less	266,347	70,958	266,347	70,958
In more than one year but not more than two	4,165	75,809	4,165	75,809
In more than two years but not more than five	4,848	50,286	4,848	50,286
In more than five years	1,763	16,489	1,763	16,489
Total	**277,123**	**213,542**	**277,123**	**213,542**

23 Losses and special payments

	2019/20		2018/19	
Group and trust	**Total Number**	**Total value £000**	**Total Number**	**Total value £000**
Losses				
Bad debts and claims abandoned	1,148	466	233	40
Total losses	**1,148**	**466**	**233**	**40**
Special payments				
Ex-gratia payments	65	12	76	14
Total special payments	**65**	**12**	**76**	**14**
Total losses and special payments	**1,213**	**478**	**309**	**54**

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 £000	31 March £000
Bank balances	6	4
Monies on deposit	-	-
Total third party assets	**6**	**4**

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

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